Received: 28 September 2022 | Revised: 24 February 2023 | Accepted: 15 March 2023

DOI: 10.1002/nop2.1732

EMPIRICAL RESEARCH QUALITATIVE

NursingOpen Open Access WILEY

Experiences and challenges of the use Subacute and Acute Dysfunction in the Elderly-SAFE Work team coordinators experiences and challenges in the introduction and use of SAFE of in home-based nursing: A qualitative study from the Norwegian context

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Abstract

Old age is the leading cause of impaired bodily function, which gradually increases healthcare service needs. To offer the best possible care in the home and to be able to detect health-related functional impairment at an early stage, it is necessary to carry out systematic and structured observations. The assessment tool Subacute and Acute Dysfunction in the Elderly (SAFE) has been developed explicitly for these structured observations. This study aims to explore the experiences and challenges of home-based care work team coordinators (WTCs) regarding the introduction and use of SAFE.

Method: The present qualitative study was performed following Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines. The data were collected through individual interviews ($n = 3$) and focus group (FG) interviews ($n = 7$). The interview transcripts were analysed using the Gioia method.

Results: Five aggregated dimensions were identified: *Varying acceptance of SAFE*, *Structuring and quality-assurance of home-based nursing practice*, Obstacles for the integration of SAFE in daily practice, *Acceptance and use of SAFE require continuous supervision and SAFE contributes to increased quality of nursing care.*

Conclusion: The introduction of SAFE contributes to a structured follow-up of functional status in patients receiving home care. In order to incorporate the tool into home care practice, it is essential to set aside time to introduce the tool and to support nurses' use of it by offering continuous supervision.

KEYWORDS
nursing assessment, nursing home care, nursing observations, older people

No patient or public contribution.

1 | BACKGROUND

The world today is facing a rapid increase in the proportion of older people, that is a population older than 60 years, while the proportion of young people is declining (Dijkman et al., 2019; Ruppert & Roberts, 2022). According to the World Health Organization (WHO), the proportion of individuals 65 years and older worldwide is projected to increase from 12% to 22% by 2050 (WHO, 2021b). All countries are preparing their health and social systems to deal with this demographic change (Keating, 2022; WHO, 2021a). Old age is the leading risk for impaired bodily function, like age-related multi-morbidity, chronic disease and related disabilities, which gradually increases healthcare service needs and is perceived as a great challenge for the healthcare sector (Tøien, 2019). Today, the population of Norway has undergone a fundamental change in its age structure. After a long period with a stable proportion of people over the age of 67, there has been an increase in recent years. This demographic now makes up almost 16% of the population (Bjørn Heine Strand et al., 2018). The reason for this is that the birth cohorts who have reached the age of 67 in recent years are relatively large and at the same time they have a longer life expectancy. The fact that the population is getting older leads to increased health challenges, even though the number of healthy life years has increased more sharply than the number of years of illness. This has important implications for the whole of society. Responding to this demographic difference requires finding new solutions and making adaptations across many aspects of society, especially in the healthcare sector, including how to work and how to provide health care in the most effective ways.

According to the forecast, in 2030, there will be 3.5 people of active working age per older adult 80 years or older. In 2035, every 3rd student needs to choose nursing and care education to cover healthcare service needs. This implies that, compared to today, fewer healthcare workers will take care of an increasing number of older adults (Alvsåker, 2022). In line with this development, the Norwegian Ministry of Health and Welfare has presented the Cooperation Reform which aims to provide the correct treatment in the right place and at the right time (Ringard et al., 2013). The reform highlights the importance of designing healthcare services based on citizens' needs, and municipalities have more responsibility for preventive work to reduce admissions to hospitals or other nursing home institutions. The older people should be able to live at home as long as possible, independently in a safe and secured environment (Morris et al., 2013). In Norway, home nursing care is provided by home care at municipality's level. To carry out clinical observations systematically, a Registered Nurse (RN) can use different types of scientifically proven tools. Some of the most widely used tools are the Mini Nutritional Assessment (MNA) to detect malnutrition (Guigoz, 2006), the Modified Early Warning Score (MEWS) for Clinical Deterioration (Subbe, 2020) and the Introduction, Situation, Background Assessment, Recommendation (ISBAR) (Marshall et al., 2009).

Home care's main task is to promote the health and independence of users of healthcare services, prevent complications related to their illness and diseases and early recovery, as well as to reduce functional impairment and suffering (Naess et al., 2017).

In the past years, several tools have been developed to detect the health impairments of older people early, one of which is the Subacute and Acute Dysfunction in the Elderly (SAFE).

Subacute and Acute Dysfunction in the Elderly is an assessment tool that aims to detect early signs of subacute and acute dysfunction among older people through structured and systematic observation and covers the complexity that characterizes the gradual development of dysfunction or deterioration of health in old age. It consists of 13 main observation areas; communication, elimination, nutrition, physical function, general self-care, personal hygiene, medical self-care, sleep, cognitive function and pain (Gjevjon et al., 2013, 2019; Gjevjon & Hellesø, 2010). The 13 areas are structured so that they can fit within the electronic patient record-system Gerica (Støme et al., 2020; von Krogh & Nåden, 2008), that is used in home-based health care.

Several studies have shown that detecting any decline in the health status of the users of healthcare services living at home is a challenge for home nurses due to time pressure, which makes it difficult to get a thorough overview of the users of healthcare services' condition (Gjevjon et al., 2013; Gjevjon & Hellesø, 2010; Lloyd-Sherlock et al., 2012). Evaluations of SAFE Naess et al. (2017) revealed that both leaders and RNs experienced SAFE to be a helpful tool for observing and assessing vulnerable older patients and makes it easier to systematically identify early signs of dysfunction. It also helped care providers gain a good overview of the patient's situation as small changes could be detected that might otherwise have been overlooked (Naess et al., 2017). SAFE is unique as it has colour codes that indicates changes in physical function and recommends further action, that is yellow indicates subacute changes, red indicates acute changes, and green indicates no changes in physical function compared to previous measurements. In addition to the SAFE tool, the nurse must take an individual assessment of the patient's health status based on clinical observations or previous journal notes. Finally, SAFE recommends when to contact the doctor. Furthermore, SAFE can provide home-based nurses competencies and skills to perform systematic assessments and identify impairments in older people living at home (Gjevjon et al., 2019). Early detection of impairments is important as it has shown to reduce the average length of stay in healthcare institutions (Abel et al., 2013).

2 | THE STUDY

2.1 | Aim

The study aims to explore the experiences and challenges of home-based care work team coordinators (WTCs) regarding the introduction and use of SAFE.

2.2 | Method

2.2.1 | Study design

The present qualitative study is performed in accordance with COREQ guidelines (Booth et al., 2014; Patton, 2014).

2.2.2 | The context of the study

In Norway, the home-based nursing service is part of the municipal healthcare service that provides healthcare and nursing services for people living at home. The service is an essential part of the care of older people, although they are not the only ones who receive nursing services at home. The municipal home-based healthcare service comprises RNs led by WTCs. The RN conducts home visits and is responsible for clinical observations focusing on general health conditions and responses to medication. The RN cooperates with the general practitioner (GP) if the patient's health status changes and if it requires an adjustment of medication or a new health assessment.

SAFE was developed, implemented, evaluated and revised within a collaboration project between Oslo University Hospital and three districts in Oslo municipality. A multidisciplinary team with members from both primary care and specialist geriatric care at the local hospital were involved in the project (Gjevjon et al., 2013; Naess et al., 2019). SAFE was intended especially for the home-based healthcare services and was established as an extension of 'Live your whole life', a quality reform from the government that was introduced in Norwegian municipalities in 2017/2018. The goal was that all older people should get better help and support to cope with life.

In 2020, there was a clear need for a mapping tool for a closer follow-up of the frailest users of healthcare services, due to increased use of nursing home places and the beginning of the Covid pandemic. The Frogner District in Oslo was part of a learning network, thus SAFE was implemented in the Frogner District just before the full pandemic in 2020. The aim was to ensure continuity and systematicity in the use of SAFE and in the follow-up of the users. It was important to increase the observation skills of employees. Teaching was therefore given in mapping with SAFE and follow-up of the results. In addition, it was given a medical equipment bag to all executive nurses.

This study was conducted in the municipality of Oslo, Norway, at the Home-based healthcare service in the Frogner district. The Frogner Home-based healthcare service is divided into three district sections, Solli, Uranienborg and Majorstua. In 2020, a collaboration was established between VID Specialized University, the Faculty of Health Sciences—Institute of Nursing and the Frogner Home-based Healthcare Service. This collaboration aimed to ensure the introduction and use of SAFE in healthcare services in the Frogner district of Oslo. The present study is a part of this collaboration project. The healthcare service is led by a unit manager and consists of approximately 750 clients. Each of the home nursing areas is led by a section leader. Each district section is divided into two or three work teams which serve a geographical location. Each of the work teams is led by a WTC (Figure 1).

The WTC has an overview of all the users of home-based healthcare services in their area in close collaboration with GPs and specialist health services. The WTC is an intermediary between professional management and the field of work. WTCs make the daily working lists and organize them so that health professionals can follow-up on their users of healthcare services according to their qualifications. The WTCs work closely with the work team, by organizing and following up work routines and healthcare services for users in their areas and providing professional guidance to healthcare workers. All users of healthcare services are assigned a nurse as the contact person responsible for coordinating the coverage of the service.

2.2.3 | Study participants

The participants in this study were identified and recruited with the help of a key person who is a co-author in this article (HKC). The key person has been involved in introducing SAFE in their area and has first-hand knowledge of which WTC in the organization participated in this project.

The key person has asked ($n = 11$) coordinators and ($n = 10$) has agreed to participate in this study. The age of the participants was between 28 and 50 years (men = 3 and women = 7). In the results the participants will be presented as respondents 1–10 (i.e. R1, R2, ...).

Because the study has been conducted in a limited, small geographic area, we have chosen not to collect information about the participants that could reveal their identity. Furthermore, central phenomena of interest experiences of being involved and introducing SAFE were focused on. What we have chosen is to present common characteristics at group level.

The participants are WTC, which means that they are nurses with at least 2 years' experience from home-based care as executive nurses which shows good nursing professional insight and familiarity with the user group on their work team. The WTC needs good skills in coordinating and prioritizing and good competence within various relevant medical subject areas. Personal uniqueness and desire to carry out the work are emphasized upon employment.

2.2.4 | Data collection

The intention was to conduct a minimum of three FG interviews with a minimum of three participants per group. Due to the pandemic and sickness absence, we did not get enough people to carry out the planned FG interviews. We chose to carry out individual interviews with those who did not come according to the agreed time.

The data were collected through two FGs, and three individual interviews. The same interview guide was used for both interview forms. FG interviews ensured the interaction between the participants, which provided detailed and varied descriptions of experiences related to the introduction of SAFE. One interviewer had the

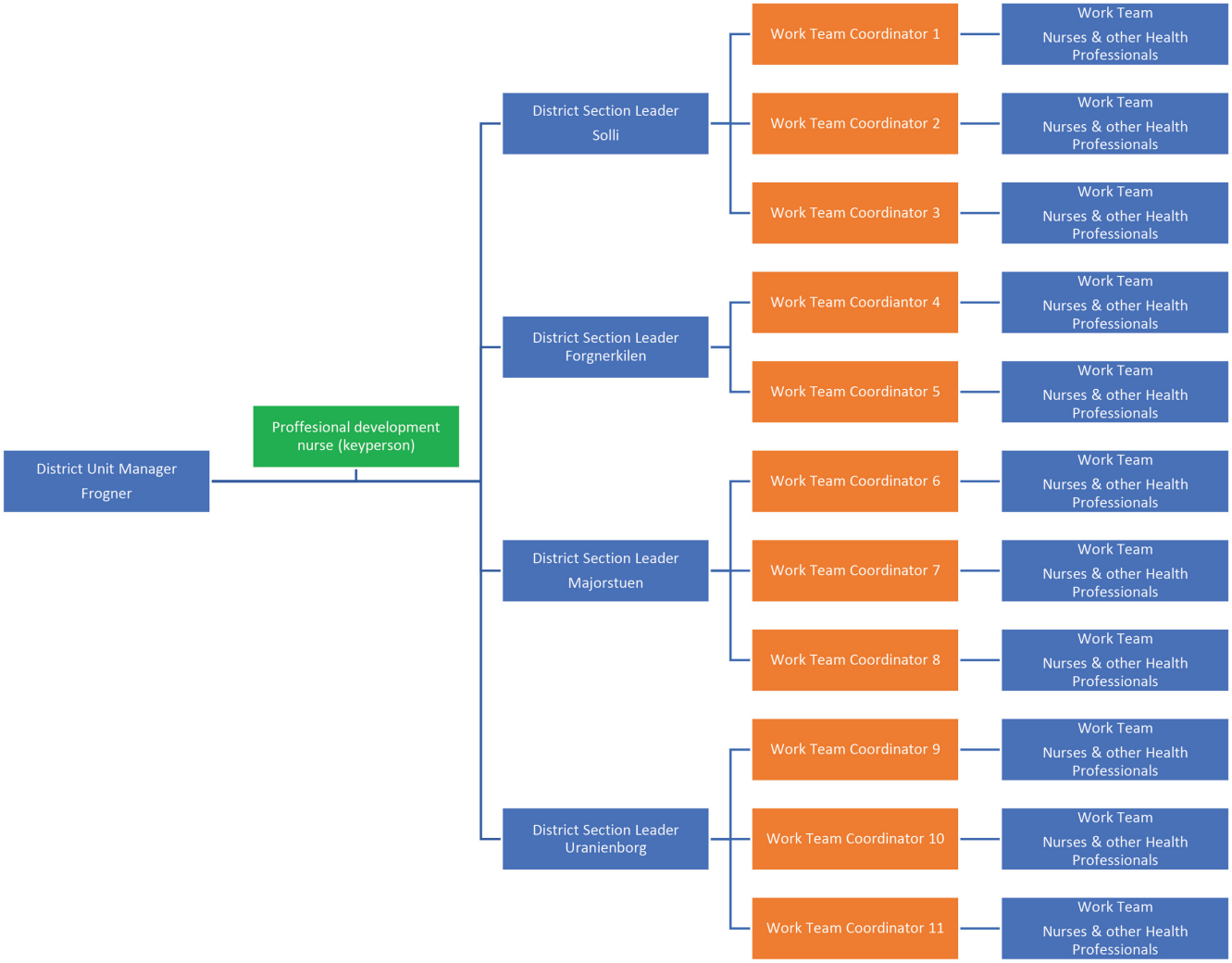

FIGURE 1 Organizational chart for Frogner District home-based healthcare service at the Municipality of Oslo.

role of moderator (AA), and the other interviewer had the role of observer (AH) to record interactions. One experienced co-author (ZP) supervised the first interview to ensure quality of the interview technique. We gained in-depth descriptions of the phenomenon of interest with individual interviews.

In qualitative research, the size the number of participants in the study is not specified, but the focus is on variety, depth and richness in descriptions of the phenomenon of interest. Data collection continues until nothing new comes up. In this study, we have already assessed that nothing new emerges after two FG interviews and two individual interviews. Still, we have decided to conduct a third individual interview to confirm it.

Both the FG interviews lasted approximately 50 min each and had three and four participants, totally seven participants (men = 2 and women = 5). The three individual interviews variated between 20 and 41 min of duration (men = 1 and women = 2; Kvale & Brinkmann, 2014; Morgan, 1996). The researchers introduced themselves and the research project before starting the interviews. The interviews were structured by an interview guide (see Table 1). They were audio-recorded and stored on a research server at VID Specialized University.

2.2.5 | Data analysis

The recorded interview data was transcribed verbatim by an external person. Transcripts were the unit of data analysis. We used the Gioia method to analyse the transcripts (Gioia et al., 2013). The analysis process consisted of the following steps: each co-author read the transcripts independently several times to get a sense of what they were about. Next, we broke down the text to identify first-order concepts. These concepts then were grouped into second-level themes. The last step was to find aggregate dimensions. The co-authors discussed each step, and a final agreement was reached (see Figure 2). Five aggregated dimensions were identified: Varying acceptance of SAFE, Structuring and quality-assurance of home-based nursing practice, Obstacles for the integration of SAFE in daily practice. Acceptance and use of

TABLE 1 Interview guide for the work team coordinators (WTCs)

Introduction of SAFE – early detection of subacute/acute functional impairment in the elderly in home service, Frogner District 2020–2022
Introduction
1. Can you tell us what is behind the use of SAFE in your institution?
2. Who introduced SAFE to you?
3. How would you describe SAFE compared to other observational tools you have used in the past?
4. How was the use of SAFE communicated to the employees who are authorized to use it?
5. How was SAFE received among the employees who were to use it?
Implementation
1. Which profession is responsible for using SAFE? Give some examples of who you think should use SAFE
2. How is the introduction and use of SAFE followed up by management? Give an example
3. How have the employees who are authorized to use SAFE been supported? Give examples
4. What concrete goals do you want to achieve by using SAFE?
5. How does management support employees who discover a serious impairment when using SAFE?
6. How did you manage the SAFE assessments? Who was responsible for that? Give some examples
7. How does the use of SAFE contribute to interdisciplinary collaboration?
8. Can you tell us what are the short- long-term goals for the use of SAFE in your organization?
Evaluation
1. Do you think it is sustainable to use SAFE as an assessment tool?
2. Is there anything else you want to tell us that you haven't been asked about that is relevant to SAFE?

SAFE require continuous supervision, and SAFE contributes to increased quality of nursing care.

2.2.6 | Ethical considerations

The project description, informed consent and interview guide were approved by the Norwegian Centre for Research Data. A written formal consent form for participation in this project and an interview guide were sent to all participants prior to undertaking the interviews. The consent form indicated that participation was voluntary and participants the right to withdraw from the study at any time without any negative consequences for them. They were informed that we would only use the information for the purposes of the present study. The collected data and personal information have been treated confidentially and in accordance with the General Data Protection Regulations (GDPR). Presentation of the results will remain anonymous. Only co-authors have access to the transcribed anonymized interviews, which are encrypted with a code and stored on the research server. The Key person (HKC) has a leader position in the home-based healthcare service in the Frogner District, was therefore not involved in the interviews and has no access to the transcribed anonymized interviews. The results will be presented at group level, and it will not be possible for participants to be identified in publications.

3 | FINDINGS

3.1 | Varying acceptance of SAFE

Our study shows the importance of properly introducing SAFE for WCTs. The WCTs explained that it is their responsibility to introduce SAFE to all nurses working in home nursing care in their departments. Nevertheless, we found a varying degree of acceptance of SAFE among WTCs due to unclear introduction of the tool and its purpose for routine application in clinical work. Most WTCs did not think that they had received sufficient information about the aims or goals and the use of SAFE, making it difficult for them to be a resource person for their employees. One of the participants expressed it this way:

> Perhaps first and foremost we [WTCs] did not get a proper introduction to what this [SAFE] is. (…) so, I think it was a bit wrong that I suddenly should be a resource person…. You should have attended a training course if you are going to be a driving force for something.
>
> (R1)

Participants mentioned that there was still confusion and insecurity among the WTCs regarding the criteria for using SAFE, that is the target group, the situations in which it should be used, and record keeping. One participant expressed it this way:

> I think you could clarify who the target group is here (…) and in which situations it [SAFE] should be taken. (…) We cannot do it [SAFE] on all [users of healthcare services]. No, but that is basically what we are asked to do.
>
> (R2)

The study's findings have shed light on the importance of having a mutual understanding of the tool's use. Because WTCs consider themselves resource persons, it is important that they receive proper training on SAFE to be able to guide and instruct their employees in this regard. Although they reported that using SAFE was not complicated, there were some challenges among WTC to make nurses understand how and when to use SAFE. Two of the participants expressed it this way:

FIGURE 2 Data structure. Reproduced from Gioia et al. (2013).

As a coordinator, I think it was difficult to get the nurses to understand what the point was [with SAFE] (…) It is not about the [users with] poor [health] (…) it is about the ones who are a bit under the radar. (…) What happened since you managed to put on those socks yourself and then you were suddenly lying on the floor somehow?

(R3)

> Some of the us are unsure about when to use SAFE and how, (…) so there is a need for an introduction to and frequent training in SAFE.
>
> (R4)

3.2 | Structuring and quality-assurance of home-based nursing practice

Work team coordinators experienced that nurses liked to use SAFE because they felt it contributed to a better quality of service for users of healthcare services. Some of the WTCs described SAFE as a self-explanatory assessment tool that gave nurses in the field more confidence when it came to identifying functional impairments among older people who live at home. They also experienced those home-based nurses worked more systematically and with all measurements, which was not previously the case in home-based nursing services. One of the participants expressed it this way:

> We use SAFE so often because it is a self-explanatory tool (….) We use it for all our users of healthcare services including the new ones. (…) Our nurses are confident in applying all needed measurements, such as using SAFE and SAFE-Baseline, and go through all the points. I think that SAFE and SAFE-Baseline are excellent assessment tools to better understand the needs of our users of healthcare services.
>
> (R4)

Some of the informants mentioned that SAFE is a tool that helps WTCs structure clinical evaluations and enables nurses to communicate with doctors and other health professionals properly. One participant expressed it this way:

> Regarding being confident in taking measurements, if someone is going to call the emergency room or ambulance, then it is excellent idea to have SAFE in hand and to be able to quickly take measurements and compare them to previous [measurements].
>
> (R5)

3.3 | Obstacles for the integration of SAFE in daily practice

This study revealed uncertainty about how often SAFE should be carried out, as there were no criteria for that, and that deciding how often to use SAFE was an individual assessment. However, nurses' opinions varied. Some of the participants mentioned that it was up to the individual nurse whether to use SAFE. In addition, some of the WTCs mentioned that cumbersome data journal system routines made it difficult to integrate SAFE into routine daily work. Thus, one of the challenges they faced was integrating SAFE into the electronic data journal systems. Several participants expressed it this way:

> Applying the SAFE assessment tool is totally an individual decision (….). There are differences regarding how home nurses apply SAFE depending on how bad the patient's health situation is. (…) Another challenge we have is the registration system for SAFE.
>
> (R7)

> The SAFE form is not available in the electronic system, which makes it easy to forget where the data has been saved (…) There is a need for a better documentation system and to remove the redundant forms.
>
> (R8)

> There is a kind of individual assessment around it, and I don't know (…) it was every second week to third month… I don't remember what they (….), usually we have many things to register. I have got the impression it [SAFE] was on hold. I thought it was not integrated into the service. So, I just let it fade out and ignored it.
>
> (R9)

Daily workload, individual priorities and lack of time were some of the reasons nurses in the field gave for not using SAFE. One participant expressed it this way:

> It depends on the general daily workload in the area (….), we have to do what we have to do (….) we don't have to register the form (SAFE)… I can only speak for myself, but I am not a master in following up (SAFE)'.
>
> (R10)

3.4 | Acceptance and use of SAFE require continuous supervision

This study revealed that there is a need for regular knowledge updates and continuous supervision for healthcare workers who are authorized to use SAFE. The WTCs mentioned that when SAFE was not sufficiently introduced, nurses had difficulty using it. Therefore, there is a need for courses to properly introduce SAFE to new staff. One participant expressed it this way:

> Not all nurses use SAFE…. some of them are unsure about when and how to use SAFE (…) so there is a need for frequent training/introduction (….) so we have to continue supervising them, especially the newly employed nurses.
>
> (R2)

This study underscores that consistent use of SAFE requires a follow-up system for the collected data to assure the quality of service. The WTCs emphasized that all nurses who apply SAFE have a responsibility to document and follow-up the patient's health status in the future. One of the participants expressed it this way:

> Nurses who have taken measurements and filled out the SAFE forms have a responsibility to follow up the collected data.
>
> (R3)

3.5 | SAFE contributes to improving the quality of nursing care

There was consensus among the WTCs that the SAFE tool improves nurses' skills in performing systematic assessments and enables them to identify deterioration and health impairment in older people living at home. The WTCs considered SAFE to be a good tool for planning home-based care services. Using SAFE has contributed to improving the quality of home-based nursing and helped with decision making at the management levels. They also mentioned that using SAFE contributed to develop the assessment competences and skills among home-based nurses in terms of documentation and communication. Two participants expressed it this way:

> They liked to work in this way because they work more systematically, especially when they can have all the measurements.
>
> (R9)

> When I started in home-based nursing care, we did not have a blood pressure manometer or other basic instruments, but with SAFE, at least we have some of them (….) we have become better at remembering that you can take measurements since you always have the equipment with you.
>
> (R10)

This study found also that the use of SAFE made interdisciplinary collaboration and communication between nurses and WCTs and health professionals easier. The WTCs mentioned that the nurses had become more comfortable with SAFE which gave them a shared professional language. One of the participants expressed it this way:

> It is good for the users of healthcare services, (….) The nurses develop competence in assessment, and we even develop a common language. Before it was almost like discretionary assessment or not true descriptions of what I meant.
>
> (R9)

4 | DISCUSSION

This research is the first qualitative study using Gioa method (Gioia et al., 2013) that identifies the aggregated dimensions of experiences and challenges of home-based care WTC regarding the introduction and use of SAFE. Data analysis showed that the variation in the extent to which SAFE was accepted was caused by inadequate introduction by management and lack of engagement from WTCs, the reasons for which were lack of mutual understanding and confusion regarding the proper use of SAFE. Similar results were shown in a study by Green et al. (2014) who found that nurses are more likely to use new assessment tools if they are considered relevant for their area of activity. It was important for team leaders to offer to the nurses training and access to resources that support the introductory phase of new assessment tools (Green et al., 2014). Romano and Minns Lowe (2022) emphasized the importance of preparing professionals to implement assessment tools by consistently using support strategies and training in the procedure (Romano & Minns Lowe, 2022).

Abel et al. (2013) found that proper use of systematic assessment is important to identify deterioration and health impairment of older people living at home. In our present study all nurses received a medical equipment bag in addition to the SAFE assessment tool. Studies have emphasized the importance of including the necessary medical equipment to cover the needs of the users of healthcare services (O'Brien & Jack, 2010). Ziylan et al. (2015) found that the home-based care service employees were missing a coherent and feasible division of responsibilities when it comes to follow-up of screening and treatment, as some experienced that they had become involved too late, which in turn lead to reduced treatment effectiveness. Similar results were found in a study exploring the influence of leadership on dementia care mapping in four nursing homes (Quasdorf & Bartholomeyczik, 2019).

To conclude, it is indicated the importance, to provide proper guidance and support for all nursing staff members on all levels when introducing new assessment tools or working routines. The management's active role in support is crucial for the new tool to be accepted by each individual and incorporated into clinical practice robustly and sustainably. Furthermore, follow-up on how the tool is used could be essential.

This study shows that using SAFE systemizes patient-centred work and increases nurses' professional self-confidence. The results are in line with recent studies on assessment tools for physical function which found that the assessment tool MEWS facilitated nurses' clinical reasoning and decision making when acute functional decline was detected in home nursing patients (Jeppestøl et al., 2022; Roney et al., 2015). The findings of a study by Moi et al. (2019) on the use of ISBAR in clinical practice showed that the participants felt more confident about their ability to quickly obtain an overview of patient situations (Moi et al., 2019).

As in our study, Taylor (2012) identified many challenges related to developing a common understanding when integrating assessment tools for health and social care (Taylor, 2012). The 2019 RN survey

also revealed many low scores indicating serious problems with staff engagement in the organization (AMN, 2019). In the present study, the use of SAFE was dependent on each nurse's individual perception and understanding. Furthermore, it shows that it was challenging to integrate the assessment results from SAFE into the existing patient record system. Similar results were found in a recent study aiming to identify benefits and barriers in the use of SAFE (Naess et al., 2019). To a certain degree, the findings from this study are in line with priorities for improving care set out in the WHO framework for patient-centred health services in terms of adding specific details about how needs can be met, including service coordination and continuity, making sure information is shared between providers (WHO, 2018).

Bracher et al. (2019) point to the importance of having a high level of support for screening activity and recommend appointing a key person to support and monitor compliance of procedures. Furthermore, it has been found that involving nursing home staff in the implementation of new routines such as assessment tools in clinical wards leads to culture change in their facilities which needs to be integrated with the implementation process to provide greater accuracy and more effective health services to their users of healthcare services (Shield et al., 2014). Results from another study provide guidance to organizations considering the implementation of routine screening and assessment procedures (Craven et al., 2017). Finally, a recent study emphasized the importance of structural empowerment, professional growth, transformational leadership and teamwork for professional development and ultimately clinical excellence (George & Massey, 2020).

To conclude, nursing staff should be included in major organizational initiatives which in turn can promote a positive and healthy workplace culture. Authorized healthcare personnel are responsible for developing their competence and, in turn, raising the quality of the clinical work they perform daily. To be able to do so, they must receive the opportunity and support in their workplaces because this responsibility is a shared responsibility between the organization and the individual employee to offer high-quality care based on proven knowledge and experience.

Our study elucidates the importance of recognizing that leaders, WTC and nursing staff all play key roles in the implementation of SAFE. It is shown that the use of SAFE as an assessment tool in home-based nursing has contributed to the establishment of common and specific professional skills among nurses. It was explored how SAFE has improved communication between nurses and other healthcare providers, as well as with the users of healthcare services. Furthermore, it was indicated that SAFE helps service coordinators make the proper decisions in service planning and management. Several studies have shown the importance of recognizing the impact both leaders and nursing staff's roles have on healthcare organizations and patient care (Eckert et al., 2014; Lv & Zhang, 2017). Other studies have confirmed that the use of assessment tools contribute to improving nurses' observational skills, which in turn facilitates decision making for leaders (Buckley et al., 2016; Mahoney et al., 2013). The findings of this study correspond to studies showing that introducing specific assessment tools provides a common language for all health professionals and that teamwork and communication between healthcare personnel are vital to quality of care and patient safety (De Meester et al., 2013; Foronda et al., 2014; Moi et al., 2019; Stewart, 2016). A study by Moi et al. (2019) similarly found that using ISBAR in clinical practice made participants more aware of their communication with other health professions and that communication became more structured. Furthermore, several studies have underlined that nurse managers have a critical role to play to improve nurses and patients' communication and interactions (Amoah et al., 2019; Madula et al., 2018). Kwame and Petrucka (2020) concluded that nursing managers and healthcare administrators should thoroughly examine nursing staff shortages and high workloads to try and minimize these factors, which affect interactions between managers, nurses and patients interaction (Kwame & Petrucka, 2020). Finally, the need to incorporate communication and interpersonal relationship skills, as well as alternative communication strategies in nursing training programmes, has been suggested by numerous authors (Amoah et al., 2019; Cubaka et al., 2018; Dithole et al., 2017).

Home-based health care is the clinical arena that has developed as quickly as specialized care. Many care recipients are moved shortly after treatment in hospitals to nursing homes and their homes. Regardless of the care context in which care recipients find themselves, they have the right to high-quality care from the authorized care staff. The use of scientifically proven observation tools in clinical bedside work contributes to performing safe care of high quality.

The present study has given insight into how SAFE was introduced into home-based health care. More scientific studies are needed to follow this up over time and involve the care recipient, namely the older people and their relatives.

5 | LIMITATIONS

Overall, the study limitations include drawing participants from only one district in one municipality with most of the participants drawn from one large healthcare service. This makes the study geographically limited. However, participants came from the whole district, which enabled the collection of data from a diverse range of WTC settings. Nonetheless, the generalizability of the study findings is limited as the purposively selected sample may not be representative of the views of the broader population of WTCs. However, the study findings do provide insight into and an understanding of the nature of WTCs' negative and positive experiences of using SAFE in home-based nursing care.

6 | CONCLUSION

We believe that SAFE as an assessment tool and its overall goals could be meaningful in practical application of home-based care services. Given current resource limitations on the implementation of SAFE, including the varying degrees of acceptance of the

tool in home-based nursing and the individual interests of using SAFE. However, the study confirms the importance of following up and providing continuous supervision regarding the use of SAFE for both current and new staff members. Furthermore, the study emphasizes the importance of properly introducing SAFE, which contributes to a better understanding of the purpose of the tool. As will as a description of how it should be integrated into daily work. The findings of this study underscore the commitment of the WTCs to promoting the use of SAFE as an assessment tool in home-based nursing in order to improve the quality of nursing care provided for older people living at home. This study demonstrates that SAFE can help us understand the health status of the users of healthcare services and shed light on existing challenges in the home-based healthcare services at the user and managerial levels. In summary, this study suggests that preparatory, educational and continuous support work are important for fully integrating SAFE into clinical activities within the home-based care system. Future research is needed to develop and integrate SAFE in home-based nursing care.

AUTHOR CONTRIBUTIONS

AA, ZP and AH contributed to study design. AA, ZP, AH and HKC contributed to data collection. AA, ZP, AH and NNW contributed to data analysis and manuscript preparation.

ACKNOWLEDGEMENTS

We thank all the participants for their valuable input and time. We acknowledge the support of the leaders of home-based nursing care in the Frogner district. This study is part of research activities related to Service development for older persons research group (TJENESTEFORSK) at VID specialized University, Norway.

CONFLICT OF INTEREST STATEMENT

There have been no involvements that might raise the question of bias in the work reported or in the conclusions, implications or opinions stated. There are no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper. Therefore, the authors claim there are no conflicts of interest for this submission.

DATA AVAILABILITY STATEMENT

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

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How to cite this article: Abudayya, A., Hamre, A., Pajalic, Z., Knudsen Cervino, H., & Wesseltoft-Rao, N. (2023). Experiences and challenges of the use Subacute and Acute Dysfunction in the Elderly-SAFE Work team coordinators experiences and challenges in the introduction and use of SAFE of in home-based nursing: A qualitative study from the Norwegian context. *Nursing Open*, *00*, 1–11. https://doi.org/10.1002/nop2.1732