



Adapting to home care in Norway: A longitudinal case study of older Adults' experiences

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ABSTRACT

This study aimed to describe how older adults with complex health problems manage their everyday lives in their own homes and how they interact with given home care. In this multiple-case study, a total of 14 individual interviews were conducted with five older adults over the course of one year. Deductive and inductive content analyses were performed. Three descriptive categories were each identified in the deductive ('home care as interpersonal continuity', 'home care as information continuity' and 'home care as management continuity') and inductive analyses ('Lack of social contact with carers', 'Desire to be heard throughout the care process' and 'Carers are short on time'). Quality home care services are difficult to realize if interpersonal interaction is subordinated to effective task-solving.

Introduction

One of the global strategies for aging well is to provide reliable health services for long-term care in the home, in the community and in institutions (World Health Organization, 2017). Similar to other Western countries, Norway substantially invests in home-based care (Asadzadeh, Maher, Jafari, Mohammadzadeh, & Hosseini, 2022), with the aim of enhancing the quality of life of older adults (van Leeuwen et al., 2019) as well as reducing the pressure on hospitals and care institutions (Mah, Stevens, Keefe, Rockwood, & Andrew, 2021). Despite a downward trend in practical assistance and a modest increase in home nursing care recipients in the last decade, the rising life expectancy is anticipated to create a substantial demand for home nursing care among Norwegian seniors (Chang et al., 2023). However, it is also acknowledged that several obstacles, including inadequate interaction (Hestevik, Molin, Debesay, Bergland, & Bye, 2019; Kumlin, Berg, Kvigne, & Hellesø, 2020), a shortage of healthcare personnel (Veenstra & Gautun, 2021), and variations in the services provided by municipalities (Rostad, Burrell, Skinner, Hellesø, & Sogstad, 2023), already pose challenges in

meeting the complex healthcare needs of older adults (McGilton et al., 2018).

Continuity of care

Continuity is a multifaceted concept and considered crucial for high-quality services, including care for older adults (Roland, Mayor, & Morris, 1986). An association between continuity of care and health outcomes has been reported in the literature. For example, a high level of continuity can result in a high level of satisfaction and perceived quality of health care, especially among people with long-term illness (Sparbel & Anderson, 2000; Van Walraven, Oake, Jennings, & Forster, 2010). A changed healthcare system, especially the shift in focus from inpatient to outpatient treatment, has led to increasing attention being paid to continuity of care. The shift in focus has increased the number of actors involved in older adults' care and thus also increased the risk of fragmented care (Gautun, Bratt, & Billings, 2020). Nursing literature emphasises the importance of a consistent approach by nurses where care is adapted based on the people's changing needs during illness

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(Hansen et al., 2012). According to Haggerty et al. (2003), changed processes in care pathways or case management are not synonymous with continuity. For continuity to exist, care must be experienced as coherent and cohesive. In the research literature, there are three reasonably well-defined dimensions of continuity, which are partly overlapping and interdependent: information continuity, management continuity and relational continuity (Haggerty et al., 2003; Meiqari, Al-Oudat, Essink, Scheele, & Wright, 2019).

Municipal health and care services in Norway

The municipalities' responsibility for care services for older adults can generally be divided into two main areas: home-based care and institutional care.

Nursing homes include different types of housing adapted for people with special needs regarding support and service. The accommodation can either be owned by the municipality or be organised as a tenant-owner association. The duration of home care for people in need of round-the-clock care depends on individual needs, and care homes are adapted for people with special needs in terms of support and/or service.

Home nursing care includes help with medication/medication management, wound care and observations. Other home health services include physiotherapy and occupational therapy. In Norway, home care is usually provided by registered nurses, while practical assistance, including help with personal and instrumental activities of daily living, is provided by nursing assistants. In many municipalities, however, it looks different, which means that home care is characterized by a relatively large similarity between nurses and other care staff. An important reason for this is the differences that exist between different parts of the country depending on demography, geography, and availability of personnel since large parts of Norway have a small population that is spread over large geographical areas, which makes it difficult for skill requirements regarding care for older adults. This means that nurses often engage in tasks that do not necessarily require nursing skills, while other health professionals are trained to perform a relatively large number of "nursing tasks".

To enhance the quality of municipal health and care services, continuity, in the form of various qualities, has been a goal in several White papers over the past decade. One White paper has followed another, emphasizing the need for care services to be individually and holistically designed so that older individuals can experience life as coherent and meaningful. For instance, in 'Future Care' (Norwegian Ministry of Health and Care Services, 2013) elements such as culture, meals, activities and well-being are central and fundamental elements of what health and social care should offer. The reform stresses that both physical and social activities are of the utmost importance for good care and that attention should be paid to the older adult's social, existential and cultural needs. Despite this clear political statement, most of the focus seems to be on healthcare activities and less focus on social activities for older adults, as also shown in the literature (Munkejord, Schönfelder, & Eggebø, 2018).

The White paper 'The primary health and care services of tomorrow – localized and integrated' was published in 2014 to accommodate recurring problems with the lack of person-centred orientation and fragmented services in the Norwegian primary healthcare system (Norwegian Ministry of Health and Care Services, 2014). Recent summarized research shows that the goals are far from being reached. For example, Hestevik et al. (2019) demonstrate that older adults experience unsafe transitions between the hospital and home, rely on family members for care tasks, and encounter services characterized by paternalistic approaches. The more recent White papers, 'A full life – all your life' (Norwegian Ministry of Health and Care Services, 2018) and 'Community and mastery - Live safely at home' (Norwegian Ministry of Health and Care Services, 2022) emphasise that older people should be able to lead meaningful and independent lives in their own homes for as long as possible, while also having access to the necessary health

services. The goals outlined in these strategies are relatively similar to the previous ones, underscoring their importance and the challenges in achieving them. From the perspective of health authorities, services characterized by continuity provide stable treatment situations and predictability for older adults (World Health Organization, 2017). In contrast, a fragmented healthcare system lacking good continuity and coordination increases the risk of harm due to communication errors, inadequate exchange of clinical information, poor medication coordination, and a higher likelihood of hospitalizations or readmissions (Øvretveit, 2011). A lot of effort has been invested in creating integrated health services, but the primary focus of research has been on measures targeting specific diagnoses (Lee, Yang, & Cho, 2022). Studies that consider the complexity of the typical situations of older adults are still lacking (Lee et al., 2022).

New insights are required to enable the interaction between the old adult and home carers as well as to promote adaptation to older adults' own homes after discharge from the hospital. Therefore, this study aimed to describe how older adults with complex health problems manage their everyday lives in their own homes and how they interact with given home care.

Material and methods

Study design

This case study is part of a larger project with the aim of providing new knowledge about service coordination and factors that promote or restrict municipal variation. A longitudinal multiple-case study with a qualitative approach was conducted to explore the unique and shared experiences of older adults in their real-life context, a context over which the researchers had minimal control (Yin, 2014). The present study was based on the cases of five older adults who received home nursing care after hospitalization. Their data were obtained from repeated qualitative interviews (Brinkmann & Kvale, 2015) over a period of 12 months. The five cases were selected from a main sample of nine cases, whose data were obtained from qualitative interviews with both family members and health personnel in addition to the older adults themselves. The five cases based on the older adults' perspectives were deemed typical on the basis of assessments of representativeness, wealth of information, and suitability to answer the study's aim.

Data collection

Because case studies are only analytically generalizable (Yin, 2014), purposive sampling was applied. To ensure a robust database, we recruited the participants via literal replication by collecting cases that would predict similar results and theoretical replication by selecting cases that would predict contrasting results for predictable reasons (Eisenhardt & Graebner, 2007; Yin, 2014), such as different municipality variables. The participants were recruited in Central Norway through managers in home care services, and an inquiry was made to municipalities of different sizes and centralities. Fifteen municipal heads for health services were approached, of whom nine agreed to have the research conducted in their municipality. The inclusion criteria for the participants were as follows: age of ≥ 65 years, hospitalization during the last three months, home nursing care with a minimum of two visits daily, and cognitive ability to consent to participation. We decided not to set criteria for the number of diagnoses. In dialogue with the managers who assisted in the recruitment, we communicated our expectation that the scope of home care services also reflected multimorbidity and complex need for help among potential participants. People who met the inclusion criteria were contacted by the researchers, who then provided verbal and written information about the study and explained the value of participation. Inclusion in the study required the participants' written consent. Along with explanation of the study information, each participant received a letter informing them that participation was

voluntary and that their contribution would be confidential and non-identifiable. The older adults also had to consent to the researchers being able to invite their next of kin and responsible health personnel to interviews. A total of nine older adults agreed to participate. Present paper is based on the cases of five of these people, including three men and two women who were aged 65–91 years and lived in small (<5000 inhabitants) and medium-sized municipalities (5000–20,000 inhabitants). Table 1 shows the characteristics of the participants. To ensure good research ethics and personal data handling, the study was assessed by the Norwegian Agency for Shared Services in Education and Research (ID: 579218).

Interviews

The participants were followed for 12 months, and semi-structured interviews were conducted three times during this period with four participants. One participant died before the third interview could be conducted and was therefore interviewed on two occasions only. The total data set consisted of 14 interviews. The interviews were conducted as conversations, and questions were formulated such that relevant information could be obtained and the participants would be encouraged to share their thoughts and feelings with the researcher (Yin, 2014).

The interviews were conducted by two authors (TMN and SAD) based on the participants’ preferences regarding place and time. The participants were asked to speak about the following themes: (i) hospitalization and how they felt after they got home, (ii) help they get from the home care service and (iii) thoughts about their involvement in care and treatment.

During the interview, the interviewer tried to avoid interrupting the participants as much as possible to provide them the opportunity to tell their story in their own words and concentrate on what they thought was important. The total length of the 14 interviews ranged between 113 and 242 min (median = 181 min). Each interview was digitally recorded and transcribed verbatim after the interview. The interviews were conducted between autumn of 2020 and 2022, and owing to the ongoing COVID-19 pandemic, six of the interviews were conducted digitally with Teams telephony (audio only, no video).

Data analysis

To deal with the large amount of data collected during the study, we considered the final reporting of the results in the analysis stage to achieve optimal readability of the results (Yin, 2014). Initially, we read and assessed the content of all nine cases but ultimately selected five typical cases as the subjects of formal analysis. These cases were chosen

to provide a fair representation of context and quotes while serving as representative examples for the others that were not included in the presentation. The purpose of the analysis was twofold: (i) to describe the message in the texts and (ii) to identify a structure for the presentation and readability of the interview texts. In the analysis, it was important to focus on each case. A qualitative content analysis (Elo & Kyngäs, 2008) consisting of an initial deductive approach followed by an inductive approach was performed. To answer the purpose of the study, we used the concept of continuity as a lens.

The analysis began as a within-case analysis, ensuring that the collected data were analysed with a sense of coherence, that is, an effort to understand each case’s story and how well the interpretation does justice to the case and answers the research question (Møller & Skaaning, 2017). After the first step, a cross-case analysis was performed, focusing on similarities and differences between the cases with the aim of producing a synthesized result to build a body of knowledge from the explored cases (Khan & VanWynsberghe, 2008).

The participants conveyed their thoughts and experiences about how receiving home care affected their lives. The analysis was conducted in two distinct phases: deductive and inductive. This methodological integrative and iterative approach has been sparsely described in the nursing literature. However, some new research, including that by Andersson, Sjöström-Strand, Willman, and Borglin (2015) and Hellzén, Alm, and Malin Holmström (2022), has described content analysis procedures that use theory as a grid for analysing textual data. According to Elo and Kyngäs (2008), the greatest advantage of content analysis is its flexibility in terms of research design, and the application of deductive and/or inductive methods must be determined on the basis of the research purpose.

Deductive phase

Deductive content analysis is useful when research on a phenomenon can benefit from further description (Elo & Kyngäs, 2008). In the deductive phase herein, a structured categorization matrix was developed (Elo & Kyngäs, 2008). The matrix was based on Sparbel and Anderson (2000) of the concept of continuity of care, which was further developed by Haggerty et al. (2003) and Wierdsma, Mulder, de Vries, and Sytema (2009) as three qualitatively different but intertwined dimensions: interpersonal continuity, information continuity and management continuity. The categorization matrix was used in the analysis as a lens that formed domains under which the data were sorted. The analysis began with several readings of the transcripts to allow familiarization with the material and obtain an overview of the texts; thereafter, the transcripts were carefully studied for content and text

Table 1
Profile of the participants.

Participant	Age (y)	Sex	Marital status	Living status	Home nurse visits	Home care assistance	Diagnosis, self-reported
Case 1, Geir	88	Male	Married	Cohabitation	Two times daily	Personal hygiene Medication	Diabetes and dizziness
Case 2, Olav	65	Male	Unmarried	Living alone	Two times daily	Personal hygiene Eating Mobilization Medication	Urinary tract infections and heart problems
Case 3, Anne	72	Female	Unmarried	Living alone	Six times daily	Personal hygiene Medication Eating Stoma care	Heart and stomach problems
Case 4, Ragnhild	91	Female	Widowed	Living alone	Three times daily	Personal hygiene Eating Toileting Mobilization Medication	Leukaemia and poor eyesight and hearing
Case 5, Ketil	76	Male	Married	Living alone	Four times daily	Personal hygiene Medication Eating Dialysis	Failing kidney function, diabetes and dizziness

corresponding to the categorization matrix, selected, coded and transferred to relevant descriptive categories in the matrix. This phase of the analysis was completed to expand the participants' descriptions of how they perceived continuity of care. The first author conducted the analysis, and two other authors reviewed, discussed and refined the results.

Inductive phase

The inductive analysis (Graneheim & Lundman, 2004) started with several open readings of the texts, which were transferred to gain an expanded understanding, that is, that which goes beyond the previous categorization of the texts in the deductive analysis. First, the texts were read several times to grasp the content and to identify 'meaning units' corresponding to the second sub-goal of the study. Second, the sentence units were condensed, with the core preserved. Third, the condensed sentence units were coded. The codes were abstracted, compared in relation to differences and similarities, and sorted into subcategories and categories to gain further understanding and perspective on the participants' view of continuity of care in relation to received home care. The analysis steps were performed for each identified domain in the deductive analysis, indicating that three separate inductive analyses were performed, one for each domain. The inductive analysis yielded three identified generic categories. The first author conducted the analysis, while the other authors acted as co-analysts during the analysis. The codes, subcategories and categories were reflected and discussed with all authors, resulting in a consensus on the findings to increase reliability.

Results

The results showed that the included cases reflected the content of the three domains that described continuity of care to varying degrees. The analysis, focusing on home care, mainly emphasised the older adult's quest to meet the carer behind the profession. The older adults tried to gain an understanding and knowledge about how the care provider balanced between supporting the care recipients' physical, social, and environmental needs and, based on this knowledge and understanding, supported the care.

The deductive analysis revealed that the data reflected the content of the three descriptive categories, which are summarized in Table 2.

Among the matrix's three descriptive categories of continuity of care, interpersonal continuity could be considered the older adults' aspiration to be seen as unique and treated holistically by care providers in the care encounter. Information continuity represented continuity of care as the participants' desire to be informed and involved in their own care, while management continuity represented continuity of care as the participants' will to be able to navigate in an organization that is not

Table 2
Summary of the deductive analysis based on the matrix dimension.

Home care as interpersonal continuity	Home care as information continuity	Home care as management continuity
"This is a small municipality, so it is rare that some unknown nurses visit me. It has probably happened, but then they come here together with someone I know and it becomes more like an introductory visit". (Case 2)	"I usually get information via SMS ... about doctor's visits and the like. Otherwise, there is not much written information, no, it is digital. After all, I have the phone number of the home care nurses, so I can just call them if there's anything". (Case 1)	"Yes, I have been sent to the hospital many times with dangerously low levels of potassium ... I regularly take blood tests. Last time, I didn't realize anything until the taxi was suddenly here (at my apartment) to pick me up. Then someone had called from the doctor's office where I take blood tests to the hospital and ordered a taxi because I had to be admitted for treatment". (Case 3)

completely comprehensible to them. The analysis further showed that continuity of care was intertwined with the context in which it took place. Continuity of care was perceived by the participants as a dynamic contextual intervention that took place in a complex interaction with and in relation to the care provider and the context in which the care took place.

Categories and subcategories emerged from the inductive analysis of the interviews with the participants (Table 3). In the interviews, the participants reflected on their experiences of how they managed their everyday lives and how they interacted with given home care.

The stories were seen as complex because there were several factors that affected the everyday life of the participants: complex health problems and their treatment and care, living status (4 alone and 1 together in their own residences), and home care assistance. The participants were all unique with their unique life stories were characterized by a life situation with complex health problems. The participants' general health was affected by physical impairment to varying degrees. The participants expressed great gratitude regarding the home care and support they received in everyday life.

The within-case analysis generated substantially similar experiences and categories for each case. The results of the cross-case analysis with divergent categories are presented below. In this study, all health professionals were referred to as 'carers' regardless of their level of education, as employees in home care services have different educational backgrounds. Fictitious names were used to refer to the participants in the text. The cross-case analysis revealed three main interrelated categories representing the findings from all five cases: *Lack of social contact with carers*, *Desire to be heard throughout the care process* and *Carers are short on time*, which are summarized below.

Table 3
Sample results of the inductive analysis.

Meaning unit	Code	Sub-category	Category
"I have to make sure that the elastic stockings are taken off in the evening, as they are not to be worn at night. It is difficult for me to take them off myself, it is not possible. It all depends on who comes on the night. So, some fix it, while others don't, then I have to fix it myself..." (Case 4)	Need help	Must ask for help	Lack of social contact with carers.
"Well, I have to say I've become a bit sceptical ... my GP seems to have noticed this. Now that I suffer so much from vertigo, I think it might have something to do with ... with the accident ... they haven't figured out what's causing the dizziness, they don't know what it is, but it could be coming from the neck. And I told the doctor that too. I'm thinking maybe I should have some physical therapy, but it doesn't matter what I say..." (Case 1)	Sceptical	Do not listen to me	Desire to be heard throughout the care process.
"They look more at the clock than at me. No, they don't have time to sit down and chat ... I'd rather not have that discussion with them ... it's better to just let them manage and complete the tasks" (Case 2)	Stress	Constantly looking at the clock	Carers are short on time.

Category 1: Lack of social contact with carers

This category refers to events in the participants' new situation at home after discharge from the hospital. All participants began their stories by talking about the last hospital stay and the time after they came home from the hospital. In some cases, hospitalization was seen as a turning point that made them feel more vulnerable and in greater need of help from others. "It is not easy to go from being completely self-sufficient to receiving help from others" (Case 1, Geir).

The increased vulnerability was a turning point in their life situation, wherein the home carers bridged the gap between the vulnerability and enabling them to live as good a life as possible through their home visits. All participants emphasised that they were generally satisfied with the support they received from the carers who visited them. Without their help, they would not be able to cope with their everyday life.

The participants were sometimes satisfied with the help they received during the home health nurses' home visits and felt that on such occasions, the nurses had good knowledge about their problems. They knew what to do when they arrived, which the participants experienced as feeling safe. "I know them (the carers) well and feel safe with them. It is true. I have nothing bad to say about them, no ... I'm happy with them" (Case 5, Ketil).

On other occasions, the participants were not satisfied with the help they received. They sometimes felt neglected, and one participant expressed irritation and disappointment that the carers seemed overly focused on tasks to be carried out. "They look more at the clock than at me. No, they don't have time to sit down and chat ... I'd rather not have that discussion with them ... it's better to just let them manage and complete the tasks" (Case 2, Olav).

Another participant disliked that the carers did not always knock or ring the doorbell but simply walked straight into her apartment. "I'm used to you knocking on the door – they come right in, unlock, and go inside. I don't dare to undress when I wash myself, because suddenly the door can open, and someone is standing there" (Case 3, Anne).

However, most participants felt that the time at home could be difficult. Even though they were physically well cared for, four participants said they felt lonely. They felt that the predictability and quality of the care encounter depended entirely on which carer came to visit. "Some carers usually have time to sit down ... others never do" (Case 4, Ragnhild).

Although the participants were generally satisfied with the help they received, they did not always feel well emotionally. In the stories, three participants who lived alone, highlighted an ever-present feeling of loneliness that plagued them and a worry that everything could suddenly end, a worry that usually affected them in the evenings and nights. "...It usually goes well, and it feels safe to have a security alarm if the worry becomes too troublesome" (Case 2, Olav).

However, the carers were not frequently the preferred choice for support and security when loneliness and worry became too troublesome. Olav (Case 2) lived alone and had no family members in the immediate vicinity. In the interviews, Olav said that his greatest support came from his personal assistant¹, whom he primarily used to call when he needed help or when life at home became too difficult.

¹ The person referred to here was employed as a user-controlled personal assistant where the older person acts as the employer. In this case, the assistant was a person who lived in the neighborhood and was a former acquaintance of the older adult, not a trained health professional/carers. More information about the User-controlled Assistance scheme in Norway can be found on this website: The Norwegian Directorate of Health. User-controlled personal assistance. [Internet]. Oslo: The Directorate of e-health; updated Friday, February 18, 2022 [retrieved Monday, January 29, 2024]. Available from: <https://www.helsenorge.no/en/help-services-in-the-municipalities/user-controlled-personal-assistance/>

Category 2: Desire to be heard throughout the care process

The participants stressed the importance of carers listening and taking their opinions into account. Often, the dissatisfaction was about an early bedtime in the evening when they wanted to stay up longer. For example, Ragnhild (Case 4) expressed that she was dissatisfied that she had to go to bed for the night too early and that she wanted to decide this herself.

The participants also argued that it was not entirely apparent that they could influence healthcare. "No, I don't think I can decide that much myself. There is a difference between the carers, it depends on who I ask ... the younger ones are stricter than the older ones..." (Case 4, Ragnhild).

The opportunities to influence the treatment of diseases or conditions were also not apparent. This was noted in the interview when Geir (Case 1) spoke of his disability with dizziness: "No, I don't really feel like they're listening to me ... If they had listened to me, they would have sent me to a physiotherapist, I think."

Carer continuity was perceived as good with a few staff changes, which indicated that the participants usually met the same carers every week. All participants stressed that they knew the carers well and that it was usually the same carers who visited them. However, during the pandemic, the situation was difficult. "I thought everyone was the same, they wore masks, and it was hard to see who was coming" (Case 5, Ketil).

All participants felt that there was a large individual difference between the carers and their willingness to listen to the participants. They said that most carers were usually in a hurry, which led to them doing only the tasks that were scheduled.

In the interviews, the participants also said that they believed that the collaboration between the general practitioner (GP) and the carers did not always work well. The participants perceived that the time for GP visits was too short and believed that the carers did not always communicate their observations to the GP before the visit. One of the participants' experiences was that the responsibility of providing the GP with information fell entirely to him. He felt that there was insufficient time for the GP visit.

"You usually don't just have one problem; you have a lot of problems. Yes, when you get old, there will be a few more problems over time. But the GP would rather not have more than one question at a time, you know. If your foot hurts, there is no more time to talk about anything else" (Case 1, Geir).

In terms of physician continuity, all participants emphasised that it was not good because doctors were constantly coming and going. "I've had several different doctors ... The one I have now is young and inexperienced. I don't trust her, but I'm glad she at least listens to me, which is more than I can say for my previous GPs" (Case 1, Geir).

The participants said that they never complained about this but felt that the lack of stability when it came to GPs had a negative impact on the cooperation and contact between GPs and carers in home care.

Category 3: Carers are short on time

After hospital discharge, home care usually worked well. The participants reported that communication between the home carers worked well and that they rarely or never forgot any planned care work activity. However, all participants agreed that the carers had work schedules that were too tight, which indicated that the time they could spend caring for the participants was limited. "When you're here, it's boring, you just sit and stare at the wall. I can walk in the hallways here, but ... I'm not very good at walking, so it's not that enticing. Sometimes I miss company, someone to chat with" (Case 5, Ketil).

The participants felt that the nurses' schedule was too restrictive and that there was rarely time for a quick chat with the nurses; the carers usually focused only on care activities. "... They must do their job and get everything written down ... they have a list they're constantly looking at..." (Case 4, Ragnhild).

Ragnhild observed that the carers were very careful about signing in and out of the home visit by registering their mobile phone via a quick response (QR) code on the wall by the front door. The carers were very concerned with this to avoid exceeding the time allotted for the assignment.

All participants felt that there was a large individual difference between the carers and their willingness to listen to the participants. They said that most carers were usually in a hurry, which led to the carers doing only the tasks that were scheduled. The participants argued that the carers looked more at the work schedule and time and the practical tasks than at them and their individual needs, including social contact to break the feeling of loneliness.

“I could have imagined that there would have been time to sit down and talk a little then. But they haven’t. They say they just must move on. And so, they go...” (Case 4, Ragnhild).

In general, the participants felt that the work of the home carers was hampered by the lack of coordination owing to the lack of time and the bureaucratic system they had difficulty navigating, as it was too complicated and therefore, difficult to understand. The system required much patience from the participants, which was characterized by long waiting times. For example, Olav (Case 2) reported that it took three months to complete the backrest for his wheelchair because the carers were not allowed to arrange it themselves, as it was a case that had to go through the help centre. “Most of the time it works, but I get tired of nagging ... You must be patient, it takes energy...” (Case 2, Olav).

Discussion

This study aimed to describe how older adults with complex health problems manage their everyday lives in their own homes and how they interact with the home care provided to them. The results of the inductive content analysis indicated that the participants understood continuity of care based on their view of home care. The findings offer an alternative and sometimes contrasting perspective to Sparbel and Anderson (2000) of continuity of care in the matrix used in the deductive analysis, which both provided an increased understanding of care provided.

Home care as interpersonal continuity vs. Lack of social contact with carers

The category *Lack of social contact with carers* reflected the participants’ perceptions of the encounter with the home care staff. The category described how the participants perceived the importance of the relationship with home carers and how they expected to be treated in their homes. The analysis showed that the participants wanted not simply care efforts but also social interaction from the carers. The participants expected to meet a competent carer who would carry out care tasks in a professional manner but also wanted to experience community and foster a social togetherness to reduce participants’ sense of loneliness and thus increase feelings of security. According to Haggerty, Roberge, Freeman, and Beaulieu (2013), interpersonal continuity is the dimension of continuity of care most valued by both carers and patients.

Our findings suggest that interpersonal continuity can be negatively affected by carers’ approach in the encounter. The participants in the study emphasised the importance of face-to-face interaction with their carer. This finding indicates the positive effect of social interaction in a caring relationship, which is something more than just performed care activities. Therefore, face-to-face interaction should be seen as a fundamental value that is central to people’s health and well-being (Martinsen, 2005; Martinsen, Kjær, & A., 2012). Our findings also suggest that carers have little time to take care of social needs in encounters with older adults, despite the knowledge that loneliness and isolation may lead to reduced well-being and poor health (Courtin & Knapp, 2017) and the risk that the encounter may turn into what Rosa and Wagner (2019) named a mute relationship (i.e., just about “doing”), a

concept close to what Martinsen (2005) framed as uncaring. Lack of attention to the social needs of older people and task-oriented care can have different explanations. Home care, like other care contexts, is characterized by a lack of qualified personnel, especially Registered Nurses (Gautun, 2020; Veenstra & Gautun, 2021). At the same time, the work intensity in the context is increasing, and a perceived mismatch between resources and tasks can lead to certain tasks being prioritized over others (Helgheim & Sandbaek, 2021). In home care, health care is also provided based on decisions that concretize and operationalize the health care that the individual is to receive in the form of tasks (Holm, Mathisen, Sæterstrand, & Brinchmann, 2017). Relational tasks are often omitted (Sworn & Booth, 2020). In home care, driving between assignments in the homes also takes time away from what can be used for direct care tasks. Face-to-face contact with the recipients is reduced, and nurses are the group of carers who spend the least time on this task (Helgheim & Sandbaek, 2021). Carers’ social competence is also important, which includes the ability to communicate at different levels, adapted to the individual and the context in order to achieve person-centred care (McCormack & McCane, 2010). Based on the participants’ perspectives, it is therefore important that carers are present both physically and emotionally during the encounter (i.e., not only actively occupied by the activity of care but also passively present in the encounter) (Rørtveit et al., 2015; Rosa & Wagner, 2019).

The analysis indicated that the participants believed that the caring encounter enabled good physical care but that issues of social interaction and equality in care were not prioritized by the carers. The participants emphasised the importance of the carer not only having a commitment to the encounter but also having an open and inviting attitude (i.e., the carer listened and looked at the participant as a subject). Several participants provided examples to the contrary during the interviews. For example, Anne (Case 3) reported that the carers did not show her respect by not knocking on the door before they visited her; she felt that she was seen more as an object than a subject in the encounter in her home. The participants also emphasised that a mute encounter (Rosa & Wagner, 2019) did not apply to all carers but was completely dependent on which carer visited them. Accordingly, close and personal caring relationships appear as a prerequisite for being able to provide good, accessible, and equal home care.

Home care as information continuity vs. Desire to be heard throughout the care process

The category *Desire to be heard throughout the care process* reflected the participants’ desire to be involved in their own care and the expectation of being enabled to make informed choices. Our results are contrasting. The participants met carers who strived to look after their best interests, stood by their side and responded to their desire to be involved and well informed about their own care. Meanwhile, although the participants felt that continuity and their involvement were good with a low staff turnover rate, they complained that some carers were too much in a hurry and did not have time to listen. Participation extended to issues relating to postponing bedtime for the night. The participants noted that they seldom felt heard or were actively encouraged to contribute suggestions or input regarding their medical treatment. Typically, their involvement hinged on the older adult initiating the discussion themselves. Research has shown that being dependent on the help of others and not being involved in one’s own care can be important factors for reduced quality of life among older adults (Ostaszkiwicz, O’Connell, & Dunning, 2012).

According to Moe, Hellzen, and Enmarker (2013), older adults emphasise the importance of being involved in the decision-making process around their own care so that they can influence care planning. Being an active participant in one’s own care is described by Breitholtz, Snellman, and Fagerberg (2013) as being in control of the situation. However, the participants in our study argued that their experience of continuity of contact with the doctor was poor owing to

the high doctor turnover rate, a reality that is common in sparsely populated municipalities (Marchand & Peckham, 2017). The participants experienced this situation but did not complain. However, they believed that they could express their own thoughts towards home care providers, indicating the possibility of their own participation, an issue that Sundler, Hjertberg, Keri, and Holmström (2020) believed is up to the carer to enable.

Home care as management continuity vs. Carers are short on time

In the category *Carers are short on time*, care was described as different care efforts based on the individual needs and preferences of the participants. The interventions were designed to support the participants. However, contextual conditions seemed to limit the carers' ability to establish care interventions based on individual needs. The analysis showed that the participants had difficulties in understanding the structures of which home care was a part and experienced the system as challenging to navigate. Challenges in comprehending the interconnections within the organization may have contributed to the older adults finding it easier to focus their attention on close relationships, specifically personal meetings with carers.

Our data showed that continuity of care existed somewhere between the participants' care needs and the contextual conditions under which the given care took place. The requirement to be able to balance these factors affected the participants' ability to receive care based on their needs and resources, which could lead to unexpected situations arising in the care encounter. As an example, Geir (Case 1) reported that the responsibility for the transfer of information to the doctor depended on him instead of the carer. In this category, the descriptions reflected a home care that lacked flexible structures adapted to the participants' needs. The carers did not always consider the participants' needs, which indicated that the participants had to learn which of the carers they could turn to. In home care, various forms of intervention are needed, as many older adults in municipalities have an extensive need for care (Nordin et al., 2017). Returning to one's own home has been reported as something positively associated with recovery, independence, and personal control (Slatyer et al., 2013). However, our findings indicated that homecoming posed a challenge since the system utilised delayed and complicated various forms of support to manage the participants' everyday life (Dossa, Bokhour, & Hoenig, 2012).

The participants felt that the home care organization was complicated and, therefore, difficult for them to handle. They reported that care was not always tailored to their individual needs, leading to a sense of loneliness, as it prevented them from engaging in different activities. The time pressure on the carers implied that they only had time for care efforts and not for social activities or personal interactions. The loss of social life can create negative consequences, such as feelings of loneliness (Andreasen, Lund, Aadahl, & Sørensen, 2015). The fact that doctors came and went was also highlighted by some participants as a problem. Difficulties in recruiting doctors are reported in the literature as a common problem in sparsely populated areas (Marchand & Peckham, 2017). It is, therefore, reasonable to assume that difficulties with physician recruitment may be a contributing factor to perceived physician discontinuity. The carers' increasingly time-optimized work schedules were also perceived as a problem for the participants because the carers had no time for anything other than scheduled activities. According to Rosa (2017), time optimization risks yielding a carer who is not present in the here and now, in what they do or in the relationship with people. Time optimization creates a mute relationship, as it risks leading not only to a distinction to the activity but also to other people (e.g., older adults) (Rosa, 2017; Rosa & Wagner, 2019). Our study showed that not all carers were restricted by their time schedules as some were able to see meaning in the encounter with the participants. In these instances, the mute relationship breaks, and the relationship becomes not only about quantity but also about quality; consequently, individual older adult's needs are considered whereby a mutual

relationship can emerge (Martinsen et al., 2012), an especially valuable aspect of home care for isolated or lonely people.

Our study focused on how older adults with complex health problems interact with home care and how they adapt to their homes after hospitalization. The participants experienced continuity of home care as dynamically and contextually intertwined with the context in which it took place and in the interaction between themselves and the carer. The participants' needs included not only physical needs but also psychosocial ones, as shown in the inductive analysis. Other studies have shown similar results. For example, Rogers, Hwang, Scott, Aiken, and Dinges (2004) reported that carers' working conditions in the form of time optimization affect the quality and safety of given care. Our study showed that safety seemed to primarily involve function, including various care and support activities. Participants, on the other hand, appeared to prioritize personal needs, such as social interaction and security. The time factor of time-optimized work schedules appears to contribute to this issue, not only reducing the well-being of older adults but also creating a dilemma for carers (Nässén, Gillsjö, & Berglund, 2023). Increasing the task load during the same time-period and tidying how long activities are allowed to take may risk the carers distancing themselves from people and thus not fully seeing their needs (Blomberg, 2013).

Conclusions

Although the encounter between older adults and their home carer is fundamentally asymmetrical, a reasonable condition is that both of them can be heard – a partnership and an asymmetric reciprocity can occur (Nortvedt and Grimen, 2004). It is reasonable to consider participation as a democratic issue. If such a perspective is adopted, government reforms (Norwegian Ministry of Health and Care Services, 2013, 2014, 2018) become mere signal policies. A central issue with this perspective is that reforms alone are not enough; they must also be actively followed up and evaluated at the municipal level. Therefore, it seems important that the levels of awareness and knowledge of the importance of social interaction are increased at both personal and structural levels within home care (Munkejord et al., 2018). Further research, especially qualitative research, is required to gain a deeper understanding of the needs of older adults with complex health problems receiving home healthcare.

Methodological considerations

The purpose of case studies, including qualitative studies in general, is not to generalize but to generate knowledge about unique conditions and experiences in specific contexts (Yin, 2014). This contributes insights that expand our existing understanding and are transferable to larger contexts (Thorne, 2020). According to Giddens (1984), assessing the transfer value of the study is possible when well-constructed cases allow us to view the microscopic (local) as macroscopic (global).

The quality of case study research is not solely determined by the number of participants or cases (Hamel, Dufour, & Fortin, 1993). Equally crucial is the construction of the cases (Hamel, Dufour, & Fortin, 1993) and the power of the data, combined with researchers' reflexivity and their ability to contextualize findings within existing knowledge and established theories (Malterud, Siersma, & Guassora, 2016). In the construction of the present case study, we prioritized representativeness in relation to the research question to be answered. Further, the information power was enhanced by conducting repeated interviews over a one-year period during data collection. Moreover, the authors, with backgrounds as both academic and clinical nurses, enriched the interpretive work and understanding of the field. Their experiences in home nursing care added a valuable dimension to the application of established theory.

Transparent and detailed descriptions of the cases were sought, and the findings were supported with quotes from the participants. The use

of Teams telephony for some interviews may have impacted communication, potentially due to challenges in hearing and comprehending the other person's speech without the benefit of non-verbal cues for confirmation. Further studies could focus on investigating older adults with complex health problems in other sparsely populated areas in accordance with our inclusion criteria.

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CRedit authorship contribution statement

Ove Hellzén: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Tove Mentsen Ness:** Writing – review & editing, Methodology, Investigation, Formal analysis, Data curation. **Kari Ingstad:** Writing – review & editing, Methodology, Investigation, Formal analysis, Conceptualization. **Mette Spliid Ludvigsen:** Writing – review & editing, Methodology, Investigation, Formal analysis, Conceptualization. **Ann Marie Nissen:** Writing – review & editing, Methodology, Investigation, Formal analysis. **Siri Andreassen Devik:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

All authors declare no potential competing interest.

Data availability

The data that has been used is confidential.

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