

This is an electronic reprint of the original article. This reprint may differ from the original in pagination and typographic detail.

Working in home healthcare and suggestions for development

Vaartio-Rajalin, Heli; Näsman, Yvonne; Santamäki Fischer, Regina; Hemberg, Jessica

Published in:
Home Health Care Services Quarterly

DOI:
[10.1080/01621424.2019.1641450](https://doi.org/10.1080/01621424.2019.1641450)

Published: 01/01/2019

Document Version
Accepted author manuscript

Document License
CC BY-NC-ND

[Link to publication](#)

Please cite the original version:
Vaartio-Rajalin, H., Näsman, Y., Santamäki Fischer, R., & Hemberg, J. (2019). Working in home healthcare and suggestions for development. *Home Health Care Services Quarterly*, 38(4), 257–269.
<https://doi.org/10.1080/01621424.2019.1641450>

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Working in home healthcare and suggestions for development

Vaartio-Rajalin, Heli*, RN, PhD, Adjunct professor, Researcher *a, b*

Näsman, Yvonne, RN, PhD, University lecturer *a*

Santamäki-Fischer, Regina, RN, PhD, Academy lecturer *a*

Hemberg, Jessica PHN, RN, PhD, University lecturer, *a*

a) Faculty of Education and Welfare Studies, Åbo Akademi University, Strandgatan 2, 65100 Vasa, Finland

b) Bachelor of Healthcare, Nursing, Novia University of Applied Sciences, Henriksgatan 7, 20500 Åbo, Finland

* Corresponding author:

Heli Vaartio-Rajalin

Åbo Akademi University, Department of Caring Science

Strandgatan 2, 65100 Vasa

Finland

Telephone: +358 50 3427164

E-mail address: hevaarti@abo.fi

Acknowledgements: -

Source of funding: -

Conflict of Interest: Authors have no conflicts of interests to state

ABSTRACT

In order to describe nurses' experiences of working in home healthcare and their suggestions for the development of this public healthcare sector, interviews with 18 home healthcare nurses were analyzed with qualitative thematic content analysis. The nurses perceived the working shifts either affirmative or non-affirmative, depending on the contextual and organizational factors affecting nurses' workload. The more the nurses perceived they could influence their work, the more engaged they were in patient-related nursing activities, patient-centeredness, collaboration and forward planning. Several concrete suggestions for the development of home healthcare on the organizational, interprofessional, team and individual levels were given.

Keywords: home healthcare, working experiences, shifts, interviews, suggestions for development

1. INTRODUCTION

As in all developed countries, the Nordic countries are experiencing challenges due to the growing number of older persons, many of whom suffer from multiple diagnoses including dementia. New diagnosis techniques and treatments facilitate the care and treatment of multi-diagnosis patients, even up to a great age. To control increasing healthcare costs, the trend in health and social care today is to transfer the care of patients, even those with complex needs, from institutions to patients' homes (Vehko, Sinervo, & Josefsson, 2017).

For patients, early discharge from hospital can lead to unnecessary suffering and readmission if their social or healthcare needs are not answered to. In Finland, about 400 000 persons over 75 years of age are discharged from hospital to home annually. Of these, half require several home care visits per day and 96% need help with their everyday life. However, during the four months following discharge, 30% do not receive any help from social or healthcare services. (Kehusmaa, Mäkelä, & Heikkilä, 2018.) This care discrepancy could reflect that the number of professionals working in home care in Finland has decreased while the number of persons needing help has increased (Vehko, Sinervo, & Josefsson, 2017) and that the possibility for informal, family caregiver-care has diminished (Rostgaard & Szebehely, 2012), which both affect the available resources negatively. One can argue that these persons discharged from hospitals to their homes choose not to receive help, but half of them were found to suffer from cognitive impairment due to age (Kehusmaa, Mäkelä, & Heikkilä, 2018) making them vulnerable with regard to informed consent to hospital discharge and home health care.

For home care leaders and staff, this results in increased pressure: on the planning, coordination, deliverance and assessment of high-quality person-centered home healthcare

that guarantees patient safety yet is simultaneously cost-effective. To date, there is little research on home care staff's experiences of their work (Vaartio-Rajalin & Fagerström, 2018).

2. BACKGROUND

Home care or home care services can be defined as professional care provided at home to patients with formally assessed needs, including primary and rehabilitative nursing care, domestic aid and respite care provided to informal caregivers (Genet et al., 2011). Home healthcare or home nursing care (hereafter HHC) encompasses a range of activities, from preventive-health work to palliative care, all with the goal of enhancing patients' functional health status and quality of life (Brazil et al., 2012). In Finland both long-term and short-term HHC services are available. These can include care for persons with complex needs, e.g., 24-hour support after hospital discharge, or occasional help for relatively simple tasks, e.g., domestic aid for frail older people or adults with a handicap (Ministry of Social Affairs and Health, 2017). Furthermore, during the past two decades various private hospital-in-home services have emerged to answer the need for somatic, psychiatric and palliative HHC services at an advanced level (Vaartio-Rajalin & Fagerström, 2018).

Similar to Sweden and Denmark (Rostgaard & Szebehely, 2012), public healthcare in Finland is available to all permanent residents regardless of financial situation. Primary healthcare services, such as HHC services, are provided through municipal health centers (Expat Finland, 2018). In most municipalities, HHC has been combined with home care services. Traditionally, the aim of HHC has been to facilitate discharge from hospital to home and prolong individuals' prospects of living at home, even for those with chronic conditions. HHC

has generally been offered when other healthcare services have been inconvenient or unsuitable for individuals with altered functional capacity or somatic illnesses, and it has been based on physician-ordered interventions and the monitoring of medicine compliance and patients' clinical condition. HHC has also included social services, e.g., the provision of functional support for activities of daily living. Older persons have typically comprised the majority of HHC patients, but working age individuals, families with ill children and terminal-phase patients are also included. (Ministry of Social Affairs and Health, 2018.)

HHC is realized in home visits, during which patients experience certain events that can threaten their dignity, integrity, autonomy and trust in nursing care (Holmberg, Valmari, & Lundgren, 2012). In their study in long-term settings Koskenniemi, Leino-Kilpi and Suhonen (2014) saw that nurses' respect for patients was expressed through *being* and *doing*. When respect was not shown, nurse-patient understanding was non-existent, and patients were not active in own care. Thus, we maintain that the ethical principles of autonomy, integrity and dignity can be seen as the core of patient-centeredness.

In the assessment of service delivery quality, patient-centered care is an important outcome that should be measured (Brazil et al., 2012). Stewart et al. (2006) identified six dimensions part of patient-centered care: (i) exploring both the disease and the illness experience; (ii) understanding the whole person; (iii) finding common ground regarding management; (iv) incorporating prevention and health promotion; (v) enhancing the provider-patient relationship; and (vi) being realistic about personal limitations and issues such as the availability of time and resources. In a scoping review, Vaartio-Rajalin and Fagerström (2018, n = 35 papers) found that while patient-centeredness appeared to be one aim of professional HHC, the concept did not explicitly emerge in relation to the recruitment of patients or the

planning or evaluation of HHC. Accordingly, Turjamaa et al. (2015) explored the content of HHC patients' electronic care and service plans and found that most of the care and service plans (n = 437) they reviewed were designed from HHC professionals' point of view and that patients' perspectives were lacking. In their study, Larsen, Broberger and Petersson (2017) found a lack of a holistic view and risks for fragmented home care due to different healthcare provider documentation systems within interprofessional collaboration. This may be one reason why more IT-related employee stress is seen in HHC than long-term care. (Vehko, Sinervo, & Josefsson, 2017.)

Researchers have raised several concerns about the HHC workforce, particularly RNs, in relation to turnover and clinical training, e.g., skilled areas of care (e.g., Pittman, Horton, Terry, & Bass 2014). In Europe, it is not thought that HHC residencies will be systematically included in nursing education (EFN-European Federation of Nurses Associations, 2015), even though many nursing students work at HHC during school breaks. This could stem from assumptions that HHC work is non-challenging and entails only the provision of primary care (Björk, Berntsen, Brynildsen, & Hestetun, 2014). Vehko et al. (2017), however, found that HHC employees are required to take a greater degree of responsibility for their work when compared to workers in institutional settings, and that employee engagement and a positive psychological state of presence in one's work role were of particular relevance in the HHC context. They revealed that how HHC is organized has a huge impact on how stressful service providers perceive their work to be, and the more HHC nurses can influence their work, the less stressed and more engaged they are. (Vehko et al., 2017.)

In a recent report for the Finnish National Institute for Health and Welfare, Kehusmaa et al. (2017) concluded that the current staff and nursing resources are not sufficient in HHC. In

Norway, Vik and Eide (2012) explored how HHC providers perceived their working conditions. In their study, high nursing workload emerged as a core category that described service providers' experiences of a stressful workday. Fagerström and Vainikainen (2014) found that nursing workload can be defined as the sum of direct and indirect patient-related nursing activities, non-patient nursing activities, and central non-patient factors: those personal/nurse-related, contextual, and/or organizational factors that may affect nurses' experiences of their nursing workload. These are organization of work (planning of work schedules; staff substitutes; meetings and training events; nursing students), working conditions (working environment; telephone traffic; information technology; interruptions), self-control (control of own work; hurry/rush; mental stress; and own work capacity), and cooperation (with physicians; with other staff; with own group).

3. DESIGN AND METHODS

The aim of this study was to describe nurses' experiences of working in home healthcare and their suggestions for the development of this public healthcare sector.

Study design

In this study a cross-sectional descriptive design was employed, and the setting comprised two municipal HHC organizations in Finland.

The sample

In autumn 2017, nursing students (n = 18) taking a healthcare administration course part of a Master's level Caring science degree program in Finland collected data at two municipal HHC organizations.

Data collection

To collect the data, the Master's students engaged in the one-to-one non-participatory observation of HHC nurses' (n =18) work during 2-3 work shifts per nurse. This observational data has also been investigated in another study, which is awaiting publication. The Master's students also conducted short (about 10 minutes) semi-structured interviews with the HHC nurses at the end of work shifts or when travelling between patient homes. During their interviews, the HHC nurses were asked three questions about their experiences and perceptions of the actual work shift and suggestions for the development of HHC: How did you experience this actual working shift? What was good and what was bad during this shift? What would you suggest to develop HHC? The interviews were tape-recorded. The HHC nurses' demographic data included their educational level, year nursing degree was awarded and work experience at HHC in years.

Data analysis

The transcribed interview data were analyzed with inductive thematic content analysis (Burns & Grove, 1997). As units of analysis, words, sentences and thought units related to the research questions were sought. The data were first simplified and the units of analysis then compared to one another, in a search for similarities and differences. Similar units of analysis, i.e., themes, were then compared to subcategories, and the subcategories to the main categories that described the HHC nurses' experiences of working and their suggestions for development of this public healthcare sector. For intercoder reliability and trustworthiness the analyses were first conducted by the Master's students during the course, then validated by their course administrators (YN, RSF), and later the raw data was independently analyzed by researcher (HVR).

4. RESEARCH ETHICS

The organizations overseeing data collection procedures in Finland categorized this study as a quality improvement project, and therefore no external ethical committee evaluation was necessary. The ethical principles delineated by the Finnish National Board on Research Integrity (TENK, 2012) were followed during the entire course of the study, including informant recruitment, data collection, data analysis and publication.

The HHC nurses received information about the study from their respective leaders and were given an informed consent letter to fill in, providing agreement to participate in the study. The information sheet contained information about the aim of the study, quality improvement process, data collection procedures, respondents' right to self-determination and aspects of confidentiality. The HCC nurses also received information about who to contact for additional information. All HCC nurses given information about the study agreed to participate. The HCC nurses were guaranteed anonymity, and all information relating to their identity was coded in the data analysis and removed from the research report.

The interview transcriptions were collected in separate boxes, and the recorded interviews saved on a USB flash drive. All data were and are safely stored in a locked filing cabinet at University. The data will not be used for any other purposes other than what was agreed upon with the respondents prior to data collection.

5. RESULTS

The HHC nurses' (n = 18) background data are presented in **Table 1**. Their educational level is not presented in detail due to their right to anonymity and integrity. All of the respondents had a professional nursing education, and the majority (56%) had one or more specializations,

such as public health nurse, midwife, internal medicine and surgery, or acute care. The HHC nurses received their nursing degrees between 1987-2017, with the majority (85%) receiving degrees between 1997-2014. Their HHC work experience varied from 1,5 months to 21 years and they all worked full time. The transcribed interview data consisted of 107 pages.

5.1 Nurses' experiences and perceptions of the actual work shift

The HHC nurses (n = 18) described the work shifts themselves to be an **affirmative experience** (main category), when *the day has gone as planned, smoothly, without any unplanned tasks* (subcategory) and they had time to discuss with their clients or time to document all the care provided in clients' care plans at the HHC office. Below are examples of the data seen in the subcategories.

“The day has gone as planned, nothing unplanned today, so I had time to discuss with my clients” (Respondent 16)

“The day has gone as planned, smoothly, no one had anything acute or unplanned today, so I have time now to document everything” (Respondent 5)

Certain factors seen prior to the actual work shift influenced the HHC nurses' perceptions of an affirmative experience, such as *interprofessional collaboration in advance* and *prioritization*.

“We usually do not have care planning meetings between three and four o'clock, but yesterday we had one, and we managed to plan the new client's care so that she already got the home service today” (Respondent 6)

“I visited the local hospital to see how one wound care client is taken care of there, so that we know in advance what kind of wound, what is needed for the wound care, in advance”

(Respondent 9)

“I decided to move some tasks to tomorrow, prioritized” (Respondent 9)

During the actual home visits the HHC nurses experienced *good client contact, good care outcomes, social interaction, variation, flexibility and creativity*, as well as the experience that *everything practical went well*.

“All clients were satisfied to have a visit and happy to see us, they are so thankful”

(Respondent 3)

“The wound seemed better today, much better, it is nice to see how your work makes a difference” (Respondent 7)

“When you get to the job and your colleagues say hello, and you can have a short coffee break and discuss different phenomena, that is a good start – the social well-being, it affects the whole working day, too” (Respondent 16)

“A day with variation, a good day” (Respondent 3)

“Usually we have GP day on Mondays, blood samples on Tuesdays and sometimes meeting with home services, and wound care on Mondays, Wednesdays and Fridays, but of course we are flexible, the clients’ needs go first” (Respondent 9)

“It is good in HHC to be creative and improvise, you are primarily alone, and to take a decision quite suddenly, all cannot be planned in advance” (Respondent 3)

However, the HHC nurses perceived some work shifts as being **non-affirmative experience** due to *barriers to smooth task management, burdensome IT programs or unclear division of responsibility leading to ethical problems.*

“I should have had better knowledge about the client before I called the hospital, I should have had the care plan in front of me when I called there the first time... but I was in a car, without a PC” (Respondent 9)

“The IT programs are very unpractical and illogical, I think, you have to click several [times] before you enter the right place in the care plan. It is the same with the three-month evaluations, we have to describe the client’s situation and health every third month and it takes a lot of time, because of all the clicking and searching from different documents” (Respondent 13)

“This client who is in palliative care... His infection required that I had to call several different service providers to get him the care he needed – and it made him suffer more and to wait a long time” (Respondent 9)

While the subcategories above all pertain to structural factors, process factors as seen below such as *weather conditions, own mistakes, unplanned work tasks, unavailable clients, ethical problems* and *communication problems* could also affect nurses’ perceptions of their work shifts.

“Bad weather today, it makes the job stressful due to long distances between clients”
(Respondent 1)

“I should have checked before the home visit that I have the blood sugar measurement apparatus with me, but I did not” (Respondent 16)

“One call from home services made my working day two hours longer, I had to coordinate the care and make several telephone calls and arrange things practically, though we were two at HHC today when usually on Fridays there is only one person at work” (Respondent 9)

“We visited a client who was not at home [at the agreed upon time], it was a long way to drive unnecessarily” (Respondent 13)

“Sometimes clients’ relatives call you and are dissatisfied; it is usually due to a misunderstanding. You cannot anticipate that they know everything about care and the care plan, they must be told also. Of course, you must have the client’s permission to give that information” (Respondent 4)

“Communication between outpatient care and inpatient care. We had not gotten confirmation from the hospital about the changed process of ordering IV medications, and the client was supposed to inform me that there is no visit tomorrow. That is not acceptable, I think the care facilities should communicate with each other” (Respondent 4)

5.2 HHC nurses’ suggestions for the development of HHC

The HHC nurses perceived that development should take place on the organizational, inter-professional, team and individual levels.

Forward planning on the organizational and interprofessional levels included *collaboration and communication between settings, professional groups and individuals; revised task division; and revised IT resources.*

“I wish that those working at the service home, closest to the clients, would look for the existing basic information before contacting HHC” (Respondent 1)

“Increased possibility to contact the GP, or to consult a GP from the client’s home somehow, for continuity of care. Like Doctagon [a private provider of social and healthcare services]. Now if I have to contact a GP I have to call the hospital and there might be one who does not know the client at all...” (Respondent 12)

“More documentation for continuity and safety, the one client we had today had a list of medicines and in it an order for a blood sample that should have been taken yesterday, but nothing was documented, only the order [for the blood sample]...” (Respondent 16)

“To receive clients’ medicines already in individual packages from the pharmacy, without having to deal with the various medicines yourself, all during the same day, would make time for other important tasks. It would also save extra visits made for prescriptions and GP consultations every time the medicine needs [a repeat prescription]” (Respondent 6)

“I wish we could have IPADs to document home visits, and to check for laboratory results, to read GPs’ texts and to take a photo of a wound or rash to show to the GP. Now I have to remember all this after home visits” (Respondent 8)

The HHC organizations should establish mechanisms to continuously inform the different professional groups about the patient’s care, to revise and clarify task division between HHC, home service and pharmacy, for example; and to arrange coordinated IT documentation systems for all involved settings. They should also provide every HHC nurse with an IPAD to check patient information before or during home visits and to document their observations, activities and recommendations.

Forward planning on the team level included *realistic, flexible schedule planning*

“To not plan in advance all the working week and think it is realistic to manage it, because there are always unplanned tasks to do and manage” (Respondent 10)

The whole interprofessional HHC team should systematically collaborate in order to plan realistic schedules for home visits, for revision of care plans together, for collegial reflections, and for administrative as well as for unplanned tasks.

Forward planning on the individual level included the *things I should have thought about in advance*.

“I should have thought about my ergonomics before wound care, to sit 10 minutes in position like I did...” (Respondent 14)

Every nurse should prior to home visit have time to check that the patient is at home as agreed, an actual idea about what should be accomplished during this visit and how, and that the nurse has all material needed.

The HHC nurses had given great thought to how HHC could be developed. As one nurse commented, “HHC is a forgotten area, it should receive more development resources. It must exist and it must run smoothly, but no one takes the time to develop it”. However, very limited data was seen on HHC leaders in this study:

“The higher leadership could... We would like to have longer time for home visits, that documentation and administrative work at the office takes time from clients” (Respondent 16)

6 DISCUSSION

The aim of this study was to describe nurses' experiences of working in HHC and their suggestions for the development this public healthcare sector. Based on interviews with HHC nurses (n = 18), work shifts were perceived as being either affirmative or non-affirmative, depending on the contextual and organizational factors affecting nurses' workload.

Affirmative experiences were related to client factors (good client contact, good care outcomes), factors related to colleagues (social interaction, interprofessional collaboration in advance), circumstantial factors (day has gone as planned, variation) and factors related to own activities (prioritization, flexibility, creativity). There were no data concerned with nurses' own mood or physical health, which may have affected their working shifts and the interviews.

The HHC nurses interviewed enjoyed having time for home visits and discussing with their clients, which can be interpreted as direct patient-related nursing activities (cf. Fagerström & Vainikainen, 2014), patient-centered care as respect for patient needs and preferences (cf. Stewart et al. 2006) and the development of a mutual nurse-client understanding that facilitates client independence (cf. Koskenniemi, Leino-Kilpi, & Suhonen, 2014, Stewart et al., 2006). The HHC nurses also perceived interprofessional collaboration and team management to be factors that resulted in an affirmative work shift, which also reflects components of patient-centered care (cf. Stewart et al. 2006). Furthermore, the more the HHC nurses perceived they could influence their work, the less stressed and more engaged they were (cf. Vehko et al., 2017): if a work shift had gone as planned, i.e., smoothly (cf. contextual and organizational factors), the HHC nurses had time for indirect patient-related

nursing activities such as documentation, social interaction with clients or collaboration with colleagues (cf. Fagerström & Vainikainen, 2014).

Non-affirmative experiences were related to structural factors such as barriers to smooth task management, burdensome IT programs, or unclear division of responsibility leading to ethical problems, or process factors such as weather conditions, own mistakes, unplanned work tasks, unavailable clients, ethical problems or communication problems. The only patient-related factor seen was related to unavailable clients, i.e., that clients were not at home at agreed-upon times. Arriving to find that a client is not at home can be interpreted as stemming from a client's perceived threat to his/her dignity, integrity and autonomy, due to home healthcare visits (cf. Holmberg, Valmari, & Lundgren, 2012) or as a sign of independent decision-making (cf. Stewart et al. 2006) or as result of poor nurse-client cooperation. The majority of the structural and process factors seen here that appeared to negatively affect the HHC nurses' work shifts were related to contextual and organizational phenomena related to added nursing workload (cf. Fagerström & Vainikainen, 2014). When the HHC nurses experienced their nursing workload as being stressful (cf. Vik & Eide, 2012), it was due to these contextual and organizational factors.

The HHC nurses here sought to overcome eventual contextual or organizational barriers for task management by taking greater responsibility for their work (cf. Vehko, Sinervo, & Josefsson, 2017), by being flexible and creative and prioritizing, if possible. They also mentioned several concrete suggestions for the development of HHC on the organizational, interprofessional, team and individual levels. All of the suggestions (collaboration and communication between settings, professional groups and individuals; revised task division; revised IT resources; realistic, flexible schedule planning) related to foresight and forward

planning, i.e., contextual and organizational factors (cf. Fagerström & Vainikainen, 2014) or working conditions (cf. Vik & Eide, 2012) that affect nursing workload.

In sum, the HHC nurses interviewed in this study perceived their work shifts as being either affirmative or non-affirmative, mainly depending on the contextual and organizational factors affecting their workload. The more the HHC nurses perceived they could influence their work, the less stressed and more engaged they were in patient-related nursing activities, patient-centeredness, collaboration and forward planning. In contrast, the more unplanned work tasks and other barriers for task management, i.e., non-patient related or indirect patient-related nursing activities, the less patient-centeredness, collaboration and forward planning the HHC nurses engaged in. Therefore, HHC work structures, such as the clarification of professional responsibilities, revision of IT functionality and process factors such as communication must be realigned through collaboration between different settings and professional groups. This should occur now, before larger problems such as accelerated staff turnover or negative patient safety outcomes are seen; until this happens, different hospital-in-home settings are not truly capable of providing somatic, psychiatric and palliative HHC at an advanced level (cf. Vaartio-Rajalin & Fagerström, 2018).

This study may have some limitations concerned with sample size and representativeness, and data collection and data analyses processes made by Master's students. However, we have aimed to tangle with these limitations by recruiting respondents from two HHC organizations, developing semi-structured interview questions and validating the students' analyses by three independent persons.

REFERENCES

- Björk, I., Berntsen, K., Brynildsen, G. & Hestetun, M. (2014). Nursing students' perceptions of their clinical learning environment in placements outside traditional hospital settings. *Journal of Clinical Nursing* 23(19–20), 2958–2967. DOI: 10.1111/jocn.12532
- Burns, N. & Grove, S.K. (1997). *The practice of nursing research. Conduct, critique and utilization*. W.B. Saunders Company, Philadelphia.
- Brazil, K., Bainbridge, D., Ploeg, J., Krueger, P., Taniguchi, A. & Marshall, D. (2012). Family caregiver views on patient-centered care at the end of life. *Scandinavian Journal of Caring Sciences* 26, 513–518.
- European Federation of Nurses Associations-EFN. (2015). *EFN Guideline for the implementation of Article 31 of the Mutual Recognition of Professional Qualifications Directive 2005/36/EC*, amended by Directive 2013/55/EU
- Expat Finland. (2018). https://www.expat-finland.com/living_in_finland/public_healthcare.html. 22nd November 2018.
- Fagerström, L. & Vainikainen, P. (2014). Nurses' Experiences of Nonpatient Factors That Affect Nursing Workload: A Study of the PAONCIL Instrument's Nonpatient Factors. *Nursing Research and Practice*, Article ID 167674, <http://dx.doi.org/10.1155/2014/167674>
- Genet, N., Boerma, W.G., Kringos, D.S., Bouman, A., Francke, A.L., Fagerström, C., Melchiorre, M.G., Greco, C. & Devillé, W. (2011). Home care in Europe: a systematic literature review. *BMC Health Service Research* 11, 207. Published online 2011 Aug 30. doi: [10.1186/1472-6963-11-207]
- Holmberg, M., Valmari, G. & Lundgren, S.M. (2012). Patients' experiences of homecare nursing: balancing the duality between obtaining care and to maintain dignity and self-determination. *Scandinavian Journal of Caring Sciences* 26, 705–712.
- Kehusmaa, S., Mäkelä, M. & Heikkilä, R. (2018). Patient education about hospital discharge – needs and service solutions. (In Finnish) Asiakasohjaus sairaalasta kotiutuessa – tarpeet ja palveluratkaisut. http://www.julkari.fi/bitstream/handle/10024/136380/URN_ISBN_978-952-343-122-5.pdf?sequence=1&isAllowed=y. 13th November 2018.
- Koskenniemi, J., Leino-Kilpi, H. & Suhonen, R. (2014). Manifestation of respect in the care of older patients in long-term care settings. *Scandinavian Journal of Caring Sciences* 29, 288–296.
- Larsen, A., Broberger, E. & Petersson, P. (2017). Complex caring needs without simple solutions: the experience of interprofessional collaboration among staff caring for older persons with multimorbidity at home care settings. *Scandinavian Journal of Caring Sciences* 31, 342–350.
- Martin, S. (2018). *Home health nursing in transformation – nurses experiences of a challenging work*. Åbo Akademi University, Faculty of Education and Welfare Studies Department of Caring Science, Master's thesis.
- Ministry of Social Affairs and Health (2018). <https://stm.fi/en/older-people-services/services-and-benefits>. 10th October 2018.

Pittman, P., Horton, K., Terry, M. & Bass, E. (2014). Residency programs for home health and hospice nurses: prevalence, barriers, and potential policy responses. *Home Healthcare Management Practice* 26(2), 86-91. doi:10.1177/1084822313511457

Rostgaard, T. & Szebehely, M. (2012). Changing policies, changing patterns of care: Danish and Swedish home care at the crossroads. *European Journal of Ageing* 9, 101–109. DOI 10.1007/s10433-011-0209-1.

Stewart, M., Brown, J.B., Weston, W.W., McWhinney, I.R., McWilliam, C.L. & Freeman, T.R. (2006). *Patient-Centred Medicine. Transforming the Clinical Method*. Radcliffe Medical Press Ltd, Oxford, UK.

TENK. (2012). *Responsible conduct of research and procedures for handling allegations of misconduct in Finland*. Finnish national board on research integrity
http://www.tenk.fi/sites/tenk.fi/files/HTK_ohje_2012.pdf 16th November 2018.

Turjamaa, R., Hartikainen, S., Kangasniemi, M. & Anna-Maija Pietilä, A-M. (2015). Is it time for a comprehensive approach in older home care clients' care planning in Finland? *Scandinavian Journal of Caring Sciences* 29, 317–324.

Vaartio-Rajalin, H. & Fagerström, L. (2018). Professional care at home: patient-centeredness, interprofessionalism and effectivity? A scoping review. *Health & Social Care in the Community* 1-9, DOI 10.1111/hsc.12731

Vehko, T., Sinervo, T. & Josefsson, K. (2017). The welfare of staff in old-age dependency services – home care development concerns (in Finnish) Henkilöstön hyvinvointi vanhuspalveluissa – kotihoidon kehitys huolestuttava. Tutkimuksesta tiiviisti 11. Terveiden ja hyvinvoinnin laitos, Helsinki.

Vik, K. & Eide, A.H. (2012). The exhausting dilemmas faced by home-care service providers when enhancing participation among older adults receiving home care. *Scandinavian Journal of Caring Sciences* 26, 528–536.

Table 1. Background data, HHC nurses (n = 18)

Educational level	Year of graduation	HHC work experience, in years
freq./%	freq./%	freq./%
RN	1985-1990	< 1 year
	1 (5%)	3 (17%)
RN + specialization/s	1991-1996	1-3 years
	1 (5%)	4 (22,5%)
	1997-2002	4-6 years
	6 (34%)	2 (11%)
	2003-2008	7-9 years
	3 (17%)	2 (11%)
	2009-2014	10-12 years
	6 (34%)	5 (28,5%)
	2015-2017	13-15 years
	1 (5%)	- (0%)
		16-18 years
		1 (5%)
		19-21 years
		1 (5%)