Registered nurse's leadership close to older adults in municipal home healthcare

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To Axel and Greta

ABSTRACT

Background The number of older adults in need of care is expected to increase, as is the care provided in older adults' homes. This highlights the need to strengthen nursing leadership. In municipal home healthcare, registered nurses (RNs) lead nursing care and there is a need for increased knowledge about RNs' leadership.

Aims The overall aim was to explore RNs' leadership close to older adults in municipal home healthcare. Specific aims were to: explore and compare RNs' perceptions of their leadership close to older adults, as well as to correlate their perceptions with age and work experience (I); explore RNs' perceptions of challenges and suggestions for improvements in their leadership close to older adults (II); explore RNs' experiences of their leadership close to older adults (III); and explore care staff's experiences of RNs' leadership close to older adults (IV).

Methods A web-based questionnaire and descriptive and analytical statistics were used (I). Open-ended questions were analysed using descriptive statistics and qualitative content analysis (II). Focus groups were analysed with qualitative content analysis (III). Individual interviews were analysed with reflexive thematic analysis (IV).

Results RNs as leaders close to older adults strived to lead with the older adult in focus, strived to build relationships as a basis for leadership and bridge organizational gaps to promote good and safe home healthcare.

Conclusions RNs' leadership in home healthcare is essential for the care of older adults. RNs build their leadership on relationships. RNs' leadership close to older adults implies striving to bridge organizational gaps. These gaps need to be addressed, which go beyond the individual RNs. Municipal governance and healthcare organizations must promote preconditions for good and safe home healthcare. Municipalities, healthcare organizations and nursing education must be prepared to develop and support strong leadership.

Key words older adult, registered nurse, leadership close to, municipal, home healthcare, questionnaire, interview

SVENSK SAMMANFATTNING

Bakgrund Antalet äldre personer i behov av vård förväntas öka, liksom vård i hemmet. Därför behöver ledarskapet i omvårdnad stärkas. I kommunens hemsjukvård leder sjuksköterskor omvårdnaden och ökad kunskap behövs om sjuksköterskors ledarskap.

Syften Övergripande syftet var att utforska sjuksköterskors ledarskap nära äldre personer i kommunens hemsjukvård. Specifika syften var att: utforska och jämföra sjuksköterskors uppfattningar om sitt ledarskap nära äldre personer, liksom utforska samband mellan deras uppfattningar med ålder och arbetslivserfarenhet (I); utforska sjuksköterskors uppfattningar om utmaningar och förbättringsförslag i sitt ledarskap nära äldre personer (II); utforska sjuksköterskors erfarenheter av sitt ledarskap nära äldre personer (III); och utforska vårdpersonalens erfarenheter av sjuksköterskors ledarskap nära äldre personer (IV).

Metoder Webbaserat frågeformulär och beskrivande och analytisk statistik (I). Öppna frågor analyserades med beskrivande statistik och kvalitativ innehållsanalys (II). Fokusgruppsdiskussioner som analyserades med kvalitativ innehållsanalys (III). Individuella intervjuer analyserades med reflexiv tematisk analys (IV).

Resultat Sjuksköterskor som ledare nära äldre personer strävade efter att leda med den äldre i fokus, strävade efter att bygga relationer som en grund för ledarskapet och att överbrygga organisatoriska gap för en god och säker hemsjukvård.

Slutsatser Sjuksköterskors ledarskap i hemsjukvården är väsentligt för den äldre personens vård. Sjuksköterskor bygger sitt ledarskap på relationer. Sjuksköterskors ledarskap nära äldre personer innebär att sträva efter att överbrygga organisatoriska gap. Gapen måste åtgärdas, vilket sträcker sig bortom den individuella sjuksköterskan. Kommunal styrning och hälso-och sjukvårdsorganisationer måste främja förutsättningar för en god och säker hemsjukvård. Kommuner, hälso- och sjukvårdsorganisationer och sjuksköterskeutbildning måste vara förberedda på att utveckla och stödja starkt ledarskap.

Nyckelord äldre person, sjuksköterska, ledarskap nära, kommun, hemsjukvård, frågeformulär, intervju

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ORIGINAL STUDIES

This thesis is based on the following studies, which will be referred to in the thesis by their Roman numerals.

I. Lillsjö, E., Willman, A., Jonasson, L.-L., & Josefsson, K. (2025). Registered nurses' perceptions of their leadership close to older adults in municipal home healthcare: A cross-sectional questionnaire study. *BMC Nursing*, 24(1), Article 554. https://doi.org/10.1186/s12912-025-03210-w

II. Lillsjö, E., Bjuresäter, K., & Josefsson, K. (2023). Registered nurses' challenges and suggestions for improvement of their leadership close to older adults in municipal home healthcare. *BMC Nursing*, 22(1), Article 80. https://doi.org/10.1186/s12912-023-01215-x

III. Lillsjö, E., Jonasson, L.-L., Willman, A., & Josefsson, K. (Under review). "To lead is a struggle against organizational preconditions": Registered nurses' experiences of their leadership close to older adults in municipal home healthcare

IV. Lillsjö, E., Willman, A., Jonasson, L.-L., & Josefsson, K. (Under review). Care staff's experiences of registered nurses' leadership close to older adults in municipal home healthcare: an interview study

Reprints of study I and II were made under CC BY 4.0 licence.

INTRODUCTION

As time passes and we live, we grow older. Ageing is individual for each person. Some are pop and rock stars at the age of 80, while for others, health problems may affect their life and how the older age will unfold. Yet people continue living with their dreams, needs and wishes even when they may be affected by health problems. People are living longer and therefore the population of older adults is increasing. The fact that today we can live longer with disease thanks to the development of medical treatments can be seen as a success for humankind. However, it is essential to rely on a well-functioning care system providing care that supports our extra years in life to be as good as possible.

Today, the trend is towards older adults, who are able, to continue living in their homes and receive care at home. At the same time, municipal healthcare organizations are strained. Registered nurses (RNs) in home healthcare are responsible for and lead nursing care as part of their daily work. There is a call for strengthening nursing leadership in future healthcare and extended knowledge is needed about RNs' leadership in home healthcare. To address this need, this thesis explored RNs' leadership close to older adults in municipal home healthcare.

BACKGROUND

The older adult

Ageing

Living involves ageing, a natural process that happens to us all. The ageing process is unique to each person and is not directly proportional to the number of years lived (Steves et al., 2012). Although ageing has associations with factors such as the person's environment and behaviour the ageing process is also random. Consequently, ageing has different meanings for each person (World Health Organization, 2015c). The definition of being old varies depending on perspective and purpose. In research, older adults can be grouped into different subgroups from 65 years to 85 years and older (Hinrichsen & Molinari, 1998). However, among older adults there are variations in health, abilities and needs as well as in personal values and interests (National Board of Health and Welfare, 2023b). Therefore, older adults are not to be seen as a homogeneous group. In this thesis, older adults refer to persons 65 years and older, each person having unique abilities, needs and goals.

Biologically, ageing is a process involving molecular and cellular damage which leads to impairments in body functions and an increased risk for disease (Kirkwood, 2008). In addition to the biological changes, ageing can entail changes that are individual to each person regarding how they are experienced. These can be changes in roles and social position, handle the loss of relationships through death and challenges in handling complex tasks (World Health Organization, 2015c). This can entail experiences, such as loneliness and it can affect self-confidence (Norell Pejner & Karlsson, 2023). Therefore, to understand the meaning of ageing for a person, all aspects of ageing need to be considered, not only the biological perspective (Nordmyr et al., 2020; Savage et al., 2021).

An ageing population

In the literature, it is well known that worldwide, people are living longer, contributing to a growing proportion of older adults in the population. Between 2015 and 2050 the proportion of the world's population over 60 years, is expected to nearly double (World Health Organization, 2025). According to the World Health Organization (2025), the increasing proportion of older adults in the world's population, population ageing, started in high-income countries but is now seen in countries worldwide. Population ageing is described to depend on factors such as improved survival at younger age and survival of people of older age, as well as socioeconomic development and improved healthcare (World Health Organization, 2015c). Living longer can hold opportunities for the older adult, their family and society (World Health Organization, 2015c), such as older adults contributing their experience (Bloom et al., 2015). However, Marmot (2015) argues that people living longer also likely means that each person has a wish for good extra years of life. One crucial part of our opportunities to experience ageing as good is described as our health (World Health Organization, 2015c).

What health implies can be interpreted in different ways, from that health implies the absence of disease (Nordenfelt, 2014). To a more holistic perspective where health is affected by a person's experiences, where a person can experience reduced health although absences of disease (Nordenfelt, 2014). However, with older age, the risk for disease and health problems increases, such as cancer, fractures, cognitive impairment (Kirkwood, 2008; Rechel et al., 2013) and multimorbidity, i.e. experiencing more than one chronic condition at the same time (World Health Organization, 2015c). Therefore, in association with an increasing population of older adults, worldwide the number of older adults in need for care is rising (World Health Organization, 2020). This implies challenges for healthcare systems (Pearson-Stuttard et al., 2019).

As a response to an ageing population, a common policy has been, and still is, to encourage ageing in place, where older adults can remain living in their homes (World Health Organization, 2015c). To remain in their homes is many older adults' wish, but there is also a financial

perspective as support and care in the older adults' home is more cost-effective than institutional care (OECD, 2023; World Health Organization et al., 2012). As a result, due to the expected growing number of older adults, where a large proportion will receive care in their homes, an increased need for home healthcare is expected (World Health Organization, 2015a; World Health Organization et al., 2012).

To need care at home

To be able to remain in the home environment as long as possible has been described as valuable by older adults (Dostálová et al., 2022). Still, when receiving care at home it is important for older adults to be able to keep integrity and control of their lives (Fjell et al., 2021; Gerdin et al., 2025). However, research has shown that older adults receiving care at home experience having to align with other persons' availability and values (Almevall et al., 2024). The older adults' lives and privacy are also affected by factors associated with their home turning into a workplace (Jarling et al., 2018). This implies that older adults have to accept organizational conditions, for example time schedules where nursing care needs to be performed in a set time (Hellzén et al., 2024; Martinsen et al., 2024). It implies not having control over who comes into their home (Gerdin et al., 2025) and meeting strangers in their home because of a lack of continuity of visiting care staff (Ernsth Bravell et al., 2021; Jakobsen & Lind, 2023). This can contribute to a feeling of loss of control for older adults (Martinsen et al., 2024) and a feeling of limited possibility to influence and affect their care (Hellzén et al., 2024; Jarling et al., 2018).

Also affected when the home becomes a workplace and is no longer a private space are the older adults' next of kin (Søvde et al., 2019). Informal care from next of kin is increasing as more older adults are receiving care at home (Ulmanen & Szebehely, 2015); informal care provided by next of kin is estimated to be a major source of care for older adults (OECD, 2023). Extensive care responsibility on next of kin is associated with negative impact, such as lower psychological wellbeing (Lethin et al., 2020), feelings of high responsibility (Søvde et al., 2019) and social isolation (Lubbers-Wolterink et al., 2025). Furthermore, although next of kin have expressed graditude for the care at the older adult's home, they have also reported dissatisfaction

involving a lack of continuity and a lack of respect among care staff for the older adult's private home (Søvde et al., 2019).

Home healthcare

Internationally, home healthcare can have different meanings, purposes and a mix of both social services and healthcare services. Moreover, there are differences in who is entitled to receive home healthcare, how it is financed, and the definition of home (World Health Organization et al., 2012). The increased need for care provided at home is emphasized in research from different parts of the world, for example Japan (Hiroyoshi et al., 2020), Australia (Palesy et al., 2018), the United Kingdom (Drennan, 2019), the United States of Amerika (Adams et al., 2021) and the Nordic countries (Martinsen et al., 2018).

In this thesis, home healthcare refers to, nursing care, medical interventions, rehabilitation and habilitation (National Board of Health and Welfare, 2014), provided in the older adult's home. Although home healthcare is not a new phenomenon, there is an ongoing shift from in-patient hospital care to care being provided by the municipalities (European Observatory on Health Systems and Policies et al., 2022). Patients are discharged earlier from hospitals (Fjørtoft et al., 2021; Haaland et al., 2023) and advanced care previously performed in hospitals is performed as part of home healthcare (Andersson et al., 2017; Brenne et al., 2022; Drennan, 2019; Melby et al., 2018). This implies that older adults with complex care needs can receive care in their homes (Andersson et al., 2017; Brenne et al., 2022; Drennan, 2019). Therefore, there is an increasing demand on home healthcare, such as increased use of medical technology (Munck et al., 2022; Strandås et al., 2019) and more complex drug therapy being performed (Aase et al., 2021).

In parallel with the change to more advanced home healthcare and an expected increased need for home healthcare, healthcare systems are urged to move away from a fragmented approach with a focus on disease, to care that is underpinned by coordination and collaboration (European Observatory on Health Systems and Policies et al., 2022) and that is person-centred (OECD, 2023). This can be seen as a way to be able to meet the increased need for care (European Observatory on Health Systems and Policies et al., 2022; OECD, 2023). Person-centred

care is grounded in a person-centred approach, which is underpinned by respect for each person, where each person's view of their situation and values is central (Ekman et al., 2011; McCormack et al., 2021) and the patient is an active partner in their care and decision-making process (Ekman, 2022; McCormack et al., 2021).

For older adults living at home with chronic conditions, this implies challenges depending on their situation, such as social isolation, problems with mobility or different needs for support in self-care (Abdi et al., 2019). Therefore, there is not only an increased need for care, but also a need for care to be based on each older adult's unique situation and needs (Abdi et al., 2019; Rudnicka et al., 2020). This further puts demands on home healthcare.

Municipal home healthcare in Sweden

Historical development

In Sweden, since the 1990s, the guiding principle has been that older adults should remain living in their own homes for as long as possible (Lennartsson & Fors, 2018). Although describing the entire history of the development of today's home healthcare in Sweden is outside the scope of this thesis, some developments will be described.

As a result of the Elderly Reform in 1992, municipalities in Sweden assumed consolidated responsibility for the care and social services for older adults, which previously had been divided between municipalities and county councils, today regions (National Board of Health and Welfare, 1996). The Elderly Reform did not provide a uniform solution for home healthcare. It was left to each county council and municipality to agree who bore the responsibility for home healthcare, although care provided by physicians was left in the county councils' responsibility (National Board of Health and Welfare, 1996). The background to the Elderly Reform was, among others, a wish for more coordinated care for older adults due to unclear responsibilities between municipalities and county councils, and also, to make the care more cost-effective. Moreover, there was a desire for care that provided the possibility for more own choices, as well as integrity and a sense of security (National Board of Health and Welfare, 1996). The organization was also influenced by business principles, for example

new public management, with goals including a more effective and resource-efficient organization (Johansson et al., 2015). Therefore, municipalities could also contract private operators (National Board of Health and Welfare, 1996).

To ensure, for example, quality of care, each person's rights and allocation of responsibilities for care providers, legislation has been applied (Svensson, 2015). In the municipalities, this implies that the Health and Medical Services Act (SFS 2017:30) regulates healthcare and the Social Services Act (SFS 2025:400) regulates social services. Over the years the legislation has become more detailed and refined (Svensson, 2015). For example, the Patient Act (SFS 2014:821) intends to shift power to the patient, strengthening the patient's rights to integrity, self-determination and participation in their care. The Patient Safety Act (SFS 2010:659) promotes patient safety in healthcare. Since 2022, the Social Services Act has required that each older adult should be assigned a designated care contact responsible for coordination and continuity of social care, which, among other things, should promote meeting the older adult's individual needs (National Board of Health and Welfare, 2022a).

Since the early 2000s, there has been a development towards fewer beds in nursing homes (Ulmanen & Szebehely, 2015), in combination with fewer beds in hospitals (Lennartsson & Fors, 2018). This has implied that more older adults receive care through home healthcare (Lennartsson & Fors, 2018; National Board of Health and Welfare, 2024). In 2023, 237,285 older adults in Sweden received home healthcare (National Board of Health and Welfare, 2025b).

Organization of municipal home healthcare

Today, most of the 290 municipalities in Sweden have taken over the responsibility for home healthcare (National Board of Health and Welfare, 2019). However, the 21 regions still have responsibility for care provided by physicians (National Board of Health and Welfare, 2019). The Health and Medical Services Act (SFS 2017:30) regulates cooperation between regions and municipalities, for example when there is a need for an individual care plan. Also, there is a legal provision for cooperation when a person is discharged from the

hospital with an expected need for municipal home healthcare (SFS 2017:612).

Because the municipalities are self-governing, it is challenging to describe the organization of home healthcare in such a way as to represent all municipalities, because it differs (National Board of Health and Welfare, 2014). However, the Health and Medical Services Act (SFS 2017:30) states that where healthcare is provided there must be an operations manager responsible, although it is common in the municipalities that the operations manager does not have an education as a licensed healthcare professional (National Board of Health and Welfare, 2025b). Therefore, the medical responsible nurse (MAS) in the municipalities has a specific responsibility for patient safety and quality of healthcare (SFS 2017:30).

The position of managers working close to care staff in the municipalities, first-line managers, in the organization can likewise vary between municipalities, depending on the size of the organization (National Board of Health and Welfare, 2021). The education of first-line managers differs, where most first-line managers for social services for older adults are educated in social work or social care (National Board of Health and Welfare, 2021). The first-line manager's responsibility for different care staff groups differs between municipalities. Although, it is common that RNs in home healthcare and care staff in social services have different first-line managers. This means that RNs in home healthcare and care staff providing social care to the older adults are often two separate working groups with different managers.

The criteria for being granted home healthcare, governed by the Health and Medical Services Act (SFS 2017:30), can differ between municipalities. Criteria that are assessed can include the extent of the need for healthcare, the duration of the need, and the ability to get to a primary healthcare centre (National Board of Health and Welfare, 2019). The decision to receive home healthcare is a decision of authority and that cannot be appealed (National Board of Health and Welfare, 2016). It is common that older adults in need of home healthcare also need social services (National Board of Health and Welfare, 2023a) under the Social Services Act (SFS 2025:400). The

social care needs are granted by case managers in the municipalities (National Board of Health and Welfare, 2014). Therefore, care in the older adult's home and care staff providing care are governed by two different laws, the Health and Medical Services Act (SFS 2017:30) and the Social Services Act (SFS 2025:400), depending on the service provided (National Board of Health and Welfare, 2019). This is further complicated by the fact that it is not always clear whether the care provided falls under the Health and Medical Services Act (SFS 2017:30) or the Social Services Act (SFS 2025:400) (National Board of Health and Welfare, 2023a; Rämgård et al., 2015). In addition, it is common that the older adult is in need of care provided by physicians in the regions, working in hospitals or primary healthcare centres. Altogether, this implies that within the older adult's care there can be two different laws governing the care and there can be two head principals for healthcare, the region and the municipality. In addition, the municipalities as head principle for social service (National Board of Health and Welfare, 2019). This creates a unique context for home healthcare, as well as creating the need for the care to be well coordinated care (National Board of Health and Welfare, 2023a).

In Sweden today there is an ongoing reorganization to "close care" (Ministry of Health and Social Affairs & Swedish Association of Local Authorities and Regions, 2023). The aim is to provide person-centred, well-coordinated care, as well as creating a socioeconomically efficient and long-term sustainable healthcare system, where primary healthcare is the hub of the person's care. To achieve this, cooperation and collaboration between regions and municipalities is essential (Ministry of Health and Social Affairs & Swedish Association of Local Authorities and Regions, 2023). Both municipalities and regions, and the Swedish government agree that the reorganizations are necessary, although this is a comprehensive transformation that will take time (Swedish Association of Local Authorities and Regions, 2024).

Care staff in home healthcare

Care staff working in municipal home healthcare consist of both licensed healthcare professionals such as RNs, occupational therapists and physiotherapists, and unlicensed care staff performing delegated nursing tasks (National Board of Health and Welfare, 2024).

Physicians are employed by the regions (National Board of Health and Welfare, 2019). The unlicensed care staff consist of care staff with or without education in care and social care (National Board of Health and Welfare, 2022b), often working in social service for older adults governed by the Social Services Act (SFS 2025:400). However, when performing delegated nursing tasks, they are regarded as healthcare professionals (National Board of Health and Welfare, 2023a) governed by the Health and Medical Services Act (SFS 2017:30). Hereafter in this thesis, care staff refers to unlicensed care staff with or without education in care and social care.

In 2022, 65 percent of care staff working in the municipalities' care for older adults had education as enrolled nurses (National Board of Health and Welfare, 2025a). Enrolled nurse has since 2023 been a protected professional title, which means that only a person with the right qualifications is allowed to use the title (HSLF-FS 2023:14). Enrolled nurses have an upper secondary school or municipal adult education in care and social care or an equivalent competence (HSLF-FS 2023:14). The number of enrolled nurses in the municipalities has decreased, for example between 2022 and 2023 by 4.5 percent (National Board of Health and Welfare, 2025b). There are challenges in the municipalities to recruit care staff, especially with an education as enrolled nurse. This affects continuity of care staff as well as the ability to provide safe care for older adults (National Board of Health and Welfare, 2025b).

With more advanced care, the demand for competence among care staff increases (National Board of Health and Welfare, 2025b). RNs in municipal home healthcare delegate nursing tasks to care staff in accordance with the Patient Safety Act (SFS 2010:659) While delegating tasks, RNs still have the responsibility to ensure that the care staff who are delegated a task perform it safe (SFS 2010:659). In today's organization, RNs describe delegation of nursing tasks, such as administration of medications, to care staff as necessary for the organization to function (Bielsten et al., 2022). This, together with fewer care staff with education constitutes a risk for patient safety (The Health and Social Care Inspectorate, 2024) and implies RNs experiencing feeling torn between organizational functioning and the responsibility for patient safety (Bielsten et al., 2022).

In Sweden, RNs in municipal home healthcare have the overall nursing responsibility (National Board of Health and Welfare, 2014). Since 2007, RNs have been awarded a license after completing a three-year university education with a bachelor in science degree (Smeds Alenius et al., 2019). The RN education in Sweden became an academic education in 1982. In 1993 the education was extended to three years leading to the possibility of obtaining a bachelor in science degree in nursing. There are several types of specialist education for RNs in Sweden (Smeds Alenius et al., 2019). The meaning of being a specialist nurse differs internationally, for example with regard to education level (Dury et al., 2014). In Sweden, specialist education is provided by universities and university colleges and ranges from 60–90 European Credit Transfer System (ECTS) (Smeds Alenius et al., 2019). The most common specialist education among RNs in the Swedish municipalities is in care for older followed by public health nurse, although there is a lack of specialist educated RNs in the municipalities (National Board of Health and Welfare, 2023b). Karlstedt et al. (2015) has shown that RNs in municipal care for older adults with a specialist education had higher self-rated satisfaction with their own professional competence, than RNs without a specialist education. Older age and more years after nursing education were also related to higher self-rated professional competence (Karlstedt et al., 2015). In this thesis, RNs with and without specialist education are referred to as RNs, unless otherwise stated.

Registered nurses in home healthcare

RNs' responsibility is nursing, an area of expertise and a scientific discipline (Alligood, 2017; Swedish Society of Nursing, 2024). According to the International Council of Nurses, the definition of nursing includes promoting everyone's right and access to the highest attainable health. This, with nursing as a basis, promotes safety and continuity of care. Nursing is grounded in science-based knowledge, ethics and relationships. An RN leads and promotes health, prevents illness, alleviates suffering, and upholds patient safety and dignity throughout life (White et al., 2025). In Sweden, RNs in home healthcare are responsible for and lead the older adults' nursing care in a unique context, previously described, characterized by different legal provisions and several head principles for the older adults' care.

Home healthcare means that the older adult's home is the setting in which the care is provided. This implies that RNs working close to older adults, and leading their nursing care, can still have a geographic distance to the older adult (Norlyk et al., 2020; Westerholm et al., 2024). Working in the older adult's home can imply a more unpredictable work environment compared with working in an institution, as the RN has to adapt to different surroundings and respect the private home of the older adult (Dowding et al., 2020; Grasmo et al., 2021; Larsson Gerdin et al., 2023). Working in the older adult's home also includes respecting and collaborating with next of kin (Bruce et al., 2024; Keyvanloo Shahrestanaki et al., 2023). RNs is an important support for next of kin, such as being available and acting as the one point contact coordinating the care (Mikaelsson Midlöv et al., 2025).

RNs' work in home healthcare is characterized by working alone and independently, with RNs needing to make their own decisions (Rusli et al., 2022; Stien & Josefsson, 2024; Westerholm et al., 2024), and implies leadership (Ranta & Kaunonen, 2024; Rusli et al., 2021). RNs are also a part of the team around the older adult's care and collaborate with other professionals, such as physicians (Jakobsen et al., 2024; Westerholm et al., 2024), occupational therapists, physiotherapists (Josefsson & Peltonen, 2015) and care staff (Lekman et al., 2023). RNs collaborate with different care providers (Brenne et al., 2024) and mediate information (Sekanina et al., 2024). However, RNs in home healthcare report working under time constraints (Hauger et al., 2025; Hoe et al., 2023). The high number of older adults under their responsibility makes it necessary for RNs to delegate nursing tasks to care staff (Bielsten et al., 2022; Stenner et al., 2023), such as administration of medications and insulin, and catheter care (Bielsten et al., 2022). RNs often have to rely on observations made by care staff (Lekman et al., 2023; Norlyk et al., 2020), which also implies more demands on care staff (Ekstedt et al., 2022; Hjalmarsson et al., 2022). Therefore, collaboration between RNs and care staff is essential (Lekman et al., 2023).

The ongoing shift to more advanced care performed in home healthcare (Andersson et al., 2017; Brenne et al., 2022; Drennan, 2019; Melby et al., 2018) puts demands on RNs (Drennan, 2019). In parallel with

increased demands, research shows challenges in home healthcare, such as provision of a patient safe care (Lindberg et al., 2022), care not being performed (Andersson et al., 2022), lack of competence among care staff (Bielsten et al., 2022) and lack of care continuity for the older adult (Johannessen et al., 2020). RNs in home healthcare have a crucial role in maintaining patient safety (Lindberg et al., 2022; Nilsson et al., 2023) and coordinating the care for older adults (Brenne et al., 2024; Näppä et al., 2023). This highlights RNs as a key figure in home healthcare, leading nursing care for older adults, in a context of challenges and rising demands.

Leadership

In the literature no consensus has been reached on a definition of leadership (Barr & Dowding, 2022; Grossman & Valiga, 2017; Northouse, 2021). According to Northouse (2021), despite the multiple ways to conceptualize leadership, some components have been seen as central; it implies a process, involves influencing, occurs in a group and involves common goals. In the literature, leadership is often distinguished from the related concept of management (Grossman & Valiga, 2017; Kotter, 1990; Northouse, 2021). In this thesis, management is not explored. Instead, the thesis explored RNs' leadership close to the patient in direct nursing care, which is included in RNs' competence and responsibility (Swedish Society of Nursing, 2024). This is, in this thesis, defined as RNs' leadership close to older adults, next of kin, and care staff in direct nursing care.

Leadership and management

Leadership is closely related to management (Grossman & Valiga, 2017; Northouse, 2021) and some of the processes are shared in common, for example influencing and working with people and achieving goals (Northouse, 2021). However, there are differences (Grossman & Valiga, 2017; Kotter, 1990; Northouse, 2021), such as that leadership is not necessarily tied to a position of authority (Grossman & Valiga, 2017). Management was implemented in organizations as a way to control and maintain effectiveness (Northouse, 2021). Hence, management implies planning, organizing, budgeting, staffing and controlling (Kotter, 1990). While leadership, according to Kotter (1990), has change and movement as its primary focus. In nursing,

leadership and management are occasionally used interchangeably, and this has led to difficulties to clarify leadership (Grossman & Valiga, 2017).

Theories and styles of leadership

Research within leadership has increased over the years and now consists of several theoretical approaches (Northouse, 2021). The leadership field has developed from focusing on the leader in terms of traits and skills to also including, for example the context, followers and culture (Avolio et al., 2009; Grossman & Valiga, 2017). When leadership is not assumed to require specific traits, research has studied leadership with a focus on how leaders perform and act (Northouse, 2021). Leaders' strategies to lead, implement and motivate can be described as different leadership styles (Dellve & Eriksson, 2016). Through this approach, leadership can be seen as possible for everyone to learn and develop (Kouzes & Posner, 2017; Northouse, 2021).

Generally, leadership styles can be categorized as focusing on human relationships or task completion. One example is transformational and transactional leadership (Cummings et al., 2018). Transformational leadership focuses on motivating followers to accomplish more than expected through relationships, and assessing and satisfying the followers' needs with an emotional and ethical ground (Northouse, 2021). Transactional leadership, on the other hand, focuses on the exchange between leaders and followers through performance, results and reward (Northouse, 2021). Furthermore, a focus on moral approaches to leadership has been developed, including the leader's humility, genuineness, and communication with followers, such as in authentic leadership (Northouse, 2021).

Leadership with a focus on relationships, such as transformational leadership and authentic leadership, has been a common focus in nursing research (Cummings et al., 2021; Hutchinson & Jackson, 2013). However, most of theories and styles in leadership have not been developed within the nursing context (Cardiff et al., 2018; Miles & Scott, 2019). This means that they have not been developed in relation to the patient, or to the meaning of healthcare (Bondas, 2003) and the complexities and challenges of the healthcare context (Hutchinson &

Jackson, 2013). Therefore, there is a need to focus on leadership in relation to the specific context of nursing (Zonneveld et al., 2021). Given this, the design of this thesis exploring RNs' leadership close to older adults in home healthcare was exploratory and inductive.

Leadership in nursing

There is no explicit agreement on RNs' leadership. Although, research has described relations between leadership and patient outcomes, such as patient satisfaction (Wong et al., 2013), patient safety (Murray & Cope, 2021; Murray et al., 2018; Wong et al., 2013) and quality of care (Boamah, 2019; Stanley & Stanley, 2019). Factors assumed to positively contribute to leadership in nursing have been studied, such as age, experience and education, but the results have been equivocal (Cummings et al., 2021). Research has also focused on other aspects, such as leadership in relation to a person-centred approach (Cardiff et al., 2018). Where person-centred leadership can be described as having person-centredness as a leader, building relationships with followers and promoting person-centred care (Jönsson et al., 2025a).

Different terms in relation to leadership have been used in the nursing literature, for example healthcare leadership, nursing leadership and clinical leadership (Stanley & Stanley, 2018). These terms have been used interchangeably if they have referred to leadership in relation to a management position or leadership in relation to clinical care (Enghiad et al., 2022). Clinical leadership has evolved from focusing on managers engaging more in direct care (Patrick et al., 2011), to highlighting leadership in direct care (Cook & Leathard, 2004; Enghiad et al., 2022). But no consensus of definition has been reached in the literature for clinical leadership (Boamah, 2019; Enghiad et al., 2022; Stanley & Stanley, 2018). Clinical leadership is also used throughout the healthcare literature in disciplines other than nursing (Boamah, 2019; Braam et al., 2023; Mianda & Voce, 2017). Therefore, clinical leadership is not always tied to a specific profession, such as RNs' (Stanley & Stanley, 2018). Research studying RNs' leadership in direct nursing care has also used the term, staff nurse clinical leadership (Larsson & Sahlsten, 2016; Patrick et al., 2011) although that term has no consensus definition in the literature (Chávez & Yoder, 2015). Due

to the lack of an explicit agreement on RNs' leadership, in this thesis, RNs' leadership is referred to as RNs' leadership close to older adults.

Use of management and leadership interchangeably in the nursing literature has been described as leading to a focus on management and less focus on leadership (Grossman & Valiga, 2017). The World Health Organization (2021b) states that there is a need to strengthen leadership in nursing throughout healthcare organizations, as a way to work towards population health goals (World Health Organization, 2021b). RNs as leaders hold a central position for safe care (Joseph & Huber, 2015). Previous research and literature within nursing have to a large extent focused on leadership in association with formal leadership positions, such as management (Booher et al., 2021; Chappell et al., 2014; Grossman & Valiga, 2017). Less research has been done on RNs' leadership in direct nursing care (Boamah, 2019; Booher et al., 2021) and there is a lack of clear models of leadership developed exclusively for RNs leading in direct nursing care (Booher et al., 2021). Studies of RNs' leadership that have been done have been conducted, for example in the hospital context (Boamah, 2019; Booher et al., 2021; Larsson & Sahlsten, 2016) and in psychiatric care (Sundberg et al., 2022). Research has emphasized the need for increased knowledge about RNs' leadership in home healthcare (Claesson, 2022; Jarrín et al., 2019), which this thesis aims to address by exploring RNs' leadership close to older adults in municipal home healthcare.

Registered nurses' leadership

RNs' leadership implies leading close to the patient in direct nursing care and is included in RNs' competence and responsibility, to promote good and safe care (Swedish Society of Nursing, 2024). Patrick et al. (2011) describe RNs' leadership as a process that is embedded in RNs' professional practice, providing direction and support to patients and healthcare teams. RNs provide direction and make clinical decisions based on research evidence, experience and the patients' values and situations (International Council of Nurses, 2021), where the encounter with the patient should be permeated by a person-centred approach (International Council of Nurses, 2021; Swedish Society of Nursing, 2024). Therefore, leadership is an essential part for RNs working in direct nursing care (Curtis et al., 2011). RNs' leadership is

also essential at a time when the healthcare context is expanding and undergoing changes (Fardellone et al., 2014; Grossman & Valiga, 2017), as the RN often are a constant part of the patient's care with skills in such as coordination and to advocate for the patient's care (Grossman & Valiga, 2017). In the municipalities, this change implies, as previously described, increased advanced care and an expected increased demand for home healthcare.

This thesis takes its starting point in research of RNs' leadership close to older adults in home healthcare as described in the literature (Claesson et al., 2020), from the perspectives of older adults (Claesson et al., 2021b) and next of kin experiences (Claesson et al., 2021a). Claesson et al.'s (2020) literature review shows that RNs' leadership in municipal home healthcare is complex, implying 10 themes: trust and control; continuous learning; competence through knowledge and ability; nursing responsibility on an organizational level; application of skills; awareness of the individual's needs and wholeness; mutual support; mutual relationships; collaborating on organizational and interpersonal levels; and exposure to challenges. Older adults experienced that RNs in partnership with them provided and coordinated the care they needed (Claesson et al., 2021b). Next of kin experienced that RNs managed to lead although organizational preconditions were a challenge (Claesson et al., 2021a). To gain further knowledge, the present thesis explores RNs' leadership close to older adults, their next of kin and care staff in municipal home healthcare.

RATIONALE

People are living longer, contributing to a growing proportion of older adults in the population. In relation to an increasing population of older adults, the number of older adults in need of care is expected to increase. The trend is towards care being performed in the older adult's home. Therefore, the need for home healthcare is expected to rise, implying increased demands on an already strained organization. RNs in home healthcare are responsible for and lead nursing care in their daily work. There is a relation between leadership and patient safety, patient satisfaction and quality of care. This highlights RNs as key figures in home healthcare for older adults. To date, nursing research has largely focused on leadership as a formal position, as in management. There is less knowledge about RNs' leadership in direct nursing care. There is a call to strengthen leadership in nursing, and research has emphasized the need for increased knowledge of RNs' leadership in home healthcare. This thesis therefore seeks to address this need by exploring RNs' leadership close to older adults in home healthcare. The thesis is expected to contribute to increased knowledge and understanding of RNs' leadership close to older adults in home healthcare. Knowledge that can support and strengthen RNs' leadership in home healthcare. Therefore, the overall aim of this thesis was to explore RNs' leadership close to older adults in municipal home healthcare.

OVERALL AND STUDY SPECIFIC AIMS

The overall aim was to explore registered nurses' leadership close to older adults in municipal home healthcare.

Study specific aims

Study I

To explore and compare registered nurses' perceptions of their leadership close to older adults in municipal home healthcare, as well as to correlate their perceptions with age and work experience.

Study II

To explore registered nurses' perceptions of challenges and suggestions for improvements in their leadership close to older adults in municipal home healthcare.

Study III

To explore registered nurses' experiences of their leadership close to older adults in municipal home healthcare.

Study IV

To explore care staff's experiences of registered nurses' leadership close to older adults in municipal home healthcare.

METHODS

Theoretical stances

This thesis is in the field of nursing and has a humanistic and holistic perspective. This involves seeing every person as an experiencing subject, with freedoms, choices and responsibility (Watson, 1988). The holistic perspective means that physical, psychological, existential and spiritual dimensions form a unity (Arman et al., 2015) where persons are interconnected with others and nature (Watson, 1988).

To outline the metaparadigm of nursing, the central concepts of nursing can be described as person, environment, health and nursing (Fawcett, 1996). *Person* includes recipients of nursing, including persons, families and communities. *Environment* involves next of kin and physical surroundings. *Health* consists of the whole range of experienced health, and *nursing* refers to the actions taken on behalf of or together with the person, through a process of assessment, planning, intervention and evaluation of goals and outcomes (Fawcett, 1996).

The ontological view in the thesis is the assumption that reality is not fixed. Hence, reality exists in multiple constructions and is socially and experience-based, unique for the person who holds them (Flanagan et al., 2025; Lincoln et al., 2018). The social world is dynamic and changing (Holloway & Galvin, 2017). By asking the person experiencing a phenomenon studied, knowledge to understand the phenomenon can be gained (Lincoln et al., 2018). In this thesis, this meant asking RNs and care staff about their perceptions and experiences of the phenomenon studied. Through people's stories of their experiences, knowledge can be created through an interpretive approach striving to understand the phenomenon studied (Lincoln et al., 2018). Interpretation sets the requirements of reflexivity, so that the produced knowledge reflects the participant's voice and reality (Holloway & Galvin, 2017; Lincoln et al., 2018).

Design

The thesis had an explorative design. This design is useful when less is known about a phenomenon (Flanagan et al., 2025) and when it is of value to study the phenomenon with an open mind (Rosengren & Arvidson, 2002; Stebbins, 2001). This can enable searching for the full nature of (Flanagan et al., 2025; Rosengren & Arvidson, 2002) and gaining new perspectives and insights about the phenomenon (Stebbins, 2001).

Quantitative and qualitative methods were used and were chosen based on the aims of the studies (Flanagan et al., 2025; Ford-Gilboe et al., 1995), where different methods can complement each other when exploring a phenomenon (Stebbins, 2001). Table 1 presents an overview of the studies included in the thesis.

Table 1. Overview of study I–IV included in this thesis.

Study	Aim	Design	Sample	Data collection	Data analysis
I	To explore and compare registered nurses' perceptions of their leadership close to older adults in municipal home healthcare, as well as to correlate their perceptions with age and work experience	Quantitative. Non-experimental and cross-sectional	Registered nurses (n = 71) in municipal home healthcare	Web-based questionnaire	Descriptive and analytical statistics
II	To explore registered nurses' perceptions of challenges and suggestions for improvements in their leadership close to older adults in municipal home healthcare	Quantitative and qualitative, with an inductive approach	Registered nurses (n = 70) in municipal home healthcare	Web-based questionnaire	Descriptive statistics and qualitative content analysis
III	To explore registered nurses' experiences of their leadership close to older adults in municipal home healthcare	Qualitative, with an inductive approach	Registered nurses (n = 14) in municipal home healthcare in municipalities (n = 5)	Focus groups	Qualitative content analysis
IV	To explore care staff's experiences of registered nurses' leadership close to older adults in municipal home healthcare	Qualitative, with an inductive approach	Care staff (n = 15) led by registered nurses in municipal home healthcare in municipalities (n = 4)	Individual interviews	Reflexive thematic analysis

Study I and II were part of a questionnaire survey exploring RNs' professional competence in municipal home healthcare. Study I and II were based on study-specific questions exploring RNs' perceptions of their leadership close to older adults in municipal home healthcare.
Study I had a quantitative, non-experimental and cross-sectional design. Using a questionnaire made it possible to reach a larger sample of RNs in an effective way (Wang & Cheng, 2020) to gain RNs' perceptions of their leadership.

Study II had a quantitative and qualitative design. Open-ended questions were used, allowing RNs to answer in their own words (Flanagan et al., 2025), their perceptions of challenges in their leadership close to older adults in municipal home healthcare and their suggestions for improvements in their leadership. Open-ended questions were analysed using qualitative content analysis with an inductive approach (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). Qualitative content analysis is a systematic method focusing on the subject and context, and emphasizes variation, including similarities and differences (Graneheim et al., 2017). It allows analysis at a manifest descriptive level, as well as an interpretive latent level, with different degrees of abstraction and interpretation. Through data analysis using an inductive approach, patterns in data were explored, looking for similarities and differences (Graneheim et al., 2017) and moving from the data to a theoretical understanding (Flanagan et al., 2025; Graneheim et al., 2017).

Study III had a qualitative design with an inductive approach, exploring RNs' experiences of their leadership close to older adults in municipal home healthcare. Through described experiences of a phenomenon, knowledge and understanding of the phenomenon can be gained (Holloway & Galvin, 2017; Vaismoradi et al., 2013). Data were collected through focus groups, which can be a useful method for exploring people's experiences (Kitzinger, 1995). The interaction and open conversations can facilitate the expression of experiences (Holloway & Galvin, 2017; Kitzinger, 1994), leading to more spontaneous descriptions suitable for explorative studies (Kvale & Brinkmann, 2014). The focus group discussions were analysed using

qualitative content analysis (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020).

Study IV had a qualitative design with an inductive approach, exploring care staff's experiences of RNs' leadership close to older adults in municipal home healthcare. The results of study I–III gave rise to the aim of exploring care staff's experiences, to contribute to further knowledge and understanding of the phenomenon (Holloway & Galvin, 2017; Vaismoradi et al., 2013). Individual interviews with open questions were used to collect data. Using open questions can make it possible to follow the participants' experiences rather than predetermined assumptions (Holloway & Galvin, 2017). The interviews were analysed using reflexive thematic analysis according to Braun and Clarke (2022), with an inductive approach. Reflexive thematic analysis is a flexible method where patterns of shared meaning across the dataset are analysed. The method allows for both semantic meaning closer to the text and latent meaning to be explored (Braun & Clarke, 2022).

Study I and II

Sample and procedure

A convenience sample was used (Flanagan et al., 2025). All RNs (n = 200) working close to older adults in seven municipalities in two geographic areas in Sweden were invited to participate. Exclusion criteria were RNs who worked as managers and did not provide direct care to older adults. The municipalities were medium-sized towns, small towns and rural municipalities (Swedish Association of Local Authorities and Regions, 2023).

After permission from operations managers, unit managers for RNs were contacted by e-mail. The unit managers were asked to send RNs an e-mail with an invitation to participate. The e-mail included an information letter, with information about the studies' aim, that participation was voluntary, that RNs could withdraw their participation without explanation, that data would be kept confidential and that the RNs' identity would be protected. The e-mail also included a link to the web-based questionnaire via the web tool "Survey and Report" used by Karlstad University. RNs gave their informed consent

in the web-based questionnaire; the questionnaire could not be answered without first giving informed consent. Two e-mail reminders were sent out to all the RNs who had been invited to participate.

Seventy-one out of the 200 invited RNs answered the questionnaire, comprising 36% of the target population. In study I, *n* = 71 RNs were included. Study II included *n* = 70 RNs due to an internal loss where one RN did not answer the questions included in study II. Table 2 provides an overview of characteristics of participants in study I and II.

Table 2. Registered nurses' (RNs) (*n* = 71) characteristics and across groups RNs without (*n* = 41) and with (*n* = 28) specialist education.

Characteristics		**RNs (*n* = 71)**		**RNs (*n* = 41) without specialist education**	**RNs (*n* = 28) with specialist education**
Female	*n* (%)	68 (96)			
Age, years	Mean (SD) min–max	48 (11.5)[a] 24–73	Mean (SD)	47.2 (13.1)[a]	49.1 (8.9)
Year of nursing graduation	Median min–max	2006[a] 1981–2020	Median	2008	2003[a]
Specialist education	*n* (%)	28 (41)[b*]			
Employment					
Permanent	*n* (%)	69 (97)			
Full-time	*n* (%)	45 (63)			
Years worked –					
as an RN	Mean (SD) min–max	16.2 (9.2)[c] 1–38	Mean (SD)	14.2 (9)[e]	18.5 (8.7)[b]
at the current work place	Mean (SD) min–max	6.7 (6.5)[c] .3–35	Mean (SD)	6.2 (6.4)[b]	6.4 (3.9)[e]
as an RN caring for older adults	Mean (SD) min–max	11.8 (8.5)[d] .8–35	Mean (SD)	9.5 (8)[f]	14.3 (7.4)[f]
as an RN in home healthcare for older adults	Mean (SD) min–max	7.2 (6.3)[c] .4–29	Mean (SD)	4.9 (4.3)[g]	10.5 (7.3)[a]

*[a] one missing, [b] two missing, [c] five missing, [d] twelve missing, [e] three missing, [f] six missing, [g] four missing, *in study II n = 29 RNs stated that they had a specialist education, although in study I, one RN was assessed as not having a specialist education.*

Data collection

Data was collected from May to November 2021. The questionnaire in the larger survey consisted of three sections: (1) background variables such as age, employment, work experience as an RN, specialist education and year for nursing graduation; (2) the Nurse Professional Competence Scale, Short Form (NPC Scale-SF), consisting of 35 questions (Nilsson et al., 2018); and (3) 21 study-specific questions, three of which were open-ended. Study I and II are based on sections one and three in the questionnaire.

Twenty questions in section three were about RNs' leadership close to older adults in municipal home healthcare. These questions were created based on 10 themes what RNs' leadership close to older adults in municipal home healthcare implies, derived from a systematic review (Claesson et al., 2020). The questions were done in collaboration with a statistician. The last question in section three was about RNs' suggestions for improvements and was modified from Andersson et al. (2019) to suit the context of this study. There was an opportunity for participants to add their own comments at the end of the questionnaire. The validity and reliability of sections one and three were discussed with a statistician and in an international research group consisting of researchers with competence in RNs' leadership close to older adults in municipal home healthcare.

To test the clarity and logic of the 21 questions in section three, RNs (n = 3) with experience in municipal care for older adults were interviewed. This was performed in March 2021, one interview with two RNs that lasted for 11 minutes and one interview with one RN lasting 16 minutes. The test interviews elicited only a spelling mistake. Before the test interviews, an information letter was sent to two operations managers in two municipalities, one of whom agreed to conduct a test interview. The operations manager together with the unit manager for RNs sent an information letter to the RNs they thought might participate. Two RNs expressed interest in participating. The third RN did not work in the municipality at the time but had work experience in home healthcare for older adults. Written informed consent was collected from all three RNs before the interviews were conducted.

Study I included the first 18 questions in section three, which were derived from nine of Claesson et al.'s (2020) themes of what RNs' leadership close to older adults in municipal home healthcare implies: trust and control (questions 1–3); continuous learning and competence through knowledge and ability (4–5); nursing responsibility on an organizational level (6); application of skills (7–9); awareness of the individual's needs and wholeness (10–11); mutual support (12–13); mutual relationships (14–15); and collaborating on organizational and interpersonal levels (16–18). The 18 questions had response categories on an ordinal scale, with a scale range from "to a very low degree" (1), "to a low degree" (2), "to a quite low degree" (3), "neither a high or low degree" (4), "to a quite high degree" (5), "to a high degree" (6) to "to a very high degree" (7). Cronbach's alpha (Field, 2018) was .895 for these 18 questions.

Study II included the last three questions in section three in the questionnaire, questions 19 - 21. These three questions were open-ended. The first two questions were derived from that RNs' leadership close to older adults in municipal home healthcare implies challenges (Claesson et al., 2020). The first question was, "*Are you as a leader close to older adults exposed to challenges?*" and the response categories were "yes" and "no". If participants answered "yes", they were asked to state what kind of challenges they were exposed to. The second question was, *"Do you talk to someone about the challenges in your leadership close to older adults?"* and the response categories were "yes" and "no". If participants answered "yes", they were asked to state whom they talked to. The third question asked for RNs' suggestions to improve their leadership close to older adults, the next of kin and the care staff in municipal home healthcare.

Data analysis

In study I the questions 1–18 with answers on an ordinal scale, were analysed with descriptive and analytical statistics using Statistical Package for the Social Sciences (SPSS) for Windows version 28. Descriptive statistics of the answers to the 18 questions were presented as median (md), min–max and quartiles (Field, 2018). The statistical analyses were chosen in relation to the use of an ordinal scale (Field, 2018; Pallant, 2020). Internal data losses were not replaced or imputed

(Pallant, 2020). The Mann-Whitney U test was used to test differences between two independent groups (Field, 2018), RNs without and with specialist education. Spearman's correlation coefficient (r_s) (Field, 2018) was used to measure the correlation between two variables, between all 18 questions and age, work experience as an RN and work experience as an RN in home healthcare for older adults. A *p*-value of <.05 (two-tailed) was considered statistically significant (Field, 2018).

In study II descriptive statistics were used to present absolute frequency (n = number) and relative frequency (%) of the questions 19 and 20, which had answers "yes" and "no", and the open-ended question 20, of whom RNs talked to about their challenges. The open-ended questions 19 and 21 were analysed separately using qualitative content analysis according to Graneheim and Lundman (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020), with an inductive approach. The answers consisted of one to 160 words and were transferred to an Excel document, making it possible to follow each step in the analysis process. Initially the answers were read in their entirety several times to gain a sense of the whole. Thereafter, the text was de-contextualized by breaking it into meaning units, with the aim in mind, consisting of words or sentences that were related through content and context (Graneheim & Lundman, 2004; Lindgren et al., 2020). The meaning units were manually condensed and coded, maintaining the content close to the original text to strengthen the credibility of the study (Graneheim & Lundman, 2004). To proceed to re-contextualization in the analysis, the codes were sorted by similarities and differences and were then abstracted (Graneheim & Lundman, 2004; Lindgren et al., 2020) by moving from closeness to the text to distance comparing and grouping the codes into subcategories and categories (Graneheim et al., 2017). Due to the nature of the data, the analysis presented the manifest content (Lindgren et al., 2020). The results were presented in terms of 11 categories of RNs' perceptions of challenges as a leader close to older adults in municipal home healthcare, and nine categories of RNs' suggestions for improvements in their leadership close to older adults. To strengthen trustworthiness, the analysis, coding process, subcategories and categories were discussed continuously by the

research team, moving back and forward in the analysis process until consensus was reached (Graneheim & Lundman, 2004).

Study III

Sample and procedure

A convenience sample was used (Flanagan et al., 2025). Operations managers for municipal home healthcare in five municipalities, in three geographic areas in Sweden, were contacted to obtain permission to conduct focus groups within their organizations. The municipalities were near medium-sized towns, small town, and a rural municipality (Swedish Association of Local Authorities and Regions, 2023). After permission from the operations managers, the unit managers for RNs were contacted and asked to send an information letter to RNs, in accordance with the inclusion and exclusion criteria. The letter included information about the study's aim, that participation was voluntary, that RNs could withdraw their participation without explanation, that data would be kept confidential, and that RNs' identity would be protected. It also provided contact information for the first and last authors (EL, KJ). RNs were invited to contact EL if they wanted to participate. EL provided oral information about the study to RNs, either during a workplace meeting where possible and before the start of the focus group.

The inclusion criterion required that RNs worked close to older adults and had at least one year of work experience in home healthcare for older adults. Exclusion criteria included RNs working as managers or in similar positions that did not involve providing direct care to older adults, as well as RNs working in municipal psychiatry or under the Swedish Act concerning Support and Service for Persons with Certain Functional Impairments (SFS 1993:387).

Sixteen RNs signed up to participate; however, two withdrew their participation due to sick leave and vacation, resulting in a total of 14 RNs participating in five focus groups. Table 3 provides an overview of characteristics of the participants in study III.

Table 3. Registered nurses' (RNs) (n = 14) characteristics across focus groups (FG) (n = 5).

Characteristics		RNs (n = 14)	FG 1 RNs (n = 3)	FG 2 RNs (n = 3)	FG 3 RNs (n = 3)	FG 4 RNs (n = 2)	FG 5 RNs (n = 3)
Female	n	14	3	3	3	2	3
Age, years	Mean min–max	48.1 30–63	47 31–62	51.3 39–59	39 30–50	47.5 43–52	55.3 49–63
Year of nursing graduation	Median min-max	2005.5 1984–2022	2014 1984–2015	2007 2004–2015	2011 2000–2022	1998.5 1993–2004	1999 1986–2008
Specialist education	n	7	1	2	1	1	2
Years worked – as an RN	Mean min–max	17.7 1–39	18.7 8–39	14 8.3–19.9	12.3 1–23.4	24.5 19–30	21.2 11–37
as an RN in home healthcare for older adults	Mean min–max	9.7 1–19.9	11 7–18	13.6 7–19.9	5.8 1–8.3	2.8 1.7–4	13.2 10–16

Data collection

The focus groups were conducted in May and June 2023. Due to logistics for the RNs to participate one focus group was held in each municipality at RNs' workplaces, in a room where they could talk privately and felt comfortable (Wibeck, 2010). EL moderated all focus groups. In focus groups one, two, and five, co-author AW served as assistant moderator, providing support when needed and summarizing discussions at the end (Krueger & Casey, 2015).

Before the focus groups started, written informed consent was collected, and EL reiterated that participation was voluntary, that RNs could withdraw their participation at any time during the focus group discussion by leaving the room, and that if anyone had questions afterwards, they could contact EL. RNs were asked to respect each other's privacy by keeping what was discussed during the focus group within the group. RNs were also informed that the purpose of the focus groups was to generate discussions based on an open question and that the moderator would ask follow-up questions if needed (Kitzinger, 1995).

To start with, some drinks and small snacks were provided to create a relaxed atmosphere (Kitzinger, 1995). A short introduction to the subject was given by the moderator, clarifying that RNs' leadership

referred to their leadership close to the older adult, their next of kin, and care staff, excluding management. Thereafter, the focus group started with an open question: "*Can you tell us about your experiences of your leadership close to the older adult in municipal home healthcare?*" Follow-up questions were asked if needed, such as: "*Can you tell us more?*" and "*Could you give any examples?*" Before each focus group ended, RNs were asked if there was anything they wanted to add. The focus groups lasted between 48 - 71 minutes (mean = 59 minutes) and were audio-recorded using a dictaphone. Background variables were collected on paper.

Data analysis

The focus group discussions were transcribed verbatim by EL and analysed using qualitative content analysis with an inductive approach (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). Data was analysed in an Excel document, making it possible to follow each step in the analysis process. Initially, the data were read several times in their entirety to gain a sense of the whole. Thereafter, the text was de-contextualized by breaking it into meaning units, with the aim in mind, consisting of words or sentences that were related through content and context (Graneheim & Lundman, 2004; Lindgren et al., 2020). The meaning units were manually condensed and coded, maintaining the content close to the original text to strengthen the credibility of the study (Graneheim & Lundman, 2004).

To proceed to re-contextualization in the analysis, the codes were sorted by similarities and differences and were then abstracted (Graneheim & Lundman, 2004; Lindgren et al., 2020) by moving from closeness to the text to distance comparing and grouping the codes into subcategories and categories (Graneheim et al., 2017). This resulted in four categories and one theme. Where the theme is as a red thread linked to the underlying meaning at a higher level of interpretation (Graneheim et al., 2017; Graneheim & Lundman, 2004). To strengthen trustworthiness, the analysis, coding process, subcategories, categories and the theme were discussed continuously by the research team, moving back and forward in the analysis process until consensus was reached (Graneheim & Lundman, 2004).

Study IV

Sample and procedure

A convenience sample was used (Flanagan et al., 2025). Operations managers in four municipalities in four geographic areas in Sweden were contacted to obtain permission to conduct interviews with care staff within their organization. The municipalities were near medium-sized towns and rural municipalities (Swedish Association of Local Authorities and Regions, 2023). After permission from the operations managers the unit managers for care staff were asked to send an information letter to their care staff. The letter included information about the study's aim, that participation was voluntary, that care staff could withdraw their participation without explanation, that data would be kept confidential, and that care staffs identity would be protected. Care staff who were interested in participating contacted EL or their unit manager. The letter explained that the interview would be conducted at a meeting in a place of the care staff's choosing, or via Zoom or phone. EL provided oral information about the study to care staff during a workplace meeting when possible and before the start of the interview.

The inclusion criterion required that care staff had at least one year of work experience in municipal home healthcare for older adults. Exclusion criteria were care staff not being led by RNs in municipal home healthcare and care staff working in municipal psychiatry or under the Swedish Act concerning Support and Service for Persons with Certain Functional Impairments (SFS 1993:387). Fifteen care staff participated in the study. Table 4 provides an overview of characteristics of participants in study IV.

Table 4. Care staff (n = 15) characteristics.

Characteristics		Care staff (n = 15)
Female	n	14
Male	n	1
Age, years	Mean min–max	40.7 24–62
Enrolled nurse	n (%)	13 (87)
Year of graduation as enrolled nurse	Median min–max	2000 1982–2019
Years worked –		
in municipal care for older adults	Mean min–max	14.8 5–32
in municipal home healthcare for older adults	Mean min–max	8.2 1–29

Data collection

The interviews (n = 15) were conducted by EL in October to December 2024. Two test interviews were first conducted to assess the logistics and the relevance of the questions, as well as the clarity of interpretation. The test interviews did not result in any changes and were included in the study data. Four of the interviews were conducted at the care staff's workplace in a room where it was possible to talk privately. One interview was conducted through the video conferencing tool Zoom Workplace; the remaining ten interviews were conducted over the phone in accordance with the care staff's wishes.

Before the interviews, written informed consent was collected and EL reiterated that participation was voluntary, that care staff could withdraw their participation at any time during the interview without explanation, that they did not have to answer the questions if they did not wish to, and that they could contact EL afterwards if they had questions. Background variables were collected and audiotaped on a dictaphone. A short introduction to the subject was given, clarifying that RNs' leadership referred to RNs' leadership close to the older adult, their next of kin, and care staff excluding management. Thereafter, the interview was based on two open questions: "*Can you tell about your experiences of the registered nurse as a leader close to the older adult and yourself in municipal home healthcare?*" and "*Can you tell about your experiences of being led by the registered nurse in*

municipal home healthcare?" Follow-up questions with focus on the study's aim were asked if needed, such as "*Can you tell me more?*" and "*Can you give any examples?*" Before the interview ended, the care staff were asked if there was anything they wanted to add. The interviews lasted between 11 - 47 minutes (mean = 27 minutes; median = 27 minutes) and were audio-recorded using a dictaphone.

Data analysis

The interviews were transcribed verbatim via the machine transcription speech-to-text service provided by Amberscript. The transcribed interviews were analysed using reflexive thematic analysis according to Braun and Clarke (2022), through a process of six phases exploring patterns of meaning across data. In phase one, the interviews were listened to by EL checking the transcriptions. Thereafter, the transcriptions were read several times by EL, to gain familiarity with the content of the data. Notes and mapping were created of reflections on potential patterns of meaning through the dataset. In phase two, the process of coding data was done by EL, systematically working through data coding with the research aim in mind. Both semantic codes, content close to the text, and latent codes, abstracted from the text, were created. The coding process was repeated, striving for a thorough and rigorous coding process (Braun & Clarke, 2022). In phase three, EL created initial themes through a process of clustering codes together, exploring patterns of shared meaning across data. The initial themes were discussed in the research group in relation to the codes and data. Phase four implied the themes being reviewed and developed by a process of re-engagement with the data, to strengthen trustworthiness of the analysis process (Braun & Clarke, 2022). The themes were developed through discussions in the research group in relation to the data. In phase five the themes were refined, defined and named by identifying the essence in each theme. In phase six, the analysis was finished by writing the report.

Pre-understanding and reflexivity

When planning and conducting research on a phenomenon, it is important to be aware of one's own pre-understanding, standpoint and professional thinking (Holloway & Galvin, 2017). Pre-understanding can include theoretical knowledge, previous own experiences, values

and preconceptions (Lundman & Graneheim, 2017). There is a need to be aware of how pre-understanding can affect choices during the research process (Graneheim et al., 2017). Although pre-understanding can also be valuable, providing an opportunity for a deeper understanding of the phenomenon (Braun & Clarke, 2022; Lundman & Graneheim, 2017). Self-awareness and introspection can affect quality both in qualitative and quantitative designed studies (Flanagan et al., 2025).

In this thesis, EL pre-understanding refers to previous experience of municipal home healthcare working as a public health nurse in a primary healthcare centre collaborating with RNs in municipal home healthcare. Working as a university teacher during RN students' clinical studies in municipal home healthcare, and theoretical knowledge acquired through reading about the phenomenon and context. EL's pre-understanding has also been influenced and developed throughout the work on this thesis. The supervisors and co-authors in all the studies had a pre-understanding through previous research and or previous work as RNs.

Reflexivity can be described as a critical reflection throughout a qualitative research process (Flanagan et al., 2025; Lincoln et al., 2018). The reflexive process strives to put the participant's voice and the phenomenon under study as priority (Holloway & Galvin, 2017), to strengthen trustworthiness of the study (Graneheim et al., 2017; Tracy, 2010). Reflexivity should be ongoing throughout the whole research process (Braun & Clarke, 2022; Tracy, 2010). Striving for a reflexive approach, reflecting on how positionality and choices shape the research (Braun & Clarke, 2023), from the planning design, to data collection, analysis and presentation (Tracy, 2010).

During the work on this thesis, EL together with supervisors has strived to keep a reflexive approach. This was done through raising awareness of pre-understanding through discussions in the team throughout the research process, including the analysis processes in study II, III and IV, to strengthen trustworthiness. EL wrote down her pre-understanding of the phenomenon before the start of study I, and has made notations of reflections and discussions during the work process of the thesis as the pre-understanding has developed. During the

analysis process of study IV, EL kept a reflexive journal, writing down reflections during the analysis process (Braun & Clarke, 2022).

ETHICAL CONSIDERATIONS

Study I and II were reviewed by the local Health, Science, and Technology faculty's review of research ethics at Karlstad University (Dnr HNT 2020/618). Study III was reviewed by the Swedish Ethical Review Authority, which raised no objections to the research project in an advisory opinion (Dnr 2021-05429-01). Study IV was approved by the Swedish Ethical Review Authority (Dnr 2024-03785-01).

In study I-IV ethical guidelines were followed. These are outlined in the Declaration of Helsinki (World Medical Association, 2024), the European Code of Conduct for Research Integrity, taking into account reliability, honesty, respect and accountability (ALLEA, 2023), and the Swedish Ethical Review Act (SFS 2003:460). Having respect, as outlined in the European Code of Conduct for Research Integrity (ALLEA, 2023), involves reflections based on the ethical principles to do good, not harm, and to respect autonomy and justice (Swedish Research Council, 2024). This also involves reflections on the benefits of the research being conducted and the generation of new knowledge.

The participants in study I-IV were informed about the study's aim, and the head principal of the research, that participation was voluntary, that they could withdraw their participation without explanation, possible risks with participation, that data would be kept confidential, and that their identity would be protected and how the study's results would be published. Contact information of the authors was provided so that the participants could contact them to ask questions.

The participants have left informed consent to participate, which have been documented according to Swedish Ethical Review Act (SFS 2003:460). In study I and II, the participants gave their informed consent in the web-based questionnaire, and the questionnaire could not be answered without the informed consent. In study III and IV, written informed consent was collected before the interviews started.

To protect the participants' integrity, the results have been reported at a group level. To protect data confidentiality, the management and

storage of data have been done in accordance with Karlstad University's guidelines, and no unauthorized have had access to the data. Karlstad University's research data group has been consulted throughout the work on the thesis and a data management plan has been developed in collaboration with the research data group for the studies. Data will be stored according to Karlstad university's research data groups guidelines in at least 10 years according to Karlstad university's guidelines for preservation.

In study IV, when performing the interview via Zoom, Karlstad University's guidelines regarding use of an end-to-end encryption feature and a virtual waiting room to protect data privacy were followed. Transcriptions in study IV were performed using the machine transcription speech-to-text service provided by Amberscript, as approved by Karlstad University for using to transcribe research material, such as data in study IV via machine transcription. To strive for trustworthiness in the research, the transcriptions were checked by EL who listened to the interviews and compared them against the machine transcriptions. The transcribed interviews in study III and IV and background variables were pseudonymized, so that data could only be linked to a specific person via a code key, stored separately from the research data.

In research, ethical guidelines from governing institutions are followed, but there is also a need for ethical reflections during the whole research process, including situations that can arise during data collection (Tracy, 2010). Therefore, during the data collection for study III and IV, EL strived to be responsive when questions were asked, considering the benefit of collecting data against the risk that the participant might feel pressured to answer. This could include judging whether more follow-up questions were appropriate or not. The participants were also informed that they did not have to answer questions and, if questions arose after the interviews, that they could contact EL.

There is also important to reflect on how the interviewer's character and actions can affect the participants (Tracy, 2010). This can be seen as part of keeping a reflexive approach involving self-awareness and having respectful encounter with the participants. Therefore, before

the interviews started in study III and IV, EL started with some small talk, such as talking about the weather, to create a relaxed atmosphere. Before the interviews conducted via Zoom and over the phone in study IV, EL described to the participant where she was talking from, a private room, and that no one else was in the room.

RESULTS

This thesis explored RNs' leadership close to older adults in municipal home healthcare. The results of the studies I–IV are briefly presented below, followed by a synthesis and a summary of the results.

Study I

Study I aimed to explore and compare RNs' perceptions of their leadership close to older adults in municipal home healthcare, as well as to correlate their perceptions with age and work experience.

The results showed that RNs perceived their ability as leaders to a high degree. Although the results illuminated that RNs perceived neither a low nor a high degree that they trusted care staff's competence to assess the older adults' condition, had space and access in their work to develop sufficient competence in leadership, and had nursing responsibility on an organizational level. The correlation analysis showed most statistically significant positive correlations between RNs' perceptions of their leadership and their work experience in home healthcare for older adults.

There were statistically significant differences between RNs without and RNs with specialist education regarding their perceptions of their leadership. RNs with specialist education perceived to a higher degree that they could apply their professional experience in their work tasks (p = .009) and had the ability to assess the individual needs (p = .014) and needs based on a holistic view of the older adult (p = .009). RNs with specialist education also perceived to a higher degree that they created good relationships with the older adults' next of kin (p = .035) and collaborated on an interpersonal level, i.e. interaction with the older adult (p = .002) and collaborated on an interpersonal level, i.e., interaction with next of kin to the older adult (p = .007).

Study II

Study II aimed to explore RNs' perceptions of challenges and suggestions for improvements in their leadership close to older adults in municipal home healthcare.

The results showed that n = 58 (83%) of the RNs (n = 70) perceived challenges in their leadership close to older adults, and n = 51 (73%) answered that they had talked to someone about their challenges. The results showed RNs' perceptions of challenges as leaders in terms of 11 categories: motivating for care; adjusting nursing care to the older adult; coordinating care for the older adult; relating to next of kin; managing communication difficulties; relating to social situations in the home; managing demands; working alone; having lack of time; collaborating with physicians; and care staff having low competence.

The results also showed RNs' suggestions for improvements in their leadership, in terms of the nine categories: adjusting the work to the older adult; clarifying RNs' responsibility; balancing demands and resources; setting time aside; improving staff's competence; ensuring staff's competence development; and improving the work environment, and cooperation between professions in the municipality, as well as between healthcare organizations.

Study III

Study III aimed to explore RNs' experiences of their leadership close to older adults in municipal home healthcare. The results illuminated that RNs as leaders struggle against organizational preconditions. The results showed in terms of four categories that RNs' leadership close to older adults implied: focusing on the older adult; trying to create a sense of security; creating trustful relationships; and managing organizational challenges.

Study IV

Study IV aimed to explore care staff's experiences of RNs' leadership close to older adults in municipal home healthcare. The results showed the care staff's experiences through three themes: RNs affect care staff's sense of security; RNs affect care staff's sense of being included; and RNs' closeness affects the establishment of relationships.

Synthesis of the results

Striving to lead with the older adult in focus

The results showed that RNs in home healthcare strived to lead with a focus on the older adult (III). RNs perceived to a high degree their ability to assess the older adult's individual needs, in a holistic way (I), and that they collaborated on an interpersonal level with the older adult and next of kin (I). Having a specialist education as an RN may facilitate RNs' leadership in aspects of assessing the older adult's individual needs and collaborating at an interpersonal level with the older adult and their next of kin (I).

RNs led and solved situations based on each older adult's situation (II, III) and involved the older adult in the decision-making process (III). RNs stated that there could be challenges in adjusting to each older adult's wishes (II, III). This could occur when the older adult's wishes and the RN's assessments were not in line (II, III), or when the older adult lacked insight into their situation (II, III). The RNs experienced a change over time, towards older adults' involvement in their care becoming more evident (III). Still, the RNs suggested that more of a person-centred care approach in the municipalities was needed to improve their leadership (II).

RNs led next of kin and care staff with a focus on the older adult's wishes, needs and best interests (III). Next of kin were seen as a valuable resource for the older adult (III). On the other hand, there could be challenges in RNs' leadership in relation to next of kin's wishes or demands, as well as care staff's wishes or demands (II, III). In these situations, RNs tried to explain that the older adult's wishes were priority (III). However, there were situations when pressure from next of kin was overwhelming. In such cases, RNs could follow the next of kin's wishes (III).

Striving to build relationships as a basis for leadership

The results showed that RNs strived to build relationships with the older adult, next of kin and care staff (III) as a basis for their leadership. RNs perceived to a high degree that they created good relationships with the older adult and next of kin through support, understanding

and encouragement (I). They experienced this as important for creating trust (III) and to try to contribute to a sense of security (III). Care staff in turn experienced it as important to have trustful relationships with RNs, to contribute to their sense of security and team spirit (IV). Care staff experienced working close to RNs promoted communication and creating relationships (IV).

RNs as leaders adapted to the older adult (II, III), next of kin and care staff (III), and supported the older adult, next of kin and care staff (III). To support care staff, RNs experienced it as essential to be available (III). This was in line with care staff's experiences of how RNs affected their sense of security through both the way they interacted with care staff and their availability (IV). Care staff had different experiences, both positive and negative ones, of how RNs interacted with them (IV). For example, positive experiences included RNs being understanding and answering questions; negative experiences included RNs being annoyed and questioning care staff (IV). RNs educated care staff (III), which was stated as important by both the RNs (II, III) and care staff (IV) as it promoted patient safety (III, IV) and the older adult's sense of security (III). RNs strived for close contact and communication with care staff to promote patient safety (III).

In contrast, the results revealed barriers to RNs' possibility to meet the older adult. The RNs and care staff both experienced a shift over time towards RNs spending less time with the older adults, and making fewer home visits (III, IV). The RNs experienced that administrative tasks took time away from home visits (III). The care staff experienced acting as a link between the older adults and RNs, forwarded information to RNs and, as care staff experienced, performed more of the RNs' work (IV). However, both RNs and care staff experienced it as valuable that RNs met the older adult regularly (III, IV); to promote quality of care (III) and create a sense of security for the older adult (IV).

RNs and care staff also experienced barriers to being able to work closely (III, IV), which made RNs' leadership more difficult (III) and, moreover, which made it difficult to establish relationships (IV). Both RNs and care staff wished to work more closely with each other (III, IV). Barriers to being able to work closely included a lack of time for

both RNs and care staff (II, III, IV); RNs having a lot of administrative work (III, IV); and the organization did not always promote RNs' being able to work closely to care staff (III, IV). Care staff experienced that being located at the same place as RNs facilitated the collaboration between themselves and RNs (IV).

Leading implies striving to bridge organizational gaps

The results showed that leading implied striving to bridge organizational gaps. RNs must handle organizational challenges in their leadership (II, III, IV) and promote patient safety (II, III).

According to the RNs, there was a need for balance between demands and resources in municipal home healthcare (II). The number of older adults in need of home healthcare has increased, and more advanced care is performed in home healthcare (II). The RNs perceived that they were responsible for too many older adults (II) and stated that their responsibilities in home healthcare were not clearly defined (II, III). There was a need for more RNs in home healthcare, expressed by both RNs and care staff (II, III, IV). The RNs experienced that they often went beyond their responsibility, for instance by coordinating the older adults' care (III), and acting as the link between home healthcare and other care providers (III).

RNs faced challenges in collaborating with physicians (II, III) and other care providers (II, III). These challenges included having difficulty contacting physicians (II, III), as well as deficient continuity of physicians (II, III), and physicians having a lack of time (II, III). Therefore, physicians could ask RNs to do their work, and RNs had to double-check the physicians' medication lists for errors (III). The RNs also had challenges getting information from other care providers (II, III). This implied that they had to, as described, "hunt for information" to be able to promote holistic care and patient safety (II).

The organization of home healthcare in Sweden is regulated by two laws: the Health and Medical Service Act (SFS 2017:30) and the Social Services Act (SFS 2025:400). This implied challenges to RNs' leadership (III). RNs experienced that the division is not clear to other care providers, older adults and next of kin (III). There was no clear line between RNs' responsibility and managers' responsibility for care

staff (II, III). Different journal systems for social care and healthcare could make it difficult to share information between RNs and care staff (III, IV). RNs could lack access to the social care journal system, and then had to rely on reports from care staff (III). Care staff also experienced it as important to be included in the team and receive information from RNs in order to do good work (IV).

The results illuminated that RNs in their leadership must handle the lack of care staff with adequate knowledge, (II, III), work experience, education (III) and care staff with deficient language proficiency in Swedish (II, III). RNs perceived neither a low nor a high degree of trust in the care staff's competence to assess the older adult's condition (I). In contrast, the results also showed that often the care staff were the ones who met the older adult, contacting and providing information to RNs (IV), and that RNs increasingly made their assessments over the phone (III). Care staff with lack of knowledge and difficulties speaking and understanding Swedish affected the older adults' care and patient safety (II, III), and made the older adult and next of kin feel insecure (III). It also led to difficulties for RNs to delegate to care staff and RNs had to spend more time on education for care staff (III). To be able to provide advanced home healthcare, RNs perceived care staff should be required to have certain language skills, and education (II). At the same time, care staff with education as enrolled nurses wished that their competence was better utilized (IV).

Summary of the results

The results showed that RNs strived to lead with the older adult in focus and strived to build relationships with the older adult, next of kin and care staff as a basis for leadership. RNs' leadership also implied striving to bridge organizational gaps. These gaps risk jeopardizing good and safe home healthcare for older adults (Figure 1).

Figure 1 *Registered nurses in home healthcare leading close to older adults, next of kin, and care staff. Registered nurses strive to have the older adult in focus and to build relationships as a basis for their leadership. As leaders, they strive to bridge organizational gaps to promote good and safe home healthcare (Illustration by Lillsjö, E., in collaboration with the University Printing Office at Karlstad University).*

DISCUSSION

Discussion of results

This thesis aimed to explore RNs' leadership close to older adults in municipal home healthcare. The results showed that RNs as leaders strived to lead with the older adult in focus and strived to build relationships as a basis for leadership. At the same time, they strived to bridge organizational gaps to promote good and safe home healthcare for older adults.

This thesis explored RNs' leadership from the RNs' and care staff's perspectives. The thesis took as its starting point previous research studying RNs' leadership close to older adults in municipal home healthcare, as described in the literature (Claesson et al., 2020), from the perspective of older adults (Claesson et al., 2021b) and their next of kin (Claesson et al., 2021a). This thesis showed that the RNs strived to build relationships as a basis for their leadership. This is in line with the results of a literature review showing that RNs' leadership implied building relationships with the older adult and next of kin (Claesson et al., 2020). The results also align with the older adults' own (Claesson et al., 2021b) and next of kin's (Claesson et al., 2021a) experiences of relationships being central to RNs' leadership in home healthcare.

Moreover, the results of this thesis showed that the RNs strived to lead with the older adult in focus. This further aligns with research studying RNs' leadership in other contexts. Booher et al. (2021) reported that RNs as leaders in the hospital context are concerned that the patient's voice be heard and they also establish relationships with nursing assistants. Larsson and Sahlsten (2016) showed that RNs as leaders in the hospital context lead with focus on the patient's needs, collaborating with mutual respect and striving to be available for assistant nurses and the patient. Jönsson et al. (2025b) described that establishing relationships is essential for RNs leading person-centred care in residential care for older adults. This, together with the results of this thesis, could be seen as relational leadership, which seems to be inherent in RNs' leadership together with a focus on the person.

Within nursing there has been focus on relational leadership, including for example transformational leadership and authentic leadership (Cummings et al., 2021; Hutchinson & Jackson, 2013). However, the majority of leadership theories and styles are not developed in nursing (Cardiff et al., 2018; Miles & Scott, 2019), or with regard to RNs' leadership. This implies that there is a lack of clear models of leadership exclusively for RNs (Booher et al., 2021). Therefore, it is essential to continue studying RNs' leadership, including how RNs lead, in order to develop further knowledge about RNs' leadership and enable the development of a model for RNs' leadership close to older adults in home healthcare. This is essential for strengthening RNs as nursing leaders as well as for nursing education. In this regard, the thesis has indicated that a specialist education may facilitate RNs' leadership (I). Further research into how education can facilitate RNs' leadership may be of value.

The results of this thesis illuminate that RNs as leaders strived to lead with the older adult in focus and strived to build relationships with the older adult and next of kin could be seen as them striving to promote person-centred care, and lead with a person-centred approach. This implies a person-centredness, with respect for each person, self-determination, mutual respect and understanding (Ekman et al., 2020; McCormack et al., 2021). Building relationships is essential for person-centredness (Ekman et al., 2020; McCormack et al., 2021). Ekman et al. (2011) conceptualize a person-centred care as having the patient's narrative as basis where listening is essential, building relationships and a partnership with shared decision making that is documented in the patient's journal (Ekman et al., 2011). According to Kristensson Uggla (2022), the patient's narrative is crucial to understanding the patient as a person. Kristensson Uggla (2020) refers to Paul Ricoeur's philosophy, in which a person's identity could be seen through *idem*, what something is, and *ipse*, who someone is (Ricoeur, 1994). Moreover, Ricoeur argues that every person in a relationship is irreplaceable, but that their role is reversible (Ricoeur, 1994). Therefore, every person the healthcare professional encounters is reversible in their role as a patient, but irreplaceable as a person in the encounter (Kristensson Uggla, 2020). McCance and McCormack (2021) emphasize that the person should be seen from a holistic

perspective, involving attention to physiological, psychological, social and spiritual dimensions (McCance & McCormack, 2021), which is also in line with the humanistic basis of nursing (Watson, 1988). In light of this, for RNs as leaders to promote person-centred care, where building relationships and listening are essential to understanding who the older adult is as a person and in a holistic sense, the encounter between the older adult and the RN is crucial.

In contrast to the results showing that RNs strived to build relationships with the older adult and next of kin, the results also showed that the RNs had challenges to meet the older adult (III, IV). It emerged that RNs today make fewer home visits (III, IV) and make more assessments over the phone (III). Older adults have experienced that deeper communication occurs through encounters that allow time and space, which enables communication involving personal stories, opinions and vulnerability (Mathiesen et al., 2025). Furthermore, these encounters should be characterized not only by physical togetherness, but also by presence (Mathiesen et al., 2023).

To get to know each older adult requires encounters, which requires investing time (Gerdin et al., 2024). This thesis revealed that RNs perceived that they were responsible for too many older adults (II) and they spent less time with the older adult (III, IV). They experienced that administrative tasks took time away from home visits (III). Research is in line with this, reporting that RNs in home healthcare have time constraints (Fjørtoft et al., 2020; Petersen et al., 2025; Snogren et al., 2025; Strandås et al., 2019) and do not frequently meet the older adult in their responsibility (Snogren et al., 2025). This reduces the possibility to know and holistically care for the person, not only focusing on practical tasks (Strandås et al., 2019). For this reason, older adults have described that they avoid starting conversations with RNs in home healthcare (Gerdin et al., 2024; Strandås et al., 2019).

Today, both international and national policy and guidelines emphasize a person-centred approach as a foundation in care (Edberg et al., 2025; National Board of Health and Welfare, 2023a; World Health Organization, 2015b), as do also guidelines for RNs (International Council of Nurses, 2021; Swedish Society of Nursing, 2024). However, to achieve person-centred care there is a need for

organizational preconditions (Britten et al., 2020; McCance & McCormack, 2021). Therefore, municipal organizations need to promote preconditions to enable RNs to meet the older adult and create relationships, as a way to facilitate person-centred care. This should include both consideration of the number of older adults within RNs' responsibility and easing the administrative burden for RNs. Digital tools may be one means of facilitating encounters and communication with older adults in the future (National Board of Health and Welfare, 2023a). Therefore, it would be valuable to research this further.

To promote holistic, person-centred care, effective staff relationships are important (McCance & McCormack, 2021). This thesis shows that the RNs as leaders strived to create relationships with care staff (III), and the care staff also emphasized the importance of building relationships with RNs (IV). On the other hand, the results showed barriers to the possibility for RNs and care staff to work closely (III, IV). Furthermore, the results showed that care staff act as a link between the older adult and RNs (IV). Similar results have been reported elsewhere, when RNs described being dependent on care staff reporting to them (Karlsson et al., 2015; Snogren et al., 2025). This highlights well-functioning collaboration and communication between RNs and care staff as key factors in the functioning of home healthcare.

Moreover, this thesis shows that RNs and care staff information sharing can be challenging across different journal systems (III, IV), implying that they have to rely on information from each other (III, IV). Several documentation systems have been reported to threaten patient safety in municipal care (The Health and Social Care Inspectorate, 2022). This, in relation to barriers between RNs and care staff to work closely, as this thesis revealed, reveals gaps in the organization, which jeopardize person-centred and safe care for the older adult. Claesson et al. (2024) states that the distance between RNs and care staff is a weak link in the organization, carrying the risk of harm to older adults (Claesson et al., 2024). Therefore, these two groups, RNs and care staff, need to be brought together for the benefit of the older adult's care. This means that the organization needs to facilitate collaboration between RNs and care staff as a unit and not as separate workgroups. Moreover, the division in relation to the two laws, the Health and

Medical Services Act (SFS 2017:30) and the Social Services Act (SFS 2025:400), needs to loosen up for the benefit of the older adults' care. Further research on preconditions and how to facilitate RNs' and care staff's collaboration and communication may be valuable.

This thesis revealed that RNs as leaders must handle a shortage of care staff with adequate knowledge and education (II, III). Moreover, RNs perceived neither a low nor a high degree of trust in the care staff's competence to assess the older adult's condition (I). Care staff lack of adequate knowledge and Swedish language proficiency among care staff was seen as a threat to patient safety (II, III) and made older adults and next of kin feel insecure (III). A shortage of care staff educated in care has previously been reported (Snogren et al., 2025), as well as challenges related to care staff's difficulties in speaking and understanding Swedish to a sufficient degree (Bielsten et al., 2022; The Health and Social Care Inspectorate, 2022). Therefore, the rising demands for more advanced care, in addition to RNs having to rely on care staff's observations, can be seen as a paradox (Norlyk et al., 2020). This thesis illuminated that RNs in their leadership tried to bridge this gap by supporting (III, IV) and spending more time to educate care staff (III).

Moreover, the results revealed that the RNs faced challenges in collaborating with other care providers and physicians (II, III), which also threatens patient safety (II, III). This is in accordance with previous research (Gjellestad et al., 2022; Gustafsson et al., 2022; Mertens et al., 2019). This thesis showed that RNs had to make an effort to "hunt for information" to promote holistic and safe care for the older adult (II), went beyond their responsibility to coordinate the older adults' care (III), and double-checked physicians' work, such as medication lists (III). Altogether this illustrates how RNs as leaders in home healthcare strive to bridge gaps between physicians, care staff and older adults within a fragmented organization and position themselves as pivotal relational leaders to promote patient safety. A functioning interprofessional collaboration is essential for home healthcare to function well (Condelius et al., 2025; Dohrn et al., 2025; Rydenfält et al., 2021; Sekanina et al., 2024). Therefore, care organizations must be structured in such a way as to facilitate communication and collaboration between professions as well as care

providers. This will promote person-centred and safe home healthcare for older adults.

The results of the thesis revealed that RNs as leaders tried to create a sense of security (III). This is in line with older adults' and next of kin's experiences that a mutual and trustful relationship with the RN contributes to a sense of security (Claesson et al., 2021a; Claesson et al., 2021b). The Swedish Health and Medical Service Act (SFS 2017:30) states that health and medical services should meet the requirements of good care, which implies, for instance accommodating the patient's need for security, continuity and safety. The term security is used in legislation, and in reports and directives for healthcare (Segersten, 2020). However, security (in Swedish, *trygghet*) is described by Segersten as a multidimensional concept which entails dimensions of basic security, such as trust in oneself, and situational security entailing aspects such as safety, support and protection (Segersten, 1984; Segersten, 2020). These dimensions together lay the ground for a sense of security for a person (Segersten, 2020). A sense of security is something the person experiences; someone else is not able to give security, but they can create preconditions for the person to experience a sense of security (Segersten, 2020).

The situational dimension of security in relation to being a patient can be described as entailing factors such as being informed of the situation, feeling trust in other persons, and feeling safe (Segersten, 2020). Johansson-Pajala et al. (2025) have stated that, to promote older adults' sense of security when providing care at home, it is essential to promote building relationships, establishing trust and promoting continuity. To be able to be involved in decision making is another condition that has been described to promote a sense of security (James et al., 2019).

The results of this thesis showed that the RNs in their leadership tried to create a sense of security (III) despite organizational challenges. These challenges included care staff's lack of knowledge, which made the older adults feel insecure (III); and RNs having difficulties meeting the older adults (III, IV) and RNs strived to promote patient safety (II, III). Therefore, also in relation to what is stated in the law (SFS 2017:30), organizations need to create preconditions that promote a

sense of security for older adults and next of kin in need of home healthcare (Josefsson, 2010).

To summarize, the results of this thesis show that RNs, as leaders, strived to have the older adult in focus and strived to lead from a relational basis. They strived to bridge organizational gaps, to promote good and safe home healthcare. According to the Swedish legislation (SFS 2017:30), all citizens have the right to healthcare on equal terms. Healthcare should be provided with respect for the equal value of all people and the dignity of the unique person, with good care including security, continuity and safety, respect for self-determination, integrity, and the promotion of good contacts between the patient and healthcare staff (SFS 2017:30). However, this thesis illuminated that RNs as leaders in home healthcare strived to bridge organizational gaps to promote older adults' rights for healthcare in line with the legislation.

Priorities in healthcare in Sweden should be based on ethical principles, including human dignity, solidarity and cost-effectiveness. However, the principle of cost-effectiveness should be subordinated to the principles of human dignity and solidarity (Swedish National Centre for Priorities in Health, 2017). The organizational gaps that this thesis reveals need to be addressed in relation to the principle of human dignity, which should precede that of cost-effectiveness. As stated in the law (SFS 2017:30), older adults have the same rights to healthcare as do the rest of the citizens, in line with non-discrimination due to age (World Health Organization, 2021a).

Methodological considerations

All studies making up this thesis were carried out in municipalities of varying locations and sizes, across various geographic areas in Sweden. This can be seen as a strength that contributes to variation in the sample. The included studies (I–IV) employed both quantitative and qualitative methods. Therefore, study I, which applied a quantitative method, will be discussed in terms of reliability, validity and generalization. Study II – IV, will be discussed using equivalent criteria for qualitative methods, trustworthiness, i.e. credibility, dependability, confirmability, authenticity and transferability (Flanagan et al., 2025; Holloway & Galvin, 2017; Lincoln & Guba, 1985).

Study I

Study I was a quantitative questionnaire study. Using a questionnaire to study perceptions has both strengths and limitations. A strength is the ability to reach a larger sample cost-effectively (Wang & Cheng, 2020). Questionnaires where participants answer questions determined by the researcher can be seen as a limitation, however (Flanagan et al., 2025). For this reason, participants were given the opportunity to add their own comments at the end of the questionnaire. The questions had answers on an ordinal scale. Using an ordinal scale is suitable when asking persons about their subjective self-assessment, because each person's rating will depend on their subjective feeling (Field, 2018). The statistical analyses were selected based on the use of an ordinal scale (Field, 2018; Pallant, 2020). Therefore, non-parametric tests were chosen when analysing the data (Field, 2018; Pallant, 2020). A limitation of non-parametric tests is that they may be less powerful than parametric statistical tests in detecting effects (Field, 2018).

Validity

The validity of a study concerns the extent to which an instrument measures what it was set out to measure and the extent to which a conclusion of a study is correct and well founded (Field, 2018; Flanagan et al., 2025).

The validity of a questionnaire concerns the extent to which it measures what it purports to measure (Field, 2018; Flanagan et al., 2025). The study-specific questions were developed based on a systematic literature review (Claesson et al., 2020) of what RNs' leadership close to older adults implies, which could be seen as a strength for the content validity (Flanagan et al., 2025). Content validity concerns the extent to which the questions represent what is being measured and whether they cover the full range of the phenomenon (Field, 2018). The questions were discussed by an international research group consisting of researchers with competence in RNs' leadership close to older adults in municipal home healthcare. This also strengthens the content validity (Flanagan et al., 2025). Content validity can be seen as a first step in validation of a measurement (Zamanzadeh et al., 2015).

To test the clarity and logic of the questions, RNs (n = 3) with experience in municipal care for older adults were interviewed. This could be seen as a strength of the face validity, concerning whether the measurement looks like it measures what it purports to measure (Flanagan et al., 2025).

Participants were invited via an e-mail from their unit manager; this could be seen as a limitation, as not all RNs may have received an invitation. The response rate was 36 percent. This may reduce the internal validity of the study, concerning the extent to which factors outside the measured factors can affect the results (Flanagan et al., 2025). The risk of selection bias, in which non-respondents differ from respondents, can affect the representativeness of the overall population (Wang & Cheng, 2020) and reduce the internal validity of the study.

Another concern of internal validity when comparing groups is how the groups differ from the start, and how this may affect the result and conclusion (Flanagan et al., 2025). In the comparison between RNs with and RNs without specialist education in study I, the groups had differences in age and work experience as an RN. These may be factors affecting the comparison between the groups and therefore reduce the study's internal validity. However, the two groups' background variables are presented to the reader for transparency.

When conducting several statistical tests simultaneously, the probability of Type I errors increases (Field, 2018). Type I errors imply that a test concludes that an effect exists when it does not (Field, 2018). This can be controlled by adjusting the p-value for statistical significance (Field, 2018). However, this was not done when conducting the statistical tests in study I. Therefore, the results should be read with the understanding that there might be an increased risk for Type I errors when conducting several statistical tests simultaneously (Field, 2018). This limitation reduces the validity of the study.

When conducting correlation analyses, it is important to interpret correlation coefficients with caution when the full range of possible scores is not represented. This may affect the precision of the correlation coefficient and, therefore, reduce the validity of the study

(Pallant, 2020). This should be taken into account when interpreting the results of the correlation analysis in study I, where most of the answers were on the higher degree of the scale.

A convenience sample was used. Because the sample was a non-random sample, the results cannot be generalized (Flanagan et al., 2025), which affects the external validity of how the results can be generalized to the larger population (Flanagan et al., 2025). However, the results may reflect the perceptions of their leadership of other RNs working in a similar context and could therefore be valuable.

Reliability

Reliability concerns consistency, meaning the absence of variation of a measurement repeated under the same conditions (Field, 2018; Flanagan et al., 2025). The study-specific questions included in study I as well as in study II have not been tested repeatedly, which is a limitation and lowers the reliability (Flanagan et al., 2025). However, one aspect of reliability is internal consistency. That is, the internal consistency across questions and measures the extent to which the questions measure the same phenomenon (Flanagan et al., 2025). Internal consistency was measured for the 18 study-specific questions with ordinal scale response included in study I. This was done using Cronbach's alpha, one of the most employed measures of scale reliability (Cortina, 1993; Field, 2018). Cronbach's alpha for the 18 questions was .895. In the literature, Cronbach's alpha of .7 to .8 are described as desirable (Field, 2018). However, the result of Cronbach's alpha for the 18 questions should be read with the understanding that the number of questions in a scale impacts Cronbach's alpha. When the number of questions increases, Cronbach's alpha also increases (Field, 2018). No further analyses of the questions were conducted. Further analyses are recommended if the questions are used again, to strengthen reliability.

Study II, III and IV

Trustworthiness

Trustworthiness of the qualitative studies in the thesis (II, III, IV) will be discussed in terms of credibility, dependability, confirmability, authenticity and transferability (Flanagan et al., 2025; Holloway & Galvin, 2017; Lincoln & Guba, 1985).

Credibility

Credibility is related to confidence in the truth of data and interpretations (Flanagan et al., 2025; Lincoln & Guba, 1985). To achieve credibility, the participants must have experience of the studied phenomenon (Graneheim et al., 2017; Holloway & Galvin, 2017). The participants should also be willing to talk about the phenomenon and be in a context where the phenomenon is visible (Holloway & Galvin, 2017). All participants in study II – IV were working in home healthcare for older adults at the time of data collection. To strengthen trustworthiness, the inclusion criteria also required RNs (III) and care staff (IV) to have at least one year's experience working in home healthcare for older adults.

A convenience sample was used (II, III, IV). Purposive sampling is described in the literature as preferable in qualitative studies to achieve variation in the sample (Flanagan et al., 2025; Holloway & Galvin, 2017). However, the sample of participants in study II, III, and IV varied in age and work experience, and represented various geographic areas in Sweden, as well as various sizes of municipalities. The fact that mostly females participated reflects that RNs and care staff in Sweden working in care for older people are predominantly female (National Board of Health and Welfare, 2025a, 2025b).

Another aspect of credibility is the richness of data (Graneheim et al., 2017). The number of participants depends on the aim, and is not always proportional to the richness of data (Holloway & Galvin, 2017). Reflections on the information richness of the data in relation to the aim are essential (Braun & Clarke, 2022; Malterud et al., 2016). Therefore, in study III and IV, the richness of data was discussed before the data collection ended.

Credibility also involves the extent to which the results reflect participants' voices (Holloway & Galvin, 2017). The authors have strived to adopt a reflexive approach in the analysis to enhance credibility (Braun & Clarke, 2022). Graneheim and Lundman (2004), argue that during the analysis process, to choose meaning units so that the meaning in the text is not lost, and that all relevant data are included and irrelevant data excluded. With this in mind, in study II – IV the analysis process was discussed in the research group as a way to address credibility (Braun & Clarke, 2022; Graneheim & Lundman, 2004).

In study III the focus groups (n = 5) consisted of two (n = 1) and three (n = 4) participants. The literature recommends various numbers of participants for focus groups. According to Kitzinger (1995), the ideal number of participants of a focus group is four to eight. The plan in study III was to include six to eight participants in each focus group. For logistics for the RNs to participate, however, one focus group was held in each municipality and workplace, which meant that it was not possible to reach the planned group size, given the number of RNs who were interested in participating in each municipality. Moreover, two RNs withdrew their participation, one because of sick leave; the other was on vacation. However, interactions during the discussions across all focus groups generated rich data. Toner (2009) argues that an advantage of small focus groups compared with larger groups may be a more intimate climate and interaction. Cancelling focus groups because of participant numbers can also result in the loss of valuable knowledge and may be experienced as an affront to those willing to participate (Toner, 2009).

Dependability

Dependability entails the stability of data over time and the possibility to follow the research process (Flanagan et al., 2025; Holloway & Galvin, 2017; Lincoln & Guba, 1985). In relation to stability over time, regarding both the focus groups (III) and the individual interviews (IV), an interview guide was used, which means that the same questions were asked and the same introduction was read. EL performed all focus groups and individual interviews. In two of the five focus groups in study III, no assistant moderator was present, which

could be seen as a limitation. The assistant moderator's task was to provide support when needed and summarize discussions at the end. However, with the number of participants (two and three participants), in those focus groups that EL held without an assistant moderator, EL was able to manage them.

In study IV, the interviews were conducted in three different ways: face to face, via Zoom, and on the phone. Most interviews were conducted over the phone. Interviewing by phone excludes the possibility of incorporating non-verbal communication (Holloway & Galvin, 2017). It may also affect the possibility of establishing a trusting atmosphere as there is a distance between the interviewer and the participant (Holloway & Galvin, 2017). On the other hand, phone interviews can contribute to a feeling of privacy for the participants, and may enable them to participate regardless of geographic distances (Holloway & Galvin, 2017; Mealer & Jones, 2014). They may also have fewer technical interruptions, which may be more prevalent when using a video conferencing tool (Lindsay, 2022). The phone interviews did not differ in information richness from those conducted face to face or on Zoom.

During the analysis, data was analysed by working systematically, documenting decisions made and steps taken to enable the possibility to follow the steps in the analysis process (Braun & Clarke, 2022; Holloway & Galvin, 2017).

Confirmability

Confirmability refers to objectivity (Lincoln & Guba, 1985), here it applies to the degree to which the results are shaped by the participants' voice and not by the researcher's own pre-understanding and assumptions (Holloway & Galvin, 2017). Therefore, reflexivity is essential and seeking agreement with colleagues is valuable (Braun & Clarke, 2022; Graneheim et al., 2017). During the analyses of study II, III, and IV there was continuous discussion within the research group. The character of the data also guided the level of interpretation possible. Therefore, in study II the results presented the manifest content. In study III and IV, the data allowed for more latent content to be included in the results.

Authenticity

Authenticity is how fairly and faithfully the results present the participants' perceptions or experiences (Flanagan et al., 2025). To demonstrate authenticity, quotes from the participants have been used in the presentation of the studies' results (Braun & Clarke, 2022; Graneheim et al., 2017). The results have also been written with the aim of demonstrating different experiences, described using language as used by the participants.

Transferability

Transferability refers to the extent to which results can be transferred to other settings and groups (Lincoln & Guba, 1985). This is judged by the reader (Graneheim & Lundman, 2004). Therefore, descriptions of the context, participants and research process have been provided in study II, III and IV, which can facilitate the opportunity for the reader to judge the transferability of results (Graneheim & Lundman, 2004; Lincoln & Guba, 1985).

CONCLUSIONS

The results showed that RNs' leadership close to older adults in municipal home healthcare implies striving to focus on the older adult and striving to build relationships as the basis for leadership. RNs' closeness affects the establishment of relationships and can impact care staff's sense of security and inclusion. RNs and care staff have the same wish to work more closely, with improved communication and collaboration. Although the communication between them seems to be deficient.

There are organizational gaps in municipal home healthcare. These gaps risk jeopardizing good and safe home healthcare for older adults. RNs as leaders strive to bridge these organizational gaps. Leadership development must therefore be systemic, extending beyond the individual RN to include municipal governance and healthcare organizations. There is a need to untangle a fragmented organization structure. This includes uniting home healthcare and the social service for the benefit of the older adult's care. It also includes facilitating RNs' leadership with its focus on the older adult and on building relationships to promote person-centred home healthcare.

RNs' leadership in home healthcare is essential for the older adult's care and RNs want to lead. To foster strong nursing leaders, there is a need for nursing education, municipalities and healthcare organizations to equip future RNs to lead in home healthcare.

Clinical implications

The thesis contributes knowledge about RNs' leadership close to older adults in municipal home healthcare and hereby follows clinical implications:

- RNs' leadership is essential for home healthcare.
- The knowledge gained of essential elements of RNs' leadership may be valuable for RNs working in home healthcare and for municipal governance.
- Nursing education needs to facilitate strong nursing leaders in home healthcare.
- It is important to promote relationships and collaboration between RNs and care staff in social service.
- To promote good and safe home healthcare for older adults, municipal governance and healthcare organizations need to be aware of and address the gaps.

Further research

This thesis explored RNs' leadership close to older adults in municipal home healthcare and it would be valuable to research this further.

- Further research would be valuable on how RNs lead in clinical practice to increase the knowledge about RNs' leadership.
- Further research on how to facilitate relationships may be valuable, based on RNs' and care staff's suggestions for improvement for enhancing their collaboration.
- Further research on whether, how and when digital tools might facilitate and strengthen relationships with older adults and between RNs and care staff may be useful.
- The organizational gaps need to be further addressed in research.

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Registered nurse's leadership close to older adults in municipal home healthcare

Registered nurses in home healthcare are responsible for and lead nursing care. This thesis explored registered nurses' leadership close to older adults, next of kin, and care staff in municipal home healthcare.

The results showed that registered nurses as leaders close to the older adults in municipal home healthcare strived to lead with the older adult in focus and strived to build relationships as the basis for leadership. The registered nurses' leadership implied striving to bridge organizational gaps to promote good and safe home healthcare for older adults.

The organizational gaps need to be addressed, which goes beyond the individual registered nurse. Municipal governance and healthcare organizations must promote preconditions for facilitating registered nurses' leadership and ensuring good and safe home healthcare. Communication and collaboration between registered nurses and care staff in social service need to be improved for the benefit of older adults' care. This thesis highlights registered nurses' leadership and promotes strengthened nursing leaders.

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