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RESEARCH ARTICLE

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What constitutes feeling safe at home? A qualitative interview study with frail older people receiving home care

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Abstract

Aim: To highlight experiences of what constitutes feeling safe at home among frail older people receiving home care.

Design: Qualitative descriptive study.

Methods: The sample consists of 12 individual recorded interviews with frail older people in their homes. Interviews were transcribed verbatim and analysed using qualitative content analysis. The data collection was performed in spring 2018.

Results: The analysis resulted in three categories: "Having a feeling of 'at-homeness'" describes the older people's surrounding environment and their efforts to maintain independence; "being able to influence" describes the importance for older people to shape their care by being in control and having an opportunity for self-determination in the context of home care; and "being able to trust staff" relates to expecting staff's knowledge and skills and to appreciating the staff's ability to create positive relations.

KEYWORDS

community care, content analysis, interviews, older people, quality and safety

1 | INTRODUCTION

In recent decades, there has been increased recognition of the importance of providing safe home-based care for frail older people (WHO, 2017) and to include the care receivers' perspective when improving the safety of care (Ericsson et al., 2019). Thus, to raise the knowledge about how to establish safe home care, it is important to explore what constitutes feeling safe at home among frail older people receiving home care.

Frail older people are in a very precarious position in society (Grenier & Phillipson, 2018). Being a frail older person means that the individual's ability to cope with everyday life or acute stressors is reduced due to ageing-associated decline in reserve and function across multiple physiological systems (Xue, 2011). Frailty is described as loss of independence, which can have an impact on how older people think and act (Warmoth et al., 2016). Moreover, frailty and vulnerability relate to experiences of losing

dignity with risk of social and emotional isolation and experience of "being homeless in life" (Hemberg, Nyqvist, & Näsman, 2019).

For many older people, their home is experienced as the protector of their privacy and identity, a place that provides a feeling of strength, independence, responsibility and usefulness. Additionally, the home enables feelings of social connection by the relationship with family and friends (Molony, 2010). Thus, older people's private home is associated with feelings of comfort and security (Gillsjo & Schwartz-Barcott, 2011). Consequently, many older people prefer living at home for as long as possible despite their increasing frailty and complex needs, that is "ageing in place"— a situation that is similar across many countries (WHO, 2015). Enabling this may require the provision of various kinds of support (National Institute on Aging, 2019; Swedish Institute, 2018). In Sweden, this support is totally tax-funded and available to all citizens regardless of their ability to pay (Anell, Glenngard, & Merkur, 2012). To adapt home care services to the frail older person's needs in a safe way, collaboration, communication and mutual understanding among care providers are required (Longo & Notarnicola, 2018; WHO, 2017). This study adopts a broad definition of "home care" that includes support provided in older people's own home by social services (municipal care workers), nursing services and rehabilitation services—since support for older people at home often requires the involvement of several organizations.

Implications for practice

- Older people's experiences of feeling safe should be an overall goal and central consideration in the development of safe home care.
- Older people should be given the opportunity to be the main decision maker about their own home care and their life in general.
- Care organizations require sufficient resources, which mean that substantial investment in staff with adequate competence is needed.

2 | BACKGROUND

Feeling safe at home is essential for frail older people's well-being (Dahlin-Ivanoff, Haak, Fange, & Iwarsson, 2007; Swedberg, Chiriac, Törnkvist, & Hylander, 2012), where experiences of feeling less safe can lead to higher stress, feeling less in control and lower self-efficacy—as well as perceiving a lower health-related quality of life (Milberg et al., 2014). Patient safety, defined as receiving health care without risks by protecting the patient from care-related avoidable harm during care and treatment, is a fundamental principle of health care and a major global concern (WHO, 2017). However, the concept does not include people's experiences of feeling safe, which could be assumed to be crucial for frail older people receiving home care worldwide. Additionally, this concept usually refers to hospital care and is not easily transferred to municipal care (WHO, 2017), since our home is considered a place of autonomy, where the opportunities for caregivers to control and adapt the physical home environment are severely limited (Lang, Edwards, & Fleiszer, 2008).

Research concerning older people's perspective of feeling safe at home is limited (Harrison et al., 2013). However, according to Jones (2016), older people strive for the feeling of physical, emotional and psychological safety in their own home. It is in line with the findings of Lang et al. (2014) and Tong, Sims-Gould, and Martin-Matthews (2016), who showed that older people's experiences of feeling safe at home were associated with risk reduction in relation to the physical body and home area. Additionally, Lang et al. (2014) showed that experiences of feeling safe among home care recipients were negatively affected by their loss of independence and decline in social activities.

Moreover, studies focusing on older people's experiences of feeling safe at home have shown that the staff's familiarity with the older person's situation, everyday routines, characteristics and preferences were all essential for care receivers to feel safe in a home care setting (Lang et al., 2009; Schaepe & Ewers, 2017; Tong et al., 2016). Additionally, feeling safe at home was affected by staff continuity (Schaepe & Ewers, 2017; Tong et al., 2016), staff's scheduling of home visits and the time that staff members were allowed to spend with clients (Lang et al., 2009; Lang et al., 2014).

To summarize, home care is a complex interactive process that often involves care providers from various care organizations and the older people themselves. Although feeling safe at home is essential for frail older people and professional knowledge about their experiences is an important prerequisite for improvement of safe care at home, the research in this field from the older person's perspective is limited. In view of these challenges, we performed an interview study with twelve frail older people who were receiving home care. Our aim was to highlight experiences of what constitutes feeling safe at home among frail older people receiving home care. The research questions were the following:

- What is important for frail older people's experiences of feeling safe at home?
- Which strategies do frail older people use to feel safe at home?
- What do frail older people want to change in home care to feel safer at home?

3 | DESIGN

The study used a qualitative descriptive design based on semi-structured interviews. The interview method was inspired by Kvale (1996). To ensure the complete and transparent reporting of the research team, study design, analysis and findings, the authors followed consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007) (File S1).

4 | METHOD

4.1 | Participants and settings

Participants were recruited from an urban and rural area in west Sweden. A purposive sampling was carried out according to Polit and Beck (2017) and included people who met the following inclusion criteria: (a) being aged 65 or older; (b) residing in their original home setting; (c) being classified as "frail old people" according to the FRESH screening instrument developed by Eklund, Wilhelmson, Landahl, and Ivanoff-Dahlin (2016); (d) being in need of home health care, rehabilitation at home and/or support from municipal care; (e) receiving services for at least the previous six months; and (f) being able to understand and speak Swedish. Those who were unable to be interviewed due to cognitive impairment were excluded.

Recruitment to the study was carried out by staff from home health care and municipal care organizations. These staff members were informed previously about the study by the first author and were asked to share an information letter and verbal information with the care recipients who met the inclusion criteria—and to ask them about their willingness to participate. Screening of older people's frailty was carried out by staff. The people who were interested in participating signed the letter and gave it back to the staff. These signed letters were returned to the first author, who then telephoned these potential participants within a week. During these telephone conversations, the first author provided more information about the study and booked a date and time for an interview. All interviews were performed in the homes of the participants as per their wishes.

Of the people who met the inclusion criteria, 16 initially agreed to participate. Four of them later changed their minds due to disease or lack of time. Ten women and two men gave their informed consent and were included in the study. The age of participants ranged from 71–93 years old (mean: 82 years old); nine lived on the mainland and three in the archipelago. All participants had assistance from a municipal care organization, and seven received home health care. In addition, all participants had assistive devices and one person had rehabilitation at home. Eleven participants lived on their own, while one lived with a partner.

4.2 | Data collection

The first author conducted semi-structured interviews using an interview guide that featured several open-ended questions (Table 1), with additional probing questions when needed for a more thorough content. The interview questions were guided by previous research, developed in collaboration with all the authors and tested with the help of three older people who did not participate in the study. The test revealed some problems in wording, which were then revised. The revised interview questions were tested on two other older people and were judged to be of sufficiently high quality to obtain appropriate data. These test interviews were not included in the study, since the older people who participated in the pilot studies did not meet all of the inclusion criteria.

TABLE 1 Semi-structured interview guide

Tell me about your experiences of feeling safe or uncertain in situations at home
What contributed to your experiences of feeling safe or uncertain in these situations?
What is important for you to experience feeling safe at home?
What do you do yourself to create a feeling of being safe at home?
What do you want to change in home care/home help/home rehabilitation to improve experiences of feeling safe at home?

The interviews, which lasted between 24–99 min, were audio recorded and transcribed verbatim by the first author. All interviews were conducted face to face between the first author and the older person, with the exception of one interview in which a relative also attended. In total, 12 interviews were carried out. The data collection was performed in spring 2018.

4.3 | Analysis

The interviews were listened to and read several times to gain an overall sense of the data. Data were analysed using qualitative content analysis as described by Graneheim and Lundman (2004). Both latent and manifest content were analysed. The manifest analysis began by identifying—for each interview—meaning units consisting of words and phrases describing the research questions. These meaning units were marked and copied into a separate document and then condensed and labelled with codes. This work was performed mainly by the first author in close cooperation and discussion with four other co-authors in the research group. Next, codes from all the interviews were compared and sorted according to similarities and differences in content. This step was followed by the creation of subcategories, which were abstracted into three categories. The categories were developed on an interpretative level, expressed the latent content (Graneheim & Lundman, 2004). All authors were involved in a continuous process that involved going back and forth between codes, subcategories and categories. Examples of the analysis process are presented in Table 2.

4.4 | Ethics

Approval was obtained from the regional Research Ethics Committee in Gothenburg (Ref. 149-17). All data were handled according to the General Data Protection Regulation (GDPR).

Attention was paid during the interviews to the participants' well-being and comfort to ensure that their needs and wishes were accounted for. The author and the participants were not related in any way.

TABLE 2 Examples of condensed meaning units and abstracted codes, subcategories, and categories

Meaning units	Condensed meaning units	Codes	Subcategories	Categories
It is not you who makes decisions in my home, it is me	It is me who makes decisions in my home	Want to make decisions myself	Striving for self-determination	Being able to influence
… and they say "yes" and do not understand what I say, it becomes very complicated	It is complicated when they say "yes" without understanding	The staff do not understand	Expecting staff's knowledge and skills	Being able to trust staff

5 | RESULTS

The analysis of interviews with older people resulted in three categories and seven subcategories (Table 3). The results are illustrated using quotations from the interviews.

5.1 | Having a feeling of "at-homeness"

This category stresses the importance of having a feeling of "at-homeness" despite extensive help and visits by several professionals. Participants' experiences of feeling safe at home were constituted by their attitude towards the surrounding environment and their opportunity to feel independent.

5.2 | Living in harmony with the surrounding environment

Living "at home" where the older person has lived for a long time and where he or she knows exactly where things are placed was described as one of the central aspects that constituted their experience of feeling safe. In addition, participants' experiences of feeling safe at home were established by their own approach to their ageing, their health, their disabilities, their relationships and also that they are adventurous and curious in their own home.

Older people felt protected if they had dedicated relatives, friends and neighbours, as these relationships led to more opportunities to satisfy their needs regarding the management of everyday life, including decreasing the sense of loneliness:

TABLE 3 Overview of categories and subcategories

Categories	Subcategories
Having a feeling of "at-homeness"	Living in harmony with the surrounding environment
	Maintaining independence
Being able to influence	Having control
	Striving for self-determination
Being able to trust staff	Expecting staff's knowledge and skills
	Appreciating staff's ability to create positive relations

> … you can always go to them and talk a little, or ask about some help that you need with something. So that is my safety.
>
> (76-year-old man)

Some participants described the staff's influence in the older person's home environment could lead to a feeling of the loss of "your own home," which resulted in experiences of disability, loneliness and uncertainty.

5.3 | Maintaining independence

Older people expressed a desire to be as independent as possible for as long as possible since it affected their experiences of feeling safe at home:

> But it's so nice that I can do it myself again. It feels so good if it is something you can do yourself for as long as you can, do what you can as long as you can, that's safety.
>
> (90-year-old woman)

They felt that the body limited them in this endeavour, and they tried to create prerequisites for being more independent by adapting their homes and by maintaining mobility with or without technical aids. Some participants, who expressed trust in their own abilities, stated that they wanted to challenge themselves by performing everyday home activities without the help of technical aids to maintain their abilities as long as possible. Older people, who valued technical aids, felt that these devices improve how safe they feel and increase their opportunities to be more independent at home and in their social life if the technical aids were adapted for their needs and home environment. The absence of assistive devices could lead to a sense of dependence, helplessness and being imprisoned in their own home, as well as the feeling of the need to adapt:

> No, I haven't come down since I don't have a stair lift, so I've been imprisoned up here and it's clear, it's not fun to not come out. I miss that very much.
>
> (71-year-old woman)

Older people expressed anxiety about not being able to continue doing what they wanted, which affected their feeling safe at home. In their experience, the need for help feels difficult as it leads to feeling dependent. To avoid the sense of dependence, the older people tried to find new ways to maintain their activities without support despite the feeling of uncertainty.

5.4 | Being able to influence

This category shows that, for older people, feeling safe at home depends on their ability to influence their own care by having control of what is happening in their home and by striving for self-determination.

5.4.1 | Having control

Older people described experiences of having control in terms of the desire to know the people who they let into their own home. Some talked about their positive attitude towards strangers, but most of the participants felt that they wanted to be informed about the people who come into their home to help, to feel safe and make the most of the staff's competence in the best way possible.

The feeling of having control was also affected by information about the staff's visit times and the opportunity to contact staff if the need arose. At the same time, older people often reported feeling calm in the event of unforeseen delays occurring if they were familiar with the staff's work. Additionally, some participants saw information about visit times as a prerequisite for facilitating their own planning of their day and the reduction of stress associated with worrying about whether the staff would come:

> Because it is also the case that if you are visiting a friend and then you hurry home because you do not know if they [staff] will come at five or seven o'clock. But had you known that they would come at seven o'clock, then you didn't have to get stressed out.
>
> (90-year-old woman)

Some older people mentioned that the organization's rules often prevented them from influencing their own care and, thus, their feeling safe at home. The participants wanted to provide input into who would be their contact person and how often they would meet that person. Furthermore, participants wanted the extent and type of home care to be based on their needs. By contrast, some older people experienced having to adapt to the organization's rules, which led to a feeling of hopelessness and disappointment. One of the participants expressed this as follows:

> For example, things like… they just empty the bin bags on Monday, Wednesday and Friday. So you have to make sure that you do not have rubbish on Thursday.
>
> (73-year-old woman)

5.4.2 | Striving for self-determination

Older people expressed a clear desire to make decisions about their own care to feel safe at home, but felt that the opportunity to do so varied. They wished to maintain their habits and wanted the staff to take their wishes into account. One of the participants described her view on decision-making in own home like this:

> They should not do what they think should be done, but they should ask me, 'How do you want this done?'.
>
> (85-year-old woman, (a))

The staff's intrusion in older people's daily routines compromised their likelihood of feeling safe in their own home as it led to feelings of sadness or irritation and as it was experienced as disrespecting the older person's wishes. The following quote illustrates how one old person described the staff's dissatisfaction with her routines:

> He just got angry with me… because I pointed out things.
>
> (73-year-old woman)

5.5 | Being able to trust staff

This category describes the importance of the older people feeling that they can trust staff to feel safe in the home care setting. Participants reported that trust was affected by the knowledge and skills of the staff members and by the staff's ability to create positive relations.

5.5.1 | Expecting staff's knowledge and skills

Older people expressed a clear desire to be cared for by staff who: (i) had received education and had professional and life skills (both considered to be prerequisites for the staff members' willingness to take responsibility); (ii) showed a sense of safety themselves; (iii) displayed an appropriate approach to caring; (iv) were accurate and honest; and (v) showed competence in coordinating the care activities. Participants also reported that feeling safe in the home care setting depended on the staff's language skills, which were a prerequisite for mutual understanding:

> I wish they [staff] could speak better Swedish. Most [people] who come are not Swedish. They speak all possible languages […] which I do not understand. And sometimes, there are misunderstandings.
>
> (88-year-old woman)

Older people reported feeling safer with staff who had been working for a long time and also trusted such staff members more—since the participants associated longer work experience with more

expertise, leading to greater trust in the staff's ability to provide care that reflected the care recipients' preferences and routines:

> They [staff] have been here for a few years, a couple, three years and they have learned what I do and what I like and how I want it.
>
> (85-year-old woman (b))

Older people who found that the staff had insufficient competence often experienced feeling annoyance, fear, a lack of confidence and the need to instruct staff. In particular, the need to instruct unprofessional staff affected older people who suffered with memory impairment, since it resulted in them experiencing the need to take on responsibility that they could not handle, as well as feeling that needs were not being met and that they blamed themselves.

5.5.2 | Appreciating staff's ability to create positive relations

Some older people thought that creating good relationships depends to a large extent on the staff's attitude and approach, which could lead to very good relationships or, in the worst case, conflicts. Older people appreciated when the staff enabled trusting encounters by being present, pleasant and positive. They also valued when the staff acted more personally because it enabled older people to talk more openly, allowing them to get to know one another on a deeper level and to develop a greater understanding of each other's situation. Trust that arose in such encounters contributed to their experiences of feeling safe that made the older people talk as they normally would, to joke, to laugh and to dare to say how they wanted things to be done. One of the participants illustrated how the staff's positive attitude made it easier for her to ask for the help she needed, saying:

> […] they want to help in the way that you feel you need help.
>
> (81-year-old woman)

Older people felt that the length of time that staff spend in their home could be seen as a prerequisite affecting the development of a good relationship and, thus, affecting the likelihood of them trusting the staff. Their experiences of staff not having enough time available at their home often resulted in the older people being unduly stressed, which, according to some participants, leads to situations in which they forget to ask for help:

> I think like… it's so difficult when they come and are in such a hurry, so you forget what you wanted to ask for… I must say, it can be difficult. I maybe wanted to get help with a lot of little things, but I forget these things when they are here.
>
> (90-year-old woman)

6 | DISCUSSION

This study highlights that, among frail older people receiving home care, what constitutes feeling safe at home includes their feeling of "at-homeness," their ability to influence their own care and having opportunities to build trust with staff. The analysis did not show any differences in older people's experiences of feeling safe in home care settings according to gender, or whether they were living alone, or with their partner.

The first category, *having a feeling of* "at-homeness," is about frail older people striving to live in harmony with their surrounding environment and to maintain independence. Similar findings were described by Petersson, Lilja, and Borell (2012), who highlighted that older people's feeling safe in everyday life could be affected by feeling at home, which includes the dwelling, the surroundings and the social environment. These findings represent a starting point for discussion about how the physical home environment and frail older people's social interactions mutually affect each other and together constitute their experiences of feeling safe at home. However, since each person experiences home in different ways (Molony, 2010), more interventions from caregivers should aim to adapt the home care environment to the unique needs of every older person and support their social communication, to maintain their feeling of at-homeness (Lang et al., 2009; Petersson et al., 2012) and to avoid frail older people's experience of "being homeless in life" (Hemberg et al., 2019).

Participants also reported that their experiences of feeling safe were affected by how likely they were to feel independent—a finding that was also mentioned in the study carried out by Lang et al. (2014). For example, the participants were happy to be able to carry out activities without assistance, which provides us with an important message about frail older people striving to maintain their abilities to continue be active. Ellefsen (2002) showed that feelings of dependence can reduce autonomy in everyday life and limit opportunities for negotiation, which—according to Breitholtz, Snellman, and Fagerberg (2013) and Warmoth et al. (2016)—can negatively affect the frail older person's feeling of self-image. Since the phenomenon of "independence" is wide and multifaceted (Plath, 2009), staff need to be aware that finding ways to support the frail older person in maintaining independence requires finding solutions in collaboration with the care recipient.

The category *being able to influence* showed that the feeling of having control in care situations helped the participants to feel safe. Previous research also highlighted older people's wish to know who is coming into their home and when (Lang et al., 2009; Schaepe & Ewers, 2017; Tong et al., 2016). Older people felt insecure and irritated by having to wait a long time for the arrival of staff without receiving necessary information about any delay, since this affected their everyday activities. This situation could be improved by better communication, where the staff members have a responsibility to provide older people with the information needed (Conner-Spady, Johnston, Sanmartin, McGurran, & Noseworthy, 2007; Kihlgren, Nilsson, Skovdahl, Palmblad, & Wimo, 2004).

The present study shows that frail older people regarded self-determination as an important component for feeling safe in a home care setting, as it plays a significant role in maintaining habits and daily routines. The staff's intrusion into older people's personal space can lead to the feeling of a reduction in capacity and autonomy, which, according to Breitholtz et al. (2013), can be a risk factor for experiencing fear, anxiety and powerlessness. Thus, home care organizations should find ways to enable older people's self-determination to help them feel safer in home care settings.

The category *being able to trust staff* shows that it is easier for frail older people to feel safe in home care settings when they feel that staff members have sufficient competence to perform their work. This factor is not surprising, as it has also been described in previous studies (Lang et al., 2009; Schaepe & Ewers, 2017; Tong et al., 2016). Nevertheless, it does provide further evidence of its importance. In addition, since older people appreciate the staff's competence to coordinate care activities, ensuring that they feel safe at home requires sufficient multidisciplinary teamwork, which—according to Brazil et al. (2004)—needs comprehensiveness, accessibility and compatibility of home care organizations to overcome current barriers. These processes depend on both administrative improvements and the development of policy framework and require improvement of patient safety culture in care organizations, effective processes of care and interested leadership (WHO, 2017).

Frail older people's experiences of feeling safe were also related to their relationships with the staff, which were based on the staff's continuity, their capacity to create opportunities to listen and their positive approach and attitude. The findings stress that staff members can make a big difference in this context, which means that staff need to have an ability to achieve well-functioning relationships with the frail older people (Craftman, Westerbotn, von Strauss, Hilleras, & Marmstal Hammar, 2015). This interaction can enable older people's participation in their own care by encouraging conversation, confirmation and acceptance of each other's feelings, thoughts and opinions (Sahlsten, Larsson, Lindencrona, & Plos, 2005). Moreover, it can lead to development of the partnership between care recipients and caregivers, which is the foundation of person-centred care (Ekman et al., 2011) and is one of the essential prerequisites for providing safe care (WHO, 2017).

Unfortunately, the staff's ability to create positive relations and ensure person-centred care is perceived to be in conflict with the caregivers' difficulties with regard to adapting home care to the needs of older people—due to the staff's allocated responsibilities, obligation to follow strict service contracts and the lack of staff with adequate competence (Longo & Notarnicola, 2018). It should also be taken into account that home care organizations are facing a challenging growth in staff shortages, which is expected to be extremely problematic in the years ahead. In Sweden alone, care organizations will need 67,000 more employees to care for older people in 2026 (Swedish Association of Local Authorities & Regions, 2018). Thus, we emphasize that the care organizations require sufficient resources, which means the need for massive investment in staff with adequate competence and development of new job strategies to ensure frail older people feel safe at home.

6.1 | Methodological considerations

Trustworthiness is related to credibility, dependability and transferability (Graneheim & Lundman, 2004). The credibility of the present study was ensured by testing interview questions and interview techniques with older people who were not the study participants but had similar characteristics. The number of participants was relatively limited, but their varied backgrounds—in terms of their age, sex, health condition, extent of home care services, home help services and place of living—enabled the description of a range of experiences of feeling safe in a home care setting. After 12 interviews had been conducted, no further interviews were included due to discussion among the authors, which concluded that data saturation had been reached. The concept of data saturation is problematic, and there is always an uncertainty about how many interviews should be included. Thus, judging when to stop the data collection is considered to be situated and subjective (Braun & Clarke, 2019; Low, 2019).

It is a challenge to keep a logical and congruent level of abstraction and degree of interpretation during qualitative content analysis (Graneheim, Lindgren, & Lundman, 2017). To ensure credibility throughout the data analysis and consistency between the data presented and the findings, all the authors were involved in the discussions regarding identification of meaning units and their condensations; code labelling; code interpretation; and the creation of subcategories and categories. Credibility of the study results was also achieved by presenting representative quotations so that the reader can judge the similarities within and differences between categories (Graneheim & Lundman, 2004).

To achieve study dependability, all data were collected in a short time frame. Additionally, the same researcher contacted all study participants and conducted all interviews. This approach ensured that all participants received the same information and that all interviews were conducted in a similar manner (Graneheim & Lundman, 2004).

To obtain transferability—and thereby give the reader the opportunity to judge whether the findings are transferable to another context—we provided a description of the study context; participants' selection and characteristics; data collection; and data analysis. The presentation of the results includes quotations, which enhance both transferability and credibility (Graneheim & Lundman, 2004).

6.2 | Limitations

Involving the frailest older people was challenging in this study since they were too tired due to their condition. The absence of the perspectives of these care recipients can be considered a limitation—as can the lack of insights into experiences of older people with cognitive impairment and those who did not speak Swedish. A text can have more than one meaning depending on the researcher's pre-understandings and degree of interpretation (Graneheim et al., 2017). Thus, there may be several possible interpretations other than the one we have presented here. The results of this

qualitative study cannot be generalized (Polit & Beck, 2004), but they have implications for a broader population of older people receiving home care.

7 | CONCLUSION

Based on our results, we advocate that home care organizations need to adapt their guidelines to ensure that they have a strong focus on frail older people's wishes to make their own decisions, their own choices and to maintain control of their actions. This would require care organizations to provide the necessary conditions for staff to listen to the older person's narrative concerning what factors contribute to feeling safe. Since the process of "ageing in place" is similar in many countries, we believe the findings can contribute to improvements in similar contexts worldwide even though the results of this study are covering only one country.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

AUTHOR CONTRIBUTION

AS, HW, EL, HB: Study design and study planning. AS: Conducting the interviews. AS, HW, EL, HB, LJ: Data analysis and drafting of the manuscript. All authors were active in reviewing and editing the manuscript.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are not publicly available due to ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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