Received: 18 September 2020 | Revised: 20 May 2021 | Accepted: 10 June 2021

DOI: 10.1111/opn.12399

International Journal of Older People Nursing

WILEY

RESEARCH ARTICLE

'My registered nurse': Older people's experiences of registered nurses' leadership close to them in community home care in Sweden

Maria Claesson RN, PhD Student[1] | Karin Josefsson PhD, RNT, Professor[1,2] | Lise-Lotte Jonasson PhD, RN, Associate Professor[3]

[1]Faculty of Caring Science, Work Life and Social Welfare, University of Borås, Borås, Sweden

[2]Faculty of Health, Science and Technology, Department of Health Sciences, Karlstad University, Karlstad, Sweden

[3]Department of Nursing School of Health and Welfare, Jönköping University, Jönköping, Sweden

Correspondence
Maria Claesson, Faculty of Caring Science, Work Life and Social Welfare, University of Borås, Sweden.
Email: maria.claesson@hb.se

Abstract

Aim: To explore older people's experiences of registered nurses' leadership close to them in community home care.

Introduction: In Sweden and throughout the world, the number of people 65 years and older is increasing. While older people are living for more years, living longer can bring more diseases and disabilities, which might lead to the need for home care. Registered nurses are responsible for older people's care needs in their leadership in community home care; this is a part of their professional role as registered nurses, and it implies that they must be multi-artists.

Design: An explorative and inductive design was used in two communities in western Sweden.

Methods: Individual interviews were conducted with older people (n = 12) with at least one year of experience with community home care. Data were analysed using qualitative content analysis.

Results: The results are presented in the theme 'my registered nurse', including five categories – relationship, professional competence, nursing interventions, coordination and collaboration and organisation – and 15 sub-categories.

Conclusions: These findings are based on older people's own experiences. This is specific, as the phenomenon of the RNs leadership is rarely explored from the perspective of older people.

Implications for practice: There is a need for organisations to create more opportunities for older people to have their own registered nurses leading close to them. This is because registered nurses have specific competences for meeting older people's individual needs and involving them as competent partners in satisfying their care needs.

KEYWORDS

community home care, interview, leadership, older people, registered nurse

1 | INTRODUCTION

Older people in Sweden who are living in their own homes are legally entitled to assistance from the communities when needed for social services and home care that aims to meet their needs. This care should be provided in older people's homes by healthcare professionals, consistently over time (National Board of Health and Welfare, 2019). Through individually adapted community home care, a registered nurse (RN) can utilise older people's own resources in the promotion of their health (Turjamaa et al., 2014). RNs in community home care in Sweden have been required to have at least a bachelor's degree from a three-year education programme since 1993, and specialist nursing education with a master's degree is preferable (Josefsson et al., 2007). Further, RNs in community home care are working independently as well as together with other healthcare professionals to support older people in need of community home care (Andersson et al., 2017; Claesson et al., 2020).

Being dependent on help could be problematic for older people because they leave both themselves and their homes in the hands of others. In such cases, they must let unknown people into their homes, including those that they did not choose themselves (Jonasson et al., 2019). Older people are often seen as a recipient and not as a partner in care (Gregory et al., 2018), although they do want to be involved in decisions about their own care at home (Gregory et al., 2017).

In Sweden and around the world, the number of older people, 65 years and above, is increasing (Population Reference Bureau, 2020). While the ageing population is living for more healthy years, living longer also brings more diseases and disabilities (Abramsson et al., 2017). With increased age, the risk of encountering health changes that may affect one's life situation increases for older people, who may then be in need of community home care (Abramsson et al., 2017; Arnadottir et al., 2011; Ljungbeck & Sjögren Forss, 2017; WHO, 2015).

RNs' leadership close to older people in community home care is a part of their professional role (International Council of Nurses, 2012) and implies that an RN must be a multi-artist (Claesson et al., 2020). To be a multi-artist means that one must build trust, exert control, engage in continuous learning and be aware of the individual's needs and their identity as a whole. There is a dividing line between leadership and management, such as the responsibility for operations and budget. Leadership, on the other hand, strives to construct changes by promoting both a view of the future and strategies to reach that view (Josefsson & Hansson, 2011). Clinical leadership and nursing leadership are evident in nursing (Stanley & Stanley, 2018), and an RN has a personal responsibility to display leadership close to older people (Jonasson et al., 2019; Josefsson & Hansson, 2011). While there are different leadership approaches (Avolio et al., 2009), there is no specific approach for nursing leadership. A prerequisite for RNs to be able to develop their leadership is supportive management and organisation. Few RNs in community care have the will to invest in their own competence and development in leadership (Josefsson, 2006).

In community home care, an RN assumes the role of a guest working in an older person's home, which places demands on the RN's flexibility, competence (Andersson et al., 2017; Kiljunen et al., 2017) and leadership (Claesson et al., 2020; Josefsson, 2006). The demands of competence include, for example, ensuring healthy ageing, mitigating ageing diseases and drug management (Davitt et al., 2016; Karlstedt et al., 2015). Furthermore, RNs are required to have knowledge about the older person's life history, the preventive measures for illness and how to reduce the consequences of illness and suffering (Josefsson, 2006). In summary, the duties of RNs highlight the importance of an RN's leadership close to older people, with a foundation in the caring sciences, as they must possess a clear patient perspective in order to maintain good and safe care (Josefsson & Hansson, 2011; Wong & Cummings, 2007). Therefore, this study aims to explore older people's experiences of RNs' leadership close to them in community home care.

What does this research add to existing knowledge in gerontology?

- Older people in community home care experienced the registered nurses' leadership close to them as if they had their own registered nurses, which they referred to as 'my registered nurse'.
- This result is unique since it highlights older people's own experiences of registered nurses' leadership in community home care.

What are the implications of this new knowledge for nursing care with older people?

- Registered nurses' competence is crucial in older people's experiences of registered nurses' leadership.
- Registered nurses' leadership contributes to older people working in partnership in the design of their own care.

How could the result be used to influence policy of practice or research or education?

- There is a need for organisations to create opportunities for older people to have registered nurses leading close to them.
- Organisations need to take into account that older people are capable of working in partnerships with the registered nurses who are leading close to them.

2 | METHOD

2.1 | Design

This qualitative descriptive study was conducted during October and December of 2019 in two communities in western Sweden. An explorative and inductive design was used to maintain openness to

the phenomenon (Dahlberg & Dahlberg, 2019). Individual interviews were conducted with older people (n = 12) receiving community home care. Data were analysed through qualitative content analysis (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). The study was approved by the Regional Ethics Review Board in Gothenburg, Sweden (Dno. 720–18).

2.2 | Inclusion and exclusion criteria

To ensure credibility, the inclusion criteria for the older people were that they had at least one year of experience of the phenomenon (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020) and were able to verbally participate in an interview. The exclusion criteria were cognitive disabilities, if it created a hindrance to participating in the interview. Exclusion criteria were also the need for an interpreter to conduct the interview but did not exclude older people with a native language other than Swedish.

2.3 | Participants and procedure

The managers of home care in two community areas were contacted and informed about the study. The purpose of this was to find RNs working with older people receiving community home care. In an effort to reach older people of varying ages, genders and experiences of the phenomenon (Sandelowski, 1995), the RNs asked the older people if they wanted to participate in the study. If they said yes, the RNs provided their contact information to the first author. A total of 14 older people were asked to provide their contact details to the first author. After telephone contact, two older people (n = 2) chose not to participate in the study. In total, 12 older people, including both women (n = 6) and men (n = 6) in the age range of 72–95 years, remained and received an information letter about the study. On average, the older people participating in the study had received community home care for 4 years.

2.4 | Data collection

An interview guide was created after discussions in several seminars with researchers with knowledge of the topic. The interview questions were constructed through literature studies and in discussions with researchers, with the goal of achieving trustworthiness (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020), based on the approach of 'open questions' to respond to the phenomenon (Dahlberg & Dahlberg, 2019; Dahlberg et al., 2008). The older people were then contacted to make an appointment for the interview. The older people chose when to be interviewed and whether to be interviewed in their homes. A test interview was conducted to assess the logistics and relevance of the questions as well as the clarity of interpretation. The test interview did not lead to changes. Thus, the test interview was included in the data.

Before the interview, the older people were shown a short presentation introducing the aim of the study. Then, the interview started with two open questions: (1) 'Can you tell me how you experienced the contact that you have had with the RN who visited you in your home?' and (2) 'Can you tell me how you experienced the RN's leadership close to you?' Follow-up questions were used when needed: How? What does that mean? Can you tell me more? Can you give some examples? Is there any particular situation you are thinking of? Is there something you miss in your contact with the RN? Do you want something to be different in your contact with the registered nurse? All interviews ended with the following question: 'Is there anything you want to add before end of the interview?' The interviews lasted for an average time of 29 min (min–max =15–42 min).

2.5 | Data analyses

A qualitative content analysis was performed on the data (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). First, the interviews were transcribed verbatim and read several times by the first and third authors in order to get an overview of the content related to the aim. This text was then divided into meaning units. Subsequently, the meaning units were condensed and abstracted into codes. Sub-categories and categories were discussed in several seminars with all authors focusing on the aim. The analysis proceeded with movement back and forth between the parts and the whole of the text; see an example of the content analysis process in (Table 1). The codes were compared with a focus on the variations in the differences and similarities, which led to one theme, five categories and 15 sub-categories (Table 2). The analysis was thoroughly discussed in the research group until a consensus was reached on its trustworthiness.

TABLE 1 Example of the content analysis process

Meaning unit	Condensed meaning unit	Code	Sub-category	Main category	Theme
'It's just that my registered nurse is very nice. My registered nurse sits down, talks, and helps me with what I need at the moment and arranges my medication'	It's nice; my registered nurse helps me with what I need	It's nice; I get help with what I need	Caring relationship	Relationship	My registered nurse

TABLE 2 Overview of theme, categories, and sub-categories

Theme	
'My registered nurse'	
Categories	**Sub-categories**
Relationship	Caring relationship Personal relationship Communication Sense of security
Professional competence	Ability Teaching Knowledge Skills
Nursing interventions	Direct nursing interventions Indirect nursing interventions
Coordination and collaboration	Coordinates staff and work duties Collaborates joint work
Organisation	Availability Keeping agreed times Continuity

2.6 | Ethical considerations

This study followed ethical principles for research, which included assurances of autonomy, no harm, doing good and justice (Beauchamp, 2013). The Helsinki Declaration guided the design (WMA, 2013), and correct, appropriate, accessible and adequate information about the study was provided to the participants. The older people who participated provided their informed consent. The interviewer had no connection whatsoever to the older people who participated. No information could be linked to the older people in the transcribed interviews or the study. The recorded interviews will be kept confidential and made available only to the research group.

3 | RESULTS

The results describe older people's experiences of the RNs' leadership close to them in community home care through the theme 'My registered nurse', including five categories – relationship, professional competence, nursing interventions, coordination and collaboration and organisation – and 15 sub-categories.

3.1 | 'My registered nurse'

The older people in community home care experienced the RNs' leadership close to them as they had their own RN, or 'my RN' (Table 2). They experienced the RNs as being both professionals and friends who they could turn to when in need. The older people perceived the RNs to be professionally competent, through their experience of a range of nursing interventions, while also coordinating with caregivers, home care assistants and work duties and collaborating in joint work within an organisation. In addition, they experienced good continuity when the RN visited them at an agreed time, and it felt as though their own RN had visited them.

> ... I have the privilege of having a registered nurse who is my registered nurse...
>
> *[5]*

3.2 | Relationship

3.2.1 | Caring relationship

The older people experienced that they had a caring relationship with the RN leading close to them, whom they called 'my RN'. The caring relationship was based on trust and confidence. It was important for the older people to feel that they had their own RN, whom they could contact when needed. The caring relationship included how the older people worked in partnership with the RN, such as when the older people felt that the RN took considered their experiences and desires. The older people also experienced that the RN could be resolute if the situation required. This was experienced as satisfactory because it created a sense of trust.

> ...so the registered nurse is more than my registered nurse you can say...'
>
> *[1]*

> ...they have the expertise, and I have the knowledge, so we mix it, and it will be good...
>
> *[2]*

3.2.2 | Personal relationship

It was valuable for the older people to have an RN who was leading close to them. This experience included a personal relationship, whereby the older people could easily converse with the RN about almost everything. The personal relationship was experienced as a mutual one, in which the older people had consideration for the RNs who led close to them and did not want to call them if it was not necessary. For example, when the older people had a cough, they took care of it by themselves without bothering the RN. They also experienced that their care was inadequate if, in their words, their 'own RN' was sick or on vacation.

> ...yes, when a registered nurse comes here, we sit and talk and have fun. And she's not formal in any way...
>
> *[11]*

3.2.3 | Communication

Older people experienced communication with the RNs as contributing to their participation in their own care. The older people

perceived that the RNs were communicating with the home care assistants via computer most of the time. In their experience, communication could sometimes fail between their 'own RN' and the home care assistants. This was because the RN seldom had personal contact with the home care assistants since their communication was carried out at a distance.

> ...we really have a dialogue, together we have found out how my wound dressing should be done...
>
> *[2]*

3.2.4 | Sense of security

The older people experienced a sense of security in the RNs' leadership; this was described as an experience of confidence and trust. A sense of security was important; for example, if the older people had problems, they knew they could turn to the RN for help. They also experienced that trust could take some time to build up, so it was important to establish a relationship with the RN leading close to them to experience a sense of security.

> ...the most important thing is that I know that the registered nurse exists and that I can call her. Well that is incredibly important...
>
> *[11]*

3.3 | Professional competence

3.3.1 | Ability

Older people perceived the RNs as having leadership abilities, such as delegating work duties to the home care assistants to meet the older people's individual care needs. They also experienced that the RNs were involved in their care plan, using their professional competence and knowledge about them as individuals. In this way, the RNs supported the older people and suggested what care they were in need of. For the older people, the RNs were professionals in their leading role based on their professional competence. This contributed to the older people's self-determination as well as the experience of participation in their own care.

> ...the registered nurse was involved in my care planning. The registered nurse supported me and presented opinions, treatment, and care that I needed...
>
> *[5]*

3.3.2 | Teaching

The older people perceived that teaching was an important part of the RNs' leadership. They experienced that the RNs taught nursing students at home visits, and this instruction could be about lifestyle changes for older people, such as advice about smoking cessation or how to exercise. They also experienced that the RNs taught other RN colleagues.

> ...there have been several students here before, and the registered nurse teaches them how to do things...
>
> *[2]*

3.3.3 | Knowledge

The older people perceived that the RNs had the knowledge to effectively lead their care. The RNs' leadership was experienced as valuable and important, and it was evident that the RNs had more knowledge than the home care assistants. The assistants turned to the RNs if they needed help with anything due to the RNs' professional knowledge. It was important for the older people that the RNs had knowledge about their medical histories, especially in the beginning of their relationship, as this created a bond between the older people and the RNs.

> ...knowledge is a huge difference and of course if you are a registered nurse you must have a very good basic knowledge...
>
> *[5]*

3.3.4 | Skills

The RNs' leadership was experienced as being demonstrated by specific skills, which could be accessed by those in the RNs' nursing profession. For example, patient safety was a part of their leadership, as was the control of medications. The older people perceived a difference between the skills possessed by the RNs and those of the home care assistants. They also experienced pain and endured harm if the RNs did not effectively demonstrate their skills in their professional role.

> ... yes, the registered nurses do not do the home care assistants' work, and the registered nurse has her own skills. Yes, it is such that the registered nurse has higher education...
>
> *[6]*

3.4 | Nursing interventions

3.4.1 | Direct nursing interventions

Direct nursing interventions were experienced as common nursing interventions administered by the RNs, such as blood sampling, wound dressing and medication administration. They also

mentioned direct nursing interventions, such as changing and flushing urinary catheters, stopping nasal bleeding, vaccinations and supplying incontinence aids. The direct nursing interventions in their homes were of great value to them. This is because, even at night, the older people could stay at home instead of going to a healthcare centre or hospital.

> ...when I have to have a blood sample taken, I do not have to go to the health care centre. You cannot get better service than when the registered nurse comes to your home and helps you there...
>
> *[8]*

> ...the registered nurse orders insulin and everything that is needed...
>
> *[1]*

3.4.2 | Indirect nursing interventions

RNs who led close to the older people were involved in indirect nursing interventions, such as follow-ups and evaluations of ongoing or new drug treatments or of other completed direct nursing interventions. Older people also experienced indirect nursing interventions as preventive since they could stop new problems from arising, thereby mitigating unnecessary harm and suffering.

> ...yes, it is the case that the registered nurse is coming before my inhaler runs out, and then I will get this vaccine...
>
> *[6]*

3.5 | Coordination and collaboration

3.5.1 | Coordinates staff and work duties

In the older people's experience, the RNs coordinated staff and work duties, which was important for older people. They also experienced that the RNs had contact with their physicians at the medical centres and hospitals or with other caregivers who were involved in their care. The older people believed that the RNs were valuable, as they coordinated the care they needed as well as the work of the home care assistants and other RNs. The RNs also coordinated care in both emergency and everyday situations.

> ...yes, it was the registered nurse who coordinated everything. The registered nurse contacted the ambulance we needed to go to the hospital and also called them...
>
> *[9]*

3.5.2 | Collaborates joint work

The RNs' leadership experienced as a form of collaboration with the home care assistants. The older people experienced communication between the RNs leading close to them and the home care assistants and believed it to be important for their own care. They also experienced that the RNs were collaborating with physicians at the medical centre to get specialist referrals in some cases, such as an advanced leg ulcer. Since the RNs could collaborate with other healthcare professionals, the older people experienced that they did not have to go to the healthcare centres so often. This collaboration was thus of great value for them.

> ...my registered nurse has stated that since nothing happened to the leg ulcer in six months, we now have to do something else, so tomorrow my registered nurse will go to my physician and ask him to write a referral to the skin specialist...
>
> *[2]*

3.6 | Organisation

3.6.1 | Availability

The RNs' leadership close to the older people made them feel that they had their 'own RN' available to them. It was also important for them that the organisation replaced the RNs leading close to them during periods of absence (e.g. vacations). They experienced such availability when their own RN was easy to reach by phone and then answered directly. Even if the RN did not answer immediately, the older people experienced that the RN called them back as soon as possible. The older people also experienced this availability when they received a visit from the RNs adapted to their own care needs.

> ...but when my registered nurse has a holiday, someone else will come, and it has gone very well...
>
> *[1]*

3.6.2 | Keeping agreed times

During the daytime, the older people never had to worry because the RNs usually visited them at an agreed time. During the night, however, the older people experienced that the RNs had problems in keeping the agreed times, and it could take a long time before they visited them.

> ...the registered nurse has scheduled times for visit; the registered nurse is always right on time, and you don't have to wait that long. But if I need help at night, it is difficult to get a hold of any nurse...
>
> *[4]*

3.6.3 | Continuity

The older people experienced RNs' leadership as they had their 'own RN' who was just visiting them most of the time. In other words, they experienced continuity in the contact with, as they called it, their 'own RN'. They were never worried that the RNs would not come to visit or call them when needed. Most of the time, it worked well when another RN visited them instead, but they each believed that their 'own RN' was the best. The older people also experienced differences in continuity between the RN leading close to them and the home care assistants. Specifically, there was strong continuity with the RNs' care but less continuity with the home care assistants.

> … I have had the same registered nurse, sometimes when my registered nurse has been busy, there is someone else coming, but otherwise, it is the same registered nurse…
>
> *[10]*

4 | DISCUSSION

The main results showed that older people in community home care experienced the RNs leading close to them as their 'own RNs', or in their words, 'my RN' (Figure 1), and included working in partnership with the RN. In a related study, Gregory et al., (2018) showed that older people wanted to work in partnership in their healthcare decisions and desired to contribute with an impact on their own health care. This study showed that older people were capable of working in partnership with the RN and that the caring relationship was based on trust and confidence. Wälivaara et al., (2013) confirmed that nursing care at home was built on a trusting relationship between the RN and the person in need of community home care, with a requirement of reciprocity in the relationship. Wälivaara et al., (2013) also showed that there was a difference in the relationship if the RN was the one primarily responsible for such care or if there was a stand-in RN who visited the person in need. This study demonstrated the importance for older people of having an RN leading close to them, whom they named 'my RN', because it created a sense of trust in the caring relationship.

Personal relationships were also experienced by older people in this study on occasions when they could have conversations about almost everything with the RN. In another study, Holmberg et al., (2012) described how older people in community home care valued when the RN was social, which made them feel equal as human beings, and they also appreciated when the RN sat down and talked with them. In contrast, Moe et al., (2013) reported that older people felt as if they were a burden for the RN who visited them since RNs are very busy. In some circumstances, older people may feel that their homes have become a workplace without a sense of privacy. For the RNs, it could be challenging to determine the boundary between a personal relationship and maintaining a standard of professionalism in their leadership close to older people in community home care.

Holmberg et al. (2012) confirmed that older people who received community home care wanted to be respected as persons and unique individuals, and they desired to have a personal relationship with the RNs. Fjordside and Morville (2016) showed the opposite, reporting that older people felt that they had a depersonalised relationship with the RNs who did not respond to their care needs. Perhaps these contradictions show that the RNs' attitudes are crucial to older people's experiences of their relationship with them. In another related study, Soares et al., (2019) showed that it was important for older people that RNs as professionals got to know them as individuals with their own histories and backgrounds. It was also important that older people had personalised and adapted care and that the RNs were aware of diversities and differences in care without making generalisations. The results showed that the older people in community home care who participated in this study experienced the RNs leadership close to them to be important in meeting their individual care needs. From a national perspective, the legislation states that all older people have the right to get their care needs satisfied on equal terms, regardless of gender, ethnicity and social status. Nevertheless, there are probably differences from a Swedish perspective in older people's experiences regarding these aspects that are important to further explore.

The older people experienced that the RNs leading close to them had the ability to lead the home care assistants in their work to meet their care needs. Although this study showed that older people found the RNs leading close to them to have the abilities to lead, it seems to be a complicated issue. Josefsson and Hansson (2011) showed that few RNs in community home care felt they had leading responsibility for the direct care for older people in home care. In this case, it is possible that the community home care organisation was organised in different ways from community to community and that the RNs had different conditions in which to manage their work. These different conditions place demands on the RNs' ability to lead as well as organisational-level demands to provide the appropriate conditions for RNs to manage their leadership.

Professional competence in this study also included skills. The older people perceived a difference between the RNs' skills and those of the home care assistants. These skills included patient safety and the control of medications. Gransjön Craftman et al., (2015) showed that older people assumed that home care assistants had the relevant skills to administer medication in a practical way. However, their experiences indicated that the home care assistants did not have the knowledge of the side effects and purposes of the medications. The administration of medication to older people in community home care is a challenge for RNs, although this assignment can be delegated to home care assistants with little to no education (Gransjön Craftman et al., 2016). This study showed that older people were aware of the RNs' specific skills and higher education, and they could discern the difference between their skills.

In this study, nursing interventions included direct nursing interventions. Older people experienced that they could stay at home and get help with procedures, such as blood sampling and wound dressing, instead of going to a healthcare centre or emergency department, even

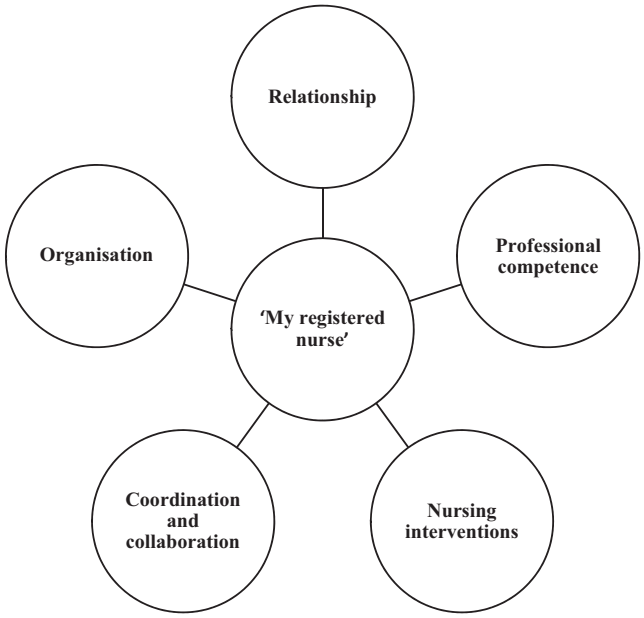

FIGURE 1 The theme and categories describing older people's experience of registered nurses' leadership close to them in community home care

at night. In another study, James and Kihlgren (2019) showed that older people felt more secure when they could stay at home at night and get help in their own environment. This is because the home reflects the older peoples' identity, and being treated there allows them to maintain their self-determination. This study highlights that RNs' leadership was important since the RNs made it possible for older people to stay at home and feel safe all day and through the night.

The level of organisation experienced by older people in this study included a sense of continuity. They experienced continuity in the RNs' care, but they experienced less continuity with the home care assistants. Russell and Bowles (2015) found that patients had more positive perceptions of care when the same healthcare professional visited them. In contrast, Gjevjon et al., (2016) reported that the majority of older people experience no problems if they are treated by a high number of healthcare professionals, provided that they are well compensated and skilled. Although the older people in this study perceived that things worked well most of the time when another RN visited them, the care of the RN who led close to them that they had named 'my RN' was experienced to be the best.

5 | STRENGTHS AND LIMITATIONS

Research involving older people's voices in community home care is limited, especially regarding the experience of RNs' leadership close to them. By interviewing older people of various ages and genders, the authors sought to capture different experiences of the phenomenon and improve the credibility of the findings. The fact that the older people was asked to participate by their own RN is a dilemma based on ethical considerations and could be seen as a limitation. The authors had several discussions throughout the whole research process, with the goal of establishing rigour and accuracy to maintain the older people's voice throughout the research process. Content analysis was used as a method of analysing the interviews due to the ability to structure and present the results using categories and themes. The authors continuously discussed the text derived from the interviews during the analysis to reduce the risk of subjectivity (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). Based on the results, it appears that the older people only had positive or neutral experiences of the phenomenon. To obtain more knowledge, additional research is required on this specific phenomenon in this context.

6 | CONCLUSIONS

The new knowledge presented here is based on older people's own experiences of RNs' leadership close to them in community home care. The older people's voices provide specific and interesting findings regarding their experiences of RNs' leadership, as they felt as if they had their own RN, who they called 'my RN'. This experience is linked to the relationship between the RN and the older people and to the RNs' professional competence. The findings also show that older people themselves are competent partners to the RNs in satisfying their care needs. A prerequisite for this partnership is that older people are given the opportunity to have their own RN, who, through their leadership role, can contribute to good and safe community home care.

IMPLICATION FOR PRACTICE:

Registered nurses' competence is crucial in older people's experiences of registered nurses' leadership.
There is a need for organisations to create opportunities for older people to have registered nurses leading close to them.
Organisations need to take into account that older people are capable of working in partnerships with the registered nurses who are leading close to them.

ACKNOWLEDGEMENTS

We would like to express our sincere thanks to all those who made this study possible, including the older people who participated and the RN who helped us to reach out to the participants.

CONFLICT OF INTEREST

The authors have declared no conflict of interest.

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.

ORCID

Maria Claesson https://orcid.org/0000-0003-2979-3705

REFERENCES

Abramsson, M., Hyden, L.-C., & Motel-Klingebiel, A. (2017). *Vem är den äldre? Äldrebilder i ett åldrande Sverige. [Who is the older one? Elderly pictures in an aging Sweden]*. NISAL.

Andersson, H., Lindholm, M., Pettersson, M., & Jonasson, L.-L. (2017). Nurses' competencies in home healthcare: An interview study. *BMC Nursing*, *16*(1), 1–8. https://doi.org/10.1186/s12912-017-0264-9

Arnadottir, S., Gunnarsdottir, E., Stenlund, H., & Lundin-Olsson, L. (2011). Determinants of self-rated health in old age: A population-based, cross-sectional study using the International Classification of Functioning. *BMC Public Health*, *11*(1), 670. https://doi.org/10.1186/1471-2458-11-670

Avolio, B. J., Walumbwa, F. O., & Weber, T. J. (2009). Leadership: Current theories, research, and future directions. *Annual Review of Psychology*, *60*(1), 421–449. https://doi.org/10.1146/annurev.psych.60.110707.163621

Beauchamp, T. L. (2013). *Principles of biomedical ethics* (7th ed.). Oxford University Press.

Claesson, M., Jonasson, L.-L., Lindberg, E., & Josefsson, K. (2020). What implies registered nurses' leadership close to older adults in municipal home health care? A systematic review. *BMC Nursing*, *19*(1), 30. https://doi.org/10.1186/s12912-020-00413-1

Dahlberg, H., & Dahlberg, K. (2019). Open and reflective lifeworld research: A third way. *Qualitative Inquiry*, *26*(5), 458–464. https://doi.org/10.1177/1077800419836696

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective lifeworld research*. Studentlitteratur.

Davitt, J. K., Madigan, E. A., Rantz, M., & Skemp, L. (2016). Aging in community: Developing a more holistic approach to enhance older adults' well-being. *Research in Gerontological Nursing*, *9*(1), 6–13. https://doi.org/10.3928/19404921-20151211-03

Fjordside, S., & Morville, A. (2016). Factors influencing older people's experiences of participation in autonomous decisions concerning their daily care in their own homes: A review of the literature. *International Journal of Older People Nursing*, *11*(4), 284–297. https://doi.org/10.1111/opn.12116

Gjevjon, E. R., Romøren, T. I., Bragstad, L. K., & Hellesø, R. (2016). Older patients' and next of kin's perspectives on continuity in long-term home health care. *Home Health Care Management & Practice*, *28*(3), 142–149. https://doi.org/10.1177/1084822315626001

Graneheim, U., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today*, *56*, 29. https://doi.org/10.1016/j.nedt.2017.06.002

Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Gransjön Craftman, Å., Grape, C., Ringnell, K., & Westerbotn, M. (2016). Registered nurses' experience of delegating the administration of medicine to unlicensed personnel in residential care homes. *Journal of Clinical Nursing*, *25*(21–22), 3189–3198. https://doi.org/10.1111/jocn.13335

Gransjön Craftman, Å., Westerbotn, M., von Strauss, E., Hillerås, P., & Marmstål Hammar, L. (2015). Older people's experience of utilisation and administration of medicines in a health- and social care context. *Scandinavian Journal of Caring Sciences*, *29*(4), 760–768. https://doi.org/10.1111/scs.12207

Gregory, A., Mackintosh, S., Kumar, S., & Grech, C. (2017). Experiences of health care for older people who need support to live at home: A systematic review of the qualitative literature. *Geriatric Nursing*, *38*(4), 315–324. https://doi.org/10.1016/j.gerinurse.2016.12.001

Gregory, A., Mackintosh, S., Kumar, S., & Grech, C. (2018). Visibility and meanings of partnership in health care for older people who need support to live at home. *Scandinavian Journal of Caring Sciences*, *32*(3), 1027–1037. https://doi.org/10.1111/scs.12545

Holmberg, M., Valmari, G., & Lundgren, S. M. (2012). Patients' experiences of homecare nursing: Balancing the duality between obtaining care and to maintain dignity and self-determination. *Scandinavian Journal of Caring Sciences*, *26*(4), 705–712. https://doi.org/10.1111/j.1471-6712.2012.00983.x

International Council of Nurses (2012). *The ICN code of ethics for nurses*. ICN.

James, I., Norell Pejner, M., & Kihlgren, A. (2019). Creating conditions for a sense of security during the evenings and nights among older persons receiving home health care in ordinary housing: A participatory appreciative action and reflection study. *BMC Geriatrics*, *19*(1), 1–12. https://doi.org/10.1186/s12877-019-1372-z

Jonasson, L.-L., Lindö, P., Lindh, T., & Josefsson, K. (2019). Life situation and participation as experienced by adult patients in palliative home care. *Nursing and Palliative Care*, *4*, 1–8. https://doi.org/10.15761/NPC.1000203

Josefsson, K. (2006). *Municipal elderly care: Implications of registered nurses' work situation, education, and competence* (Doctoral Dissertation). Karolinska Institutet.

Josefsson, K., & Hansson, M. (2011). To lead and to be led in municipal elderly care in Sweden as perceived by registered nurses. *Journal of Nursing Management*, *19*(4), 498. https://doi.org/10.1111/j.1365-2834.2011.01228.x

Josefsson, K., Sonde, L., & Robins Wahlin, T.-B. (2007). Registered nurses' education and their views on competence development in municipal elderly care in Sweden: A questionnaire survey. *International Journal of Nursing Studies*, *44*(2), 245–258. https://doi.org/10.1016/j.ijnurstu.2005.11.029

Karlstedt, M., Wadensten, B., Fagerberg, I., & Pöder, U. (2015). Is the competence of Swedish registered nurses working in municipal care of older people merely a question of age and postgraduate education? *Scandinavian Journal of Caring Sciences*, *29*(2), 307–316. https://doi.org/10.1111/scs.12164

Kiljunen, O., Välimäki, T., Kankkunen, P., & Partanen, P. (2017). Competence for older people nursing in care and nursing homes: An integrative review. *International Journal of Older People Nursing*, *12*(3), 1–10. https://doi.org/10.1111/opn.12146

Lindgren, B.-M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *International Journal of Nursing Studies*, *108*, 103632. https://doi.org/10.1016/j.ijnurstu.2020.103632

Ljungbeck, B., & Sjögren Forss, K. (2017). Advanced nurse practitioners in municipal healthcare as a way to meet the growing healthcare needs of the frail elderly: A qualitative interview study with managers, doctors and specialist nurses. *BMC Nursing*, *16*(1), 63–72. https://doi.org/10.1186/s12912-017-0258-7

Moe, A., Hellzen, O., & Enmarker, I. (2013). The meaning of receiving help from home nursing care. *Nursing Ethics*, *20*(7), 737–747. https://doi.org/10.1177/0969733013478959

National Board of Health and Welfare. (2019). *Communally funded health care. Pilot study*. Socialstyrelsen.

Population Reference Bureau. (2020). *2020 world population data sheet with a special focus on changing age structures*. Retrieved from http://www.worldpopdata.org/

Russell, D., & Bowles, K. H. (2015). Continuity in visiting nurse personnel has important implications for the patient experience. *Home Health Care Management & Practice*, *28*(2), 120–126. https://doi.org/10.1177/1084822315617141

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, *18*(2), 179–183. https://doi.org/10.1002/nur.4770180211

Soares, C. C., Marques, A. M., Clarke, P., Klein, R., Koskinen, L., Krasuckiene, D., Lamsodiene, E., Piscalkiene, V., & Küçükgüçlü, Ö. (2019). Older people's views and expectations about the competences of health and social care professionals: A European qualitative study. *European Journal of Ageing*, *16*(1), 53–62. https://doi.org/10.1007/s10433-018-0466-3

Stanley, D., & Stanley, K. (2018). Clinical leadership and nursing explored: A literature search. *Journal of Clinical Nursing*, *27*(9–10), 1730–1743. https://doi.org/10.1111/jocn.14145

Turjamaa, R., Hartikainen, S., Kangasniemi, M., & Pietilä, A.-M. (2014). Living longer at home: A qualitative study of older clients' and practical nurses' perceptions of home care. *Journal of Clinical Nursing*, *23*(21–22), 3206–3217. https://doi.org/10.1111/jocn.12569

Wälivaara, B.-M., Sävenstedt, S., & Axelsson, K. (2013). Caring relationships in home-based nursing care – Registered nurses' experiences. *The Open Nursing Journal*, *7*(1), 89. https://doi.org/10.2174/1874434620130516003

WHO (2015). *The growing need for home health care for the elderly: Home health care for the elderly as an integral part of primary health care services*. World Health Organization. Regional Office for the Eastern Mediterranean.

WMA. (2013). Declaration of Helsinki: Ethical principles for medical research involving human subjects. *JAMA*, *310*(20), 2191–2194. https://doi.org/10.1001/jama.2013.281053

Wong, C. A., & Cummings, G. G. (2007). The relationship between nursing leadership and patient outcomes: A systematic review. *Journal of Nursing Management*, *15*(5), 508–521. https://doi.org/10.1111/j.1365-2834.2007.00723.x

How to cite this article: Claesson, M., Josefsson, K., & Jonasson, L.-L. (2021). 'My registered nurse': Older people's experiences of registered nurses' leadership close to them in community home care in Sweden. *International Journal of Older People Nursing*, 00, e12399. https://doi.org/10.1111/opn.12399