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RESEARCH ARTICLE

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Balancing contradictory requirements in homecare nursing—A discourse analysis

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Abstract

Aim: To explore prevailing discourses on nursing competence in homecare nursing to boost understanding of practice within this field.

Design: A qualitative study with a social constructivist perspective.

Methods: Six focus-group interviews with homecare nurses in six different municipalities in Norway. Adapting a critical discourse analysis, data were linguistically, thematically and contextually analysed in the light of theories on competence, institutional logic and discourses.

Results: The analysis found homecare nursing to be a diverse and contradictory practice with ever-increasing work tasks. Presented as binary oppositions, we identified the following prevailing discourses: individualized care versus organizing work; everyday-life care versus medical follow-up; and following rules versus using professional discretion. The binary oppositions represent contradictory requirements that homecare nurses strive to balance. The findings indicate that medical follow-up and organizational work have become more dominant in homecare nursing, leaving less time and attention paid to relational and everyday-life care.

KEYWORDS

competence, contradictions, critical discourse analysis, focus groups, home health care, nursing

1 | INTRODUCTION

Over the past 20 years, the provision of health care in many countries has shifted towards an increased number of patients receiving healthcare services at home (Ashley, Halcomb, & Brown, 2016; Genet et al., 2011; Merrick, Duffield, Baldwin, Fry, & Stasa, 2012; Tarricone & Tsouros, 2008). This is also the case in Norway (Vabø, 2012), where this study took place. As a result, home health care (HHC) has become more extensive and complex and requirements for staff and professional competence have increased (Halcomb, Stephens, Bryce, Foley, & Ashley, 2016; Vabø, Christensen, Jacobsen, & Trætteberg, 2013). Thus, HHC has been the subject of increasing attention and discussion.

In Norway, as in the rest of the Nordic countries, HHC is a municipal, publicly funded service provided to the population based on assessments of healthcare needs, forming part of the universal welfare model, where all residents receive services (Brennan, Cass, Himmelweit, & Szebehely, 2012; Vabø, 2012). Extensive

public healthcare services are costly, and in recent years, several political reforms have aimed to make healthcare services more cost-effective. Thus, while more tasks have been transferred to municipal healthcare services, increased emphasis has been placed on efficiency and economic sustainability (Ahgren, 2014; Gjevjon, Romøren, Bragstad, & Hellesø, 2016). A major Norwegian healthcare reform that was implemented in 2012 accelerated the development (Norwegian White Paper no 47, 2008–2009). One consequence of this is that patients are discharged earlier from hospitals and more patients at home need advanced care (Gautun & Syse, 2017).

Another change worth noting is that in several Western countries, including Norway, there has been an increased market orientation in healthcare services, for example, the use of New Public Management (NPM), which emphasizes cost-effective approaches and standardized tools (Vabø et al., 2013). In homecare nursing, this becomes evident through formalized methods for measuring quality and allocating healthcare services (Björnsdóttir, 2014; Davies, Wye, Horrocks, Salisbury, & Sharp, 2011). Allocation of homecare services in Norway is outlined in individual time-managed care contracts that show how much health care each individual receives from the municipality (Holm, Mathisen, Sæterstrand, & Brinchmann, 2017).

Home health care comprises several healthcare services, of which nursing is a significant part. In Norway, nurses, auxiliary nurses and nurse assistants provide HHC, covering a range of care needs and medical treatments at home (Holm et al., 2017; Tønnessen, Nortvedt, & Førde, 2011). All homecare nurses in Norway are Registered Nurses with bachelor's degrees, and some have additional education (see Table 1). Nurses play a key role in providing high-quality care to sick and frail patients at home, which is an important part of the responsibility as nurses (Andersson, Lindholm, Pettersson, & Jonasson, 2017; Bing-Jonsson, Foss, & Bjørk, 2016; Halcomb, Davidson, Salamonson, Ollerton, & Griffiths, 2008). Therefore, nurses' competence and practice in HHC is an important topic to elucidate, and in this study, we do this by exploring how homecare nurses talk about their competence and practice. The study has a discursive approach, which means exploring language use in a particular context (Fairclough, 2013).

1.1 | Background

Competence here is viewed as a multi-faceted construct applied to professionals, referring to knowledge and skill levels needed to perform tasks and duties ethically in a given context (Cowan, Norman, & Coopamah, 2005; Eraut, 1998; Garside & Nhemachena, 2013; Lejonqvist, Eriksson, & Meretoja, 2016). The notion of competence touches on what nursing practice is seen to encompass in a given context. The homecare nursing context is situated in a welfare system that renders healthcare services to the community and professional, bureaucratic and market-oriented logics shape and fuel practice (Evetts, 2009, 2013; Mik-Meyer, 2017; Molander, 2016). To understand the complexity of practice, we apply an institutional-logic perspective to explore governing relationships in organizations (Thornton, Ocasio, & Lounsbury, 2012). This perspective provides a theoretical approach for understanding how socially constructed norms in an institution govern professional practice (Thornton et al., 2012).

Over the past 20 years, several studies have explored competence in homecare nursing, with some addressing the development of competency standards to measure and assess homecare nurses' competence (Andersson et al., 2017; Halcomb et al., 2016; Irvine, 2005), while others have examined competence levels and documented inadequate competence in areas such as elderly, palliative and psychiatric care (Bing-Jonsson et al., 2016; Furåker, 2012). Studies reveal homecare nursing to be a comprehensive practice with extensive competence requirements (Andersson et al., 2017; Flöjt, Hir, & Rosengren, 2014; Melby, Obstfelder, & Hellesø, 2018; Öresland, Määttä, Norberg, & Lützén, 2011; Purkis, Ceci, & Bjornsdottir, 2008). This is also evident in studies on ethical dilemmas associated with lack of time and the necessity of prioritizing between different homecare nursing needs (Öresland et al., 2011; Tønnessen et al., 2011). Further, studies show that homecare nurses experience conflicting demands that challenge their relationships with patients (Strandås, Wackerhausen, & Bondas, 2018; Wälivaara, Sävenstedt, & Axelsson, 2013; Wollscheid, Eriksen, & Hallvik, 2013).

Although there are several studies on various aspects of nurses' competence in HHC, there seems to be limited knowledge of how

TABLE 1 Nurse participants and settings in the focus group interviews

Group no	Age mean (range)	No. of participants	Female	Years of experience in HHC mean (range)	Participants with specialization[a]	Setting[b]
1	36.4 (25–52)	5	5	9.4 (3–16)	2	Rural
2	41.6 (34–47)	5	4	9.3 (3–16.5)	3	Urban
3	47 (24–60)	5	5	8.7 (3.5–22)	4	Suburban
4	50.6 (23–61)	6	6	7.4 (2–18)	3	Urban
5	44.4 (26–60)	5	4	14.5 (7–20)	1	Suburban
6	44.8 (40–51)	5	5	14.8 (10–26)	3	Rural

[a]Specializations included advanced clinical nursing, acute care, cancer, psychiatric care, geriatrics, diabetes, administration, pedagogy, primary health care, infections and disease control.

[b]Rural: small-sized municipality distant to hospital and city, 3,000–16,000 inhabitants; suburban: medium-sized municipalities outside a city, 28,000–50,000 inhabitants; urban: 250,000–670,000 inhabitants.

TABLE 2 Interview guide from the focus group interviews

	Themes for discussions
1	What is important to you when you go to a patient's home? What do you emphasize? What is especially required of you in a home context?
2	Which competencies do you think are important in your daily work as a homecare nurse? What do you think is important for being a skilled home nurse? What characterizes a skilled home nurse? How has this changed in recent years?
3	What is the special expertise of homecare nurses related to other professions?
4	What do you find particularly challenging in your practice?
5	Is there anything you would like to have more time for in your practice?

homecare nurses handle conflicting competence requirements and logics and what takes precedence in their practice.

1.2 | Aim

The article aims to identify prevailing discourses on nursing competence in homecare to boost understanding of nursing in this field.

2 | THE STUDY

2.1 | Design

Building on a social constructivist understanding, the study applied a qualitative approach influenced by Fairclough's (2003, 2013) descriptions of critical discourse analysis. Critical discourse analysis is here both a theoretical perspective and a methodological approach.

Discourses are understood as linguistic expressions that occur in a certain perspective and context (Fairclough, 2013). A discursive approach involves a study of language in use, searching for explicit and latent meanings and how actors use language to construct their versions of the world (Crowe, 2005; Fairclough, 2003; Fealy et al., 2018). Discourses are often about hegemony over what is the "right" understanding of reality and a struggle to define relevant discourses (Fairclough, 2013). The present study is based on the premise that discourses are both constructed and constructive (Fairclough, 2003); thus, language can shape practice while also reflecting it. Data were constructed through focus-group interviews with nurses working in homecare, a method chosen to construct knowledge through reflections and interactions between participants (Halkier, 2010; Krueger & Casey, 2014).

2.2 | Context and participants

Focus-group interviews were conducted in six different Norwegian municipalities. The settings were chosen strategically to ensure geographic and demographic variety, comprising two urban, two suburban and two rural districts in Norway. Another relevant factor was proximity to hospitals: Long distances between hospitals and patients characterized rural districts. Each focus group contained five to six participants, for a total of 31, and we carried out one interview at each site. The participants were selected and recruited through designated contact people in each municipality. Inclusion criteria were that they must be Registered Nurses working clinically in homecare and they wanted to participate in a focus-group interview. We did not stipulate any further criteria and let the contact people decide what was possible at each site. Nevertheless, in the end, the participant sample comprised a wide range of ages and years of experience (Table 1).

2.3 | Data collection

The focus-group interviews were conducted over four months in 2017–2018 at the nurses' workplaces. Each focus-group interview was conducted in one session, with the six sessions lasting between 60 and 90 min each. The first author was the moderator in all interviews, together with a co-moderator. We used a semi-structured interview guide with discussion themes, but remained flexible to include other perspectives (Table 2). The moderator's role was to facilitate discussions in the groups and challenge participants to elaborate and provide examples. The co-moderator observed, took notes and asked follow-up questions at the end. The first author digitally audio-recorded and transcribed the interviews verbatim, and then, the co-authors checked the transcriptions for accuracy. The interviews and analyses were conducted in Norwegian, and then, quotations in the form of statements and word usage from the transcripts were translated into English. The focus groups comprise this study's unit of analysis and are referred to as fg1–6.

2.4 | Ethics

The research project was approved by the Data Protection Authority in the Norwegian Centre for Research (reg.nr. 54,386) and by homecare managers in each municipality. Informed oral and written consent was obtained from all participants before the interviews. The participants were told that they were free to withdraw from the study at any stage of the interview process without any consequences and

that all data would be anonymized. Interview transcripts and audiotapes were kept in separate locked files and only relevant researchers had access to data.

2.5 | Analysis

We adapted Fairclough's three-dimensional framework and analysed the interview transcripts as linguistic text, discursive practice and social practice (Fairclough, 2003, 2013). In the first analytical phase, we conducted a linguistic examination of the text, examining word frequencies, expressions and the use of modal auxiliaries, for example, *must*, *can* and *should*. In the next phase, we interpreted themes that emerged from the text. The interactions in the focus groups were part of knowledge construction (Halkier, 2010) and conveyed the level of engagement. Based on this, we identified prevailing discursive practices.

The last analysis phase entailed linking the discursive practice to a broader socio-cultural context and theories. Connecting the findings with theories on institutional logics and nursing helped us discover what the discourses might signify. The three dimensions in the analysis model are intertwined and the analysis was a reciprocal process. Looking for patterns and emerging discourses in texts, we found themes and expressions that were associated with each other as binary oppositions. Binary oppositions work as a rhetorical way to convey a value hierarchy and represent a kind of polarization that describes a tension field (MacLure, 2003; Whitehead, 2010). One example of this was when participants described what care aspects were important to them, but lamented that they have less time for them because other tasks require their attention.

2.6 | Rigour

We strived for reflexivity throughout the study by discussing data and interpretations together on the research team. Co-authors participated in data collection as co-moderators, read the transcripts, checked the coding's credibility and verified emerging themes. All authors contributed to analytical discussions and validation of emerging discourses in the texts. All authors read the transcripts to develop a richer understanding of the content and the co-authors discussed and verified translated quotes. The article complies with COREQ guidelines (Tong, Sainsbury, & Craig, 2007).

3 | FINDINGS

Through text analysis, we discovered patterns and discursive practices in how nurses talked about their work and competence. The findings revealed homecare nursing to be a diverse practice with a wide range of requirements, which was evident in all focus groups. The following quote illustrates how participants emphasized diversity by pointing out that in homecare nursing, they encounter patients with very different healthcare needs:

> *The patients require that we have expertise in everything, regardless of their diagnosis and situation, because we are nurses who come to their homes.*
>
> *(fg2)*

By exploring how they talked about their work, we identified prevailing discourses on their HHC practice. Presented as binary oppositions, the participants spoke of individualized care versus organizing work, everyday-life care versus medical follow-up; and following rules versus using professional discretion. The binary oppositions point to contradictory requirements that homecare nurses face and constantly strive to balance.

3.1 | Individualized care versus organizing work

The first contradictory discourse was between individualized care and organizing work. The nurses talked about the need to be able to meet each individual patient's needs while also keeping track of many patients while coordinating services. Mainly, nurses linked the individual approach to assessing each patient's needs. Several named this the “core competence” or “basics” of homecare nursing. The emphasis on assessing needs and changes in each health situation was equally evident in all focus groups. The nurses frequently talked about the importance of getting to know each individual patient to facilitate quality care. Close interactions with patients seemed to be perceived as challenging, while also particularly meaningful. All the nurses said they wished they had more time for relational contact with each patient:

> *There was a time when we had time to sit down with patients and drink coffee. Yes, we had more time to talk with the patients before than we do today.*
>
> *(fg3)*

Thus, individualized care was identified as a prevailing discourse in homecare nursing in the sense that the nurses view this as a core value and something on which they want to spend time. However, the discussions in the focus groups revealed another discourse that competes for time and attention. We identified organizing work as a prevailing discursive practice. The participants often talked about how much time they spend organizing and facilitating the delivery of care services to patients:

> *We spend a lot of time coordinating and contacting doctors and other services. Phone calls take a lot of time. Such work is not visible and it may seem like we have only had a long break.*
>
> *(fg4)*

This statement illustrates the pressure nurses face when it comes to various tasks that need to be done and their frustration that organizing work is not recognized. In several of the focus groups, participants spoke of the fact that they should inform their colleagues more often about their time spent facilitating care services to make this aspect of the work more visible. The nurses emphasized how coordination and facilitation of services were particularly important in their homecare work, providing many examples of how inadequate coordination could hamper patient care. This topic elicited much focus-group discourse and frustration. In addition, patients with complex and unstable health situations require significant follow-up care and collaboration with other healthcare professionals. In all focus groups, they talked about how sicker patients at home lead to more readmissions to hospitals, thereby generating much organizing work for homecare nurses. The discursive practices of individualized care and organizing work were presented as contradictory, with homecare nurses constantly striving to balance between them daily.

3.2 | Everyday-life care versus medical follow-up care

Another binary opposition that we identified was everyday-life care versus medical follow-up care. Tension seemed to exist between the need to understand each patient's everyday needs at home while being significantly occupied with medical follow-up on diseases and symptoms. Everyday life was presented as a central area in the work as a homecare nurse, emphasizing the home situation and what is important for the patient to have for good daily living at home. The nurses talked frequently about the uniqueness of working with patients in their own homes and the importance of knowing each patient's home situation:

> *There is a big difference between seeing a patient in a hospital bed and seeing him in a chair at home with family pictures around.*
>
> *(fg6)*

Thus, participants emphasized this necessary approach to homecare as opposed to hospital care. Homecare nurses described how adjusting to each patient's everyday-life situation at home comprises specialized expertise that entails being respectful of each patient's home and life choices:

> *It is important to be aware that it is the patient's own home and that we are only visiting. Although now, many patients have so many procedures and technical equipment that it almost becomes like an institution.*
>
> *(fg5)*

This quote shows how technical equipment and procedures affect patients' everyday lives at home and can threaten their notions about feeling secure at home. Furthermore, the quotation illustrates how the discourse on medical follow-up at home challenges the everyday-life discourse. The nurses talked much about how important it is to know each patient's home situation, and the patient's family and local community. Here, we found a slight difference between groups—it seemed like participants in rural districts were more familiar with their patients' surrounding contexts. The everyday-life care discourse also was linked to the fact that homecare nurses often know patients for a longer time.

On the other hand, we identified a rather dominant discourse practice that was more diagnosis-oriented. When asked whether caring for patients receiving health services at home has changed, the answer was a clear *yes* in all groups: "Yes, they have become sicker and have more complex problems" (fg1). The nurses talked about how practice has become more disease-oriented, with increasingly sicker patients in need of advanced follow-up care at home. The homecare nurses were particularly keen on conveying how diverse and demanding their work has become, including the need to be skilled in many advanced clinical procedures, thereby requiring more specialized knowledge and skills:

> *Another thing in homecare nursing, which is perhaps the most exciting field in nursing right now, is that we receive patients with fairly complex needs from the hospitals. We perform a lot more advanced medical procedures in patients' homes than before and this requires a high level of expertise from us.*
>
> *(fg4)*

Increasing requirements for medical follow-up on patients with severe and unstable health conditions appear to leave less time for contact and relationships with each individual patient and thus also less attention to everyday-life care. Although the participants pointed out that everyday life is an important area for their work, they elaborated on this to a lesser degree than compared with the advanced medical procedures.

3.3 | Following rules versus using professional discretion

In the last binary that we identified—following rules versus using professional discretion—practising two dominant discourses became evident. On one hand, rule-oriented practice emerged as participants talked about abiding by contracts for allocated services for each patient. On the other hand, they also strongly emphasized the need for professional discretion and the ability to find solutions outside the box.

Rule-oriented practice was manifested through linguistic expressions such as *delivering services*, *being efficient* and *following the contract*. One nurse noted, "It all depends on the care contract of the patient" (fg2). This discourse highlighted how contracts served as both written promises for patients' services and task

lists for nurses. The following focus-group dialogue exemplifies this:

> *-Is the work task-focussed? Is that what you say?*
>
> *-Yes, often it is. You go in and do a task and then you leave again. So, you do what is on your list.*
>
> *(fg4)*

Another dominant discourse that we identified concerned homecare nurses being competent and responsible. This is a contrasting discursive practice compared with merely following the rules. Words and concepts frequently associated with this included *professional expertise*, *discretion* and *accountability*. These concepts often were used instead of, or to elaborate on, the concept of professional competence. They emphasized the importance of nurses' ability to recognize changes in each patient's health state, and assess these changes' severity. In Norwegian homecare, nurses work quite autonomously and solitarily, which all groups emphasized. Everyone talked about how important it is that the nurse who comes to the patient's home has sufficient knowledge and can make the right assessments. Thus, the competent nurse often was described as independent and able to effect customized solutions in each patient's home. The following focus-group dialogue illustrates this:

> *-We need to create solutions that work and we have to constantly adapt to the patient and the family and also to each home with interior and available equipment.*
>
> *-And when we are with a patient far from the office and something is missing, we have to solve it. If you do not have a urine bottle, you use the soda bottle. You kind of get inventive then.*
>
> *(fg6)*

The participants underlined the need to be both *flexible* and *able to think on your feet*. This seems to express an urgency in demands, describing a practice that is constantly changing and requires that they react quickly:

> *We must improvise a lot and be solution-oriented; I think that's very important.*
>
> *(fg3)*

The word *must* suggests what the participant perceives as urgent in practice. These sentences' modality revealed participants' normative opinions on the matter. When they talked about nurse competence, they linked professional knowledge and skills with personal attributes, for example, being calm, friendly and flexible. A competent homecare nurse is one "who can handle unforeseen events with expertise and calm" (fg2).

Although the nurses emphasized the importance of a competent nurse being able to work independently, they also spoke about professionalism as a collective HHC project. When they talked about finding good solutions and using professional assessments, all the participants emphasized that this must be done together due to situational complexity. Thus, the discourses on competence in homecare nursing are not presented merely as individual characteristics, but as a common project.

4 | DISCUSSION

This study aimed to identify prevailing discourses on competence in homecare nursing to seek increased understanding of this field of work.

4.1 | A diverse and contradictory practice

Through a rather broad approach to exploring discourses in homecare nursing, we gained insight into a diverse and complex practice. Homecare nurses cover a multitude of tasks and functions in their work, demanding a great deal of professional competence. Homecare nursing is described as varied and extensive (Halcomb et al., 2016; Melby et al., 2018), which may create tensions between different expectations and needs. The linguistic analysis showed how the nurses often used the modal verb *must* when talking about their practice. This points to a practice that comprises many tasks that they believe must be done, often leading to acute and urgent tasks taking precedence during a busy workday.

We identified some dominant discourses that can be linked to governing institutional logic in the welfare system where homecare nursing takes place (Thornton et al., 2012). The way nurses talked about their practice reflected not only their professional-oriented logics, but also governing bureaucratic and market-oriented logics (Mik-Meyer, 2017; Molander, 2016). This became especially evident in the contradictory discursive practice between rule-driven and more flexible professional approaches. The nurses' discourses told of a practice characterized by contracts and rules, while strongly emphasizing the importance of professional discretion. Our findings show how the nurses manoeuvre between different logics and seem to apply a rule-governed flexibility to be able to attend to each patient's individual needs while being loyal to the bureaucracy's logics. The conflict between professional discretion and bureaucratic standardization in homecare nursing is described in several studies (Björnsdóttir, 2014; Davies et al., 2011; Strandås et al., 2018; Wollscheid et al., 2013). Our study highlights how this tension affects the ability to provide quality nursing care. Nursing practice is context-dependent and is shaped by its organizational structure, and this clearly was evident when the nurses talked about what governs their practice. The discourses in the focus groups reflected the management and organization of each setting and municipality.

The binary oppositions that were identified highlight a tension field between several prevailing discourses and the conflicts that homecare nurses experience. These tensions become particularly

evident when they face patient needs that go beyond what service-efficiency requirements allow.

4.2 | Medical follow-up and organizing work-gain priority

HHC nurses face many challenges related to following up on patients with severe and often unstable conditions, which was evident in all the binaries. Changes as a result of more patient groups receiving health care at home affect nurses' work and the need for expertise. Sicker and more poorly functioning patients at home have elicited more medical follow-up and advanced technical procedures in homecare nursing, with medical follow-up identified through focus-group data as a dominant discursive practice in homecare nursing.

A lack of nursing resources leads to care rationing, thereby causing nurses to spend more time on medical follow-up and clinical procedures and less time on basic needs (Tønnessen et al., 2011). The increased need for nursing expertise to follow-up with seriously ill HHC patients is highlighted in several studies (Ashley et al., 2016; Furåker, 2012; Gautun & Syse, 2017) and supports our finding that medical follow-up has become a bigger part of homecare nursing.

Sicker patients also lead to more frequent transfers in and out of hospitals and nursing homes, thereby requiring that nurses spend more time on organizing work. The nurses emphasized the amount of time they spend organizing and facilitating care trajectories for each patient and organizing work was identified as a prevailing discourse in homecare nursing. Findings from other studies highlight how organizing work has gained a central place in homecare nurses' practice (Bjornsdottir, 2018; Melby et al., 2018). Nurses spend lots of time on this part of their job, though it appears hidden and unrecognized. Allen (2014) calls this the "invisible work" of nurses. These findings relate to discussions about nursing content and whether organizational work is part of nursing or whether it comes at the expense of relational work.

4.3 | Less time for relations and everyday-life care

The identified discourses provide insight into what the nurses spend time on and what they think is important. Building on an understanding that discourses are both constructed and constructive (Fairclough, 2003), the discourses elucidate governing values and structures that determine what is constructed as being crucial in their practice. The homecare nurses talked about assessment and follow-up on patients' basic needs as an important work area to contribute to patients' everyday lives at home. The discursive practices of individual care and everyday life seem to convey core values in homecare and the nurses emphasized this as unique in HHC. Many studies underline relational work with patients as being the basis of homecare nursing and crucial for promoting health and a good everyday life (Bjornsdottir, 2018; Strandås et al., 2018; Wälivaara et al., 2013). However, our study shows that other discourses often take precedence and that nurses have less time for relational contact with their patients.

Several study participants were concerned that they had less time to follow-up on everyday-life care for their patients. A previous study showed how nurses in hospitals and homecare nursing have different perspectives when they consider patients' care needs (Hellesø & Fagermoen, 2010). In hospitals, medical diagnoses and technology were more prominent, while homecare nurses appeared to take a more holistic approach, with a greater emphasis on the individual's everyday life. Our study's findings indicate that this is changing. Less time for relational work can lead to the loss of basic qualities in homecare and to patients not getting the health care they need.

The discourses point to a practice that entails contradictory requirements that homecare nurses are striving to balance. The discourses highlight how nurses must be able to assess needs for a wide range of different patients and understand each patient's individual everyday-life circumstances. In addition, the prevailing discourses show increasing demand for nurses with solid organizing and collaborative skills, and specialized medical knowledge and skills. These are comprehensive requirements that challenge both individual and homecare nursing's collective competence.

4.4 | Limitations

Although the study is done in the Norwegian homecare context, the results highlight challenges that are relevant outside this context. The findings cannot be generalized, but they can be transferred internationally to other contexts that face similar changes in homecare nursing. In the study, we aspire to show the data's richness to allow readers to consider the findings' relevance. However, the extent of rich data is limited in extant articles, so we provided examples of linguistic expressions and interpretations to show how we identified prevailing discourses in the interview text.

5 | CONCLUSIONS

This study identified several prevailing discursive practices in homecare nursing and revealed how some seem to take precedence over others. Medical follow-up and organizational work have become more dominant in practice, leaving less time for individual relational work and everyday-life care. Another finding is how organizational logics affect work and how nurses strive to adapt to this while maintaining their own professional core values in homecare. This contributes to an increased understanding of current contradictory requirements in homecare nursing that nurses constantly balance.

Homecare nursing has an impact on individual patient's health and everyday life, and it is therefore vital to elucidate the content and governing requirements for this work. Thus, it is important to include the voices of homecare nurses when it comes to the consequences of changes in their work. Highlighting and discussing

homecare nursing as work and competence is relevant for practice development, nursing education and policymakers. It is necessary to be aware of ongoing changes and how they affect nursing practice and, not least care for patients. An important question is whether the changes in homecare move in a desired direction based on the population's needs, political intentions and nursing values. Further research is needed on homecare nursing and ongoing current changes of the healthcare services.

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CONFLICT OF INTEREST

The authors have declared no conflict of interest.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and met at least one of the following criteria (recommended by the ICMJE [http://www.icmje.org/recommendations/]): substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; drafting the article or revising it critically for important intellectual content.

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