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ORIGINAL ARTICLE

Alone yet accountable, the unseen buffers: A qualitative study of nurses' experiences working in home care during the COVID-19 pandemic

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Abstract

Background: Norwegian society's resilience during the COVID-19 pandemic resulted in low mortality rates and moderate economic decline. The accessible primary healthcare system played a vital role in this, especially in the care of elderly and chronically ill patients. However, nurses in home care experienced emotional burdens, ethical dilemmas and limited access to protective equipment. These challenges were overshadowed by media coverage of hospital struggles, and municipal home care services were oddly absent from post-pandemic reports. This research therefore aimed to explore and describe how nurses experienced working in home care during the pandemic.

Methods: We designed a qualitative study and conducted semi-structured interviews with nine home care nurses from different municipalities in Southeast Norway. Systematic text condensation inspired by Malterud was employed for data analysis.

Results: Nurses' experiences were described through two categories: 'adapting approaches' and 'adapting work practices'. The results showed how nurses often felt alone while simultaneously shouldering a significant responsibility for patients facing a novel and unfamiliar illness. The pandemic necessitated treating patients in their own homes to minimise infection risks, intensifying the nurses' treatment responsibilities. Furthermore, limited access to medical expertise and physical separation from management due to remote work accentuated feelings of isolation and amplified the nurses' responsibility for patient care. Additionally, the nurses encountered frequent changes in work routines, demanding adaptability.

Conclusion: This study underscores the significant role of home care nurses, who, despite feeling professionally isolated and unsupported, demonstrated impressive adaptability. They served as a crucial buffer in the healthcare system, ensuring vulnerable individuals received essential care. This highlights the importance of a robust primary healthcare system with a skilled nursing workforce that can work autonomously, shoulder responsibility, and make clinical decisions, even when medical expertise is less readily available. It also reminds us that healthcare preparedness depends on collaborative efforts across all sectors.

KEYWORDS

COVID-19, elderly, experiences, home care nursing, nurses, primary health care, qualitative research

INTRODUCTION

The resilience of Norwegian society played a pivotal role in achieving low mortality rates and modest economic decline during the COVID-19 pandemic [1]. The high level of public trust, rapidly implemented containment measures, low population density as well as the fortunate welfare model and responsive healthcare system were particularly highlighted as important factors [2–4]. The COVID-19 commission underscored how accessible and highly developed primary healthcare services played a crucial role in the care of elderly people and people with chronic conditions [3]. However, despite this, municipal home care services were strangely absent in the reports following COVID-19. Nurses' efforts and burden in hospitals, on the other hand, were well documented [3, 4]. The challenges they faced included heavy workloads, extended shifts and inadequate resources and staffing, further exacerbating their already demanding circumstances [5–7].

BACKGROUND

The challenge of balancing infection control to protect vulnerable patients while maintaining patient safety and care was particularly pronounced in home care services [8, 9]. In these services, patients often belong to a highly vulnerable group, frequently comprising elderly individuals with multiple chronic conditions [10]. The elderly were identified as particularly vulnerable due to the association between increasing age and co-morbidities, with critical or severe disease progression, risk of hospitalisation and mortality if infected [11, 12]. Therefore, it was recommended for older individuals to receive healthcare services in their own homes if possible [13]. Also, to prevent infection transmission and prioritise care due to capacity constraints, more patients previously treated in hospitals were redirected to home care services [14]. In addition, general practitioners (GPs) prioritised face-to-face consultations for patients with acute or chronic conditions requiring physical examinations [15]. Leaving the home care nurses in a situation with a heavy workload and great responsibility [6].

To adapt, home care services had to rapidly adjust to meet patients' needs [16–18]. Understanding infection risks and their consequences was vital for protecting vulnerable patients and guiding clinical decisions in home care. However, the initial stages of the COVID-19 pandemic saw limited national and global knowledge [3, 4]. The post-COVID-19 reports also confirmed the evolving and unclear nature of infection control guidelines for healthcare personnel. This lack of guidance left nurses uncertain when facing typical and atypical COVID-19 symptoms, leading to concerns about their ability to manage such cases effectively and professionally [3, 19, 20]. This situation led to an atmosphere of unpredictability and uncertainty among nurses [19, 21, 22]. Priority issues and ethical dilemmas led to emotional burden and challenges [23]. In addition, insufficient access to personal protective equipment (PPE) [21] added to nurses' anxiety about potentially transmitting the infection to patients and their families [24].

While the media extensively covered the struggles of healthcare personnel and the strain on hospitals during the COVID-19 pandemic, there was a noticeable lack of attention given to the dedicated nurses working in municipal home care services [14]. Almost 'overnight', their working conditions underwent significant changes, yet their experiences have been largely overlooked in post-COVID-19 studies and reports, which have predominantly focused on hospital-based healthcare personnel [20, 23, 25].

This research highlights the voices of home care nurses, intending to provide a comprehensive understanding of the pandemic's impact on healthcare in Norway, offering insights with international relevance. While Norway had low overall mortality rates, most deaths occurred among those over 70, with a median age of 84.8 [26]. This study acknowledges the unique pandemic challenges faced by nurses caring for these vulnerable patients at home. By exploring these challenges, the research fosters learning and contributes to improving home healthcare services. In essence, the aim is to explore and describe how nurses experienced working in home care during the pandemic.

METHODS

Design

A qualitative descriptive–interpretative design was employed to explore the experiences of nurses working in home care during the COVID-19 pandemic. The data collection process involved conducting semi-structured individual interviews. To analyse the data, a systematic text condensation approach inspired by Malterud [27] was employed. First author (LHF) is an experienced primary care

nurse and educator in Advanced Practice Nursing. She holds a doctoral degree in Health Sciences, and has extensive experience in qualitative research. Second author (ES) has a master's degree in Advanced Practice Nursing, and has more than 10 years of experience from home care nursing.

Participants and setting

Participating nurses were recruited from municipalities in the south-eastern part of Norway. The inclusion criteria required the nurses to have worked in municipal home care from March 2020 and throughout the pandemic. To achieve maximum diversity, nurses with varying levels of work experience and age were sought.

Home care managers, acting on behalf of the researchers, disseminated information about the study and provided a written invitation to nurses who met the inclusion criteria. The sample consisted of nine female home care nurses [1–9], aged between 20 and 65 years, who were purposively selected based on the inclusion criteria. The nurses had no further education beyond a bachelor's degree in nursing. Seven nurses held full-time positions (100%), while two worked in part-time positions (60%–80%). All nurses had been employed in home care services throughout the pandemic. The setting represented home care departments in both large urban municipalities and rural municipalities. In these home care departments, nursing staff mainly consisted of Registered Nurses (RNs), assistant nurses (ANs) and assistants.

Data collection

Data were collected by ES from August to October 2021 through semi-structured interviews to explore the nurses' pandemic experiences in home care. The interviews lasted between 50 and 75 min and followed an interview guide consisting of open-ended questions, allowing for free expression of experiences while maintaining a certain structure. All interviews took place at the nurses' workplace, accommodating their convenience and promoting a comfortable and secure environment. Following the recommendation of Brinkmann and Kvale [28], we began with warm-up questions about nurses' experience and the rewarding aspects of their profession. We also inquired about changes in their nursing practices and challenges during the COVID-19 pandemic. Selective follow-up questions further explored specific assessments, actions and elaborations on relevant topics. All interviews were audio recorded and transcribed verbatim by ES.

Data analysis

Data analysis was conducted using systematic text condensation, following the methodology proposed by Malterud [27]. This approach is an inductive method for performing thematic cross-case analysis on qualitative data, consisting of the following steps: (1) total impression – from chaos to codes; (2) identifying and sorting meaning units – from codes to code group; (3) condensation – from code groups to sub-groups; (4) synthesising – from condensation to categories entailing descriptions and concepts.

Table 1 provides exemplification of the stepwise analysis.

To commence the analysis, both ES and LHF thoroughly reviewed all interviews to gain a general understanding of the material. ES then proceeded with the analysis, collaborating with LHF throughout each step. During the initial phase, ES carefully examined the interviews line by line to identify meaning units which were subsequently labelled with codes and then grouped into code groups. The third step entailed abstracting and condensing the content and dividing it into sub-groups. The condensates were written in the 'first-person' form to maintain proximity to the original text. Additionally, a 'golden quote' was selected for each sub-group to serve as an example of its content (see example Table 2). In the final step, two categories

TABLE 1 Exemplification of the analysis based on the four steps of systematic text condensation described by Malterud (2012).

Step 1: Codes	Step 2: Code groups	Step 3: Sub-groups	Step 4: Categories
• Infection control measures • Risk of infection • Altered work tasks • Prevention	Different modes of working	1. Embracing new ways of working 2. Changing workplace routines 3. Adjusting to working with personal protective equipment (PPE)	Adapting work practices
• Organisation • Assessments • Novel and unknown disease • Personal considerations • Clinical leadership • Nurse's role and responsibility	Holistic approaches	1. Navigating isolation and responsibility 2. Adapting to the unknown 3. Ensuring personal and collective safety 4. Balancing precautions and patient Well-being	Adapting approaches

TABLE 2 Example from the process of analysis.

Code	Code group	Meaning units	Sub-group	Condensate	Synthesis	Category
Prevention	Approaches	'I myself have been meticulous with infection control, meticulous with hand hygiene, distance, and the fact that I have not exposed myself to too much infection'. [5] 'We also divided workgroups into cohorts, in order to prevent becoming close contacts with all colleagues'. [2] 'Therefore, hygiene is very important to protect oneself and the patients'. [1] 'We have talked a lot about what we did in our free time; we have lived quite boring lives for 1.5 years to avoid getting infected and passing it on to the patients'. [3] 'We have tried to live restrictively outside of work, not having too many close contacts at all'. [8] 'I have been very careful in my personal life about who I spend time with; I have not attended large gatherings'. [4] 'I have not seen my grandchildren since March 2020'. [7] 'I felt a great responsibility for what I did in my spare time. It was not about me, but I have constantly thought that I could infect patients. I think that I have been more considerate in my personal life because of my job as a nurse, as I can infect patients – I feel that I have had a great responsibility. I feel that this responsibility as a nurse limited me in what I did privately to avoid getting infected and not bring it to patients'. [9] 'The employer provided us with guidelines and reminders to live restrictively'. [6]	Ensuring personal and collective safety	I myself have been meticulous with infection control, meticulous with hand hygiene and I have avoided exposing myself to too much infection by reducing my private contacts. The employer also provided us with guidelines for that, and divided work groups into cohorts. Having few close contacts to limit the risk of transmission was important to me as a nurse. I have not attended large gatherings, I have not seen my grandchildren since March 2020 and I have only had contact with immediate family to avoid getting infected. It was not about myself, but about the fear of unknowingly infecting my patients. As healthcare professionals, we have to be at work, and it is crucial that we do not bring any infections to our patients, so we had to be conscious of the number of close contacts we had. I think that I have been more considerate in my personal life because of my job as a nurse, as I can infect patients, and I have felt a great responsibility not to be a source of infection. I have used face masks and maintained good hand hygiene – as preventive measures. When you always treat it as if there is always a risk of infection, you automatically reduce the risk of transmission significantly. Thinking about basic infection control practices is important to protect oneself and the patients and to limit the spread of infection.	All the nurses saw themselves as potential sources of infection when in contact with patients and felt a great responsibility as nurses to limit the risk of transmission. They also received guidelines from their employer. Therefore, they chose to have few close contacts, avoided participating in large gatherings, and was very cautious in their personal lives. As one of the nurses shared, she had not seen her grandchildren for 1.5 years due to the potential risk of transmitting the infection to vulnerable patients. It was not about fear of getting infected themselves, but about the risk of infecting high-risk patients. Furthermore, the nurses mentioned that they had been extremely meticulous in following basic infection control practices, such as practicing good hand hygiene and wearing face masks when interacting with patients.	Adapting approaches

referring the main result of analysis presented reconceptualised descriptions of nurses' experiences working in home care during the COVID-19 pandemic.

Ethical considerations

All nurses received oral and written information about the aim of the research, the voluntariness of participation and their rights to withdraw. Informed consent was obtained from all nurses. As this project dealt with nurses' experiences, rather than health outcomes or health data, the project did not require approval by an ethics committee in Norway, however, data management and safety were approved by the Norwegian Agency for Shared Services in Education and Research (Sikt) (project number 529225). The Consolidated Criteria for Reporting Qualitative Studies (COREQ) was used for study reporting [29].

RESULTS

The results provide a comprehensive understanding of nurses' pandemic experiences, summarised into two categories identified through rigorous analysis: 'adapting approaches' and 'adapting work practices'. The category 'adapting approaches' reveals how nurses protected themselves and patients while navigating uncertainties in patient care. It also highlights their dedication to infection control, despite challenges in balancing precautions and patient care. The category 'adapting work practices' explores the various adjustments nurses made to their work practices, both within healthcare settings and during patient interactions. The results are illustrated in Figure 1.

Adapting approaches

The nurses' experiences of adapting their approaches were evident in the findings. Due to the risk of infection, doctors and other healthcare institutions aimed to minimise physical contact with patients. Consequently, nurses often felt a sense of isolation when facing challenging decisions in patient situations while providing care at the patients' homes. Additionally, they had to navigate and learn to assess a novel and unfamiliar disease that presented symptoms resembling those of other illnesses. Driven by the precautionary principle, nurses prioritised safeguarding patients by minimising physical interactions. Moreover, the nurses' experiences of approaching patients were influenced by their concerns about the patients' well-being considering the imposed restrictions.

Navigating isolation and responsibility

The results revealed a prevalent sense of isolation among nurses. At the workplace, the feeling of being alone was linked to shouldering a substantial amount of responsibility, as exemplified here:

> While working in home care, you frequently find yourself alone, considering, "Have I done it correctly?" Yet, it is crucial to trust your own judgment because of the solitary nature of the role. Often, you are the only nurse on duty, bearing significant responsibilities. (8)

Nurses expressed that they were physically present while managers and many others worked remotely. Consequently,

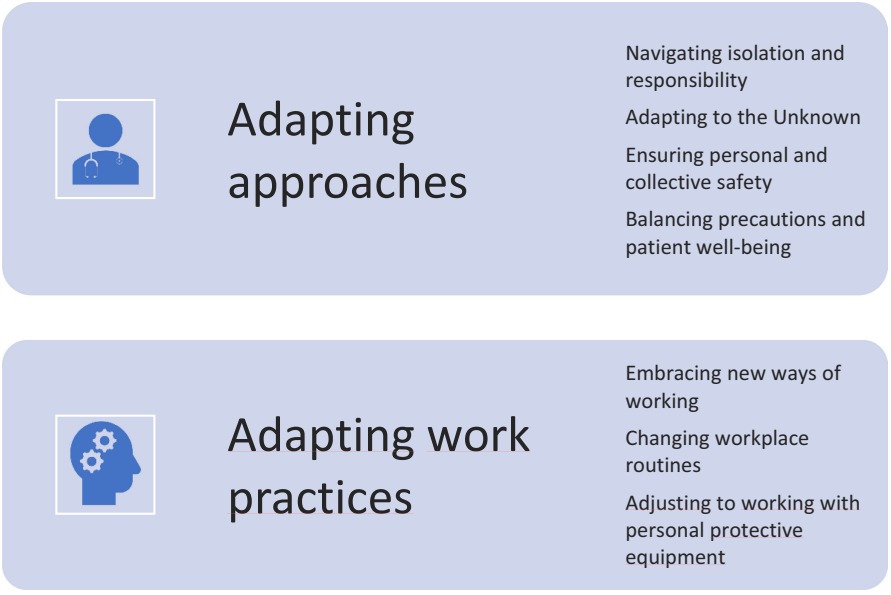

FIGURE 1 Categories and subgroups.

they undertook most of the daily tasks and felt a heightened sense of responsibility. With limited accessibility to management, nurses found themselves at the forefront of addressing professional and organisational inquiries due to their physical presence.

The nurses also experienced a significant responsibility when providing care at patients' homes, intensifying the feeling of being alone. Home nursing already demanded independence; this was intensified throughout the pandemic. They described how they had to make difficult decisions alone while caring for patients with complex illnesses. Access to medical facilities was limited, thus they often had to assess the urgency of a doctor's supervision to prevent transmissions. This applied to patients who were previously sent to GPs or the emergency room for an assessment, who nurses now assessed at home to ensure the fewest possible meeting points for physical contact. The challenges were exemplified by a nurse's quote:

> The problem was truly that the hospital didn't want the patients in, it applied to both COVID-related and general cases due to infection risk. I had numerous discussions with the hospital to get the patients admitted. We met a lot of resistance. (8)

Nurses described how GPs avoided home visits due to infection risk, making it hard for patients to secure appointments. Even those with mild COVID-19 symptoms were often denied GP visits. Emergency departments were also strict in admissions, leading patients to be referred to paramedics, who were deemed better at infection prevention. Nevertheless, nurses sometimes faced ambulance refusals due to infection concerns. These situations raised doubts among the nurses about patients receiving essential care. Nurses acted as patient advocates, tirelessly pushing for hospital or GP access. As this nurse described:

> It was a very demanding period, and I wonder if the patients really got the help they needed. I felt very alone as a nurse, and I experienced having to fight for the patients to get them into hospital or to a GP, for example. We really were the patients' advocates, we learned that even more during the COVID-19 pandemic. (7)

Adapting to the unknown

When COVID-19 emerged, nurses faced the challenge of dealing with a new disease. They had to assess patients' symptoms in the context of COVID-19 while distinguishing them from other illnesses. COVID-19 symptoms often resembled those of other diseases, causing confusion. One of the nurses explained this dilemma:

> It seemed as if the symptoms were somehow replaced, and "everything" was evaluated as COVID-19. The symptoms the patient previously had suddenly didn't count anymore. Even if the symptoms had been present for a while, they were no longer considered in relation to the underlying condition, and they were simply attributed to COVID-19. (8)

Nurses emphasised the significance of COVID-19 tests as an important measure to assess and differentiate COVID-19. However, making assessments, especially for vague symptoms like delirium, falls or worsening chronic conditions, was challenging due to the unfamiliar and complex spectrum of symptoms sometimes caused by COVID-19. Some nurses found their expertise lacking while navigating this unknown territory, resulting in a feeling of uncertainty about when to reach out to the GP, or make treatment recommendations. Additionally, they described how other health personnel such as GPs, also seemed to struggle with uncertainties facing this unfamiliar disease. So even if they described peer support becoming a crucial factor in their way of adapting to the unknown, it was not sufficient in all cases.

> I also experienced that the GPs was uncertain; they didn't know either. So, I often felt alone with a great responsibility. I wish we had better guidelines to assess COVID patients, what to look for, when and how to react. (8)

Ensuring personal and collective safety

The results revealed that the nurses themselves felt a great personal responsibility to protect themselves and others from the risk of infection. Several mentioned being anxious about doing anything that could lead to situations of transmission and, ultimately, the loss of human lives. Consequently, they imposed restrictions on their personal lives. All nurses reported isolating themselves and choosing to have as few close contacts as possible, typically limited to immediate family members. They avoided attending large gatherings and mostly stayed at home, except for going to work. They also made the decision to refrain from leisure activities such as going to the gym or participating in choir

rehearsals, even when national restrictions were eased for the general population. One nurse shared that she had not seen her grandchildren for 1.5 years because she did not want to expose herself to the risk of infection. The following quote emphasises this:

> I have taken more precautions in my personal life because of my job as a nurse, as I could infect patients. I feel I have a great responsibility, and it limits what I do privately to avoid getting infected. (9)

Balancing precautions and patient well-being

The results revealed that nurses took active measures to modify their patient approach and services to prioritise caution. Due to their perception of physical contact as a transmission risk, they made deliberate efforts to minimise such interactions. They conducted comprehensive reviews of patients' care plans to identify essential healthcare needs. Collaborating with patients, they scaled down or temporarily halted certain services. For instance, patients who previously received daily visits for tasks like compression stockings or shower assistance shifted to less frequent observation visits or phone consultations. In some cases, nurses provided training to patients for self-management. Some nurses also informed patients to call them when needed, while others proactively called patients daily or weekly to check on their well-being. Many mentioned feeling uncertain about whether the patients would be able to manage without assistance.

Furthermore, many patients independently opted to reduce or cancel daily visits from nurses due to their own infection concerns, relying on family members for care. This mutual understanding of infection risk was evident among both nurses and patients. One nurse explained:

> I experienced that most patients felt safe and well taken care of. However, we also had patients who did not want visits from us due to the risk of infection. I think it's okay. But then you also have patients who, in a way, can't say no to getting help, for example when you are completely dependent on getting out of bed, or making breakfast, you're quite stuck in that choice, as a patient. Then you are very reliant on personnel knowing what they're doing. But I think most have felt safe. (1)

In addition to reduced home care visits, day care services were suspended, and many patients who had regular rotations in nursing homes had to stay at home instead. The reduction in services due to precautionary measures raised concerns among nurses. They worried about patients coping with the introduced restrictions. They noted that patients isolated themselves to minimise infection risks, and that family members refrained from visiting to prioritise infection control. Witnessing this isolation was emotionally challenging for the nurses. They shared examples of patients who had experienced significant isolation, even likening it to wartime experiences. The nurses reported that they observed a deterioration in patients with mental health problems. Sleep problems among patients were also widespread, and many struggled with anxiety, they said. The nurses emphasised that loneliness and isolation were significant health concerns, sometimes overshadowing the fear of COVID-19 infection, as illustrated in the following quote:

> At the beginning, there were many patients who isolated themselves. At that time, I was more concerned about isolation and loneliness than the actual infection. (4)

Adapting work practices

Nurses had to modify their work practices due to the pandemic and implement innovative measures to ensure infection control. This included adjusting their working methods when caring for patients at home, as well as changing workplace routines.

Embracing new ways of working

The nurses explained that to reduce contact between healthcare personnel and patients, they had to adjust their way of working. Employers purchased mobile devices that allowed nurses to have video consultations with GPs in the patients' homes. Remote follow-up care flourished, and the installation of technical equipment was prioritised by the municipality. Patients who tested positive for COVID-19 and needed additional monitoring were provided with saturation meters. The nurses were responsible for providing patients with training on how to use the saturation meter and called them daily to check their oxygen saturation levels. In this way, it was easy to detect changes in their health condition and assess whether hospital admission was necessary.

> We had patients with reported needs due to COVID. We conducted remote follow-up care then. The patient would be provided with a

> saturation meter, and we could monitor them on a screen. We had to call them when we noticed a decrease in saturation and talk to them. (6)

Changing workplace routines

In the workplace, the nurses adopted several specific modifications to ensure infection control. To prevent the potential spread of the virus within the staff and the risk of mass quarantine, they implemented staggered work schedules, ensuring that not all employees were present in the office simultaneously. Lunch breaks were also scheduled at different times, and the timing of morning reports was rotated. The staff was organised into distinct groups, with each group meeting in separate rooms or offices at different times. As this nurse explained:

> We also divided workgroups into cohorts, in order to prevent becoming close contacts with all colleagues. (2)

Former meeting rooms were repurposed into office spaces, and vacant offices, resulting from administrative staff working remotely, were utilised to maintain physical distancing between employee groups. During the early stages of the COVID-19 pandemic, many nurses continued to follow the same set of regular patients. However, once patients and staff had access to vaccines, they began following up with different patients. One nurse summarised it as follows:

> We divided the staff into groups to avoid absences due to illness and used multiple rooms. We also made sure that each one of us didn't went to the same patient, so we had the same list of patients for extended periods. It worked well in terms of organization. (9)

Furthermore, to enhance infection control during their patient visits, the nurses took measures in their vehicles. They created dedicated boxes containing infection control equipment, which they carried in their cars. These boxes also held disinfectants for cleaning the car's interior, including the steering wheel and other equipment. When asked about the persistence of these measures, a nurse confirmed their continuation:

> We paid significant attention to our cars, ensuring thorough cleaning after each shift, including the steering wheel, surfaces, and equipment, such as computers. These measures are still in place, and we have no plans to discontinue them. (5)

Adjusting to working with PPE

Nurses encountered the necessity of using PPE when interacting with patients to ensure infection prevention. This measure, while essential, posed several challenges. Nurses found it unfamiliar and, in certain situations, described it as impersonal, particularly when dealing with terminal cases in the patient's home. They were concerned about the dignity of patients seeing them wearing face masks, especially in end-of-life situations. Several nurses expressed how infection control equipment acted as a barrier between them and the patients, hindering their ability to make accurate observations and assessments. For instance, the use of gloves affected their sense of touch, making it challenging to discern a patient's temperature. Communicating effectively while wearing masks presented another hurdle, often necessitating repeated explanations, particularly with elderly patients.

Despite the need for PPE, many nurses faced limited access to essential items like face masks, yellow protective gowns and face shields within the municipality, especially at the pandemic's onset. Several nurses shared their experiences of receiving only one face mask per shift, which they had to use for all their patients throughout the day. Employers also struggled to secure an adequate supply of hand sanitizers, resulting in rationing. One nurse succinctly summarised the situation, stating,

> The most significant challenge in the beginning was the uncertainty and scarcity of personal protective equipment. It was almost impossible to obtain, and that was the most challenging aspect of it all. (3)

DISCUSSION

The purpose of this study was to explore and describe how nurses experienced working in home care during the COVID-19 pandemic. The key findings shed light on how nurses often felt isolated, burdened with significant responsibilities and faced with challenging uncertainties due to the pandemic. Factors such as limited access to medical expertise due to infection risks, and the absence of physical leadership resulting from remote work, seemed to contribute to this sense of isolation and heightened responsibility for patients. Moreover, the nurses encountered a dynamic work environment

characterised by constant changes in routines, demanding their adaptability. Navigating an unfamiliar disease in such demanding circumstances further intensified their feelings of uncertainty throughout the pandemic.

Alone yet accountable, the unseen buffers

The nurses in this study expressed a heightened sense of responsibility during the pandemic, carrying a heavy burden of patient care. When the pandemic hit, the nurses faced tough situations. They had to assess patients' symptoms for both underlying conditions and COVID-19, advocate for patients and work diligently to ensure they received necessary care. Constant workplace changes, limited access to protective equipment and the introduction of new working methods may have contributed to a sense of losing control over their working situation. With limited support from others, this likely intensified their feeling of bearing the responsibility alone. Descriptions of lonesomeness and isolation are not unique for this study, even if previous studies have mainly focused on hospital settings. Loft and Berthelsen conducted a scoping review of Nordic nursing research during COVID [30]. Their main finding was precisely the nurses' challenge of social isolation during the pandemic, underscoring the need for awareness of the consequences of social distancing for patients, relatives and health personnel. Nurses' feeling of being isolated and left alone has also been evident internationally [31–35]. Several factors may have inhibited this feeling of being alone. In Norway, the hospital capacity issue increased the pressure on primary health care [36], at the same time as collaboration between healthcare services clearly declined [6]. This resulted in fewer hospital admissions [37], and challenges related to medical examinations, treatment and follow-up in different healthcare settings [38]. A decline of in-person consultations with GPs and increased use of e-consultations was also documented, meaning that the GPs were less physically present [39]. In hospital settings, nurses felt isolated due to staffing challenges and experienced loneliness while caring for isolated patients [31–35]. The home care nurses in this study also lacked collegial support to some extent, however, the most prominent finding pertained to the absence of collaborative persons capable of contributing to clinical decisions. Their descriptions thus highlight a feeling of what Williams [40] termed professional isolation, a sense of geographical distance from – or lack of peer support. The nurses' sense of professional isolation may have been utterly worsened by their leader's remote working, making them less accessible – often reachable only through email or phone. Williams [40] also described professional isolation in the social context of feeling unsupported, undervalued and not being recognised for their achievements, as well as lacking communication and mentorship. Instead of expected support, nurses were burdened with extra tasks like leadership duties, infection control and workplace restructuring. The perceived lack of relational leadership and support may have led to isolation and a heavier workload as described by others [6, 30, 41, 42]. From a systematic review researching how leadership styles influence nursing workforce outcomes, Cummings et al. [43] concluded that relational leadership practices are crucial to support nurses and enhance their job satisfaction and productivity. This accentuates the significance of having on-site leadership in healthcare settings, enabling nurses to focus on their core responsibilities and deliver optimal patient care. The experience of professional isolation underscores the importance of leadership practices that prioritise support, mentorship and effective communication, especially during times of crisis.

Nurses described the challenge of adapting to the 'unknown'. Evidence-based information about how to care for COVID-19 patients was lacking for these nurses at the pandemic outset, as it did for their international counterparts [31, 44, 45], leading to substantial uncertainty regarding transmission and health impact of COVID-19. Nevertheless, the nurses in this study illustrated the extent to which they prioritised the safety of their patients, adopting stringent measures even in their personal lives. In addition, they took responsibility for changing workplace routines to protect themselves, colleagues, patients and relatives from infection. In home care services, nurses consistently offer long-term care, nurturing stronger relationships with patients and their families. This might lead nurses to feel that their responsibility goes beyond the professional domain. Globally, research has also recorded pandemic-induced changes in personal behaviour and work routines among nurses [16–18, 45, 46]. Some studies even emphasised the nurse's uncertainty of the unknown and fear of infection, combined with the lack of resources and other personnel as a reason for distress and solitude [47–50]. In a situation marked by numerous changes, coupled with the weight of significant responsibility, as encountered by the nurses in this study, it is not surprising that they expressed feelings of uncertainty. While this study did not delve into burnout or mental health, it is still reasonable to assume that the sense of uncertainty, bearing a feeling of sole responsibility for patient care, while adapting to unknown challenges, could have negatively affected their well-being. In the aftermath of COVID-19, several studies have documented the burnout of nurses during COVID [44, 48, 50]. Research also suggests that nurses experienced increased workloads, negatively impacting their mental health due to additional tasks and responsibilities [22]. The nurses played a crucial

role as a buffer in the healthcare system, ensuring that the most vulnerable individuals received proper care. This was especially important at a time when hospitals were in the spotlight, focusing on treating the most critically ill patients.

Methodological considerations

Methodological considerations play a crucial role in enhancing the trustworthiness of this study, yet certain limitations need acknowledgement. The relatively small sample size, consisting of nine nurses from distinct home nursing departments in separate municipalities, may restrict the perspectives and potentially overlook the diversity of experiences across various home care settings. This limitation raises concerns about achieving data saturation. Additionally, the selection of participating nurses by their leadership introduces a potential selection bias, as insights into non-participants and the overall number of potential participants approached are lacking.

Moreover, the personal pandemic experiences of the primary researcher, ES, working in home care, might have introduced a preconception in the study. ES's first-hand experiences could have influenced question formulation and response interpretation, possibly impacting outcomes.

Despite these limitations, the study contributes valuable insights into nurses' pandemic experiences in home care services, enhancing the transferability of understanding for home care nurses during COVID. The trustworthiness of the study is strengthened through rich descriptions and transparent documentation of data collection and analysis processes. However, careful consideration of the discussed limitations is crucial when interpreting the findings.

CONCLUSION

This study has enlightened the significant responsibility and unique challenges faced by home care nurses during COVID-19, including a profound sense of professional isolation. The pandemic accelerated changes in healthcare delivery, emphasising the importance of reducing physical contact and in-person medical services. Home care services emerged as a critical component in achieving these objectives, reducing hospital admissions and mitigating infection risks.

Despite their critical role, home care nurses experienced isolation and perceived limited support. This highlights the enduring impact of social distancing on nursing practice. Nevertheless, nurses demonstrated adaptability, going above and beyond to provide care and serving as a vital buffer in the healthcare system.

In terms of practical implications, this study underscores the importance of a robust primary healthcare system capable of delivering adequate care, even in times of crisis. It highlights the significance of nurses' competency, autonomy and clinical decision-making abilities, especially when immediate medical expertise may be scarce. Institutions should invest in training and development programmes for home care nurses to enhance their adaptability and resilience, as well as empower them with greater autonomy in decision making. Initiatives addressing the professional isolation may also prove helpful, for example strategies to foster a supportive work environment, communication protocols or resources for emotional support. The study also serves as a reminder that a country's preparedness for healthcare crisis depends on collaborative efforts across all sectors.

Future research should investigate the effectiveness of support systems for home care nurses during and after crises. For example, through exploring the impact of peer support networks, leadership interventions and organisational policies on moderating feelings of isolation. Furthermore, studying the long-term mental health effects of pandemics on home care nurses and identify intervention strategies may provide important perspectives. Moreover, future research should evaluate the effectiveness of home care services' preparedness strategies to guide future crisis planning. This includes assessing the need to enhance municipal services in terms of capacity, cooperation and competence development. Conducting comparative studies across regions to understand contextual influences on home care nurses' experiences may enlighten these perspectives.

AUTHOR CONTRIBUTIONS

LHF and ES collaborated on designing the study. ES conducted interviews, transcribed data, and alongside LHF, engaged in the analysis. LHF was responsible for composing the primary manuscript text and Figure 1, while ES prepared Tables 1 and 2. The manuscript underwent a comprehensive review and final approval for publication by both LHF and ES.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no competing interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on reasonable request from the corresponding author. The data are not publicly available due to privacy and ethical restrictions.

ETHICS STATEMENT

This study was conducted in accordance with ethical standards for scientific research. The research protocol, including recruitment procedure, information to participants and interview guide, was approved by the Norwegian Centre for Research Data (project number 529225) before we commenced the study.

CONSENT TO PARTICIPATE

Before conducting the interviews, the participants signed written consent for participation, in which they agreed to take part in an interview to be used in a scientific publication about nurses' experiences of working in home care during the pandemic.

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