

ORIGINAL ARTICLE

The experiences and needs of frail older people receiving home health care: A qualitative study

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Abstract

Background: Due to the rapid ageing of the population, there is increasing demand for long-term care in the people's home environment. Such care aims to allow the people to stay at home and avoid hospitalisation or other institutional care. In home health care, care must be provided at the highest possible quality, with the focus on the people's needs and experiences.

Objectives: This study explores the experiences and needs of frail older people receiving home health care.

Design and methods: An exploratory descriptive qualitative approach was chosen. Audio-taped semi-structured interviews were conducted with fifteen older people receiving home health care. A content analysis was used to analyse the data collected.

Results: The content analysis identified one main theme, three categories and seven subcategories related to frail older people's needs and experiences of home health care. The main theme was quality of care. The first category, Safe and Secure Care, consisted of three subcategories: Education and Experience of Nurses, Information, and Continuity of Care in terms of personnel continuity and regular care. The second category, Autonomy, contained two subcategories: Decision-making and Self-sufficiency. The last category, Relationship with Professionals, consisted of two subcategories: Personality of Nurse and Partnerships.

Conclusion: Older people are able to express their satisfaction or dissatisfaction with home health care. The results of this study revealed that the quality of care is crucial for frail older people.

Implication for practice: The provision of home health care is inherently highly specific; home care nurses should work to provide the highest possible quality of care. In particular, nurses should focus on ensuring that the care they provide is safe, effective, timely, efficient and person-centred.

KEYWORDS

experiences, home health care, needs, older people, quality of care

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1 | INTRODUCTION

The rapid ageing of the population worldwide has resulted in increasing demand for both primary and long-term care. Long-term care allows people with impaired health or reduced self-sufficiency to receive care while respecting their basic rights, freedoms and human dignity (WHO, 2020a). Long-term care therefore aims to give people the highest possible quality of life, together with independence and autonomy, including the opportunity of participating in care. Quality long-term care includes respect for the values, preferences and needs of the individual, and can be provided as home-based care or institutional care, with home health care expanding rapidly in all countries (WHO Study Group on Home-Based Long-Term Care, 2000). According to Eurostat (2018), in the European Union's member states, home care was provided in one in five households where there were people requiring assistance due to their long-term health problems. The highest percentages of households receiving home care were recorded in Luxembourg (88%), the Czech Republic (58%) and Denmark (54%).

The provision of home care is based on the aims and principles of long-term care. Home care seeks to allow the people, in particular older people, who is often suffering from complex chronic diseases and reduced self-sufficiency, to remain at home and thus avoid hospitalisation or other institutional care (Holmerová et al., 2014). Older people are particularly at risk of developing frailty syndrome as a result of complex chronic diseases that reduce the body's functional reserves, including a reduction in compensatory and adaptive mechanisms. Manifestations of frailty syndrome can be: (1) non-specific (unintentional weight loss, extreme fatigue, frequent infections); (2) falls; (3) delirium; and (4) fluctuating disability (Clegg et al., 2013). Therefore, it is crucial to secure home care of the highest possible quality (Holmerová et al., 2014).

The literature has various definitions of quality of care, but almost all definitions share similar elements. Shirley and Sanders (Shirley & Sanders, 2016) emphasise that quality of care is a comprehensive concept that covers safety, efficacy, outcomes and patients' experiences. Campbell et al. (2000) define quality of care in terms of 'whether individuals can access the health structures and processes of care which they need and whether the care received is effective'. According to the World Health Organization, quality of care is as follows: 'the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and person-centred' (WHO, 2020b). The Institute of Medicine states that in order to ensure high-quality care, it is necessary to provide person-centred care with the following dimensions: (1) respect for patients' values, preferences and expressed needs; (2) coordinated and integrated care; (3) providing information, communication and education; (4) ensuring physical comfort; (5) providing emotional support and relieving anxiety; and (6) involving family and friends (Institute of Medicine, 2001). However, to ensure quality care and its improvement, the results of care must be measured. Measuring the quality of care focuses not only on the results of care

What does the research add to existing knowledge in gerontology?

- This study is a qualitative inductive description of the experience and needs of older people living in the Czech Republic who receive home health care.
- Home health care nurses' training and experience are essential not only for the provision of professional nursing care, but also for the provision of professional information and advice to patients. Care provided by trained and experienced nurses is perceived by patients as quality care.
- Continuity of care in the sense of personnel continuity and regular care provision is important for the provision of quality care.
- A nurse's personality and communication skills are very important in building a relationship with the patient.

What are the implications of this new knowledge for nursing care with older people?

- The provision of home health care is inherently highly specific; home care nurses should work to provide the highest possible quality of care. In particular, nurses should focus on ensuring that the care they provide is safe, effective, timely, efficient and person-centred.
- Nurses should proactively identify their patients' needs and wishes in home health care. Care for patients in their home environment should be properly planned in advance, taking account of their needs and wishes. Patients should be actively engaged in care planning.

How could the findings be used to influence policy or practice or research or education?

- Additional research, especially qualitative research focusing on patients' needs as viewed by nurses providing home health care, is required.
- Organisations providing care for patients in their home environment should train nurses to be competent in a holistic approach to patients that takes their biological, social and psychological needs into account.

but also on patients' satisfaction and experiences (Howell & Zeitlin, 2017).

It is therefore clear that the planning and delivery of person-centred home health care must not only be based on the patient's state of health: it must also take into account the wishes and needs of patients and provide care in a way that preserves the patient's dignity and autonomy. Subsequently, however, it is necessary to evaluate the care provided. This is the only way to ensure that care is provided in the highest possible quality.

To date, there is no research in the Czech Republic focused on the experiences and needs of older people in home health care. Dostálová et al. (2020) conducted a scoping review to find out what is known so far about the needs of older people in home health care. One criterion for including studies in the review was that studies could be in either English or in Czech. However, no studies in the Czech language or studies conducted in the Czech Republic were found. Carrying out such research in the environment of the Czech Republic is therefore essential. Research findings can help understand the needs of older people in home health care. Taking research results into account when planning and delivering home health care will also make it possible to provide care of the highest possible quality.

This study explores the experiences and needs of frail older people receiving home health care.

2 | METHODS

2.1 | Design

An exploratory descriptive qualitative approach was chosen (Grove et al., 2013). A qualitative descriptive approach is used to directly describe the research area; this approach is based on describing and interpreting the experiences and actions of individuals and groups in a social and cultural context. During data collection, the researcher focuses on 'what' and 'why' (Holly et al., 2014). Data were collected using semi-structured interviews and then subjected to a content analysis (Graneheim & Lundman, 2004).

To ensure the trustworthiness of this study, the recommendation made by Graneheim et al. (2017) was followed. To increase credibility, participants from four different home health care agencies were included in the research to ensure greater diversity and enough data to cover significant variations. To meet the transferability criteria, participants' profiles were compiled and their statements were quoted in the text, which supports the authenticity of the research. The criterion of dependability was fulfilled by the fact that the individual steps of analysis and subsequent processing were continuously discussed by the members of the research team until a consensus was found. All authors discussed the content of the manuscript and agreed on its final form, which ensured confirmability. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to report important aspects of this study (Appendix S1, Tong et al., 2007).

2.2 | Setting

In the Czech Republic, health care in their home environment is provided by home health care agencies. Home health care agencies can be either public or private, and the health care must always be provided in accordance with applicable legislation. Health care is usually provided to patients seven days a week, with a maximum of three visits per

day with a time allowance of fifteen, thirty or forty-five minutes. The number of visits, their length and the required nursing procedures are determined by the patient's attending physician. Guided by the indication of the attending physician, the nurses plan and subsequently provide care in the patient's home environment. Nurses are obliged to continuously inform the patient's attending physician about the patient's health condition and any changes thereto.

Home health care patients are cared for by 'general nurses' who must be properly educated in accordance with European Commission Regulation 2005/36/EC (European Parliament, 2005). Since 2005, general nurses must have at least a bachelor's degree or a three-year education within a post-secondary technical school for the training of general nurses (Ministry of Health & CR, 2021). In the following text, the term 'nurse' will be used for general nurses.

2.3 | Participants

A purposive sampling method was chosen to select suitable study participants (Campbell et al., 2020). Study participants were selected to match the aim of the research as closely as possible. The inclusion criteria were women and men aged 65 and over living in their own homes and currently receiving home health care, whose medical records featured: (1) more than one chronic disease (without diagnosed dementia or overt cognitive impairment) and (2) reduced self-sufficiency in daily activities assessed according to the Barthel scale (ADL); ADL ≤ 65 (Mahoney & Barthel, 1965).

Participants were recruited from four different home health care agencies (one public and three private) based in three regions of the Czech Republic. Eligible participants were recruited according to predetermined criteria by the head nurses of home health care agencies. The nurse leaders handed over the list of eligible participants to the nurses who provided regular nursing care to the selected participants. The nurses subsequently contacted the selected participants during regular visits to ask whether they agreed to participate in the research. If they were interested in participating in the study, an appropriate date for a semi-structured interview was set by agreement between the nurse, the participant and the researcher. Ten women and five men participated in the study. All participants lived in their own homes, either alone (10) or with family members (5), and received regular assistance from home health care services, ranging from daily to weekly care. Health care included general supervision of the patient's health, medication and insulin administration, wound dressings, blood pressure checks, blood sampling and rehabilitation. Participants' ages ranged from 71 to 92. The main profile of the participants is shown in Table 1. None of the recruited participants refused to participate in the research or dropped out during the research.

2.4 | Data collection

Data were collected through semi-structured interviews ($n = 15$) conducted between January and August 2020. The original

TABLE 1 Profile of participants

Interviewee	Gender	Age	Living alone	Living with family	Medical history	ADL score
1	M	78		x	Diabetes; Hypertension; Stroke	10
2	F	92	x		Diabetes; Heart failure; Venous leg ulcer	65
3	F	91	x		Arthritis; Ischaemic heart disease; Stroke	50
4	F	77	x		Diabetes; Chronic obstructive pulmonary disease; Venous leg ulcer	60
5	M	65		x	Arthritis; Chronic kidney disease Diabetes; Venous leg ulcer	55
6	M	71		x	Arthritis; Heart failure; Leukaemia	60
7	M	71	x		Diabetes; Multiple sclerosis	40
8	F	71	x		Diabetes; Osteoporosis; Venous leg ulcer	60
9	F	74	x		Asthma; Chronic kidney disease; Hypertension	65
10	M	91		x	Arthritis; Ischaemic heart disease	55
11	F	80		x	Hypertension; Osteoporosis	65
12	F	79	x		Autoimmune diseases of the musculoskeletal system; Chronic kidney disease; Ischaemic heart disease	60
13	F	75	x		Asthma; Ischaemic heart disease	65
14	F	86	x		Diabetes; Hypertension; Osteoporosis; Venous leg ulcer	65
15	F	82	x		Heart failure; Parkinson disease	65

Abbreviation: M, male; F, female; ADL, Activities of daily living.

TABLE 2 Semi-structured interview guide

Can you describe your experience of the home health care you're receiving?

How is this care provided?

What are your needs in relation to the home care you're receiving?

How are those needs taken into account in the provision of home care?

What would ideal care look like?

What would an ideal nurse be like?

intention was to conduct face-to-face interviews in five regions of the Czech Republic, but due to the coronavirus pandemic and the related restrictions some interviews were conducted by telephone. Coronavirus measures and related restrictions were also a reason to stop collecting data, as cooperation with other home health care agencies was no longer possible, including the possibility of interviewing home health care patients by telephone. For this reason, data collection was performed only in three regions of the Czech Republic.

All interviews were recorded and transcribed verbatim. Of the total number of interviews, six were face-to-face interviews and nine were by telephone. Interviews lasted from 25 to 60 (mean 42) min. A list of open-ended questions drafted by all authors served as a guide for the interviews (Table 2). All participants were asked an initial question: 'Can you describe your experience of the home health care you're receiving?' To understand the context of the narrative, participants were asked additional questions such as: 'Can you tell me more about what you think? How do you view this situation? What does it mean for you? Can you tell me more about why this is important for you?' All interviews

were conducted by the first author. Face-to-face interviews took place in participants' homes by prior arrangement, and home health care nurses were present during these interviews. The presence of nurses during face-to-face interviews with respondents was a requirement of the manager of home health care agencies, as the respondents had known the nurse for a long time and the presence of a stranger in the form of a researcher entering their environment could be undesirable for them. The nurses did not intervene or participate in the interviews. The respondents were not stressed by or anxious about the presence of nurses during the interviews. The dates of the telephone interviews were agreed with the participants in advance. No nurses were present during the telephone conversations, nor were any members of the respondent's family or loved ones present.

Field notes (Phillippi & Lauderdale, 2018) were made during and immediately after the interviews. The notes included both the location where the interview took place and information about the participants (age, whether they live alone or not). Furthermore, the notes included the participants' actions during the interview, their moods, expressions of emotions and other relevant data important for a comprehensive understanding of the participants' statements. The notes also included information on any change in the topics prepared for the interviews, including the justification for the changes.

2.5 | Data analysis

The analysis utilised inductive content analysis, as described by Graneheim et al. (2017). Content analysis is a systematic method for analysing verbal or written communication using a coding and categorising approach (Graneheim & Lundman, 2004; Vaismoradi

TABLE 3 Example process of analysis

Unit of analysis	Code	Subcategory	Category	Main theme
...it's so nice, talking to them (nurses)..., I don't have anyone to talk to like that...	Social contact	Partnership	Relationship with Professionals	Quality of Care
... I'm sad here, ...that's how I find out some information... we talk (with nurse)... about what's new, what's going on, what is on TV... just about everything...	Social contact	Partnership	Relationship with Professionals	
... so I don't know if anyone will replace her (the nurse), I don't know. I'd fight for her to stay here...	Same nurse	Continuity	Safe and Secure Care	

TABLE 4 Main theme, categories and subcategories

Main theme	Categories	Subcategories
Quality of Care	Safe and Secure Care	Education and Experience
		Information Continuity
	Autonomy	Decision-making Self-sufficiency
	Relationship with Professionals	Personality of Nurse Partnership

et al., 2013). This method is suitable for exploring an individual's or a group's opinions, attitudes and experiences (Downe-Wamboldt, 1992). During the analysis, the manifest content is usually coded first, and then, the researchers search for latent content that is formulated as a theme (Graneheim et al., 2017).

The analysis process involved several steps that were regularly discussed by all authors. Participants' accounts were generally more broad-ranging than required for the research, and the analysis therefore focused solely on data that was relevant to participants' experiences of home health care. Interviews were reread several times to fully understand their content and significance. Meaning units, words, sentences and paragraphs related to the objective of this study were first identified and coded as manifest content. These codes were then grouped into seven subcategories according to their similarities. Subsequently, the subcategories were grouped into categories. In the last step, latent content was defined, which resulted in one main theme (Table 3). The main theme, categories and subcategories that emerged during the analysis are presented in Table 4. The results were reported according to Consolidated Criteria for Reporting Qualitative Research guidelines (Tong et al., 2007).

2.6 | Ethical considerations

This study was approved by the Ethics Committee of the Gerontology Centre in Prague (No. 2018/11/276219). All participants were provided with both oral and written information about the study. Oral and written consents were collected from all participants prior to the start of data collection. Emphasis was placed on the voluntary nature of the participants' involvement in the study. Participants were told that they could withdraw from the study at any time without giving a reason. The data were stored in accordance with the General Data Protection Regulation (EU Regulation - GDPR). To maintain confidentiality and to protect participants' personal data, the recorded

data were de-identified by code and stored on a password-protected computer, and only the authors had access to this material.

3 | RESULTS

Experiences and needs in the provision of home health care, as viewed by the participants, can be summarised in three main categories: Safe and secure care, Autonomy, and Relationship with professionals. The main theme that we use in this article for these three categories is 'Quality of care'. This section is structured according to the individual categories, with each category discussed from the participants' perspective. Participants have been quoted verbatim to ensure authenticity.

3.1 | Safe and secure care

The participants' accounts showed that their general experience of home health care was positive, with care described as 'amazing, great, perfect, excellent', etc. Care provided by trained nurses with sufficient experience and good communication skills was perceived by participants to be good. The continuity of nursing personnel and the individual nurses' attitudes were also important to them; such care gave participants reassurance and confidence.

3.1.1 | Education and experience

Participants highlighted that nurses needed to be qualified and experienced in order to provide professional care. If participants received care from a qualified and experienced nurse, they perceived this care as safe, and they expressed satisfaction with the care provided, in which case the nurses were viewed as professionals who are able

to cope with unexpected situations. Some participants described a trained nurse as someone who 'knows what to do'. One participant said: '...it's important for me that she's skilled and qualified... Basically it's important that I always feel safe with her, really feel safe with her...' (Interviewee 3). Another participant remarked: '...they have to be qualified. It's not just that. After all, they have to understand this (medical issues) ...' (Interviewee 10). If nurses did not demonstrate sufficient knowledge and experience, participants regarded them as amateurs and rejected their care. As one participant said: '...having an amateur here, I don't know, I wouldn't want that...' (Interviewee 6).

3.1.2 | Information

Nurses' training and experience were closely related to the provision of professional advice and information for patients. For the participants, it was very important that nurses not only gave them information about their health status but also advice on how to improve their health. One participant said: '...and most importantly, they can advise me. If there's something I don't know, they can give me advice. That's ideal...' (Interviewee 13).

Participants reported that sometimes the nurses did not know the answers to their questions. Nurses' willingness to search for information if they did not immediately know the answer was appreciated by the participants. As one said, '...if I ask them something, they can answer me. And at the same time, if I ask them a question and they don't know the answer, they'll find out and explain everything to me in detail on their next visit...' (Interviewee 12). In some cases, nurses gave participants information not just about their health status, but also about social security and assistance. Participants expected nurses to take the initiative when providing information, and any lack of information or reluctance to provide information made participants feel insecure. As one participant said: '...If she doesn't tell me herself, I feel stupid for asking...' (Interviewee 9).

3.1.3 | Continuity

The continuity of care provided—meaning the continuity of personnel and of the care itself—was practically the central theme for the participants. Participants defined personnel continuity as the provision of care by the same nurse. If participants were to have confidence in their care, it was important that they were cared for by the nurse they were used to. If nurses were rotated, patients felt mistrustful and sad. One participant commented: '... so I don't know if anyone will replace her (the nurse), I don't know. I'd fight for her to stay here...' (Interviewee 3). The advantage of personnel continuity was that not only were nurses familiar with the participants' health status, but they also had an opportunity to get to know the participants and their other needs and wishes. One participant said: '...you're used to them and you know what to expect from them, and what they can expect from me...' (Interviewee 2). If another nurse had to visit instead of the usual one, participants appreciated being informed in advance which nurse would be visiting.

Besides personnel continuity, continuity of care was also important for the participants. They were satisfied if care was provided regularly and nurses agreed with the participants the times for their visits and kept to this schedule. As one participant said, '...and they visit just as we agreed, and I like that, when people keep their promises...' (Interviewee 14). As it was important for participants to adhere to the time agreed for a visit, they appreciated being informed in advance of any change to the schedule. They found uncertainty about the timing of visits and any changes to them unpleasant. One participant remarked: '...it was so annoying, I didn't know when they'd come or even if they'd come...' (Interviewee 7). Participants planned their daily activities around the time agreed for a visit, and failure to stick to this schedule disrupted their activities. 'It's important for me to know when she's coming... I have that sort of fixed in my mind. And if that gets derailed, it throws me off balance. Or, I don't know, I start wondering about what might have happened...' (Interviewee 2).

Allocating sufficient time for visits was also important for patients. If nurses were in a rush, participants felt uncomfortable, as if they were a nuisance. One participant said: '... I don't like it if she says 'I'm in a hurry' ... I like it when she makes time for me...' (Interviewee 10). However, participants realised that nurses have a large number of patients and could not spend as much time with them as they would like. As one participant said: '... sometimes she has enough time for me and sometimes she doesn't, because she's got another patient...' (Interviewee 14).

3.2 | Autonomy

Participants described autonomy in two ways: being involved in the provision of health care in terms of decision-making and cooperation with nurses, and maintaining their self-sufficiency.

3.2.1 | Decision-making and cooperation

The opportunity to participate in care provision was crucial for some participants, who expressed their satisfaction at being able to participate in their own care. They were also pleased if nurses were interested in their current health status and adjusted care accordingly; for participants, this meant they were treated with respect. One participant reported: 'It's important (to discuss care provision with the nurse). It's important, because I also have days that are pretty good and days that aren't. ...When I wasn't feeling well, we didn't exercise. We always agreed on this...' (Interviewee 13).

3.2.2 | Self-sufficiency

Despite the fact that participants were aware of their deteriorating health, which restricted their daily activities, they emphasised the importance of preserving their self-sufficiency and independence as

far as possible. This was expressed as the ability to perform simple daily activities such as walking, shopping and preparing food. To maintain these activities, it was important for participants to receive assistance in the form of rehabilitation or other exercises. As one participant commented, '...I have to get some exercise, and if I don't go out, I have to have some movement...' (Interviewee 15). Another participant remarked: '... I do these exercises because I can't keep my balance...' (Interviewee 2). As part of rehabilitation, nurses, for example, verticalised patients, practised moving from bed to chair with them and, above all, performed walking exercises. Participants were also educated by nurses about the exercises they could perform independently at home and which helped them to maintain or improve their self-sufficiency, as one participant stated: '...I exercise on my own; the nurse taught me exercises that I do regularly, every day...' (Interviewee 6).

3.3 | Relationship with professionals

3.3.1 | Personality of the nurse

The personality of the nurses and their approach to the participants played an important role in care. Participants needed nurses to be empathetic, capable of understanding participants' needs and wishes concerning their health status and their personal lives. One participant said: 'It's important that she's nice. She doesn't have to smile all the time, but you need to feel some empathy ...' (Interviewee 6). Participants described smiling, pleasant and helpful nurses as ideal. A nurse's positive attitude towards a participant not only facilitated communication between them but also gave the participant the confidence to openly discuss important health issues with the nurse. In their accounts, participants did not hide their fear that they might be cared for by nurses who did not have a positive attitude. One participant expressed: '...If a nurse visited me and was complaining and being unpleasant, I wouldn't be able to sleep. I'd feel bad...' (Interviewee 8).

3.3.2 | Partnership

For many participants, being at home meant they felt lonely and excluded from social life, as participants expressed: '...as I am here alone, I have a long time here... you know, I have almost no friends any more...' (Interviewee 3); '...old age is terrible, that loneliness... you can't do anything, you can't go anywhere...' (Interviewee 8). Despite the fact that most of them were in contact with their families and friends, visits by nurses were an opportunity to enhance their social life. One participant noted: '... I'm sad here, ...that's how I find out some information... we talk... about what's new, what's going on, what is on TV... just about everything...' (Interviewee 11). Participants saw nurses not only as professionals who looked after their health, but also as partners they could talk to, and they looked forward to seeing them. The nurses became part of their lives, which

allowed them to develop a relationship with the nurses '... I always really look forward to them, they are my girls... I like them very much, all of them...' (Interviewee 15). In some cases, participants thought of nurses as members of the family. One participant said: 'You know, if they didn't visit, the days would feel long, because they brighten up my day when they come... To me, they're like daughters...' (Interviewee 2).

4 | DISCUSSION

This study has sought to explore the experiences and needs of frail older people receiving home health care. Despite the fact that the older people's experiences and needs overlapped, the analysis revealed three main categories related to the objective of this study—Safe and Secure Care, Autonomy, and Relationship with Professionals. These three categories were summarised under one main theme: 'Quality of Care'.

In general, during the interviews the participants expressed satisfaction with the provision of home health care. They especially drew attention to the opportunity to stay in their home environment during illness or periods of diminished self-sufficiency, which has proved to be a great advantage for them.

As the results of our study showed, the quality of care provided is important for older patients, while one of the features of quality care, according to older patients, is the care provided by trained staff with sufficient experience.

Nurses providing home health care usually work without medical supervision. Their work therefore consists of independent decision-making and depends on their education and experience (Duke & Street, 2005; Williamson, 2007). Holmerová et al. (2018) assert that qualified and trained staff are one of the basic preconditions ensuring quality care. This is in line with other studies that emphasise the importance of the provision of quality care. Their authors consider quality care to be care provided by trained and skilled nurses, and their findings indicate that patients view such care as professional (Bagchus et al., 2015; Moe et al., 2013; Randström et al., 2013). This corresponds to the definition of 'professional' in the Cambridge Dictionary (2020): 'having the qualities of skilled and trained people'.

The results of our study also showed that one of the basic indicators of the quality of care is the involvement of patients in the care provided.

Active participation can lead to better quality healthcare provision, better health outcomes and better quality of life. Patient participation in healthcare provision also indicates an appreciation of the patient's humanity and individuality (Vahdat et al., 2014). This is confirmed by Breitholtz et al. (2013b) who reported that patients involved in the provision of care felt in control of their care, in terms of making decisions in line with their needs and wishes. It is therefore important for patients to be treated with respect and to be regarded as a competent human beings (Liveng, 2011). This can be promoted by involving patients in discussions (McCabe, 2004).

Communication with the patient in the provision of care proved to be very important in our study. It turned out that effective communication not only affects the quality of care but also supports the individuality of the patient.

Communication must not only concern issues related to care: nurses should also show an interest in their patients' daily lives. Such communication can provide reassurance for the patient and reveal other significant needs or wishes that the patient would not otherwise express (Sundler et al., 2016). Managing effective communication is influenced by the nurse's personality and attitude to patients. The nurse's personality and approach to patients were another topic that emerged from our analysis and was especially emphasised by older patients in the interviews.

In particular, empathy is considered an important personality trait for nurses. In interpersonal communication, it plays a vital role in gaining trust and is therefore very important when nurses are building relationships with patients (Wan et al., 2019). Empathy, the ability to understand other people's feelings facilitates communication between patient and nurse and also helps avoid any conflicts that may arise during care (Duan & Hill, 1996). It is therefore a key part of the nurse–patient relationship (Richardson et al., 2012). The findings of Strandås and Bondas (2018) reveal that a good nurse–patient relationship enhances not only the patient's physical health but also promotes emotional, mental and social well-being. Jarling et al. (2018) point out that sufficient time must be devoted to establishing a relationship between nurse and patient that is based on mutual trust.

In our study, the patients placed great emphasis on continuity of care, in terms of both staff continuity and continuity of care in terms of regular care. The results of studies by From et al. (2009) and Moe et al. (2013) showed that the continuity of care and the allocation of sufficient time are important factors in the assessment of the quality of care for patients.

The continuity of care can be described as a 'cornerstone of care' and an 'essential element' of general practice (Freeman et al., 2003). According to Hill et al. (2014), continuity of care means care that corresponds not only to health needs but also to the patient's personal context. They emphasise that maintaining continuity is essential to improve patients' health, especially for patients with multiple diseases.

As already mentioned in this discussion, the quality of care provided (with all its components) is very important when caring for people. Patients are not only very sensitive to the care provided, but the way in which it is provided also has an impact on their quality of life. Henderson (2006) states that nurses providing home health care should be able to assess a patient's health, identify needs and form a relationship with the patient. According to Cohen-Mansfield et al. (2017), in order to provide quality care for older people in their home environment, it is necessary (1) to focus on their needs and treat them with respect, and (2) to establish a good relationship with them. The quality of care therefore depends on nurses' ability to perceive their patients' needs and interact with them. Nurses' skills also include the ability to anticipate situations that may be dangerous to patients.

This is in line with the findings of earlier studies (Breitholtz et al., 2013a; From et al., 2009; McGarry, 2010; Moe et al., 2013; Samuelsson & Wister, 2000) and of the present study.

4.1 | Limitations of the study

One limitation of this study was the relatively small participant sample as a consequence of the restrictive measures introduced in response to the coronavirus pandemic. As a result of these measures, no further collaboration with home care agencies in the research was possible. In view of these measures, the data collection method also had to be changed during the data collection. Instead of the originally planned face-to-face interviews, part of the interviews were conducted by telephone, which at least made it possible to complete data collection at home health care agencies which, despite the pandemic situation, were willing to complete the research collaboration. Some participants' statements may have been influenced by the presence of nurses from home health care agencies during the face-to-face interviews. Although the sample of participants was relatively homogeneous, heterogeneity related to gender (10 women and 5 men) was not taken into account in the data analysis. The gender heterogeneity of the participants might have affected the transferability of the results. It is also necessary to keep in mind the risk of subjectivity in the interpretation of data, which may be caused by the researcher's assumptions (Holly et al., 2014). Emphasis was also placed on the trustworthiness of this study (Graneheim et al., 2017), which was supported by an effort to describe the methods in detail so that the strengths and weaknesses were understood.

5 | CONCLUSION

The results of this study show that the quality of care provided is important for older patients. The training and sufficient experience of nurses are essential not only for the provision of professional nursing care but also for the provision of professional information and advice to patients. Ensuring the continuity of care also proves to be essential. This includes both continuity in the sense of personnel continuity, when care is provided mainly by the same nurse, and continuity in the sense of care itself, that is regular care. Equally important are the personalities of nurses and their approach to patients. The personality of nurses facilitates both communication between the nurse and the patient, as well as facilitating the establishment of a friendly relationship between the patient and the nurse, which in turn promotes mutual trust.

In general, ageing is associated not only with changes in social status but often also with changes in health status, specifically worsening health. As has been demonstrated, it is important for older people to remain in their own environment for as long as possible. One way they can do this during periods of illness or reduced self-sufficiency is for medical care to be provided in the form of home health care. As the provision of home health care is inherently highly

specific, home care nurses should work to provide the highest possible quality of care. The present study has set out an overview of the needs and experiences of frail older people receiving home health care. Additional research, especially qualitative research focusing on patients' needs as viewed by nurses providing home health care, will be required to gain a deeper understanding of the needs of older people in order to ensure quality care.

6 | IMPLICATION OF PRACTICE

The provision of home health care is inherently highly specific; home care nurses should work to provide the highest possible quality of care. In particular, nurses should focus on ensuring that the care they provide is safe, effective, timely, efficient and person-centred.

Nurses should proactively identify their patients' needs and wishes in home health care. Care for patients in their home environment should be properly planned in advance, taking account of their needs and wishes. Patients should be actively engaged in care planning.

Organisations providing care for patients in their home environment should train nurses to be competent in a holistic approach to patients that takes their biological, social and psychological needs into account.

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CONFLICT OF INTEREST

None.

AUTHORS' CONTRIBUTION

IH and VD planned the methodology and the design of this study. VD, AB, HB and IH prepared the interview guide. VD conducted the interviews and analysed and interpreted the data with IH's supervision. All authors discussed interview transcripts and analysis during each stage. VD drafted the manuscript under the IH's supervision. AB, HB and IH contributed with complementing perspectives in the interpretations and suggested improvements to the text. All authors read and approved the final manuscript.

DATA AVAILABILITY STATEMENT

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

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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