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Older persons' expressed worries during nursing care at home: Do health complexity and nature of nursing care in the visit matter?

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ABSTRACT

Objective: Older persons receiving home care express more cues and concerns compared to other clinical contexts. Increased health condition complexity requires a corresponding increase in nursing competence. The aim of this study was to explore how complexity of older persons' health and nature of the visit influenced their expressed worries.
Methods: In this cross-sectional explorative study, we analysed older persons' expressed worries (n = 508) identified by the Verona Coding Definitions of Emotional Sequences (VR-CoDES) in 129 audio-recorded home care visits with older persons (≥65 years), collected in 3 city districts and 1 rural area in Norway.
Results: Expressed worries of 45 older persons were included in the analysis: 18 had low health complexity, 5 moderate and 22 high health complexity. The nature of the visit affected the number of expressed worries, health complexity did not. Most of the worries were expressed during basic nursing care visits and/or medication administration.
Conclusion: Findings suggest that home visit type may influence the older persons' expressed worries. The complexity of the older persons' health condition seems to have little impact on the expressed worries.
Practice implications: Knowledge about communication in different complexity of visits is important when planning care for older persons.

1. Introduction

The United Nation has declared 2021–2030 as the decade of healthy ageing [1], with a corresponding increase in health policies aimed at active ageing and enabling people to live at home for as long as possible. Further, shorter hospital stays and increased outpatient and home care services seem to be the trend in many countries [2]. Nursing care in the home, which is an integral part of primary health care, is a health care service in which trained nursing staff provide care in the private home of the person in need. High-quality nursing care in the home is salient for supporting older persons' needs. It is also a prerequisite for allowing older persons to live longer at home by avoiding or postponing the need for long-term institutional care. Home care services are available in most European countries [3], and usually covers the basic needs of a person, including nutrition, elimination and personal hygiene, but also more complex nursing procedures, administration of medicines and psychosocial needs [4]. The goal is to enable people to live a fulfilling life at home, regardless of their age and health situation [2].

For over a decade, the World Health Organization has emphasized that the growing older population in Western countries will require a health care system that is able to respond to diverse and complex care needs [5]. The rapid increase in age-related diseases will result in a corresponding increase in the complexity of procedures and the need for individualized care delivered to older persons [6]. This kind of appropriate and timely home care relies on nursing staff's ability to detect each person's care needs by using appropriate assessment measures [7]. One way care needs are expressed is through signalling emotional concerns [8], which entails that the nursing staff are sensitive to expressed worries. However, home care

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visits are often short, with predefined tasks, hindering the ability of nursing staff to detect emotional concerns [9]. Moreover, the assessing of care needs is a complex process, as it is influenced by several factors, including the lived life of the person, biomedical and psychosocial aspects, and an understanding of health and possible reasons for perceived health issues [10]. This requires nursing staff with comprehensive skills and competencies [6].

Studies from home care have shown that though patients' basic care needs are well taken care of, their psychosocial needs tend to be neglected [9,11]. However, while the nursing staff may not explicitly attend to the psychosocial needs of older patients, they often find ways to integrate emotional talk into procedures or other tasks [12]. This kind of person-centred communication has the potential to improve the patients' physical and psychosocial health outcomes [13]. Person-centred communication requires the nurse to be attentive, sensitive and empathic to the patient [14], and appropriately respond to their emotions and facilitate self-management—two main functions of communication. Hafskjold et al. [15] identified four categories of emotional worries expressed by older persons receiving home care in Norway: worries about relationships with others, about health care-related issues, about ageing and bodily impairment, and about life narratives and value issues. However, studies have shown that home care nurses find it difficult to talk with older persons about existential issues, preferring instead to talk about the tasks to be done [16–18].

Based on our earlier study on communication in home care, we know that older persons receiving home care express relatively more concerns and cues to registered nurses (RN) and nurse assistants (NA), compared to findings from studies on consultations in medical offices [19]. This may indicate a more symmetrical relationship between home care staff and older persons. In fact, older persons define the home care nurses as an important part of their social network, stressing the potential value of the nurse-patient relationship [20]. In addition, older persons expressed their concerns more explicitly to the RNs than to the NAs. However, we do not know if the older persons' communication of worries in home care varies based on the complexity of the visits—taking the nature of the nursing care in the visit (i.e., the tasks the nursing staff must undertake during the visit) as well as the person's health situation related to frailty and multimorbidity into account. This knowledge is needed to develop and provide good quality care and knowledge-based services in this context.

1.1. Aim

The aim of this study was to explore how older persons' health complexity and nature of the nursing care in the visit influenced their expression of worries to the nursing staff.

2. Methods

The study had a cross-sectional, exploratory quantitative design, undertaking a secondary analysis of data from the COMHOME study, a large international research project exploring communication in home care [3].

2.1. Setting and sample

The study was conducted in home care in Norway. The sample included 45 older persons (≥65 years) receiving home care and their nursing staff. In total, 16 registered nurses (RNs) and 17 nurse assistants (NAs) holding a permanent position and providing care in older persons' homes took part in the study. Older persons with cognitive decline, unable to provide informed consent, or too frail were excluded from the study.

2.2. Data collection

In this study, we reviewed 144 audio-recorded visits including older persons' expressed worries (n = 638). We excluded expressions of pain felt in the moment (e.g., exclamations like 'ah', 'oi', 'oof', or 'ouch, that hurt!'), leaving 129 audio-recorded visits and 508 expressed worries eligible for analysis. The audio-recordings were collected in three city districts and one rural area in Norway, December 2013 to April 2014. Previous papers describe the data collection in detail [15,21].

2.3. Measures

2.3.1. Health complexity of the older person

We applied the medication lists of the older persons receiving home care as a proxy for health complexity, as information concerning their medical histories was not available for analysis. We used the Anatomical Therapeutic Chemical (ATC) classification system to systemize the different medications across the 14 first-level anatomical/pharmacological groups [22]. We defined three patient health complexity categories based on the number of medications used (mean = 8.4) and the number of ATC groups (mean = 4.2). A cut-off for the different groups was set as the median score (eight for number of medications and four for number of ATC groups). Thus, we ended up with the following three groups:

1. *Low complexity*, where the number of medications prescribed were below eight and the number of ATC categories were below four (No. of meds < 8 AND ATC < 4);
2. *Moderate complexity*, where either the number of medications prescribed were below eight or the number of ATC categories were below four (No. of meds < 8 OR ATC < 4); and
3. *High complexity*, where the number of medications prescribed were eight or more and the number of ATC categories were four or more (No. of meds ≥ 8 AND ATC ≥ 4).

2.3.2. Nature of the nursing care in the home care visits

We organized the nature of the home care visits into five categories representing the nature of the nursing care in the visit as reported by the nursing staff:

1. *Basic nursing care* represents visits where the main purpose of the visit was to help the older person with activities of daily living, such as bathing, dressing and meals.
2. *Medication administration* represents visits where the purpose of the visit was to hand out the medicine.
3. *Nursing procedures* represents visits where the nursing staff helped the older person with instrumental tasks, such as wound care, compression stockings or inserting a hearing aid.
4. *Basic nursing care + medication administration* represents visits with a combination of basic nursing care and medication administration.
5. *Nursing procedures + basic nursing care or medication administration* represents one or more nursing procedures in addition to basic needs and/or medication administration.

2.3.3. Expressed worries

We defined older persons' worries as identified by the VR-CoDES [8], based on the nature [19] and content [15,21] of their expressed worries. We defined the nature of these expressions using three categories, to capture whether the expressed worries were phrased as an unpleasant state or circumstance, an emotion, or a contextual hint of an emotion (Fig. 1).

The categories represent sum categories of concerns and cues identified by the VR-CoDES [19]. Further, we organized the content of the expression into four categories: 1) worries about relationships with others, 2) worries about health care-related issues, 3) worries about ageing and bodily impairment, and 4) life narratives and value

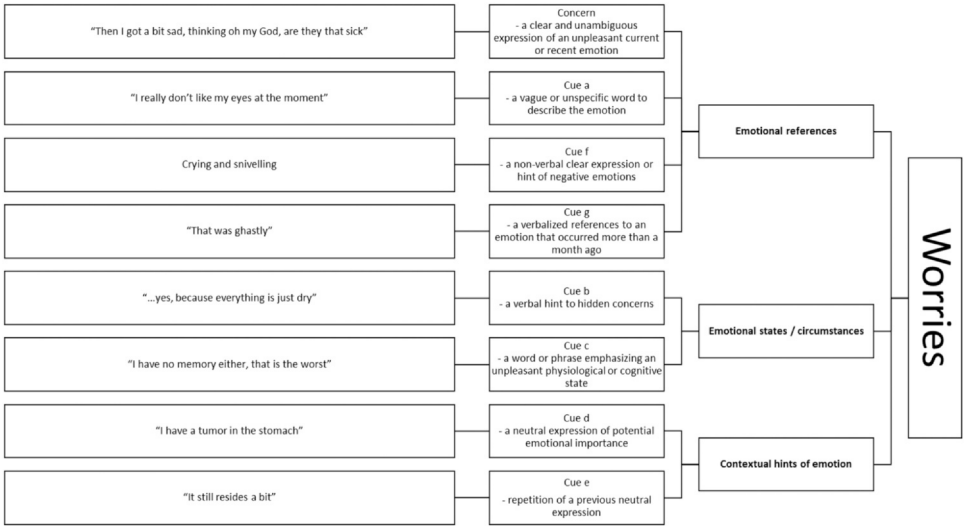

Fig. 1. The nature of older persons' expressed worries.

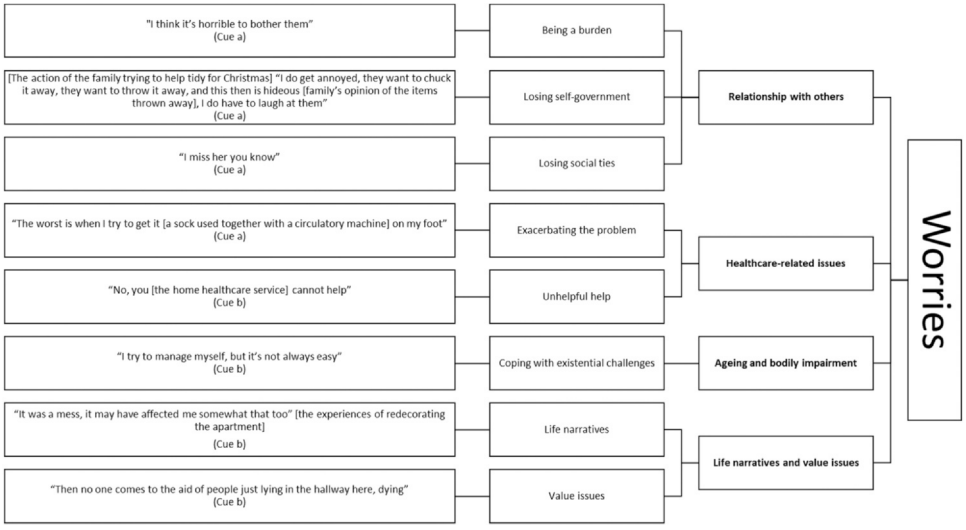

Fig. 2. The content of older persons' expressed worries.

issues (Fig. 2). The categorization was based on overarching themes derived from an in-depth inductive content analysis of the older persons' worries expressed during home care visits in earlier publications from the COMHOME study [15,21].

2.4. Analysis

We used IBM SPSS Statistics, version 26.0 [23] and Excel (Microsoft Office Professional Plus 2016) for the statistical analyses. The data were analysed in summation and frequency tables. Group differences and associations were analysed using standard statistical tests: chi-square, Spearman correlation, and multivariate linear regression. Multivariate regression was used to estimate a model for number of worries per home care visit based on nature of the nursing care in the visit and visit length. The significance level was set at <5%.

2.5. Ethical considerations

The study followed the ethical principles for medical research involving human subjects [24]. The Norwegian Social Science Data Services (ID 36017) approved the study. Both the older persons and the nursing staff received oral and written information and provided written informed consent to participate.

3. Results

3.1. Sample characteristics

Overall, expressed worries of 45 older persons (36 females and 9 males) were included in the analysis. Their mean age was 84 (SD = 8.5), ranging from 65 to 94 years. In total, 129 visits were analysed. The number of visits per patient ranged from 1 to 9, with a mean of 3 visits per older person.

3.2. Health complexity of the older persons

Among the older persons, 18 had low health complexity, 5 moderate health complexity and 22 high health complexity. There was no significant difference in age and gender between older persons with different health complexity.

3.3. Nature of nursing care in the home care visit

Of the 129 home care visits, 49 (38%) of visits were basic nursing care, 40 (31%) basic nursing care and medication administration, 22 (17%) nursing procedures and basic nursing care and/or medication administration, 14 (11%) medication administration

and 4 (3%) nursing procedures. In all, 17 RNs and 16 NAs provided the home care visits. There was no significant difference in the nature of nursing care in the home care visits between the RNs and NAs.

3.4. Expressed worries related to health complexity and nature of nursing care in the home care visit

The mean number of expressed worries per person was 11 (SD = 13). Older persons with low health complexity expressed 12 (SD = 17) worries, persons with moderate health complexity 10 (SD = 6) worries, and persons with high health complexity expressed 11 (SD = 12) worries. The mean of worries per visit was 4 (SD = 4), ranging from 1 to 22 worries. The number of worries was significantly different for visits of different nature of nursing care (p = 0.04), ranging from a mean of 3–5 worries per visit. The number of expressed worries per visit was lowest in single medication administration visits (n = 3), and highest in single basic nursing care visits (n = 5) and combined basic nursing care and medication administration visits (n = 5).

The expressed worries were phrased as an unpleasant state or circumstance, an emotion, or a contextual hint of an emotion in 300 (59%), 193 (38%) and 15 (3%) of cases, respectively. In 291 (57%) of the expressions, the worries were related to ageing and bodily impairment; in 98 (19%), they were related to health care-related issues; and in 60 (12%) and 59 (12%), they were related to life narratives and value issues, and relationships with others, respectively.

In all, 249 (49%) of the worries were expressed by older persons with high health complexity, and 207 (41%) and 52 (10%) by older persons with low and moderate health complexity, respectively. The nature of the expressions was not statistically significantly different between older persons with low, moderate and high health complexity (Table 1). However, the nature of the expressions was significantly different regarding the nature of the nursing care in the home visits (p = 0.035). During medication administration, the majority of expressed worries (64%) were phrased as an emotion, whereas in the other types of visits, the majority of the worries were phrased as an unpleasant state or circumstance (55–66%) (Table 2).

The content of the worries was not statistically significantly different between older persons with low, moderate and high health complexity (Table 3). However, the content of the worry was significantly different regarding the nature of the nursing care in the home visits (p = 0.002) (Table 4). The majority of expressions (50–59%) were related to ageing and bodily impairment for all types of visits. Worries stating an emotion were significantly more often expressed during basic nursing care and/or medication administration visits. The majority of these worries were related to ageing and bodily impairment (54%), as well as life narratives and value issues (19%) and relationships with others (16%), and only a small number (11%) were related to health care-related issues. Worries phrased as an unpleasant state or circumstance or as a contextual hint of an emotion were not statistically different for visits of different nature of nursing care.

Analysed at visit level, the mean numbers of worries per visit was 4 (SD = 4), ranging from 1 to 22. The number of worries was significantly correlated with the nature of nursing care in the visit (r_s = −0.234, p = 0.008) and the visit length (r_s = 0.362, p < 0.001), but not with patient complexity. A multivariate linear regression model was calculated to predict numbers of worries based on nature of nursing care in the visit and visit length. A significant regression equation was found (F(2126) = 11,532, p < 0.001), with an R^2 of 0.155. The number of worries expressed during the visits is equal to 4.285–0.713(NATURE OF NURSING CARE IN THE VISIT) + 0.089(VISIT LENGTH). NATURE OF NURSING CARE IN THE VISIT was coded as 1 = basic nursing care, 2 = medication administration, 3 = nursing procedures, 4 = basic nursing care and medication administration, and 5 = nursing procedures and basic nursing care and/or medication administration, and VISIT LENGTH is measured in minutes. The mean length of the visit was 18 min (median 14 min), range 1–70 min. During basic nursing care visits, three more concerns were expressed than during visit category 5 (nursing procedures and basic nursing care and/or medication administration), and the number of expressed worries increases by one for each 11 min increases in visit length.

4. Discussion and conclusion

In this study, we explored whether the worries that older people expressed during nursing home care visits varied based on the patients' health complexity or the nature of the nursing care in the home care visits. Findings offer new and detailed knowledge about the communication of concerns related to own health situation between older persons living at home and home care nursing staff. Given that a growing number of older people are receiving care services in their home, this knowledge is important for nursing care to be sufficiently tailored towards the needs of the older population.

4.1. Discussion

The number of older persons' expressed worries differed with regard to the nature of the nursing care in the home visit. Most of the worries were expressed during visits involving basic nursing care, and only 3% were expressed during visits involving nursing procedures. This suggests that communication in home care may differ depending on the task(s) of the nursing staff, which is highly correlated with visit length. Nursing procedure visits (e.g., measuring blood glucose levels) are often shorter in duration than basic nursing care visits (e.g., helping with personal hygiene), which might be one reason for this observed difference. We do not have additional data that confirms whether the older persons intentionally communicated differently to the nursing staff. Here, individual interviews with the older persons shortly after the visits would have provided more in-depth understanding regarding how the nature of nursing care of the visits affected their propensity to express worries. However, we do know that persons receiving home care can sense when the nursing staff is stressed, based on their body language [25]; studies have also found that shorter visit times reduce patients' ability to express their needs [9]. In our study, the time factor indicated that the older persons would express one worry more for every 11-minute increase in visit length. This indicates that the predefined task for the visit is a stronger indicator than visit length for the number of expressed worries. This finding may be due to the fact that the nursing staff's attention

Table 1
Nature of worries by patient health complexity, n (%).

	All	Emotion		Unpleasant state or circumstance		Neutral or context	
Low health complexity	193	79	(38.2)	125	(60.4)	3	(1.4))
Moderate health complexity	300	23	(44.2)	26	(50.0)	3	(5.8)
High health complexity	15	91	(36.5)	149	(59.8)	9	(3.6)

Table 2
Nature of worries by scope of nursing care in the home care visit, n (%).

	All	Emotion		Unpleasant state or circumstance		Neutral or context	
Basic needs	250	82	(32.8)	159	(63.6)	9	(3.6)
Basic needs and medical administration	147	62	(42.2)	81	(55.1)	4	(2.7)
Nursing procedures and basic needs and/or medication administration	59	19	(32.29	39	(66.1)	1	(1.7)
Medication administration	36	23	(63.9)	12	(33.3)	1	(2.8)
Nursing procedure	16	7	(43.8)	9	(56.2)	0	(0.09

Statistically significant difference in nature of worries between types of visits, chi-square p = 0.035

is often focused on performing the specific procedure, leaving less room for conversing with the older person about health related issues, as well as personal and sensitive issues. Nurses can find it challenging to balance being truly 'with' their patients while doing procedures [26], and a recent study on home care in Norway found that nurses found it difficult to deviate from predefined task(s) [27]—thus limiting the time and space for emotion-related talk during shorter visits. However, in home care, nursing staff can develop a relationship with the elderly over time, as they might have recurrent visits over a long period. In these kinds of established nurse–patient relationships, the nurse is more likely to obtain a more thorough and focused assessment of their older patient's needs, and may intuitively know when he/she is likely to open up [28]. In these instances, the nursing staff might therefore choose to adjust their approach to the older persons, depending on the predefined tasks for the visit.

Nursing procedures are typically performed by RNs, whereas basic needs procedures tend to be performed by NAs [29]. This was however not the case in our sample, and we cannot conclude whether the difference in older persons' expressed worries can be explained by the different type of nursing staff. In a previous paper from the COMHOME study, Hafskjold et al. found that the worries expressed to RNs were more explicit than the worries expressed to NAs [19]. This means that the emotional cues NAs receive from their older patients may be vaguer, and thus more difficult to identify and assess. This represents a paradoxical challenge for NAs, who have less formal competence than RNs [7]. Moreover, in a recent study, we found that the NAs responded with a more person-centred approach than the RNs [30], indicating that NAs make great effort in supporting the older persons in the specific visit. If an older person's expressed worry requires further follow-up but is not detected by the NAs, the RNs miss important information about the older persons' emotional state and needs, which they cannot then attend to. Indeed, it has been shown that the psychosocial needs of older persons receiving home care are less attended to than other needs [31]. Home care nursing staff work mostly alone, and careful documentation of performed assessment, clinical judgements and decisions is therefore essential. However, the competence in documentation among nursing staff in home care is insufficient [7]; therefore, even if an NA does accurately identify an expressed worry as reflecting an emotional need, they may neglect to inform the RN—and thus the need remains unattended to.

We found that the main content of the expressed worries involved topics related to ageing and bodily impairment (59%). This is in line with other studies, and suggests that older persons worry about their ability to manage living at home [9,32]. As one's body and bodily functions are central to personal expression and self-esteem [33], one important function of the nursing staffs' communication is to support the older persons' beliefs in their own abilities to manage at home [34]. Most people want to continue to live in their home environment as long as possible, if they are able to receive nursing care in their homes that is tailored to their needs and allows them to be independent [9].

The number of expressed worries were evenly distributed between the older persons with high, moderate, and low health complexity. As we did not have information about the older persons' diagnoses or other health history information, we used their medication lists as a proxy to indicate the complexity of their conditions. It is possible that we were unable to prove significant differences in the expressed worries based on health complexity because the medication lists were an inadequate proxy. The visits during which the most worries were expressed were those involving basic nursing care. These typically involved help with personal hygiene (e.g., bathing or using the toilet); as such, in these situations, the nurses naturally have a physical closeness to the older person. Studies suggest that allowing another person into one's personal space may produce positive outcomes, such as increased well-being [35] and improved cognitive function [36]; it is also likely that physical closeness leads to more open and honest communication. Moreover, these are the types of visits where the older person can be more actively involved, as they may have specific preferences with regard to how they usually perform their hygiene routines. This may strengthen their relationships with the nursing staff: indeed, a recent review found that older persons in home care developed a better relationship with the nursing staff when they were able and allowed to participate in care planning [9]. Basic nursing care visits are also usually of longer duration than some of the standardized nursing procedures, and this may better facilitate older persons' sharing of their emotion-related thoughts and needs. However, it should be noted that time is perceived differently by older persons and by nursing staff [37], and this could influence the communication between the two. Nursing staff frequently report that they lack time with their patients. It has been found that they during home care visits sometimes chose to manipulate the system in different ways to complete their obligations toward the older persons for example, i.e. by adjusting the timer for the visit, or performing tasks that were not predefined because the nurses had professional ideals concerning how to provide the best care for their patients [27].

Table 3
Content of worries by patient health complexity, n (%).

	All	Ageing and bodily impairment		Health care-related issues		Relationships with others		Life narratives and value issues	
Low health complexity	207	123	(59.4)	38	(18.4)	25	(12.1)	21	(10.1)
Moderate health complexity	52	27	(51.9)	8	(15.4)	10	(19.2)	7	(13.5)
High health complexity	249	141	(56.6)	52	(20.9)	24	(9.6)	32	(12.9)

Table 4
Content of worries by patient scope of nursing care in the home care visit, n (%).

	All	Ageing and bodily impairment		Health care-related issues		Relationships with others		Life narratives and value issues	
Basic needs	250	143	(57.2)	52	(20.8)	27	(10.8)	28	(11.2)
Basic needs and medical administration	147	87	(59.2)	29	(19.7)	18	(12.2)	13	(8.8)
Nursing procedures and basic needs and/or medication administration	59	34	(57.6)	12	(20.3)	4	(6.8)	9	(15.3)
Medication administration	36	19	(52.8)	4	(11.1)	3	(8.3)	10	(27.8)
Nursing procedure	7	8	(50.0)	1	(6.3)	7	(43.8)	0	(0.0)

Statistically significant difference in content of worries between types of visits, chi-square p = 0.002

4.2. Conclusion

In this study, we found potentially important nuances in the emotional communication between nursing staff and older persons receiving home care. Our findings suggest that the nature of the nursing care in the visit and visit length may influence the older persons' expressed worries. The complexity of the older persons' health condition seems however to have limited impact on the expressed worries. Further studies should consider using a more precise measure for the complexity of the older persons' health condition, such as medical diagnosis or subjective functional levels. How nurses respond to the expressed worries in the different types of visit should also be explored.

4.3. Practice implications

Overall, our findings indicate that the nature of nursing care in the home care visit, i.e., the specific task(s) the nursing staff were appointed to do, influenced the expressed worries from the older persons more than the health complexity, i.e., the number and type of medications prescribed. Our study implies that older people express psychosocial needs during home care visits, highlighting the importance of health care providers' knowledge and skills in empathic and supportive communication, as well as ways to manage such needs. This knowledge is useful for healthcare policymakers, and could be used to better tailor the competence of nursing staff to meet the needs of the older population.

CRediT authorship contribution statement

Lena Heyn: Conceptualization, Methodology, Formal analysis, Writing – original draft, Writing – review & editing, Visualization. **Espen Andreas Brembo:** Conceptualization, Methodology, Formal analysis, Writing – review & editing. **Hilde Eide:** Conceptualization, Methodology, Writing – review & editing. **Linda Hafskjold:** Conceptualization, Methodology, Formal analysis, Writing – review & editing. **Vibeke Sundling:** Conceptualization, Methodology, Formal analysis, Writing – review & editing, Visualization. All authors have given final approval of the version to be published.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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