



FEATURE

Home-care nurses' distinctive work: A discourse analysis of what takes precedence in changing healthcare services

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Abstract

Ongoing changes in many Western countries have resulted in more healthcare services being transferred to municipalities and taking place in patients' homes. This greatly impacts nurses' work in home care, making their work increasingly diverse and demanding. In this study, we explore home-care nursing through a critical discourse analysis of focus group interviews with home-care nurses. Drawing on insights from positioning theory, we discuss the content and delineation of their work and the interweaving of contextual changes. Nurses hold a crucial position in home healthcare, particularly in ensuring care for sicker patients with complex needs. Assessing health needs, performing advanced care, and at the same time, providing customized solutions in various homes were identified as distinctive for home-care nurses' work. Changes have made nurses' work become driven by comprehensive tasks and acute medical needs that require much of their competence and time. Urgent care seems to take precedence in nurses' work, leaving less time and attention for other tasks such as conversations and support for coping with everyday life. This underlines the need to investigate and discuss the content and scope of nurses' work to help shape the further development of home-care nursing.

KEYWORDS

discourse, focus groups, home care, nursing practice, professional development

1 | INTRODUCTION

Over the past 20 years, healthcare services have changed, with an increasing proportion of services taking place in municipalities at the community level. This is a trend in many Western countries and entails that more patients are receiving healthcare at home (Ashley, Halcomb, & Brown, 2016; Genet et al., 2011; Merrick, Duffield, Baldwin, Fry, & Stasa, 2012; Tarricone & Tsouros, 2008). Nursing is a crucial part of home healthcare (HHC) and impacts people's

everyday lives and health. Thus, exploring the work of home-care nurses is important for patients and healthcare services in all countries where such nursing takes place. These recent changes further demonstrate the need for more knowledge about the content and delineation of home-care nurses' work. This study aims to gain insight into the distinctive work of home-care nurses and what takes precedence in today's healthcare.

The study took place in Norway, which has undergone these kinds of changes in healthcare services (Vabø, 2012). A major

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healthcare reform implemented in Norway in 2012 further accelerated this development (Norwegian Ministry of Health & Care Services, 2009). One consequence is that patients are discharged from hospitals earlier, and more patients at home need advanced care (Gautun & Syse, 2017). Like the rest of the Nordic countries, Norway, has a municipal, publicly funded HHC that is provided to the population based on assessments of healthcare needs (Brennan, Cass, Himmelweit, & Szebehely, 2012; Vabø, 2012). HHC includes several healthcare services, of which nursing is a significant part. In Norway, nurses, auxiliary nurses, and nurse assistants provide HHC, covering a range of care needs and medical treatments at home (Holm, Mathisen, Sæterstrand, & Brinchmann, 2017; Tønnessen, Nortvedt, & Førde, 2011). All home-care nurses in Norway are registered nurses with a bachelor's degree, and some have additional education.

Home healthcare has become more comprehensive and complex, which in turn places high demands on personnel and expertise (Bing-Jonsson, Foss, & Bjørk, 2016; Halcomb, Stephens, Bryce, Foley, & Ashley, 2016). Home-care nursing is diverse with increased expectations for the nurse's work and competence (Andersson, Lindholm, Pettersson, & Jonasson, 2017; McCarthy, Cornally, Moran, & Courtney, 2012; McInnes, Peters, Bonney, & Halcomb, 2017). Patients with multimorbidity constitute a frail group with complex healthcare needs and unstable clinical conditions, placing high demands on home-care nurses' time and expertise (Andersson et al., 2017; Halcomb et al., 2016; Næss, Kirkevold, Hammer, Strand, & Wyller, 2017). Studies indicate that home-care nurses in most countries provide multidimensional care from the basic to the advanced level, and also that they are well positioned to contribute to direct delivery of care, coordination, and leadership of HHC services (Barrett, Latham, & Levermore, 2007; De Vliegher et al., 2014; Smolowitz et al., 2015).

The context of working in a patient's home poses challenges relating to the provision of care and working conditions. Several studies have highlighted the professional and ethical challenges encountered by performing nursing in a home context (Martinsen, Mortensen, & Norlyk, 2018; Öresland, Määttä, Norberg, Jörgensen, & Lützén, 2008) in addition to the logistics of traveling from home to home (Holm & Angelsen, 2014; Skinner, Yantzi, & Rosenberg, 2009). Home-care nurses face many expectations and demands, and a massive time restraint is highlighted by many as characteristic of their work (Bendix Andersen, Beedholm, Kolbæk, & Frederiksen, 2018; Fjørtoft, Oksholm, Førland, Delmar, & Alvsvåg, 2020; Pusa, Hägglund, Nilsson, & Sundin, 2015; Turjamaa, Hartikainen, & Pietilä, 2013).

Nurses' work is influenced by collaboration with other healthcare professionals and services, and studies point to ambiguities in understanding each other's work and responsibilities (Kusi-Appiah, Dahlke, & Stahlke, 2018; Larsen, Broberger, & Pettersson, 2017; McInnes et al., 2017). Additionally, there are gray zones when it comes to the distribution of work tasks in home-care nursing, and many tasks are performed by both nurses and auxiliary nurses (Johansen & Fagerström, 2010). Furthermore, studies show how

home-care nurses strive to refine their work, which encompasses a wide range of tasks and responsibilities (Furåker, 2008; Johansen & Fagerström, 2010; Öresland, Määttä, Norberg, & Lützén, 2011; Purkis, Ceci, & Bjornsdottir, 2008). Recent studies highlight this and argue for the crucial position of nurses in today's healthcare in both caring for the individual patient and in coordinating care work (Allen, Purkis, Rafferty, & Obstfelder, 2019; Melby, Obstfelder, & Hellesø, 2018; Sekse, Hunskår, & Ellingsen, 2018).

Thus, studies on the work of home-care nurses point to a changing practice with blurry boundaries in the sense that there are an increasing number of tasks and needs to be solved, time pressures and ambiguities in the distribution of work tasks. We therefore argue the need to explore and make visible the work and boundaries of home-care nurses. In this study, we apply a discursive approach, exploring language use to get insights into a particular nursing context and what prevails (Fairclough, 2013) in that context. We address this by investigating how home-care nurses talk about their professional work.

1.1 | Theoretical framework

The study applied critical discourse analysis (CDA) as both theory and method (Fairclough, 2003) to investigate language use to see what this uncovers about home-care nursing. Discourses are understood as linguistic expressions that take place within a certain perspective and context and often include hegemony over what is the 'right' understanding of reality (Fairclough, 2013). This approach adheres to an understanding of discourse as both constructed and constructive. The way we talk is shaped by practice, while also actively shaping and changing our practices, identities, and social relationships (Fairclough, 1992, 2013). Thus, discourses about nurses' work provide a picture of how nursing is understood and enacted in a given time and context.

This study explores how home-care nurses delineate their professional work and, through this, seek to reveal what takes precedence. 'Profession' can be broadly defined as an occupation building on the scientific knowledge that is applied to particular cases (Abbott, 1988; Freidson, 2001). Another definition links professions to the social mandate in that professionals perform public services based on knowledge acquired through a specialized education (Molander, 2016). With this understanding, home-care nursing is a professional work based on specialized expertise and a social mandate. Professionals are seen here as collective actors who constantly maneuver within their specific contexts (Abbott, 1988; Freidson, 2001). This maneuvering process can be understood as boundary work (Abbott, 1995; Liljegen, 2012). According to Abbott (1995), a profession has a relatively stable core, while the boundaries that determine what is within the professional boundary are more fluid.

Within this framework of understanding, nurses negotiate work boundaries to distinguish their work from others and position what is their alleged area of professional work. This was a perspective that

emerged through the analysis and led us to choose positioning theory as an analytical lens. Positioning theory present an alternative to role theory and provides a dynamic perspective on how individuals or groups continuously position themselves in encounters with others (Harré & Langenhove, 1991; Harré & Moghaddam, 2003; Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009).

The positioning process consists of speech acts, storylines, and positions that are intertwined and mutually determinative (Harré & Moghaddam, 2003; Kayı-Aydar, 2018). In line with Kayı-Aydar (2018), we see storylines as different ways of talking about a topic. Storylines may draw on different discourses, and positioning and discourses are thus closely intertwined. The participants involved are constantly positioning themselves through verbal expressions that tell about the positions they assume. Each position that an individual or group assumes or is given is associated and legitimized with certain rights and duties (Harré et al., 2009). The positions that home-care nurses assume elucidate how they understand and make use of the available repertoire of expectations, tasks, and values related to their practice. Thus, positioning is closely connected to individual or group self-identity, which emerges and is shaped through the discourses (Harré & Moghaddam, 2003).

2 | DESIGN AND METHODS

The study used an explorative qualitative design. Inspired by CDA (Fairclough, 2003), the study builds on a social constructivist understanding that considers knowledge as linguistically constructed in a social context. Data construction took place through focus group interviews with home-care nurses, one interview per site as we considered that this was sufficient to gain insight into the use of language each place. We chose focus group interviews because it emphasizes interaction and shared dialogue to develop data on different opinions, knowledge, and values (Halkier, 2010; Krueger & Casey, 2014). We conducted one interview per site and considered that this was sufficient to gain insight into the use of language in each interview and we wanted to explore this across different geographic settings.

TABLE 1 Nurse participants and contexts in the focus group interviews

Focus group	FG1	FG2	FG3	FG4	FG5	FG6
Context ^a	Rural	Urban	Suburban	Urban	Suburban	Rural
Age, mean (range)	36.4 (25–52)	41.6 (34–47)	47.0 (24–60)	50.6 (23–61)	44.4 (26–60)	44.8 (40–51)
No. of females/males	5/0	4/1	5/0	6/0	4/1	5/0
Years of experience in home-care, mean (range)	9.4 (3–16)	9.3 (3–16.5)	8.7 (3.5–22)	7.4 (2–18)	14.5 (7–20)	14.8 (10–26)
Participants with specialization ^b	2	3	4	3	1	3

^aRural: small-sized municipality distant to hospital and city, 3,000–16,000 inhabitants; Suburban: medium-sized municipalities outside a city, 28,000–50,000 inhabitants; Urban: 250,000–670,000 inhabitants.

^bSpecializations included advanced clinical nursing, acute care, cancer, psychiatric care, geriatric, diabetes, administration, pedagogy, primary healthcare, infections, and disease control.

2.1 | Focus group interviews

The focus group interviews took place over 4 months in 2017–2018 at the nurses' workplaces.

One of the interviews lasted 60 min and the rest were 90 min long. The first author was the moderator in all the interviews, together with a co-moderator. We used a semi-structured interview guide with discussion themes but were open to including other perspectives (Table 1). The role of the moderator was to facilitate the dialogue in the groups as well as to challenge the participants to elaborate and provide examples. The co-moderator observed, took notes, and asked follow-up questions at the end. The interviews were digitally audio-recorded and transcribed verbatim by the first author and then checked for accuracy by the co-authors. We conducted the interviews and analyses in Norwegian, so the statements quoted from the transcripts have been translated into English. The focus groups constitute the unit of analysis in this study and are referred to as FG1 through FG6.

During the interviews, participants discussed various aspects of nursing competence in home-care. In this article, we analyze how participants talked about what is special about home-care as a context, what the work and responsibilities of the nurses are, and what characterizes a proficient home-care nurse. Constructing data in focus group interviews means that the statements are the result of interactions in the group and not just individual opinions. The interactions in the focus groups were part of the knowledge construction (Halkier, 2010) and revealed, among other things, how different themes engaged and influenced the participants. For example, there was much laughter when talking about challenges at work, and thus, the laughter served as a kind of discourse marker showing what was particularly relevant and engaging to the participants.

2.2 | Context and participants

The focus group interviews took place in six different municipalities in Norway, and we selected contexts strategically to facilitate geographic and demographic variation. The sites included two urban,

two suburban, and two rural municipalities. Another variation was the proximity to a hospital, and the rural municipalities were characterized by long distances to hospitals and between patients. The participants in the focus group interviews consisted of 31 registered nurses working clinically in home-care services—29 females and 2 males. There were five or six participants in each focus group. None of the participants had a leadership position that could affect the group dynamics.

The participants were selected and recruited through designated contact persons in each municipality. Inclusion criteria were that they worked clinically in home-care and wanted to participate in a focus group interview. These were quite broad criteria to ensure enough participants, and it turned out that the sampling strategies were made slightly different in each location. In some places, all nurses who were at work that day participated, while in other places, there was a selection of nurses from one or more districts within the municipality. This reflected local differences in the organization and the number of nurses in each municipality. However, it turned out that the contact persons had recruited participants with a range of ages and years of experience (Table 1).

2.3 | Research ethics

The research project was approved by the Norwegian Data Protection Authority within the Norwegian Center for Research (Reg. No. 54,386) and by the authorities in each municipality. Participation in the interviews was voluntary, and we obtained informed oral and written consent from each participant before the interviews began. Participants were free to withdraw consent at any stage of the interview without any consequences. All recognizable data about patients, staff, and places were anonymized. Interview transcripts and audio images are kept separately in locked files, and only relevant researchers have access to the data.

2.4 | Analysis

We analyzed the focus group interviews adapting Fairclough's (2013) three-dimensional analysis framework and analyzed the interview transcripts as linguistic text, as a discursive practice, and as a social practice (Fairclough, 2003). The dimensions are intertwined, and the analysis constantly moved between them. NVivo 11 Pro software (2017) was used to facilitate data management and analysis.

We started with an exploration of the text where we looked at word frequencies, expressions, and the use of modal auxiliary verbs like *must*, *can*, and *should*. Next, we examined recurring themes (storylines) that appeared in the text. According to Fairclough (2003), the choice of tools in a CDA depends on the research objectives and the nature of the debate under analysis. During the analysis, we discovered how participants talked about what is special about their work as home-care nurses by making comparison with other health professionals and services, and this led us to choose positioning as

an interpretive tool. In this study, we understand positioning as a discursive practice. The verbal expressions and storylines reveal positions the participants assume as home-care nurses. For example, the nurses' positioning became apparent through their use of terms like *we* and *us as nurses* when seeking to clarify what is within their particular work position.

The last part of the analysis entailed linking the discursive practice to a broader sociocultural context and relevant theories. This helped to identify what the discourses in the focus group interviews might be about. Thus, the analysis work was reflexive in that the researchers discussed data and interpretations together in light of a CDA perspective. All authors contributed to analytical discussions and validation of emerging discourses in the texts, as well as verified and discussed transcripts to develop a richer understanding of the content. The article complies with COREQ guidelines (Tong, Sainsbury, & Craig, 2007).

3 | FINDINGS

The discussions in the focus groups revolved around stories of what the home-care nurses' work encompasses. Although there were some differences related to geography and proximity to hospitals, they talked about working as a nurse in HHC in remarkably similar ways across settings. The findings revealed home-care nursing to be a diverse field of work, and the participants highlighted this by telling about the wide range of patients of different ages and with different health needs.

Because you can really say that we have to know everything because we encounter so much. After all, we have the full range of patients, from the smallest children to the oldest elderly.

(FG2)

Throughout participants noted that hospitals are discharging patients earlier, and many stay at home longer, even with complex and unstable health needs. These changes have a major impact on nurses' work:

We have sicker patients now than 10 years ago. There is much more pressure to have the elderly and sick at home for longer, and we see that there is much more need for clinical expertise now than before.

(FG6)

A pervasive theme in the discussions about nurses' work in HHC was their responsibility to ensure adequate care at home for patients with complex needs. This emerged as an overarching position for the home-care nurses' work. Through storylines about the proficiency of home-care nurses and their work, we identified three positions as distinctive for nurses' work. The first position involved independently assessing and capturing altered healthcare needs. Secondly,

it was to perform advanced procedures in the patients' homes, and lastly, to provide customized solutions in different homes.

3.1 | Independently assess and capture changing healthcare needs

The first position that we identified as distinctive for the home-care nurses' work was assessment of the patients' health and changing conditions. This position stemmed from repeated storylines about how every time they enter a patient's home, they need to evaluate the situation then, and there to capture any changes. The participants linked this position to the special context of working in the patients' homes, as well as the nurses' competence and responsibility in following up on these observations.

Monitoring health needs and capturing changes were referred to as core tasks in home nursing and crucial for patients to stay at home. This is especially important in a home-care context, where the nurses can observe more than in a hospital context.

In the patient's home, I get to know the person and family in a completely different way, and I can uncover more and see needs that go beyond just what is on the task list. The patients are so much more than just the tasks.

(FG4)

The participants pointed out how they strive to have a *holistic* approach by looking at the entire situation of patients in the assessments, including their everyday lives at home. They conveyed an understanding of the term holistic approach as seeing the patient as a whole person in relations, and not just a diagnosis.

When you come into a home you must be good at using your clinical gaze to get an overview of the situation. That is the expert home-care nurse.

Yes, that you get the whole situation in the home concerning living conditions, nutrition, and many things. How does the patient manage to take care of himself, and how much help is needed? And you need to have a good dialogue with the patient.

(FG3)

Being able to include and assess the patient's situation was presented as a characteristic of a proficient home-care nurse.

A characteristic that was highlighted was that home-care nurses mainly work alone in patients' homes, and *independence* was a frequently used term to describe their work and needed expertise. This places additional demands on their ability to capture changes in patient situations. The participants elaborated with stories about how the nurse who comes to the patient must be able to make decisions and act there and then.

Yes, independence is required. Being able to work independently. You need to be able to work under a bit of stress, and you must be able to make decisions there and then that you know can have big consequences.

(FG2)

The participants strongly emphasized the importance of professional knowledge in terms of awareness about what to observe, what the observations mean, and what must be done. This requires the professional expertise that nurses possess. The emphasis on nursing expertise became especially evident when they talked about how healthcare professionals with less education can make observations but lack the knowledge to know what the observations mean. The following dialogue illustrates how the participants justified this position by referring to their competence as nurses:

We have a unique education that enables us to meet each patient and see their needs.

Much is about observations of the basic needs of the patient, and that you see and consider everything you observe. If you wash the legs of a patient, you do not just wash the legs, you consider the entire patient and possible health problems that may occur.

(FG1)

Another specific aspect of working in HHC is that they are only with the patient for a limited time before moving on to other patients and homes. The participants pointed this out and emphasized the importance of being able to assess each situation independently in order to provide sufficient care. This was a recurring storyline about the nurses' work and responsibility in home-care. Also, assessing health needs is important for further follow-up and negotiations on the level of care for each patient.

The prevailing discourses showed that the nurses assumed a position as clinical experts in the assessment of health needs at home, while at the same time this was an ascribed position from other healthcare professionals in HHC, like auxiliary nurses and general practitioners.

There are many situations during a workday where extra follow-up and observations of patients are needed. And then we, as home-care nurses, are being asked for. After all, we have a responsibility as nurses.

(FG6)

The home-care nurses legitimized the position with their professional competence and responsibility in addition to the relationships with the patients. Knowledge of the individual patient and their family was particularly emphasized by the nurses working in rural districts, who had often known the patients for a longer time. At the same time, participants talked about having less time for relational

contact with each patient than before, which impaired their knowledge of the individual patient.

3.2 | Perform advanced procedures in patient's home

A consequence of at-home care of sicker patients with unstable conditions is that advanced procedures and medical follow-up have become a larger part of the work of home-care nursing, which the participants emphasized:

Home-care nursing is an exciting field in nursing now. We have more patients with complex needs, and we perform much more advanced medical procedures in the patients' homes than before. This requires a high level of expertise from us.

(FG4)

The nurses were keen to convey that there are now more advanced clinical procedures that nurses must perform in homes and that cannot be assigned to staff with lower levels of competence. At the same time as the home-care nurses referred to themselves as generalists, they also stated that there is now a growing need for specialized knowledge.

After all, we are generalists, and we must be. We must know something about everything. At the same time, we also need special expertise, and we often become skilled in some areas because we have a special interest in it or we have a lot of experience with it.

(FG2)

The discussions in the focus groups revealed how home-care nursing now includes many tasks that previously belonged in a hospital context, and the participants pointed out that there is an increased need for specialized nursing expertise in several areas like palliative care and dementia care. Several of the participants described the specialist tasks as particularly interesting, which is what makes working in HHC more attractive. The home-care nurses stressed that most medical procedures can be performed in the patient's home. Examples of advanced procedures that they highlighted are injections, intravenous treatment, and continuous pain relief through painkillers, enteral nutrition, respirators, and even dialysis at home. In our study, it was particularly the home-care nurses in rural municipalities who claimed they have a lot of experience with advanced treatment. They emphasized that they go to great lengths to allow patients to stay at home for as long as they want and to avoid tiring trips in an ambulance.

Follow-up of advanced clinical procedures in home-care poses several challenges. In the focus groups, they discussed how demanding it is to be up-to-date and deal with specialized tasks that they

may not encounter as often when working in diverse general service. Another aspect that was highlighted the logistics:

It is a challenge with all the logistics of making sure the right equipment and medicines are in place when the patient needs it. We spend so much time getting it right.

(FG4)

There was much discussion and laughter in the groups when discussing the organizational work needed to ensure follow-up of advanced procedures at home, demonstrating the challenges this adds to their work.

3.3 | Provide customized solutions in various homes

This position evolved from numerous stories about how home-care nurses must be creative and find good solutions to handle whatever may arise.

More tasks have been transferred to the healthcare services in the municipality. The information and planning are not always up-to-date, but we remain with it and must deal with it.

(FG3)

A frequent storyline in the focus groups was how all the changes in health services have a major impact on their work. 'We are left with everything and must deal with it', was a phrase used by several. Participants emphasized that they cannot reject patients who need help at home. The discussions in the focus groups revealed how nurses assume a great responsibility to handle the different tasks. This was evident, among other things, in the widespread use of the modality '*must*' when participants talked about their work. They *must* handle all the tasks and patient needs and find solutions. The participants talked about being creative in the sense that they often have to find alternative solutions tailored to each situation:

We must be creative and find other solutions in a home than in hospitals, where there are hospital beds and more available equipment and medical help.

Yes, we have to improvise a lot and be solution oriented. I think this is very important in home-care.

(FG3)

The participants constantly pointed out that home-care nursing is a 'different kind of nursing' than in a hospital. Having the patient's private home as context for the work was an underlying storyline in the discussions. Also, participants emphasized that it is not only one home that is the context:

There is a lot of focus on how you meet the patient in the home and how you behave in the patient's arena. But it is not just one home; we travel to and enter into many different homes.

(FG2)

They talked about how they need to be flexible to tune in to different patients and home situations. The participants elaborated on how this presents practical challenges such as logistics and travel in all kinds of weather and conditions. Also, they talked extensively about having unpredictable workdays, where a number of different things happen, and they constantly have to cope with new tasks. One recurring phrase was that in home-care you *must be able to think on your feet*. The home-care nurse must be flexible and prepared to act quickly. These statements point to a high degree of urgency and time pressure in the nurses' work. They also linked the unpredictable to the fact that they never quite know what they will meet behind the next door. Although the unpredictable was talked about as a challenge that nurses face, it was also presented as something they like about their work.

That is something I find stimulating about working in home-care nursing. You never know what is behind the next door. After all, that is kind of what I like about this work.

(FG3)

A significant part of the work to ensure customized and sufficient care at home is clinical leadership. For the nurses, this entails delegation and supervision of work tasks and planning, prioritization, and follow-up of the patient care. The leadership function was in relation to auxiliary nurses and staff with less formal competence and was presented as a dominant part of their work.

4 | DISCUSSION

The findings provide insight into nurses' distinctive work in HHC, along with work positioning in a changing context. Drawing on insights from positioning theory (Harré et al., 2009), we see the entwining of nurses' work and contextual changes. According to Freidson (2001) and Abbott (1995), professionals maneuver within their specific contexts in ongoing boundary work that is influenced both internally by the norms of the profession and from the outside by societal and policy processes. The findings showed that nurses experience HHC as ever-changing in terms of work tasks and competence requirements, and change was a persistent storyline in their work positioning. More patients, work tasks, and responsibilities have been transferred from hospitals to HHC, and this has a great effect on the work and work boundaries. As a result, home-care nursing is becoming increasingly diverse and comprehensive (Melby et al., 2018; Purkis et al., 2008).

Our analysis revealed three positions as distinctive for nurses' work in HHC. The first position is assessment of health needs, which is a vital task and responsibility that home-care nurses must follow up at every home visit. Nurses' assessment competence is important in all contexts, but specific aspects of a home context make it crucial. In particular, frail patients living alone depend on the nurse to detect changes and assess the health situation in the moment (Næss et al., 2017). Nurses' knowledge of patients and continuous assessment gives them a strategic position as gatekeepers in contributing to adequate healthcare. This points to the fact that nurses' voices are important in negotiations on the level of care, although the nurses in our study felt that they were not adequately included in such decisions.

The next position that we identified was providing advanced procedures and medical follow-up. The findings revealed how nurses' time and attention are increasingly directed toward sicker patients needing advanced care at home. Several other studies confirm this trend and point to the importance of nurses in following up seriously ill patients in HHC (Barrett et al., 2007; Næss et al., 2017; Sekse et al., 2018). The prevailing discourses indicate that specialized medical follow-up has become a larger part of nurses' work in HHC, leaving less time for patients with stable or slowly progressing conditions. The transfer of tasks from hospitals has resulted in home-based healthcare being increasingly colonized by medical ideology and logic where treatment and urgent needs take precedence. A recurring expression in the findings was that home-care nursing is 'a different kind of nursing' than what takes place in a hospital setting. This statement stands in contrast to the fact that specialized medical tasks have gained a greater place in the work of home nurses. Other studies confirm how specialized home-care is ruled by a medical logic (Glasdam, Ekstrand, Rosberg, & van der Schaaf, 2020; Pusa et al., 2015), leaving less time for everyday life care that traditionally is a part of home-care nursing.

The last position was to coordinate and provide customized solutions in various homes. Working in the patient's own home impacts the working conditions and nurses must adapt their work accordingly. This is a special feature of the work that is often highlighted in studies of home-care nursing (Martinsen et al., 2018; Öresland et al., 2008). Also, the work takes place not only in one home but in many different homes, and thus includes many varied contexts. This perspective has been less elucidated in studies of home-based nursing, although some studies have highlighted the logistical challenges (Holm & Angelsen, 2014; Skinner et al., 2009). The work being done in many different homes means that a high degree of flexibility is required to provide customized solutions in each home.

Exploring nurses' work only by seeing what tasks they perform is too narrow and does not appropriately capture the work of home-care nursing (Halcomb et al., 2016). The participants in our study delineated work boundaries to some degree based on work tasks, but at the same time, they emphasized their professional responsibilities and mandate that go beyond a task-based focus. The positions that are assumed or taken are often associated and legitimized with certain rights and obligations, according to a positioning perspective

(Harré et al., 2009). The nurses legitimized their work mainly based on the patients' needs and their professional competence and responsibility. Often, they illustrated this by comparing their work with other professional groups and services through ongoing constructions of what their work encompasses.

One purpose of CDA is to illuminate a prevailing practice and whether anyone is disadvantaged through it (Fairclough, 2013). By exploring what characterizes nursing in this context, we touch on the question of what nursing is and should be in today's healthcare. The identified prevailing discourses indicate that home-care nursing is moving toward being a more specialized medical service, which has implications for what gets attention and is talked about. Our study showed that patients with complex and urgent needs receive much of the nurses' attention, leaving less time for patients with gradual deterioration. This indicates that some patient groups appear to be disadvantaged in a service that is becoming more specialized. In particular, this includes the elderly and people with mental illnesses who need support to cope with everyday life at home alone (Brennan et al., 2012; Næss et al., 2017). This change is also evident by discourses on how nurses have less time to talk with patients. Although the nurses are concerned about having a holistic approach to patients, it turns out that there is limited scope for them to include the entire patient's life situation.

Home-care nurses assume a great deal of responsibility for patient care and take on a position of keeping everything together. This is a comprehensive work order that requires a lot of nurses' competence and time. While this gives a picture of nurses as skilled and efficient professionals, it is also problematic. It means that nurses often have too little time, which can jeopardize patient care. Lack of time contributes to further delineation of the tasks in nurses' work and a rationing of care (Purkis et al., 2008; Tønnessen et al., 2011).

Our findings demonstrate how contradictory values are at stake in today's home-care nursing. Home-based healthcare is located within broader political and social changes that are often linked to market-oriented and medical ideologies, which challenge nursing care that require more time and presence (Aranda & Jones, 2008; Bendix Andersen et al., 2018; Fjørtoft et al., 2020; Glasdam et al., 2020). Nurses hold a crucial position to make these consequences visible to the public and ensure that basic values in nursing are safeguarded for at-home patients.

Discourses on nurses' work also point to tension fields in terms of what kind of competence is in demand. The findings revealed a practice that is both general and at the same time increasingly more specialized, and the home-care nurses are expected to handle a range of care needs in a patient's home. In our study, we found that nurses were keen to convey the growing need for specialized medical knowledge and skills and that this makes it more attractive to work in HHC. With a critical discursive perspective, it is relevant to ask whether the nurses have a hidden agenda when they speak as they do. It may be questioned whether this is a desired development for the nurses because it makes their position more important in prevailing medical discourses. Moreover, it seems that this knowledge

is given more priority and status in HHC today, at the expense of knowledge on everyday life and basic needs. This shows the need to discuss the content and development of nurses' competence.

Investigating the language use of nurses in HHC helps elucidate their professional identity in this context, which is an important contribution in applying discursive and positioning perspectives (Fairclough, 2013; Harré et al., 2009; Kayı-Aydar, 2018). Home-care nurses' consistent use of *we as nurses* suggests a common understanding of their professional identity that is shaped and revealed through discourses about themselves and their work. With an understanding of discourses as both a reflection and agents of shaping changes, nurses need to be aware of how they talk about their professional practice and thereby change it. Furthermore, it is important that nurses take a professional and ethical stance on what good nursing care is in home-care and make this visible to the public.

5 | CONCLUSION

Healthcare-related changes in society impact nurses' work in HHC, and our findings on prevailing discourses on today's home-care nursing show how comprehensive and multifaceted the work is. This requires tremendous responsibility to ensure quality care for home-dwelling patients with complex and often unstable health needs.

Our study shed light on the home-care nurses' distinctive work and what gets prioritized. Nurses hold crucial positions in home-based care through assessing needs, following up with advanced medical care, and organizing the work. Based on insight from positioning theory, we have elucidated the dynamics of the delineation of work and the intertwining of contextual changes. Changes have made the work of nurses driven by extensive tasks and urgent medical needs that require their expertise and time. This underlines how nurses and their competencies are invaluable assets in HHC, while at the same time demonstrating the need to discuss the development of home-care nursing. There is a need for further research on ongoing changes and what takes precedence in home-care nursing.

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