Older home-living patients’ perceptions of received home nursing and family care

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Older Home-Living Patients’ Perceptions of Received Home Nursing and Family Care
Studies focusing on older patients’ perceptions of the nursing care, and their experiences related to receiving family care, are sparse. Therefore, the aim of this study was to describe how older home nursing patients perceived the care they received from both the home nurses and their family. Structured interviews were used to collect data among 242 persons aged 75+ years who received home nursing, and 193 persons receiving family care. Perceptions about the amount and the quality of nursing care were investigated. Dependency, relationship and safety were focused in the questions about the family care. Descriptive statistics, the Mann-Whitney U test, the chi-square test, Spearman’s rho and stepwise multiple regression were used in the analyses. The level of satisfaction with the home nursing was high. Nevertheless, areas of improvement were identified: a lack of continuity in the care, the nurses’ shortage of time, and a lack of information and communication. The majority of the study group was comfortable with receiving family care, and did not perceive their care providers as worn out. More than half of the group was not confident that their family could extend their help if needed.

Key words: caregivers, next of kin, older people, patient satisfaction
OLDER CARE-DEPENDENT people living in their own homes often receive a considerable amount of both home nursing and family care, and they depend on these care resources to continue living at home. A consequence of the chronic shortage in public health services is that family caregivers play crucial roles in providing the care to this patient group.

Research aimed to describe and investigate provision of formal and family care to older home-living individuals are quite extensive, especially regarding the division and structuring of care functions (Armi, Guilley, & d’Epinay, 2008; Karlsson, Edberg, Westergren, & Hallberg, 2008). Nevertheless, studies focusing on the patient’s perception of the care they receive are very limited and partly old (e.g. Gävfert & Ek, 1996; Laferriere, 1993; Reeder & Chen, 1994).

In Norway, like in the other Nordic countries, the main responsibility for care services to older people rests on the welfare state, and the service organization is often referred to as the Nordic welfare model (Sand, 2005). The care services in these countries are well developed. And while the social policies in many other countries, for example in Eastern Europe, emphasize family obligations to a greater degree, the next-of-kin in the Nordic countries have no obligation to provide care to older family members (Daatland & Lowenstein, 2005; Sand, 2005). Nevertheless, even though a generous amount of public care is provided, the availability of family care may be decisive for an older person’s opportunity to continue living in own home (Karlsson et al., 2008). Another Norwegian study also showed that public care seemed to complement rather than substitute family care (Dale, Sævareid, Kirkevold, & Söderhamn, 2008).

Studies focusing on patients’ perceptions of the home nursing care provided, either in a Scandinavian context (Gävfert & Ek, 1996; Törnquist, Gardulf, & Strender, 2000) or in other European countries like England (Bailey, 2007), tend to report an overall high satisfaction with the received care services. Dimensions reported in an American study (Laferriere, 1993) to be associated with the patients’ satisfaction were the nurses’ competence, technical quality and the delivery of care services, communication and personal relationship between the client and the care provider. Some Swedish studies have emphasized the nurses’ ability to listen and to involve the patients in decision-making (Gävfert & Ek, 1996), and the appreciation of the individuals’ own desires and needs (Törnquist et al., 2000). Continuity of care with a minimum of nurses involved, sufficient information, and opportunity to reach the nurses by telephone or have them to do an extra visit if needed, are areas that have been valued by older home-living patients (Bailey, 2007; Caris-Verhallen & Kerkstra, 2001; Gävfert & Ek, 1996).

Some studies have indicated that older people may tend to avoid seeking help from public sources for medical or
care reasons, maybe because they lack information and knowledge about available help. Consequently, they may have unmet care needs, as reported in a study from United Kingdom (Howse, Ebrahim, & Gooberman-Hill, 2004).

Little is known about older home-living individuals’ perceptions of receiving family care, and studies regarding this topic are needed. An American study (Crist, 2005) showed that most of the care recipients in her study were comfortable with involving family care in their daily lives, and that receiving family care may even have a positive meaning for older persons, especially when the care relationship was good. However, other American studies have reported that older care-recipients had worries about being a burden to their care-giving family members (Johnson, Sulmasy, & Nolan, 2007), and that they had a feeling that their own contribution was limited (Parsons, Cox, & Kimboko, 1989). This is in line with the results from a Norwegian study reported by Lingsom (1997).

Reciprocity in the patient–caregiver relationship is seen to be highly valued by the older care recipients, either in the service offered by formal care providers or by the family (Roe, Whattam, Young, & Dimond, 2001; Wolff & Agree, 2004). The term «relationship» is preferred by some older people to describe informal care provision, rather than «care» and «cared for» (Gooberman-Hill & Ebrahim, 2006).

To conclude, even though older people in general may be satisfied with the amount and quality of the nursing care they receive, the literature indicates that there are areas for improvement. Studies focusing on older home-living patients’ perceptions of the nursing care they receive are not numerous, and studies focusing on experiences related to reception of family care are even sparser. Both nursing and family care will be decisive in the future to make it possible for older people to remain in their homes as long as possible, which in a recent Swedish study by Harrefors, Sävenstedt and Axelsson (2009) was shown to be in accordance with the older persons’ own preferences. Therefore, more studies regarding the patients’ perceptions of care are needed.

**Aim**

This study aimed to describe older home-living patients’ perceptions of receiving home nursing and family care.

**Method**

**Subjects and sampling procedures**

The study group consisted of persons aged 75 years and older from five urban and two rural municipalities in southern Norway. Although rural, the two municipalities were partly densely populated areas, and on the other side, the urban municipalities had partly scattered settlements. All the municipalities were located close, or fairly close, to the coastline, but consisted of agricultural areas as well. The four smallest municipalities had, at the time this study was implemented, 4300–8800 inhabitants. The three largest municipalities (all cities) had 17800, 39500 and 72400 inhabitants, respectively.
All the persons invited to participate received home nursing services.

Of 348 clients invited, 88 (25%) declined to participate. Before the interviews were completed, nine people died and nine were permanently institutionalized. The final sample consisted of 242 respondents, or 70% of the patients initially invited to participate. Forty-nine persons did not receive family care, and they were excluded from the study group when perceptions of family care were measured. As data collection was confidential, no further information was obtained about the individuals who declined to participate.

Inclusion criteria were capacity to give informed consent to participate, ability to communicate adequately, and strength to take part in a structured interview lasting between one and two hours. All recipients of home nursing in five small municipalities were included. In two larger municipalities, respondents were selected by random sampling. The chief nurse in each municipality care unit determined which patients fulfilled the inclusion criteria. An attending home nurse invited potential participants into the study. Each respondent received both oral and written information about the study. Written informed consent was obtained before the interviewer contacted the respondents by phone. Data collection was based on a structured interview using a questionnaire containing 375 questions. Each interview lasted about 90 minutes. Interviewers read the questions aloud and wrote down the participants’ answers.

Measures

The questionnaire was designed for a larger study focusing on different aspects of life for care-dependent, older home-living individuals. In the current study, the following measures were used:

Socio-demographic variables measured were age, sex, marital status (single/widowed or having a spouse/partner), educational level (low = primary school or less/high = more than primary school), residential conditions (urban/rural dwelling, sheltered/not sheltered housing) and having children (yes/no).

Subjective health was assessed by the general question «How is your health now?», and based on a scale of 1 (poor), 2 (not very good), 3 (good) or 4 (very good).

The amount of home nursing was measured using an ordinal scale for frequency of visits (1 = less than weekly, 2 = once a week or more, 3 = once a day/night, and 4 = more than once a day/night). Amount of family care was measured using an ordinal scale for frequency of help from family members, including help from a spouse (1 = no family help, 2 = less than weekly, 3 = once or more weekly, and 4 = once day/night).

Perceptions of the home nursing were measured by questions about the patients’ opinion of the amount of help they received, the continuity of nurses and the degree of cooperation with them, whether the nurses accommodated the patients’ wishes and needs, whether the nurses were short of time during their visits, and their overall satisfaction with the quality of nursing care.
Perceptions of family care were measured by questions about the respondents’ level of dependence on family care for managing home living, whether they found the family care bothersome, whether they considered their family to be worn out, and the importance of the family help in being able to continue their home-living situation. In the case of increased care needs in the future, the respondents were asked about their confidence in extended family care.

An additional question related to the patients’ overview and knowledge about the municipal care services was asked: «Do you feel that you have sufficient knowledge about available municipal services?». The response categories were «no», «I should know more» and «yes».

**Analyses**

Descriptive statistics were used to represent characteristics of the study group, the amount of help received from home nurses and family members, and perceptions of the nursing care and the family care they received. The question about subjective health was dichotomized as good or poor.

Mann–Whitney U test was used to test differences between amount of home nursing in relation to age (< 85/85+ years), sex, marital status (single/widowed or having a spouse/partner), residential conditions (urban/rural dwelling, sheltered/not sheltered housing), cohabiting (yes/no), educational level (low = primary school or less, high = more than primary school), and having children (yes/no). Differences regarding amount of family care were treated the same way using the same variables as listed above. Mann–Whitney U test was also used to test differences between socio-demographic groups and groups with poor/good subjective health, respectively, concerning perceptions of home nursing and family help. Spearman’s correlation coefficient ($r_s$) was used to measure association between frequency of family help and number of children.

The respondents were divided into two groups according to whether they knew the nurses well or not, how they perceived their level of cooperation (good/not good), and whether the nurses accommodated their wishes and needs (yes/no). Chi-square test was used to test any relationship between these variables and the sociodemographic group variables. The Mann–Whitney U test was used to test differences regarding amount of home nursing.

A series of stepwise multiple regression analyses, with different dependent variables, were used to identify possible relationships between amount of family help, socio-demographic characteristics, subjective health, frequency of home nursing and some of the variables used to describe the patients’ perceptions of receiving family care.

Two-tailed tests were used in all analyses, and $p$-values < 0.05 were considered significant. Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS) for Windows, Version 17.0 (SPSS Inc. Woking, Surrey, UK).
**Ethical considerations**

The study was approved by the Regional Committee for Medical Research Ethics and the Norwegian Data Inspectorate. The study has been designed and implemented according to common ethical principles in clinical research. These include the principle of respect for autonomy, the principle of non-maleficence, the principle of beneficence, and the principle of justice (Beauchamp & Childress, 2009).

**Results**

**Description of the study group**

The study group consisted of 141 (70.7%) women and 71 (29.3%) men, $M_{age}$ = 84.6 years, age range: 75–98 years. There were no age differences between men and women. The majority of the subjects lived in not-sheltered housing (69.4%), and most of them were 85+ years of age ($p = 0.046$). Most subjects were widowed (68.2%), and the women constituted 78.2% of this group. Nearly three-quarters (74.5%) of the total study group lived alone. The majority had children (81.8%), women more frequently than men ($p = 0.019$).

**Amount of home nursing and family care**

Ninety-eight persons (40.5%) received home nursing at least once a day/night. There were no socio-demographic differences in relation to the amount of home nursing received. The majority of the study group (64.9%) also received family care once a week or more.

Table 1 shows the frequency of home nursing visits in combinations with frequency of family care. The median value for home nursing was «Once a week or more». The Md value for family care was «Once a week».

<table>
<thead>
<tr>
<th>Amount of Home Nursing</th>
<th>Less than weekly</th>
<th>Once a week or more</th>
<th>Once a day/night</th>
<th>More than once a day/night</th>
<th>Total family help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of Family Care</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>No help</td>
<td>11 (4.6)</td>
<td>16 (6.6)</td>
<td>11 (4.6)</td>
<td>10 (4.1)</td>
<td>49 (20.2)</td>
</tr>
<tr>
<td>Less than weekly</td>
<td>16 (6.6)</td>
<td>31 (12.9)</td>
<td>9 (3.7)</td>
<td>13 (5.4)</td>
<td>69 (28.5)</td>
</tr>
<tr>
<td>Once a week</td>
<td>19 (7.9)</td>
<td>34 (14.1)</td>
<td>17 (7.1)</td>
<td>18 (7.5)</td>
<td>88 (36.4)</td>
</tr>
<tr>
<td>More than once a week</td>
<td>6 (2.5)</td>
<td>11 (4.6)</td>
<td>6 (2.5)</td>
<td>13 (5.4)</td>
<td>36 (14.9)</td>
</tr>
<tr>
<td>Total home nursing</td>
<td>52 (21.6)</td>
<td>92 (38.2)</td>
<td>43 (17.8)</td>
<td>54 (22.4)</td>
<td>242 (100)</td>
</tr>
</tbody>
</table>

*One respondent missing

Those individuals who had children received help more frequently from their family than the childless group ($p < 0.001$), and the frequency of family care was associated with the number of children ($r_s = 0.17, p = 0.001$). The group with a spouse or partner had more family care than those who were single ($p < 0.001$), and co-residing individuals had more family care than those living alone.
(p < 0.001). The group not living in sheltered housing also received a greater amount of family care than their counterparts who were living in sheltered housing (p = 0.010).

Perceptions of home nursing

Most of the subjects (93%) were satisfied with the amount of home nursing they received, and there were no differences in relation to demographic characteristics (i.e., sex, age, marital status, educational level, residential or living conditions).

The questions asked, and the distribution of the patients’ responses regarding home nursing, is reported in Table 2.

Table 2. Patients’ perceptions of the home nursing (n = 242)

<table>
<thead>
<tr>
<th>Variables/questions</th>
<th>Labels</th>
<th>n (%)</th>
<th>Labels</th>
<th>n (%)</th>
<th>Labels</th>
<th>n (%)</th>
<th>Median when question applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, how satisfied are you with the quality of the nursing care?</td>
<td>Not satisfied/ tolerable</td>
<td>7 (2.9)</td>
<td>Fairly satisfied</td>
<td>30 (12.4)</td>
<td>Very satisfied</td>
<td>205 (84.7)</td>
<td>Very satisfied</td>
</tr>
<tr>
<td>How well do you know the nurses?</td>
<td>Not well</td>
<td>51 (21.1)</td>
<td>Fairly well</td>
<td>112 (46.3)</td>
<td>Well</td>
<td>77 (31.8)</td>
<td>Fairly well</td>
</tr>
<tr>
<td>Is it usually the same nurse(s) who is/ are visiting you?</td>
<td>No</td>
<td>177 (73.1)</td>
<td>I don’t know</td>
<td>14 (5.8)</td>
<td>Yes</td>
<td>50 (20.7)</td>
<td>No</td>
</tr>
<tr>
<td>Any specific home nurse to whom you feel particularly connected/confident?</td>
<td>No</td>
<td>111 (45.9)</td>
<td>I don’t know</td>
<td>48 (19.8)</td>
<td>Yes</td>
<td>82 (33.9)</td>
<td>I don’t know</td>
</tr>
<tr>
<td>To what extent do the nurses allow for your own wishes and needs?</td>
<td>Not so well</td>
<td>22 (9.1)</td>
<td>I don’t know</td>
<td>21 (8.7)</td>
<td>They respond well</td>
<td>199 (82.2)</td>
<td>They respond well</td>
</tr>
<tr>
<td>Are the nurses in hurry when they are visiting you?</td>
<td>No</td>
<td>84 (34.7)</td>
<td>I don’t know</td>
<td>38 (15.8)</td>
<td>Yes</td>
<td>119 (49.2)</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you feel confident that the home nurses could extend their services with increased care needs?</td>
<td>No</td>
<td>9 (3.7)</td>
<td>I don’t know</td>
<td>47 (19.8)</td>
<td>Yes</td>
<td>181 (74.8)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*2 respondents (0.8%) missing *1 respondent (0.4%) missing *5 respondents (2.1%) missing

In general, the great majority of the study group was very satisfied with the quality of the nursing care they received. Only seven persons (2.9%) reported not being satisfied, all of them in urban areas. The group that perceived themselves as having good subjective health were more satisfied with the quality of home nursing than the group reporting poor health (p = 0.005). A great majority of the study group (96.7%) also perceived that the
cooperation with the home nursing service was good, and it was positively correlated to satisfaction with the amount of home nursing they received ($p = 0.001$), and how well they knew the nurses ($p = 0.043$). In addition, the group with positive experiences of nurses emphasizing with their needs and wishes perceived the cooperation to be considerably better than the group with negative experiences ($p < 0.001$).

Regarding continuity, most of the subjects said that they knew their home nurses well/fairly well, although nearly 80% said that there were usually many different nurses involved in their care. There were no differences between demographic groups, but the individuals who said that they knew the nurses well received more home nursing than the group reporting that they did not know them well ($p = 0.034$). The majority of the patients said that they had one or few nurses that they were particularly connected to or confident with.

A large proportion of the study group reported that the nurses took their needs and wishes into consideration, although 17.8% were not fully satisfied. Individuals in urban areas were less satisfied with the nurses’ attention to their needs compared with the rural dwellers ($p = 0.013$). About half of the patients felt that the nurses were in a hurry when they were visiting them.

Regarding extension of home nursing care, 23.1% of the sample was not quite confident about receiving more care if needed. Those less than 85 years of age were less confident than the older group ($p = 0.012$), and those living in not-sheltered dwellings were less confident compared with the group living in sheltered dwellings ($p = 0.024$).

About two-thirds of the study group (66.8%) reported insecurity and a lack of overview as a result of inadequate information and knowledge about available services offered by the municipality. This was not related to demographic characteristics, current perception of subjective health, or any of the questions about home nursing.

Perceptions of being dependent on family help and the family care-providers’ situation

Forty-nine individuals (20.2%) did not receive any family care, leaving a group of 193 persons (79.8%) who received various levels of care. The questions asked and the distributions of the patients’ responses regarding family care are reported in Table 3.
Table 3. Patients’ perceptions of the family care (n = 193)

<table>
<thead>
<tr>
<th>Variables/questions</th>
<th>Labels n (%)</th>
<th>Labels n (%)</th>
<th>Labels n (%)</th>
<th>Median when question applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>How dependent are you on help from your family?</td>
<td>Very dependent 63 (32.6)</td>
<td>Somewhat dependent 48 (24.9)</td>
<td>Not dependent 82 (42.5)</td>
<td>Somewhat dependent</td>
</tr>
<tr>
<td>Bothersome to receive family care?</td>
<td>No 146 (75.6)</td>
<td>Somewhat bothersome 18 (9.3)</td>
<td>Yes 18 (9.3)</td>
<td>No</td>
</tr>
<tr>
<td>The last three months: Do you feel that your family is worn out?</td>
<td>Very worn out 4 (2.1)</td>
<td>Some worn out 16 (8.3)</td>
<td>Not worn out 143 (74.1)</td>
<td>Not worn out</td>
</tr>
<tr>
<td>How important is the family care you receive for continuing living at home in the future?</td>
<td>Not important 27 (14.0)</td>
<td>Somewhat important 68 (35.2)</td>
<td>Very important 78 (40.4)</td>
<td>Somewhat important</td>
</tr>
<tr>
<td>In the case of increased care needs, do you feel confident that your family could extend their help?</td>
<td>No 52 (26.9)</td>
<td>I am not quite sure 46 (23.8)</td>
<td>Yes 91 (47.2)</td>
<td>I am not quite sure</td>
</tr>
</tbody>
</table>

*not applicable: n = 11 (5.7%)  †not applicable: n = 30 (15.5%)  ‡not applicable: n = 20 (10.4%)  §not applicable: n = 4 (2.1%)

Among those who received care, the group that had a spouse or partner received more care than the individuals who were single (p < 0.001), and the group living in not-sheltered dwellings received more care than the group living in sheltered dwellings (p = 0.004). The co-residing group received more care than the living-alone group (p < 0.001) (Table 4, pp. 227–228).

Table 4. Standardized regression coefficients for predictors for frequency of family care and variables describing the perception of family care

<table>
<thead>
<tr>
<th>Dependent variables in the regression analyses</th>
<th>Predictors</th>
<th>Beta</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>More frequent family care</td>
<td>Dependent on family care for living at home</td>
<td>-0.47</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Co-residing</td>
<td>0.38</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Male sex</td>
<td>0.13</td>
<td>0.047</td>
</tr>
<tr>
<td>R²=0.51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family worn out</td>
<td>Troublesome to receive family care</td>
<td>0.56</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Being single</td>
<td>-0.24</td>
<td>0.001</td>
</tr>
<tr>
<td>R²=0.56</td>
<td>Less frequent family help</td>
<td>-0.14</td>
<td>0.046</td>
</tr>
<tr>
<td>Bothersome to receive family care</td>
<td>Family worn out</td>
<td>0.68</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>R²=0.47</td>
<td>Dependent on family care for living at home</td>
<td>0.16</td>
<td>0.029</td>
</tr>
</tbody>
</table>
Most patients (75.6%) reported that they were not bothered by receiving family care, and those who were most concerned about receiving such care more often perceived their family caregiver as worn out (Table 4). The group that had a spouse/partner and those who were co-residing found it less bothersome to receive care from their family compared to the singles ($p = 0.002$) and the group who lived alone ($p < 0.001$).

The group that had a spouse/partner reported their family to be more worn out compared with the single group ($p < 0.001$). Those in the co-residing group thought they were more worn out than the group that lived alone ($p < 0.001$). The urban dwellers more often believed that their families were worn out than did those living in rural areas ($p = 0.011$), as did the group that had poor subjective health compared with those with good health ($p = 0.011$). The individuals who perceived their family members to be worn out were more dependent on family care ($p < 0.001$) than those who thought that their family was not affected, and they were more worried about receiving such care (Table 4).

The co-residing group was more dependent on family care than the group living alone ($p < 0.001$), and the individuals who had a spouse/partner were more dependent than the single individuals ($p < 0.001$). Further, those who reported poor subjective health were more dependent on family care than those in good health ($p = 0.003$). In addition, the group that reported being dependent on family care also received a larger amount of family care than those who perceived themselves not necessarily to be dependent on this care ($p < 0.001$). The same group also received less frequent home nursing, and they were better educated (Table 4).

With regard to managing living in own homes in the future, the group that did not live in sheltered housing perceived the family care as more important than the individuals living in sheltered houses did ($p = 0.001$), although this result was not supported by the regression analysis (Table 4).
The group with single individuals thought it would be more important than the group that had a spouse/partner ($p < 0.001$), and the lower educated and the alone-living group regarded it as more important compared with the higher educated and the co-residing group, respectively (Table 4).

**Discussion**

**Amount of home nursing and family care received**

A large proportion of the individuals in the study group received home nursing frequently, and the care arrangement often represented a combination of home nursing and family care. Public home care delivery in the Nordic countries is generous and the threshold for service allocation is low compared with many other European countries, for example in eastern European countries like Italy and the Czech Republic (Carpenter et al., 2004). Daatland and Lowenstein (2005) compared the public welfare regimes vs. intergenerational family solidarity in five different countries: Norway, England, Germany, Spain and Israel. They found that Spain and Germany had low social care service level compared to Norway and England. On the other side, the Spanish individuals in that study had distinctively higher contact frequency, either face-to-face or telephone contacts, with their children.

Nevertheless, despite a generous degree of home nursing provision, a large proportion of the group in our study also received care from their families frequently. This result showed that the welfare system in Norway has not crowded-out the family, but rather, family care often complements rather than substitutes for public services, which has been reported in other studies (Daatland & Lowenstein, 2005; Dale et al., 2008; Gautun, 2003; Lingsom, 1997). A more generous welfare system has not replaced or substituted the family care. On the contrary, a helpful partnership seems to be more constant across European countries than could be expected (Daatland & Lowenstein, 2005; Litwin, 2005). A frequently referred Norwegian study (Lingsom, 1997), has shown that the solidarity and the care responsibility between family members remain stable and strong, despite changes in family patterns and structures.

Even if older individuals in the northern parts of Europe often live alone, and co-residing with children is rare, this study showed that co-residing was associated with more family care. The most probable explanation for this may be that the carer was a spouse or partner, or that help from children was provided in greater amounts when both their parents were alive and lived in shared households. Tomassini et al. (2004) found a higher level of parent–adult child contact frequency in Italy than in the northern European countries, although the contact level in all the countries included was high. In a Dutch study by van Gaalen, Dykstra and Flap (2008), it was found that the number of children was no indicator of increased contact frequency with older parents. They also refer to other stud-
ies, and claim that adult children with several siblings have less frequent contact with parents than children from small families. In the current study, the number of children was only slightly associated with the amount of family care provided, and the daughters or the daughters-in-law did not represent a more important care resource than the sons or the sons-in-law did (Dale et al., 2008).

Perceptions of home nursing

That the overall level of satisfaction with home nursing was high in this study group accords with other studies (Bailey, 2007; Törnquist et al., 2000). Most of the individuals said that they knew their nurses well or fairly well, and those who knew the nurses well reported to be most satisfied with the cooperation with the nurses. Nevertheless, a greater proportion of the study group reported that many different nurses were usually involved in their care, which indicates a lack of continuity. The study by Gävfert and Ek (1996) showed that home nursing patients, and especially those with the greatest care needs, emphasized their need for continuity of care, although it seemed to be less important for long-term patients who had received home nursing for several years.

Although more than half of the individuals in the current study reported being more connected with one or several nurses with whom they felt confi
dent, a considerable portion of the group either did not report this or were unsure. The relationship between the care recipient and caregiver is shown to be crucial for home-living patients’ satisfaction with the care they receive (Olsson & Ingvad, 2001). The nurses’ attitude and ability to elicit the patients’ opinions, and involve them in decision making regarding care, are qualities appreciated by older home nursing patients (Gävfert & Ek, 1996). Törnquist et al. (2000) also identified that not being involved in the decision making was one of the areas of patients’ dissatisfaction. However, although older people want to be involved in their own care, their definition of involvement may be more focused on the caring relationship and receiving information than on active participation in decision-making (Bastiaens, Van Royen, Pavlic, Raposo, & Baker, 2007). Another area of dissatisfaction reported in the study by Törnquist et al. (2000) was the feeling that the care was not based on their personal desires and needs. Most of the individuals in the current study group perceived that nurses considered their needs, but the result indicates a potential for improvement. We can make no further comments regarding the unmet needs because further information is unavailable. But other studies have shown that issues such as a lack of information, guidance and interest in patients’ emotional and spiritual needs are some of the areas that are objects of dissatisfaction (Bailey 2007; Caris-Verhallen & Kerkstra 2001; Reeder & Chen 1994; Törnquist et al., 2000). A previous study showed that the level of physical functioning in the current
study group in general was good (Dale et al., 2008), which could indicate that the patients’ care needs in this area were met.

Shortage of time may be one reason for the nurses’ inattention to the patients’ needs. Almost half of the patients felt that the nurses were in a hurry when they were visiting them. Other studies have reported this to be a cause for dissatisfaction, for example Bailey (2007), who found that one reason for this was the feeling of guilt over taking up the nurses’ time.

The majority of the patients in our study reported a lack of information about the available municipal services, and nearly one-quarter was not quite confident that more care could be provided in case of extended needs. In addition to those living alone in not-sheltered dwellings, the youngest group felt most insecure. The main reason for this may be a more general uncertainty and unpredictability about the future concerning available services.

Perceptions of receiving family care

A great proportion of the patients in the study group perceived themselves as not being dependent on the family care they received, and this is probably related to the availability of public services. Daatland and Lowenstein (2005) investigated the relationship between formal and family care in four European countries. They found that generous welfare state services had not crowded out the family, but dependency on the family may have decreased. An additional possible explanation may be that family members provide more care than necessary to older family members by performing tasks that they preferable could, and should, do for themselves (Crist, 2005). Most of the older individuals in Crist’s study considered the family care as part of the relationship, and not as help with specific tasks. Surprisingly, those who were most dependent on family care in the current study were reported to have better subjective health. One explanation may be that they perceived better health as a consequence of a generous amount of care provided.

There is some evidence that the reception of family care may be bothersome for older home-dwelling persons, and especially the fear of being a burden and the loss of autonomy and independence are reported to be major concerns (Johnson et al., 2007; Parsons et al., 1989). Nearly three-quarters of the individuals in our study group did not perceive their care-providing family members as worn out, and an equal proportion of the group was not bothered about receiving family care. This result is supported by Crist (2005), who found that older home dwellers comfortably incorporated help from family members into their lives. In fact, the situation of receiving care had a positive meaning for the individuals in Crist’s study. Nevertheless, less than half of the study group felt confident that their family could extend the care in case of increasing needs in the future. Confidence and expectations about available formal services may be one explanation for this.
an ageing spouse or partner represented the main caregiver in some of the cases, and thus, an extension of care duties would not be appropriate or realistic.

One explanation for the positive perceptions about not being a burden to their family caregivers may be that some kind of reciprocity tends to characterize the relationship. This seems even more evident because having a spouse or partner, and co-residing, indicated fewer concerns about being a burden. Individuals in this generation probably had a strong sense of solidarity and responsibility for each other as spouses/partners, and the reciprocity in such close relationship may be particularly evident.

Methodological considerations
Considering the discrepancy between the results found in the analyses of group-differences and the regression analyses, the explanation may be that other variables included in the equations influenced the results in the latter.

A limitation of this type of study (Törnquist et al., 2000) is that the most vulnerable and care-dependent older persons may have been excluded from participating, either by the home nurses or by the patients themselves. This could partly explain the high satisfaction with the home nursing services, and likewise the positive experiences with receiving family care. Due to a possible homogeneity in the sample, generalizations made outside the study group should be done so with caution. Another methodological problem is that the high patient satisfaction may be influenced by hesitancy to negatively evaluate the care providers (Laferriere, 1993).

Conclusion
This study has shown that the older home-living patients in general were satisfied with the amount and quality of the home nursing services they received. Still, some areas of improvement were identified. The continuity of the care could be better, and the nurses should spend some more time in the patients’ home, and especially leave more room for conversation and information. With regard to the perception of the family care, the majority of study group was not bothered about receiving such care, and did not perceive that their family carers were worn out. The dependency on help from the family, both present and in the future, was considerable, but half of the subjects were not confident that their family could extend their help in case of increased care needs.

References


