

District nurses' experience of working in home care in Sweden

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Abstract

Background: Home care was previously included in healthcare centers in county councils in Sweden. Today, home care is the responsibility of municipalities. Consequently, the work of district nurses from healthcare centers has changed, and they face a new mission and new challenges. The aim of this study was to explore district nurses' experiences of working in home care after the municipalization.

Methods: The design was descriptive with an inductive approach. Five district nurses working in different municipalities were interviewed. Qualitative content analysis was used.

Results: The district nurses experienced their work through the following themes: organization, local environment and leading the team, and defined the themes in terms of inadequacy, collaboration, control, comfort, continuity and own competence. Their work was free and pleasant with more time for the patients. At the same time they at time had difficulties to carry out their work. Recipients' condition in municipality home care experienced as better as a consequence of cross-border cooperation, compared to earlier organisation of home care. District nurses work involved a great nursing responsibility and required leadership. They experienced losses of competence as well as new competence.

Conclusions: District nurses' work was at times difficult because of organisational barriers. There is need of improvements and tools for district nurses to carry out their work and to promote their competence development. The organisation is not functioning optimally in municipal home care. Cooperation between municipality, primary care and inpatient care needs improvement.

Citation: Josefsson K, Peltonen S (2015) District nurses' experience of working in home care in Sweden. *Healthy Aging Research* 4:37. doi:10.12715/har.2015.4.37

Received: April 20, 2015; **Accepted:** July 12, 2015; **Published:** November 1, 2015

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Competing interests: The authors have declared that no competing interests exist.

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Introduction

Sweden is divided into 290 municipalities and 20 county councils, including hospital and primary care with healthcare centers [1]. There is no hierarchical relationship between municipalities and county councils, since they have their own self-governing local authorities that are responsible for different activities [1]. Responsibility for home care has been transferred from the county council to municipalities in most of Sweden. This directly impacts the District Nurses (DNs), as now they work in the municipality

instead of healthcare centers. The municipality is also responsible for healthcare in the patient's home for those who cannot get to a healthcare center [2].

Home care is defined as care in the home, which is typical continuous and interventions preceded the care and social care planning [2]. An increasing number of people receive home care, and most of them are 65 years and older; age-related diseases are common, as well as terminal care. Home care is done in interdisciplinary teamwork for the patient to achieve the maximum quality of life [3].

Patients in home care should have a nursing charge nurse, who cooperates with the county council, initiates and participates in care planning [2]. This calls for a powerful reinforcement of more specialists trained in advanced nursing, such as DNs [3]. DNs have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering [4]. Nursing work should also be based on science and proven experience, while being conducted in accordance with laws and regulations. DNs will be responsible for the planning, managing, and development of nursing work in cooperation with other professionals, organizations, and authorities. It requires advanced abilities of the DNs to work independently, collaborate in teams all while leading the nursing work [5].

DNs think that health promotion is important [6]. However, when DNs experience a conflict between health promotion and disease-oriented work, health promotion has a lower priority and the most elementary issues must be resolved first. Home care often involves long-term relationships with patients and their families, and these relationships usually last for several years. DNs describes their work as complex and positive, as it is a close interaction with the patient and their family. Being able to provide person-centered care is highly valued by DNs and there is a professional pride to work hard for patients' health. At the same time, it is difficult to set boundaries between professional relationships and common friendship in clinical work, and especially in a home environment where the boundaries are not easily defined [7].

A multidisciplinary approach is needed to facilitate teamwork and health promotion in order to meet both health and social care needs, as shown before [8, 9]. The planning of health care occurs after the assessment of the health and social care needs of the nursing team members. DNs have the highest medical competence among employees of Swedish municipal home care [8, 9]. DNs and registered nurses are responsible for leading, prioritizing, distributing and coordinating nursing within the team [9], with the ultimate goal of exercising and improving home care.

In summary, the responsibility for home care has been mostly transferred to municipalities in Sweden. This has changed DNs' work, as they previously worked in

home care that was included in health care centers in county councils. There is limited research on the impact of the municipalization of home care on DNs' work experience, and it is important to explore how their work has changed.

The aim of the present study was to explore district nurses' experiences of working in home care after the transfer of home care to municipals from county councils.

Methods

Research design and ethics

The study was performed during 2014 in a geographic area in central Sweden. The design was explorative with an inductive approach with individual interviews [10]. Data were analyzed using qualitative content analysis [11]. The ethical principles were followed for medical research involving humans [12]. Before giving their informed consent, DNs were provided with information about the study. They were informed about the voluntary participation and that they could end the interview at any time without giving any reason. They were guaranteed confidentiality and anonymous presentation of results.

Sample and data collection

Inclusion criteria were: 1) DNs had at least one year work experiences in home care and or reception work at health care centers in the county councils; and 2) Employment and working in municipal of home care at least one year.

The sample consisted of five district nurses from five different municipalities in order to provide a broader representation. The employers were contacted via email for their approval to contact DNs, get the names of DN employees, and approval to interview them in the workplace. An information letter was sent to all five DNs with information about the study and an expression of interest to participate. The participants sent an interest announcement to the research team.

The interview questions were constructed after processing the literature and discussing the interview questions with colleagues at seminars. 1) Can you talk about your experience working as a DN in municipal

home care? 2) Can you talk about any changes in your work that you have experienced? 3) Have you lost anything in your work? 4) Has anything positive been added to your work? Supplementary questions were used as needed including the following: A) Can you give examples; B) What do you think about this; and C) Can you elaborate on that and tell me more?

The questions were tested on one registered nurse in order to control the logistics of the trial, relevance of the questions, usage, and expected time to fill in the questionnaire. One of the interview questions was found to be vague and difficult to interpret, so the question was clarified and revised.

The participants decided when the interview would take place, and each interview was conducted at each participant’s respective workplace. They received additional written information and gave their informed consent before the interviews began. The interviews were conducted in a private room, took an average of 30 minutes, and were recorded and transcribed verbatim.

Data analysis

A qualitative content analysis was performed [11]. The analysis began with the interviews being transcribed and then read in their entirety several times to get an overview of the content. Meaning units describing the DNs’ work experiences after the municipalization of home care were identified and condensed. Thereafter, these condensed meaning units were abstracted to 219 codes. The analysis went on to compare the content of the different codes to discern

similarities and differences. Codes with similar content were grouped together in 23 subcategories. The content of the subcategories was compared and abstracted into six categories. In the final stage of the analysis the categories were abstracted to three overall themes: organization, local environment, and leading the team. We thoroughly discussed the analysis process until we reached a consensus. The different steps in the analysis were discussed in the research group and in several seminars. Table 1 shows an example of the content analysis process.

Results

The results are organized into the three themes that emerged from the content analyses: organization, local environment, and leading the team. Within these themes are six categories: inadequacy, cooperation, steering, work satisfaction, continuity, and DNs’ competency (Table 2). Subcategories are reported in the running text under each category.

Organization

Inadequacy

DN experienced municipal organization as inadequate. They described the municipals’ organization as messed up and sometimes lack guidelines, such as the threshold principle. DNs stated that cooperation gaps exist between the municipal home care and primary and hospital care. DNs stated that they have lost the power to carry out certain tasks and their capabilities are not fully utilized.

Table 1. Example of the qualitative content analysis process

Meaning unit	Condensed meaning unit	Code	Subcategory	Category	Theme
...I feel that the municipality in the first place was totally unprepared for what they really took over for something and it is the basis, I think the whole management of the whole thing, I do not think they really understood what it meant...	...the municipality was totally unprepared for what they took over. It is the basis for the entire management. They did not understand what it meant...	Unprepared municipal decisions	Unprepared organization	Municipal inadequacy	Organization

Table 2. Overview of categories and themes

Categories	Themes
The municipality's inadequacy	Organization
Cooperation	
Steering	
Work satisfaction	Local environment
Continuity	
District nurse's competence	Leading the team

The contact with the physicians and their support is lacking and support from other colleagues feels inadequate. DNs' work has become more difficult because of limited access to patients records, and because some patients lack a care plan, preventing the DNs to offer sufficient insight to perform optimal home care. The lack of preparation from the municipalities has negatively impacted DNs' work by inhibiting their power and their specialized excellence in home care.

"...we have so unclear guidelines whatsoever, which is home care patients for this document we will go after're very, very sketchy, that's the threshold principle..."

"...I feel that here I am tied behind its back, here I'll do what the health center says to me, and do, and I certainly can not take anything samples, perhaps a blood sugar...yes, I think I stand far away from the physicians...not to talk to a physician at once even though I feel it would be appropriate and that kind of problems I have encountered every now and then, and then you get this feeling that you are alone..."

Cooperation

DNs' work affects cooperation in the organization and cooperation with the home service. DNs experienced that when home care became the responsibility of the municipality, cooperation and teamwork improved between DNs and other staff, such as rehab staff, occupational therapists, physiotherapists and care manager and, above all, home services staff. Cooperation with home service staff constitutes a large part of DNs' work and is mostly positive, since

it is beneficial to have workmates and to be available for home service staff. At the same time, the proximity was experienced as double-edged, since it may be too intense and stressful.

"...they can participate and observe how a patient should be able to move easier and what facility needed they can train the patient and strengthen their resources, so I think I get much help from them (the rehab staff) ..."

"...it is very much home care contacts, very much both tags, with knocks on the door and on the phone...there may be disadvantages in that they contact the DNs for everything, because they know that we are so close..."

Steering

DNs experienced that the work in municipal home care is steered from the organization level. Steered missions can come from inpatient care and primary care. When guidelines and policy documents are clarified by the organization, it is positive and serves as a support at work, when assignments sometimes are perceived shoddy. DNs' work is influenced by the fulfillment of organization-driven missions and to provide care to patients when the regulations justify home care.

"...I think it is more paragraphs one should take into account, it was like easier before, that I can feel, it is more controlled, I think so...here it will be more a specific mandate, this should go and do...and what I think is positive in the municipality is that there the criteria for what is to provide home care..."

"...now I have a role where I will carry out missions, county-driven missions as it is called from either inpatient or from family physicians, so already there, I am guided in what I should do something..."

Local environment

Work satisfaction

DNs experienced work as good and pleasant, and they liked to work with older patients. DNs can plan large parts of the working time, including how and when the patient visits are conducted. This makes them feel a sense of freedom because they have spare time and

the working environment feels freer and less stressful, compared to before the municipality took over responsibility for home care. Working in the patient's home was perceived as relaxing as the DNs are not "trapped" all day. They appreciate that they have the opportunity to be outdoors and get fresh air.

"...I have my timing, but there is nothing that says nine o'clock I will be there and at three o'clock I will be there, but often I get the steer them these visits little self...it becomes more relaxed than at a reception I think so. It's always a guest in their home but it still feels that it somehow is a freer surface of staying in..."

"...today I do not telephone and all that other stuff, but what you do if you take samples so what you do it at home...and it gives more time with them as it is mostly old people who have home health care...I consider this positively..."

Continuity

DNs stated that patients would have continuity in the municipal home care, such as having one principal organizer, less total staff, and often the same staff members. DNs say this leads to safer patients and more secure home care. Patient autonomy is respected in the home. There is time to sit down and talk with the patient, increasing awareness of the patient. DNs also serve as the patients' advocate by coordinating the patients' health and social care contacts.

"...it is the same person who comes and then it becomes not so many involved so ... when you work like this in home care...then it is long care contacts...one follows a patient a long time and I think this is inspiring, you really get to know them year after year, their relatives too. I think that is a security for patients in home care...now we are in the patients' home and then it will be as different..."

"...it was the same principal organizer (the municipality) for home care and home service and for running into each other so much, home service carry so much of this care with all medications and any insulin and it becomes much easier, it became safer..."

Leading the team

District nurses' competence

DNs mentioned that they lead, teach, supervise, inform staff, and delegate to other professionals, and this is primarily for home care staff. The nursing responsibility for the patient was experienced as large, and sometimes it feels like too much. DNs work independently so it is essential for the DNs to have prior work experience and be safe in their professional capacity, as well as daring to trust themselves. DNs acquire and develop new knowledge in different areas, such as interpreting agreements and rules, and learn from other professionals on the team.

"...the medical is after all on me, the nursing responsibility, many times I meet the patient and family and home service staff with all their questions...sometimes it almost feels like it gets too big when it gets a lot with some patients, sometimes you can feel that they are almost too sick to be at home and then feel it...but god...can I take responsibility for this..."

"...and yes, you are more alone in the work so you have to trust that what you can...you become proficient at interpreting agreements, rules and stuff...what to undertake, yes it is more like that now, it is much more..."

Discussion

The results are discussed on the basis of the three themes emerged from the analysis: organization, local environment, and leading the team.

Organization

DNs in this study experienced the municipal organization as inadequate, for example DNs lack access to and support from physicians and colleagues. They lack access to patient record data and important information, limiting their care for them. DNs stated that cooperation with primary care and inpatient deficiencies make work difficult. Work is delayed when physician is not available. In order to perform secure home care, the availability of documentation is required to be available to staff, so that intervention can be implemented and monitored [9]. There must be

a protocol for staff to access patients' records around the clock. Documentation regarding patients must follow across organizational boundaries and different types of care. Access to physicians and DNs should be available around the clock in home care, which is often lacking today [9].

DNs experienced that decisions come from above, disregarding the DNs input on the rules, guidelines and mission. The same show earlier research with DNs and registered nurses in municipal elderly care; they do not have influence in overall issues and important decisions [8]. This may be challenging and frustrating and might affect the DNs' feelings of not being able to offer patients optimal care, and can lead to stress of conscience and burnout [13]. Our reflection is that staff often turn themselves inside out and find their own solutions to give patients the best possible care, without having influence on a higher level.

The results showed that the municipal home care is organized so that cooperation between DNs and home help groups has increased. DNs experience that it increases patient safety and continuity of care. The result was positive and consistent with Josefsson [9] who argued that a secure home care requires teams that work together across borders. Each profession's expertise should be fully utilized in purpose to deliver a secure home care. Earlier research [14] suggested that the holistic view of humanity is strengthened when the DNs work in teams and cooperate with other occupational groups. In health promotion, a holistic view of humanity is especially important, as well as in palliative care. Our reflection is that home care is not only about medical diagnoses, but the patient needs more of a health promotion perspective. There is a clear distinction between hospital and home care. Hospital care is a temporary solution to a pressing problem. Home care is a solution to a longstanding problem, in many cases, lifelong.

DNs felt that they were constantly available to patients, relatives and colleagues, which felt strenuous and stressful. Working together with other employees in the same premises next door can become too intense. McGarry [15] emphasized the need to maintain professional distance and clear boundaries between the work of nurses and patients. Yet it is obviously difficult to define and maintain boundaries

in an environment like a home, where the boundaries are not always definable. DNs' relationships in home care with patients and their families can either be seen as a resource or a burden for both the patient and the DNs [16]. It is important that DNs has a professional distance to the patient, relatives, and colleagues.

Local environment

DNs experienced comfort and security in the patient's home and in the office, as well as the large possibility to plan and control working days because the work is flexible. An earlier study [17] reported on primary care and concluded that it is solely registered nurses that feel that they have a bit more space for health promotion. In home care, DNs can often decide how long a patient visit can take. The results showed that the DNs stated that they have spare time to get to know the patient so that they can better understand the patients. This contrasts earlier research that reported that DNs and registered nurses in municipal elderly care experienced time pressure in their work [8]. McGarry [15] argued that time is described both as time in the ordinary sense but also in the sense of "having time" which refers to the feeling of being interested.

The results showed that there were usually few DNs responsible for the same patient, resulting in greater continuity and, according to DNs, promotes security of the patient and relatives. Caring for patients in their homes often involves long-term relationships, and typically for several years [18]. Some of the work involves listening to the patients' experiences [7]. DNs feels that they learn something in these meetings, which increases their understanding of the patients they care for. McGarry [7] argues that the key in the DNs role is to provide care based on a holistic ethos. This creates the relationship between the DN and the patient. Likewise, an earlier study reported that establishing good contact and building trust between the DNs, the patient and the patient's family is very helpful for further communication and work [17]. Relatives should be viewed as a natural resource and natural partner in home care [9]. Our reflection is that a faulty organization is a great risk to increases in staff turnover and continuity may be lost.

Leading the team

The results highlight the DNs' role to lead the team, and that the DNs explained that long term strategies are needed for them to be effective leaders who can ensure patients safety and implement quality improvements [19]. There is also an advantage when DNs have work experience, confidence, and trust in oneself. According to another study, these qualities lead DNs to work independently to increase knowledge and confidence [17]. Our reflection is that to be a leader requires courage, confidence and experience. Not all DNs initially take a natural leadership role, nor is it obvious from employers to require them to lead. It may take time to develop leadership. But in an organization as home care, it is especially important to get a clear mandate and given space to work as a leader. In addition to leading, it requires that the DNs supervise staff and delegate tasks.

DNs experience that their nursing responsibilities are large and include educating and informing patients, relatives and other professionals. DNs are also active in developing a core of research-based professional knowledge that supports evidence-based practice [4]. DNs assume the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education [4]. An earlier study argues that DNs' and registered nurse's work is about performing nursing, leading, making decisions and sound judgement when a specific intervention is relevant [9]. Their responsibility is to supervise and coordinate patient care. DNs and registered nurses play a key role in home care, and patients should have access to their competence. DNs also work as a coordinator in palliative care [20].

The lost competence DNs experienced in this study in home care was replaced with new insights gained in other areas. Earlier studies argue that the single most important factor of safety, security and quality in home care is about the staff's competence [9]. Good nursing care requires that staff's competence is utilized and that their work is supported by the organization. Josefsson and Hansson reported that DNs in municipal elderly care felt that their leadership competence was not fully used, even though it is an important factor affecting the quality of care [19].

Overall, DNs have changed employment, and a new principal, the municipality, controls the type of care and home care. It is important to understand the differences between primary care home care and municipal home care. When the DNs work was performed under the health care law, home care interventions were fewer and more medically oriented. In the municipal home care that is controlled by both the health care law and social law, the focus is on the whole patient. DNs state that their competence acquired in primary care are not fully used in home care, making the DNs feel that sometimes they work with their hands tied. Our reflection is that the municipality must decide how to deal with organizational deficiencies and through increased cooperation between the municipality, primary and inpatient care.

Methods

To achieve trustworthiness, the analysis process was discussed to reach agreement, and was also discussed with colleagues at several seminars [10, 11]. The intention was to clearly describe the method and results with descriptive quotations. The Swedish context and the sample size was a threat to transferability. However, other DNs working in municipal home care might identify with the results. The fact that it is based on a small sample of participants and the Swedish context, is a threat to transferability. However, all of the DNs worked in different work settings, which had different sizes and which were distributed over Central Sweden, so other DNs working with municipal home care might identify with the results. No ethical problems or conflicts occurred during the study.

Conclusions

According to the DNs in this study, municipal organization is not functioning optimally to carry through to home care. DNs' work was sometimes difficult due to organizational barriers. DNs' work was free and pleasant with time for the patients. DNs experienced that the patients' conditions were better in municipal home care, compared to home care in the county councils. Continuity and security in home care was a positive consequence of increased cross-border

cooperation between DNs and home care services. DNs' work requires leadership, and the nursing responsibility is great. DNs have lost parts of their competence, which is replaced with competence in other areas.

In terms of clinical implications, the municipality organization should decide how to deal with the existing shortcomings, so that the DNs can exercise their work optimally. There is need of improvements and tools in order for DNs to carry through their work and to promote their competence development in a satisfactory way in the municipal home care. The cooperation between the municipality, primary and inpatient care needs improvement.

Acknowledgments

We are grateful to the participants in this study and to the proofreading services from the team at Healthy Aging Research.

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