

RESEARCH ARTICLE

Older persons and relatives' experience of coordinated care planning via a video meeting

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Abstract

Aim: The study aimed to describe coordinated care planning via a video meeting from the perspective of older persons and their relatives.

Design: A qualitative inductive research design was used to describe older persons and relatives' experience of care planning via video meeting.

Methods: Eight unstructured interviews were conducted. Purposive sampling resulted in a sample of four older persons and four relatives. The material was analysed by qualitative content analysis.

Results: The theme being excluded illustrates how the older persons and their relatives experienced care planning via a video meeting as lack of a personal relationship, meaninglessness and lack of participation. The older persons and their relatives had a feeling of being excluded and in an unfamiliar situation. Lack of information about the meeting's structure and content impaired their ability to prepare for it beforehand, which led to uncertainty.

KEYWORDS

coordinated care planning, distance technology, older person, participation, person-centred care

1 | INTRODUCTION

With an ageing population, the growing number of older persons with complex care needs increases the demands on and challenges faced by health care (Blix, 2013). In association with discharge from hospital, coordinated care planning is carried out with different parties such as the hospital nurse, primary care and municipal care to ensure that older persons receive adequate help in their homes (National Board of Health & Welfare, 2019). An increasing number of functions in the healthcare system are being digitized, but knowledge and understanding of how technology can be used without losing the person-centred approach are needed (Beirao, Den Ambtman, De Pourcq, De Regge, & Simões do Carmo Dias, & Kandampully, 2016). Previous research on

information and communication technology (ICT) in health care has focused on, for example, attitudes among nurses regarding the implementation of ICT in home nursing (Nilsson, Skär, & Söderberg, 2008); nurses' experiences of using ICT for supporting people living at home (Nilsson, Skär, & Söderberg, 2010); nurse managers' perspectives on the challenges and opportunities associated with technology (Sharpp, Lovelace, Cowan, & Baker, 2019); and how nursing students learn with the support of clinical ICT (Lee, Carson, Clarke, Yang, & Nam, 2019). Previous research has also found that while digital services in health care are used in Sweden, they are more common in urban areas (Ekman et al., 2019). However, there is a lack of research from the perspective of older persons and their relatives regarding the use of ICT in health care.

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2 | BACKGROUND

Greiner and Knebel (2003) propose that all healthcare professionals should be educated in informatics and work as members of an interdisciplinary team employing evidence-based methods and quality assurance to provide person-centred care. Digital work methods such as coordinated care planning via video conferencing require skills and competencies in nursing informatics (Shubber, Östlind, Svensson, & Larsson, 2018). Video meetings are frequently used in health care today, and nurses need to be able to manage this method. eHealth is a collective term that refers to all forms of ICT use in health care. ICT is based on communication between people, and an example is care planning via a video meeting (Grundén, 2001). eHealth in the form of telemedicine or video meetings can mean that specialist expertise and resources are utilized more efficiently (Nilsson et al., 2010). Telemedicine and video technology could be a way of improving the efficiency of care. However, several authors highlight the risks of digitalization in health care (Allwood, 2017; Birkler & Dahl, 2014; Jacobs, Van der Zijpp, Lieshout, & Van Dulmen, 2017). The challenge for eHealth is that digitization can lead to objectification, rather than a meeting between two people (Birkler & Dahl, 2014). In an increasingly digitized care setting, it is important to promote relationships and consider the patients' autonomy and dignity in order to avoid dehumanization (Jacobs et al., 2017).

All persons are unique and each meeting must be conducted in a dignified manner (Lögstrup, 1994). Fredriksson (1999) describes the relational aspect of a caring meeting as listening, presence and touch. The conversation concerns the relationship, not just the information conveyed in the communication. There is a difference between talking to the patient and *with* the patient. According to Buber (2013), genuine presence means that an "I" meets a "you," which is a prerequisite for person-centred care. It is important that communication between nurses, patients and relatives occurs efficiently and safely (Kripalani, Jackson, Schnipper, & Coleman, 2007).

Performing care planning via a video meeting can save time and increase access to participating parties, regardless of geographical distance. Previous studies show that healthcare professionals perceive care planning through video conferencing as functioning well. However, this form of meeting can make it difficult to see the others as persons. In digital meeting rooms such as video conferencing, there is no possibility of body contact, which creates challenges for adequate interaction and communication. There is limited research on older persons' experience of coordinated care planning through a video meeting. To ensure a safe and secure video meeting for older persons and their relatives, further knowledge about how they experience coordinated care planning via a video meeting is needed. Therefore, the research question is how older persons and their relatives experience care planning via a video meeting.

2.1 | Aim

The study aimed to describe coordinated care planning via a video meeting from the perspective of older persons and their relatives.

2.2 | Design

A qualitative inductive research design was used to fulfil the aim of the study. A qualitative approach allows a phenomenon to be described, explained and understood without generalization of the result (Creswell, 2013; Polit & Beck, 2017). Qualitative studies are valuable for gaining a deeper understanding of a phenomenon and elucidating how people experience it in their context.

Qualitative interviews were chosen as complex and subtle phenomena such as emotions and experiences are usually best explored through interviews (Kvale & Brinkmann, 2009). A qualitative interview can capture a variety of perceptions or experiences of a phenomenon and produce an image of a versatile human world.

2.3 | Sample

The study was conducted in southern Sweden. Municipal nurses, primary healthcare nurses and nurses who coordinate hospital care planning mediated contact with suitable informants who volunteered to participate in the study. Approval was obtained from the managers of the departments.

Inclusion criteria were older persons (≥ 70 years) who had recently participated in care planning via a video meeting and relatives who had recently participated in care planning via a video meeting with an older person. The relatives could have been physically present with the older person or participated via telephone.

Exclusion criteria were cognitive impairment or dementia and severe loss of hearing or language difficulties that would greatly complicate an interview. Contact details were only provided for those informants who met the inclusion criteria.

Strategic selection was employed, and the sample consisted of eight persons: four older patients and four relatives. Of the relatives, three had physically attended a care planning meeting via video at the hospital with the older person, while one was connected to the video meeting by telephone.

2.4 | Data collection

The data collection was carried out during 2019 through individual unstructured interviews with older persons and their relatives. In unstructured interviews, the researcher listens to the informants' narratives with as little interruption as possible (Polit & Beck, 2017). The informants received information about the study and gave

verbal consent to participate. The interviews lasted for up to 50 min and were conducted at a site selected by the informant. Several ($N = 5$) interviews were conducted by telephone due to large geographical distances or the informant's wishes. The age of the older persons, three women and one man, varied between 70–83 years ($Md = 79$ years, range = 13). All had previously participated in care planning via a video meeting. The relatives comprised three daughters and one son who had participated in care planning video meetings, either by physically attending or by Skype™. The age of the relatives ranged from 45–58 years ($Md = 54$, range = 13).

The opening question was "Please tell us about your experience of care planning via a video meeting," which allowed the informants to freely express their story, thoughts and feelings. Probing questions such as "How did you feel?" or "What were you thinking then?" were also posed. The interview was audio recorded on a mobile phone and transcribed verbatim by the first author.

2.5 | Data analysis

The material was analysed by qualitative content analysis (Graneheim & Lundman, 2004) with an inductive approach. The method is based on describing variations by identifying similarities and differences in the material. The material contains both manifest and latent content, where the manifest content consists of the obvious, visible content that can be analysed and categorized without being interpreted, while the latent content corresponds to an underlying message that can be found between the lines (Graneheim & Lundman, 2004). The authors attempted to bracket their pre-understanding to avoid being guided by it when processing the manifest content (Polit & Beck, 2017).

The analysis began by reading the interviews in their entirety to obtain an impression of what they were about. Polit and Beck (2017) believe that this initial phase of the analysis process is relevant for understanding the material. Next, meaning units were identified in the text (Graneheim & Lundman, 2004). The meaning units were then coded in relation to the content.

In the next step, the codes were sorted into subcategories based on the manifest analysis. Subcategories consist of codes that have a similar content (Graneheim & Lundman, 2004). The content of the subcategories was further processed into preliminary categories.

Finally, themes were created as a way of linking the latent message from the categories and the analysis (Graneheim & Lundman, 2004). The themes were checked backwards to ensure that the original understanding was correct.

2.6 | Rigour

In order to ensure validity, Graneheim and Lundman (2004) highlight the importance of the data collection method and the quantity of data. To fulfil the aim of this study, unstructured interviews were chosen as the data collection method. The interviews began with an

open question, after which the informants were allowed to narrate. Corbin and Morse (2003) believe that the unstructured interview method is advantageous when exploring complex areas or phenomena, which the topic of this study is for older persons.

The quantity of data required to answer a research question in a credible manner varies according to the complexity of the phenomenon and the data quality (Graneheim & Lundman, 2004). Interviewing older persons with complex care needs was a challenge and ethically sensitive. The Helsinki Declaration (2018) states that it is particularly important to study medically disadvantaged patient groups. Studying older persons can facilitate evidence-based safe care. Several interviews were conducted by telephone instead of face-to-face due to large geographical distances and at the request of some informants. Phone interviews can be regarded as a weaker method than a personal meeting when the interviewer cannot see the informant; thus, facial expression and body language as a source of information are lacking (Opdenakker, 2006). However, the advantage of telephone interviews is that they enable access to informants in a larger geographical area, while saving time by eliminating the need for long journeys (Mann & Stewart, 2000; Musselwhite, Cuff, McGregor, & King, 2007).

It was challenging to interview older persons with impaired hearing on the telephone, and the author had to repeat the questions more often compared to the face-to-face interviews, something that Musselwhite et al. (2007) believe is a difficulty with telephone interviews. However, the author checked with the informants to ensure that they had heard and understood the questions and this form of interview enabled the author to access more informants than was possible in the immediate area. A larger number of informants can be considered a strength as it leads to more comprehensive material.

The validity of a study also refers to the reliability of the data collection and analysis, that is the security of the "truth" of the results (Lincoln & Guba, 1985). A critical element for credibility is the selection of appropriate meaning units. It can be difficult to handle meaning units that are too broad, as they can contain different meanings. A great deal of time was therefore allocated to the analysis, which took place in several rounds with breaks for reflection. The text material was read repeatedly, and the manifest content processed in several iterations, whereby a new and deeper understanding of the phenomenon was obtained. Validity also refers to how well categories encompass the data and how similarities and differences within and between categories can be assessed (Graneheim & Lundman, 2004). We present a condensation template with examples based on the analysis where it is possible to follow the process from meaning unit to category, which can be considered to strengthen the validity as the reader is given an insight into the work involved in the analysis and can thus judge its accuracy. One way to further strengthen validity is presenting quotations.

2.7 | Findings

The overall theme that emerged from the analysis of older persons and relatives' experience of coordinated care planning via a video

meeting was *being excluded*, and the categories were *lack of a personal relationship*, *meaninglessness* and *lack of participation* (Figure 1).

2.8 | Being excluded

The feeling of being excluded originates from the experience of being in an unfamiliar situation with limited knowledge and information about what will happen. It was also described as being at a disadvantage compared to the healthcare professionals who are familiar with the technology and have knowledge of the decisions planned for the patient. Meetings via video were perceived as impersonal as it was difficult to imagine the other on the screen as a real person. Lack of a personal relationship also appears in cases where the healthcare professional prepared poorly for the meeting and had insufficient knowledge about the older persons. Exclusion is further apparent to relatives as they experience a meaninglessness in care planning via video conferencing in cases where it is perceived as vacuous or unable to meet the older person's needs. Being excluded can also be reinforced by factors that restrict participation. This may include lack of experience of video technology in eldercare, which limited opportunities to participate on an equal level. In the care planning meeting via video conferencing, neither the older persons nor their relatives felt that they were listened to as the decisions had been made before the meeting.

2.9 | Lack of a personal relationship

Both the older persons and their relatives experienced care planning meetings via video conferencing as impersonal, where it was difficult to feel community with the persons on the screen. The pictures of the healthcare professionals on the screen were often small and far away, which contributed to the feeling that it was not real. The older persons experienced the meeting as strange, impersonal and

somewhat surreal when the people on the TV screen started talking to them. This sense of unreality amplified the experience of exclusion. An older person narrated:

"There was a large TV screen. It lit up and then it started talking. I was wondering if it heard what I said. And then it answered 'yes, we can hear you'. There were a lot of people there."

(Informant 1)

Both the older persons and their relatives experienced lack of a personal relationship in the video meeting when the nurses did not remember their name or called them by the wrong name. When the older persons and their relatives experienced that healthcare professionals were poorly prepared, the feeling of lack of a personal relationship in the video meeting was further reinforced. This contributed to an impression that the meeting did not focus on the older person. Relatives experienced care planning via video conferencing as disappointing, due to expectations not being met or the meeting not resulting in what they perceived as beneficial or constructive. The older persons experienced a feeling of abandonment, mainly because their need for care and help was not noticed during the video meeting and they were not listened to. This led to lack of trust in the healthcare professionals and insecurity about video meetings and care planning as a phenomenon. Both the older persons and their relatives preferred a face-to-face meeting.

2.10 | Meaninglessness

An experience of meaninglessness occurred for relatives when they felt that the care planning meeting via video conferencing did not contribute anything to the older person's care. In the following quotation, a relative questioned the care planning meeting and for whose benefit it is performed:

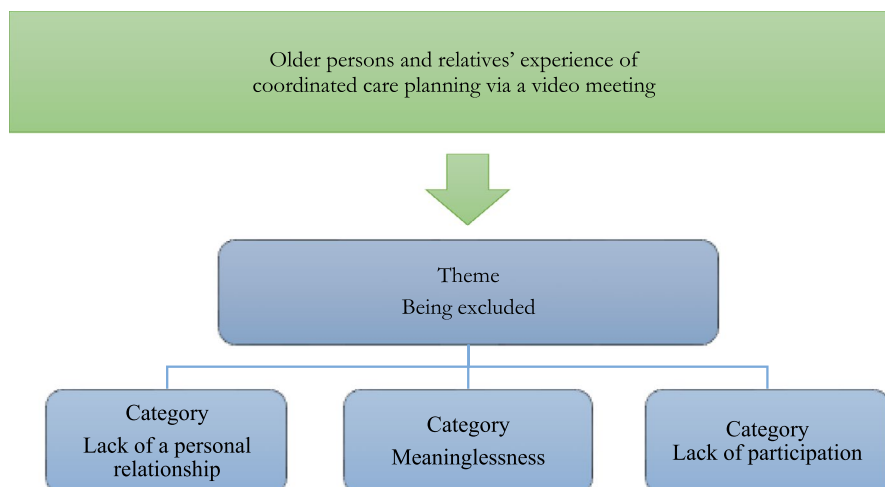


FIGURE 1 Illustration of the result consisting of a theme with associated categories

"I felt that I was asking myself who these care planning meetings are really for."

(Informant 7)

Relatives who had previous experience felt it was meaningless to participate again as they believed that it would not lead to anything. However, they stated that it was important to be involved in order to act as a support for the older person. The following quotation describes one relative's ambivalence to participating in care planning when she actually distrusts the outcome of the meeting:

"And the last time I thought that 'there is no point in me being there'. But then I did it anyway, for my mother's sake...so there would be someone there."

(Informant 5)

During the care planning, the relatives were present at the video meeting either on site with the older person or by telephone. It was an opportunity to participate even if they lived far away. This could be done via Skype™ or from their own home computer. Sometimes the relatives were not informed about these possibilities or that the meeting would be via video. One relative described the disappointment when arriving at the hospital:

"The meeting turned out to be via Skype, but no one told us about this beforehand [...] Had I known would not have needed to spend 4 hr in the car."

(Informant 7)

2.11 | Lack of participation

Lack of participation was experienced when insufficient information was given before the meeting and due to the absence of interaction and communication during the meeting. Both the older persons and their relatives felt that information and preparation were lacking. The following quotation describes an older person's experience of information before the video meeting:

"No, I was not told anything like that. I did not know what we would talk about. There was supposed to be a meeting, they said."

(Informant 2)

Care planning meetings via video conferencing were experienced as strange by both the older persons and their relatives. For the older persons, video conferencing was an unfamiliar phenomenon that they did not really know how to relate to or participate in. Having a relative physically present on site to support them provided security. Relatives also considered that it was important to participate in care planning meetings via video conferencing to gain insight into care decisions and planning, and to support the older person in the unfamiliar situation that video conferencing could entail.

Not knowing what to expect and how to prepare for the care planning meeting via video conferencing led to uncertainty and made it difficult to plan ahead about the need for help at home. When these questions surfaced during the video meeting, the relatives and older persons had difficulty answering them. The following quotation describes an older person's wish to be given the questions before the meeting:

"I didn't know what we would talk about at the meeting. Had I been informed in advance of the questions that I needed to think through...like what aids I need and things like that....that would have helped a lot."

(Informant 1)

Both the older persons and their relatives felt that they themselves had to visualize and imagine what it was like to participate in a video meeting without previous knowledge, while at the same time trying to prepare for the care planning. Older persons who had been informed about the care planning and meeting arrangements beforehand had time to prepare their questions.

An important factor in how care planning via video creates the possibility for participation is the technical and spatial conditions. Older persons with a hearing impairment found it difficult to participate in the conversation, which could lead to an impression of being left out of the discussion. When they had difficulty hearing what was said during the meeting, the older persons developed strategies to avoid feeling embarrassed about asking the healthcare professional to repeat the information:

"Some things got lost. You pretend you hear and just nod. Ashamed to say 'what?' too many times."

(Informant 1)

Both the older persons and their relatives experienced that the technology limited their opportunity for participation as it was difficult to hear what was being said. The communication was experienced by both the older persons and their relatives as asymmetric, where it was mainly the healthcare professionals who communicated among themselves while the older persons and relatives became the recipients of information and decisions.

3 | DISCUSSION

Both the older persons and their relatives experienced care planning via a video meeting as an unfamiliar situation and being excluded. Lack of information about the structure and content of the meeting impaired the ability to prepare beforehand, which led to uncertainty. The difficulty participating in the video meeting experienced by the older persons and relatives can be related to what has previously been described about coordinated care planning in physical meetings. Previous studies address the institutional structure involved in care planning and the democratic process it entails,

which are often hampered by factors that hinder patient participation (Efraimsson, Sandman, Hydén, & Holritz Rasmussen, 2006; Foss & Hofoss, 2010). Bull, Hansen, and Gross (2000) argue that healthcare professionals should design strategies that strengthen the relatives' possibility for participation. One of the benefits of having relatives present at these meetings is that everyone gets the same information at the same time (Griffith, Brosnan, Lacey, Keeling, & Wilkinson, 2004).

Care planning meetings via video conferencing involve several challenges to treating the older persons and their relatives as partners. Patient participation is characterized by a relationship where healthcare professionals transfer a part of their power to the patient. Shifting the power to the patient is one of the basics of person-centred care (Entwistle & Watt, 2013; McCormack & McCance, 2006). However, older persons often assume a passive role in care planning via video, where they await information from the healthcare professionals who are considered the experts, both in terms of care and video technology. A study by Bångsbo, Dunér, and Lidén (2014) describes how older patients took or were assigned different positions during coordinated care planning. Having an active position meant that the patient was involved, expressed her/his thoughts as a whole person and could exert influence. In contrast, a passive position meant that discussions were held over the older patient's head and she/he was unable to fully participate.

Inadequate preparation and information prior to a care planning meeting via video conferencing contribute to a feeling of uncertainty and lack of reciprocity that tends to overshadow the experience and hinder participation, influence, and co-determination in care. Previous studies show that central aspects of care planning meetings are shared information and knowledge, where patient participation is characterized by mutual and active commitment (Cahill, 1996; Sahlsten, Larsson, Sjöström, & Plos, 2008). Efraimsson et al. (2006) reported that when older persons lacked experience and knowledge of coordinated care planning, it contributed to their perception of the situation as foreign. The fact that care planning is performed via video conferencing, which is unfamiliar to most older persons, makes the situation even more complex and challenging. A more active role could possibly be promoted by preparing the patient for the meeting, which improves her/his understanding and increases safety (Heinrich & Karner, 2011).

There is a risk that communication via a screen comparable to that in a care planning meeting via video becomes impersonal as the other person becomes an object on the screen. Human beings are dependent on the affirmation and recognition of fellow human beings. Buber (2013) believes that this confirmation can also take place through a silent dialogue in an interpersonal relationship. A silent dialogue occurs when two people respect each other without reservation and in reciprocity. This is what Buber describes as an "I-You" relationship between two people who become subjects for each other. Snellman (2001) states that this can easily lead to a relationship of power for the purpose of exercising control, a so-called "I-It" relationship. There are thus parallels to dehumanization, which would counteract person-centred care where the patient should be seen as an equal partner. In contrast, a subject-subject meeting and

an "I-You" relationship involve reciprocity, acceptance and confirmation (Buber, 2013).

Video technology is used to get closer to each other despite great geographical distances, but it is important that the technology itself does not constitute an obstacle to person-centred care. Pols (2012) states that based on a socio-technological understanding of nursing informatics, one should avoid pitfalls where physical contact between healthcare professionals and patients is romanticized and strived for. A video meeting can thus be good and a face-to-face meeting bad, as well as the opposite. A face-to-face meeting does not necessarily become personal or warm just because two people meet. At the same time, the results show that the majority of both the older persons and their relatives experienced the video meeting as impersonal. Hedqvist and Svensson (2019) revealed that the outcome of care planning was not perceived to depend on whether the meeting was carried out on site or via video, but instead on the ability to convey a genuine presence and commitment during the conversation. This may possibly be the central aspect that is perceived as lacking. Thus, it can be more about how the technology is used than the technology itself. Ihde (1995) argues that the relationship with technology changes depending on use, context, and understanding and that we change and become something new through our interaction with technology. Technical artefacts thus have no meaning in themselves, but are co-created with people in new constellations.





Reciprocity and an equal relationship are part of person-centred care, but are challenged in care planning meetings via video. The difficulty of seeing the other persons on screen as real people to interact with created a sense of unreality. According to Allen et al. (2008), poor image quality and small screen sizes can make communication difficult. Showing only the head, so-called head framing, appears to be the worst option, while no difference was found between a face-to-face and a video meeting where both head and torso were visible (Nguyen & Canny, 2009). It is especially important that the delay in sound transmission is as short as possible for understanding the content of the conversation, particularly in meetings with several participants (Kegel et al., 2012).

Knowledge and competence in this area are important for enabling nurses to hold person-centred meetings with patients and participate in the development of functioning digital meeting forms. Care planning via a video meeting creates new challenges as nurses need to build and maintain a good caring relationship via a screen (Wälivaara, 2012). This study contributes to an understanding of care planning via a video meeting from the perspective of older persons and their relatives. The study also provides recommendations for nurses in the form of a checklist to be used when coordinating care planning via a video meeting.

3.1 | Limitations

Some limitations need to be considered. As this study only included persons who were interested in and capable of sharing their

TABLE 1 Checklist for coordinated care planning via a video meeting

	Inform both the older persons and their relatives that the meeting will be via video. If this is the first time for the patient, it can be of great benefit to show her/him the meeting room, demonstrate the video equipment beforehand and go through how the meeting works to make the older persons and relatives feel secure about what is going to happen and what is expected of them.
	If possible, give written information to the older persons and relatives before the care planning meeting. The material should state which topics will be covered during the care planning with questions about care and needs that the patient and the relatives can read and consider in advance.
	Prepare yourself well for the video meeting by familiarizing yourself with the technology and equipment and gather knowledge about the patient. This applies to all parties in the video conference.
	Avoid talking over each other during the video meeting by clearly distributing the dialogue and taking turns to speak. Calculate for a certain delay in the audio transmission. Clear pronunciation and slower dialogue can give older people time to process and deliver their answer, especially those with hearing impairments. Alternatively, real-time texting on the screen can be a possible aid in specific situations.

experiences of care planning via a video meeting, the findings should be interpreted with caution. Older persons with severe cognitive impairment or dementia were excluded. During the study, it was challenging to interview older persons with impaired hearing via the telephone as the interviewer had to repeat the questions more often compared to the situation in face-to-face interviews, which supports the findings of Musselwhite et al. (2007) regarding a known difficulty with telephone interviews. However, the interviewer checked several times to ensure that the informants had heard and understood the questions. Another limitation is the size of the study, as it was difficult to recruit informants. A larger number of informants can be considered a strength because it can provide more comprehensive material. However, despite being small, this study may contribute to a deeper understanding of the experiences of older persons and their relatives related to care planning via a video meeting, and confirming previous knowledge in this area.

Despite the view of the author, it is up to the reader to decide whether it is possible to transfer the results of the study to other contexts (Graneheim & Lundman, 2004). The study describes the selection and characteristics of informants, the data collection and analysis process, and provides a detailed presentation of the results, which can be considered to enhance transferability. The result could possibly be transferred to regions with similar coordinated care planning arrangements. Parts of the result pertaining to the requests of the older persons and their relatives for participation, information and transparency in their care can also be transferable to coordinated care planning, regardless of the meeting method. Similarly, the result may be transferred to other countries with similar healthcare systems, where routines and arrangements for coordinated care planning are consistent with the study context.

4 | CONCLUSION

Older persons and their relatives perceived coordinated care planning via a video meeting as being excluded, which limited their ability to participate. The main challenge is to provide a meeting with conditions that facilitate participation and co-determination for both the

older persons and their relatives. Information about the care planning is central to how older persons and their relatives experience participation. The difficulty with a video meeting is that it can be experienced as impersonal and unreal. Playing an active part in care planning via a video meeting depends on the opportunities provided by the healthcare professionals, where preparation and information are important. The technology should also function well with good sound and image, and healthcare professionals attending the meeting must be aware of the special challenges in terms of communication and interaction inherent in video meetings.

This study deepens the understanding of the vulnerability of older persons and their relatives in care planning via a video meeting and also highlights the challenges faced by nurses when attempting to facilitate the participation and co-determination of older persons and their relatives. By giving nurses knowledge of what a coordinated care planning meeting via video means for older persons and relatives, the nurses can support them before, during and after the meeting, thus promoting participation, transparency and co-determination.

4.1 | Clinical implication

Coordinated care planning via video meetings can become a functioning communication method in nursing practice, provided that older persons and relatives are given the opportunity for participation and co-determination. Below is a checklist (Table 1) to use in the clinical setting as support for coordinated care planning via video.

As health care all over the world is becoming increasingly digitized and many types of care meeting are digital, further research is needed to create more knowledge and understanding from different countries and cultures about older persons and relatives' experiences of care planning via video meetings.

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CONFLICT OF INTEREST

No potential conflict of interest was reported by the authors.

AUTHOR CONTRIBUTIONS

ATH, SP and MK: Study design and manuscript preparation. All the authors have contributed and agreed on the final version of the manuscript.

ETHICAL APPROVAL

Ethical approval for the study was received from the University Ethical Council (Dnr SPÅ 2019:1/190429). The study adhered to the ethical requirements of the Helsinki Declaration (2018). The informants were provided with both oral and written information about the study and their right to withdraw at any time without having to give a reason. Oral and written consent was obtained from the informants before the interview.

There is a risk that the informants do not represent older persons in general, due to their complex care needs and extensive functional and health impairments. By adjusting the length and pace of the interview, we made it possible for these people's story to emerge.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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