Journal of Multidisciplinary Healthcare

Dovepress
Taylor & Francis Group

Open Access Full Text Article

ORIGINAL RESEARCH

It's Like Doing Simultaneous Mind Puzzles: Exploring How Care is Understood and Experienced by Nursing Assistants Working in Sweden with Older Persons

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Background: The care of older persons is facing several challenges, especially as care tasks are becoming increasingly rationalized with less opportunity for relational engagement between nurse assistants and older persons. Evidence suggests this engagement is needed to promote well-being and satisfaction among the older persons with whom they work. The aim of this study was to explore how care, in the context of worker perspectives, is understood and experienced in home or residential care facilities.

Participants and Methods: Focus-group interviews were conducted with experienced nursing assistants (n = 14) working in urban municipalities in Sweden. Data were analyzed using reflexive thematic analysis.

Findings: The main theme: "This work is more than a checklist of tasks, it's like simultaneous mind puzzles", exposes the shortcomings of a "task and time" oriented care system while expecting individualized relational care practices. Three subthemes emerged: "It's about responsibility, not remuneration", "Knowing them is part of the job" and "We do a lot that is not our job". Participants expressed working responsibly day-to-day to find solutions to meet the needs of older persons. Tensions experienced between task and relational care orientations align to variation in understandings of care. These subthemes highlight that their work requires being context-sensitive to adapt in the moment, much like trying to solve mind puzzles.

Conclusion: Increased rationalization of care, while expecting focus on relational aspects, sets nursing assistants in a challenging position. This paradox negatively affects the health of nursing assistants by creating unsustainable work. Without recognition of the required cognitive engagement in problem solving that is part of their work, the challenges of retention, sick leave and burnout are unlikely to be addressed. To ensure coordinated continuative care for older persons, nursing assistants need time and agency to enact relational practices that facilitate doing their work's dynamic care puzzles.

Keywords: assistant nurse, homecare, residential care, work, relational care, fundamental care

Introduction

Having an educated workforce to support aging populations is a growing challenge globally, Sweden included, where the proportion of those 80+ years is expected to increase 50% by 2031. Nursing assistants (NAs), accounting for the majority of this workforce, support older persons with complex health conditions, many whom are frail and vulnerable.[1,2] To meet this future care demand recruitment of around 72,000 NAs will be needed.[2] The care that NAs provide is linked to the older person's well-being and satisfaction.[3,4] However, high job strain can pose a risk for NAs and in turn negatively impact on an older person's satisfaction with care.[5,6] Unfortunately, sick leave among NAs is twice as much as other

Received: 19 September 2024
Accepted: 9 December 2024
Published: 16 January 2025

occupations in Sweden.[7] The work of NAs, or paid unlicensed personnel working in health and social care, is informed by many stakeholders, eg, policy, health system, older persons, health professionals, colleagues, society and themselves. Older persons' perspectives on care have been explored in home and residential settings.[3–6,8] However, integration of multiple perspectives, particularly worker perspectives, is needed, as work situations are influenced by political and organizational trends.[9] The authors argue for a need to explore care specifically from the worker perspective in different contexts. Because systems differ within and between countries, qualitative accounts and contextualized analyses can provide knowledge to inform practice areas facing similar tensions.

Theoretical Framing from Relational Care

Work for NAs is challenged by how care, as a concept, is understood differently depending on its framing, resulting in tensions where understandings come into conflict.[10] The debate around care is often presented as a dichotomy, rationalized vs relational. One side with an objective medicalized view aligned with neoliberal policies influencing a managerial focus on health system rationalization.[11] Termed "science of caring", this framing takes an objective, and technical orientation to care.[12] On the other side is a subjective relational perspective informed by nursing theory, sociology, informal caregiving and feminist theory, which are grounded in ethics and compassion.[12,13] Caring is defined "as an ongoing action and state of being"[13] and includes "biophysical, psychological, cultural, social and environmental dimensions which can be studied and practiced to provide holistic care to people".[14] The relational logic of care strives to make apparent subjective, often invisible and situational contexts to caring actions.[10] These are not easily grasped through a universal definition but through narratives allowing exploration of what "good" care or a "good" life might mean based upon the situation. Meeting an older person's needs can be accomplished by "tinkering" with goods and processes to find a unique solution.[15]

This paper is framed using relational care, which recognizes the personhood, experiences, emotions, situations and morality of those engaged with care practices.[16] Situations arise where autonomy and independence are not easily established and require collaboration, or interdependence, with other persons towards establishing what values are of priority.[17] Organizational factors often impact the possibility for application of relational care. A cultural shift is needed to focus on relation development rather than on itemized care processes,[17] or codified work that overemphasizes the measurable.[11] NA work occurs within the context of these conflicting organizational perspectives on care.

Nursing Assistants in the Swedish Context

The job of NA is one of the most common in Sweden, with 119,000 employed in aged care in 2021, where 79,200 of those were at residential facilities.[18] In 2022, of those working as NAs in aged care, 88% were women with an average age of 45, with a mean length of time working of about 14 years.[19–21]

Policy in Sweden dictates NAs need to have diverse skills and abilities. Good judgement requires foundational knowledge to notice important health status changes in the older person and what subsequent actions to take, requiring continuity of care.[22] Maintaining a professional decorum when meeting older persons, relatives, and colleagues is emphasized, along with an understanding of ethics and workplace values that inform one's approach to practice.[22]

NAs are expected to understand fundamental care and activities of daily living.[23] Primarily this includes personal or body care, eg, toileting, bathing, personal and oral hygiene, support to eat and drink, and dressing. It can also be domestic care, eg, taking out trash, bed making, cleaning, laundry, safety monitoring of environments, shopping, meal preparation, and administrative tasks (documentation and phone calls).[22,24] NAs also aid with mobility in and outside the home/residence and using assistive devices.[24] Further, the older person's well-being is supported by NAs through relational care in the forms of social support and companionship.[22,24,25]

During the past decades, the work of NAs in Sweden has intensified and resulted in mental exhaustion.[26] NAs' responsibilities have shifted away from relational aspects of work including simply being together, listening or domestic care, towards a focus on mechanical aspects of bodily care.[26] This trend can be partially attributed to complex care needs among older people as life expectancy increases combined with shortages of licensed professionals within healthcare.[1] Increasing differentiation in work tasks in aged care has resulted in some workplaces designating tasks like shopping and cleaning to uneducated staff, while those with training take on more medicalized tasks. However, evidence is lacking on

the potential impact of differentiation to care continuity.[18] NAs can be personally delegated tasks such as providing medication and changing dressings under the supervision of a registered nurse (RN).[22] They may also collaborate with rehabilitation personnel in coordinating assistive devices and training for clients. In addition to high care demands within home and residential care, rationalization and time regulated routines,[7,26] as well as added administration,[25] pose a risk for the core of care work. Further, those working in aged care in Sweden have been subject to regular changes to roles, the work environment and organization, most of which show negative health effects on staff.[27,28]

Exploring care from the NA perspective is urgent because their work is unsustainable.[1,7] NAs experience high sick leave, low retention, and high turnover.[7,29] NAs have the highest rate of sick leave of all professions in Sweden,[18] and staff work despite being ill more than other health professionals.[30] Studies exploring job strain report often feeling unhappy or depressed, and having difficulty sleeping by 70% of homecare NAs and by about 56% of residential NAs.[20,21] These studies suggest that strain and negative stress result from excessive workload, unreasonable expectations, limited control, lack of support, promotion or recognition from management, peers and/or relatives, and poor interprofessional relationships.[21,31] Furthermore, it has also been suggested that these work environments lack managerial support, recognition, authority and/or autonomy, as well as sustainable scheduling practices.[32] The impact of COVID-19 exacerbated this by further isolating NAs from supervising RNs.[1] However, how "care" is framed and contributes to job strain factors has yet to be explored.

Homecare differs from residential care as NAs work alone in the older person's home rather than on site in close proximity to other care professionals, such as RNs.[33] Identifying the NAs' perspective in studies from residential care can be challenging as different professional positions are often grouped as "nursing staff". Despite common origins of "care", there are differences in work experiences between RNs and NAs, such that it is important to understand the NAs' unique perspective.[34] However, challenges faced by NAs may also align to shared understandings or organizational structures with licenced professionals.[35,36]

Another difference in the work settings is that the majority of older persons receive support at home – 151,000 persons 65+ in 2023 versus 82,000 persons 65+ living in residential care that year.[37] This is due to various policies and reforms that have reduced the available places in residential care toward having more older adults age-in-place in their homes, thus those in residential settings tend to be older, more frail and sick, 70% have dementia and have a life expectancy on admission of 22 months.[26,38]

The meaning of work for NAs aligns with understandings of relational care, suggesting work can simultaneously be both motivating and discouraging and is connected to the relationships that they develop.[32,39,40] For residential NAs, work gives a sense of family belonging, pride in performing tasks, or autonomy. Further, relational and familial bonds with patients or clients are motivating and meaningful for NAs,[39] but straining when bonds are not supported.[40] The meaning of work in homecare suggests a similar duality of enjoying autonomy, relationships, and variety in work but struggling with lacking boundaries, structure, and support for unpredictable work.[41,42] Relations with homecare clients provide positive meaning, but, similarly to residential care, could contribute to negative work situations, eg, boundaries, emotional stress, or a client's death.[32] Trends to rationalize work without recognizing variation in meanings of work for NAs and the relationships they navigate contribute to a worsening work environment.[7] This study builds upon these meanings of work for NAs, focusing on how care is conceptualized.

Additional knowledge is required by organizations and policymakers for sustainable development of NAs' work,[1] to enable continuity of care for older persons,[7] and meaningful work for NAs.[42] Relying on NAs' resilience, as is presently done, cannot be the primary solution to work sustainability.[1] The aim of this study was to explore how care, in the context of worker perspectives, is understood and experienced in home or residential care facilities.

Materials and Methods

Study Design

The study takes an interpretive qualitative design with online and in-person focus groups and reflexive thematic analysis.[43] The authors' perspective on knowledge is informed by social constructivism,[44] and utilizes a reflexive methodology throughout.[45] The study was approved by the Swedish Ethical Review Authority (Dnr 2019–05489).

Participants and Setting

Participants were NAs with a care or nursing degree from an upper secondary program or adult vocational program, employed in Swedish health and social care to support a plethora of care services.[22] Participants (n = 14, no dropouts) were recruited, by their managers, through convenience sampling[46] from an urban municipality in central Sweden. The municipality's older person services administration facilitated contact with managers of two public residential care units and two public homecare service providers within care for older persons. Managers received written information about the study via Email and were asked to recruit groups of 3–4 participants. Participant inclusion criteria were needed to have been employed as NAs longer than 6 months, and ability to speak about their work experiences and care. Three online groups and one in-person group with few participants were conducted following the Swedish Public Health Agency's recommendations regarding gatherings to keep physical distance from each other and avoid the spread of COVID-19. Participants were all women and had been working between 6 and 34 years in the profession, with an average of about 20 years, see Table 1.

Data Collection

Due to restrictions on gathering in person during the COVID-19 pandemic, three focus groups were performed via Zoom™[47], and one focus group was held in the informants' workplace, in a private room. Informed consent procedures were followed, including information about the study, that participation was voluntary with the possibility to withdraw without explanation at any time, and information about possible risks/benefits, and that any published responses or quotes would be anonymized. Focus groups were between 50 and 90 minutes in length, conducted in Swedish – the workplace language, though not all informants were native speakers, and recorded on a digital device. An interview guide with open-ended questions was followed. First, second and last authors were present at the focus groups, where EA held the focus groups and AL or LF took notes and assisted. All authors except for the first, a doctoral student, have doctoral degrees and previous experiences in research using focus groups. The research group includes four female and one male researchers.

The interview guide constituted open questions about participants' work experiences such as: "Can you share a bit about your work? How do you see care for older people from your perspective in residential care or homecare?" followed by questions such as, "What is your role?" and "How does this situation affect your work?" After periods of discussion, short summaries were used to check if discussions had been understood correctly. EA used follow-up questions to clarify, such as "Could you please explain?", "How did that make you feel?", or "What do you mean by that?" Following a participant response, peers were given opportunity to build upon that with similar or contrasting experiences, or participants would offer audible sounds (along with head nods) of agreement or disagreement. The exemplars in the findings include the discussion flow and auditory responses of the participants where possible. Audio recordings were transcribed by AL using Olympus DDS Player (Version 7 Plus) offline and anonymized.

Table 1 Participant and Focus Group Discussion Characteristics

Characteristics					**Totals**
Focus group number	1	2	3	4	4
Number of participants	4	3	4	4	15
Gender, female/male	4/0	3/0	4/0	4/0	15/0
Range, length of employment, years	12–13	6–34	20+	12–30	6–34
Month and year of focus group	March 2021	March 2021	March 2021	October 2021	March-October 2021
Place of discussion	Online Zoom™	Online Zoom™	Online Zoom™	Onsite at office	Online (3), onsite (1)
Type of care facility	Residential	Homecare	Residential	Homecare	Residential (2), homecare (2)
Facilitator, observer (author initials)	EA, AL	EA, LF	EA, LF	EA, AL	EA (4), AL(2), LF(2)

Data Analysis

Interpretation of participants' understandings of care, in the context of their work, was developed using reflexive thematic analysis.[43] An inductive analysis of group discussions led to construction of patterns from the data.

The analysis was led by AL who started listening to all recordings and reading transcripts separately. An inductive approach was used during coding using the software program ATLAS.ti (version 9.1.3). After one transcript was coded, codes were shared and discussed in person between EA and AL. AL used memos to define how codes were used. The coding process of all transcripts included discussions on depth and richness of data,[48] grouping of codes, meanings, and patterns noticed in the data set. Initial themes and subthemes were developed based upon AL's interpretations of the patterns grounded in exemplars. AL reviewed the codes reflecting on which ones build on each other to create clusters, these were then reflected as to how they related to prior literature on care and the work of NAs, as well as to the breadth of the data set. Ideas for themes were pulled from an interpretation or a partial quote that stood out from the data and stuck, especially during or shortly after discussions with co-authors, Table 2. These were expressed in writing and illustration to establish meaning and relationships to each other. AL, EA and LF discussed, refined, and rearranged the themes to improve clarity of relationships. AL grouped codes on post-it notes on a wall to visually explore theme and subtheme names and relationships outside of ATLAS.ti and the linear format of writing. Different colors allowed for arranging layers of codes and exemplars with notes on interpretations and possible themes to better reflect on relationships and whether clusters should be merged or nested. AL repeatedly returned to the original transcripts to reflect on if the constructed findings aligned with the discussions from both work contexts and all four focus groups. AL developed a graphic summary of the themes and subthemes to further contextualize the findings based upon narratives from the focus groups, Figure 1. The subthemes were further refined, and three subthemes were finally identified. AB and AP were included at this stage to critically reflect upon the analysis and provide additional perspectives on the three subthemes.

The analysis of quotes was made first in Swedish (a language that all authors have as a first or second language) and then translated to English. This translation was validated by two authors, EA and AP, who independently checked translations and then compared them for consistency. All names and locations in quotes are pseudonyms. All authors discussed and revised the manuscript and approved the final version.

Findings

Main Theme: This Work is More Than a Checklist of Tasks, It's Like Simultaneous Mind Puzzles

The main theme highlights tensions that imbued the shared experiences of care in the context of work for participants. Work constituted carrying out or supporting rationalized tasks that make up personal and domestic care. Care, which was seen as part of this work, required establishing and nurturing personal relationships to specifically tailor these tasks for, or with, the older person. This coordination was invisible and often charged with conflict between the tasks expected and the situation encountered. Active relational collaboration with older persons was expressed as fundamental to support the puzzling together, or coordination, of their work and the well-being of the older persons. Although relational activities, like conversing, could occur in parallel to rationalized tasks, this was an important distinction in reasoning about what to foreground among participants.

Table 2 Example of Raw Data to Development of Subtheme

Original Text (Quote)	Codes	Notes on How Code is Used	Subtheme
It is really a lot that is not our job. So interior décor and window cleaning and to cook some of the food. And so. All-in-all haha, no but there is a lot that is so, there is so much time taken from the care of the resident that is taken to do many other things, there is cleaning the unit and common spaces.	Doing a bit of everything	Maybe someone else could do some of the work like cleaning…	We do a lot that is not our job
	The work is tuff and weighs on you	It can feel heavy at times the work	

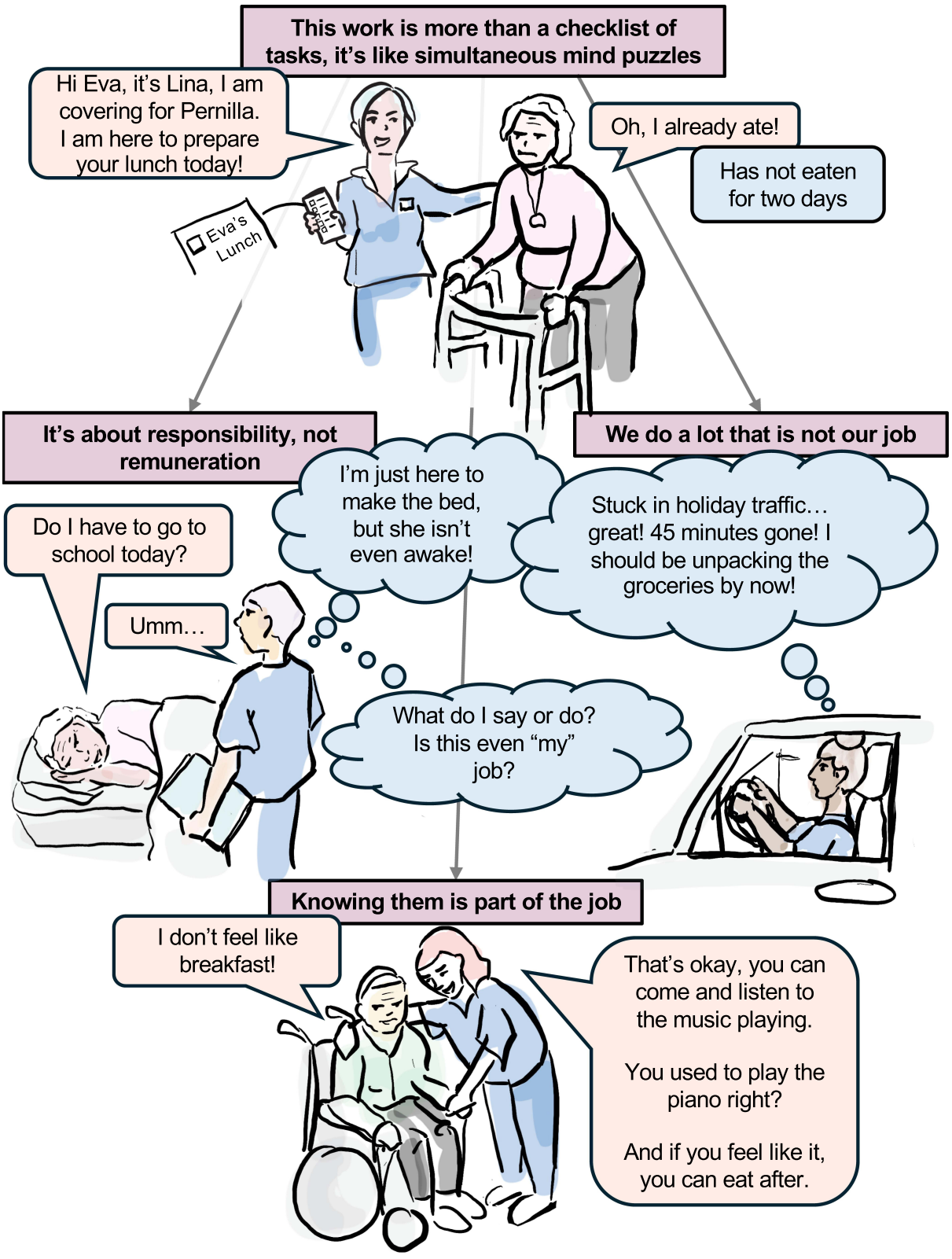

Figure 1 Graphic summary of the main theme and subthemes, illustrated by the first author.

Three subthemes are offered as further exploration of these findings, see Figure 1. These highlight ethical implications for care when situated between rationalized tasks and relational care that occasionally presents as unpredictable.

Subtheme 1: It's About Responsibility, Not Remuneration

A sense of curiosity and genuine interest in older people was raised as foundational to the participants work and care. It was about seeing value in the life of those they meet and grasping their responsibility in shaping the quality of the older person's life. The meaning of work was not about work for the sake of having work, or remuneration, but about relational meanings as part of caring. For participants, recruitment of colleagues able to connect with older people was important, as was highlighting the complexity and uniqueness of their work.

Elina: But this right here that they are curious, that is what it is about. And want to absorb, that is also what it's about. […]
Anna: We actually lack staff, but at the same time they need to be staff who like to work with older people.
Elina: Yes, yes
Maria: And not just to take this job to have a job.
Anna: No, exactly, exactly. For that is what many…
Yasmin: Yes, that is what many do
Anna: It is not an assembly line business.
[Group 4, Homecare]

The participants recognize that there are staffing shortages but discussed feeling that public rhetoric around care for older people has portrayed their work as if anyone can do it, to which participants were critical.

The participants in both residential and homecare settings expressed being an NA means being prepared for the work, but felt many were not. They conveyed that their work was sometimes reduced to a rhetoric of rationalized tasks, a job that can be performed on autopilot, neglecting the importance of unspoken and unacknowledged relational aspects as an integral part of care:

Maria: I think they are a little bit shocked too when they get out and see how it is to work in homecare, they do not think that it is so much that you need to think about and so much responsibility, and they probably think that now we just go home and make the bed and stuff like that, but then they realize that oh, that it not the case.
Anna: It was a couple years ago that they said, yes but all can work in homecare, just like that, no, you actually cannot. […]
Anna: So that is why we always say, politicians and government employees, come and work in homecare so you can see how it is yourself. Because it is not like anything else.
[Group 4, Homecare]

Participants expressed feeling a moral dilemma when their work is communicated like a checklist. They felt their work required taking responsibly and respectfully collaborating in another's life and adapting to the situation.

Subtheme 2: Knowing Them is Part of the Job

The NAs experienced relational care as central to their work. Participants spoke about having the skills to build a relationship with each older person, with the aim of facilitating living a good life. Building rapport was not only through dialog but by encouraging engagement in personally relevant and meaningful activities in their environment:

Stina: There was a woman who came and it was really a hard time with her, but we knew that she, she learned to play the piano. And then when we came to pick her up, she did not want to come out of the room. And we said to her, it would be good if you come to eat with the other residents who sits out there so it will be nice with music playing and so, you could just try it out for a while. And then every day, that was what kept her going. So she liked, and she found a friend there. And then not only that, that sat in a wheelchair and started to wheel herself to Birgitta and then after lunch she went to the large room and started playing the piano herself. So she made a life change that we did not believe she would.
[Group 3, Residential Care]

Recognizing and adapting care to the individual enabled the older person to participate not only in the intended activity of mealtime but also socialization and musical performance. This relational care dynamic of observing what gives meaning to someone's life and creative problem solving, or tinkering, aligns with how participants felt that their work required puzzling together unique happenings that confront them in their day-to-day work.

Participants also raised tensions grounded in a contrast between an older person's decisions or preferences and their own well-being (such as being a lifelong smoker), or counter to their own past preferences. Part of what they do to identify a care approach is to reflect on who is this person today, who were they, or who are they becoming.

Eva: Really this is very difficult stuff, what happens if someone comes in who has been a vegetarian all the time, begins to eat ham sandwiches? Should we support the person as they have been their whole life, or should we support that person as they are today? There is usually no simple answer and then for example reflection is really important, that you can talk to each other and maybe preferably to relatives too.
[Group 3, Residential Care]

The ethical implications of not knowing, or figuring out, who a client is, were also raised. Participants conveyed that one cannot perform routines on autopilot, enacting care requires adapting and revising their approach based upon the day-to-day older peoples' situation and demands from their work situation. This was connected to continuity of care, including implications for safety and quality of care:

Helena: We have so many hourly employed staff and they come home to someone who they do not know. Or the person with dementia does not know them and then they will not have them, and then they say that "I have already eaten". And they believe the person, it is not their fault, and say "okay then I go". And then maybe, it was someone who had not had food in two (days), or a weekend.
[Group 2, Homecare]

Participants expressed time for communication and reflection is important for respectfully navigating care. It is not possible to rationalize an approach to discrete situations, especially when involving the older people, colleagues, and relatives. The participants' discussions around needing to know the older people to establish a relationship supporting adaptability and continuity of care were aligned with what they feel is their job, what they should be doing, and what they experienced as meaningful work.

Subtheme 3: We Do a Lot That is Not Our Job

While work environments for residential and homecare are different, in both settings participants expressed they were doing activities or services they felt were not part of their job. Unclear work boundaries were discussed and explored by participants who questioned which activities should be part of the job. The participants voiced a profound dedication and commitment to work activities aimed at the well-being of the older person, or care. However, some tasks were questioned.

Karin: It is really a lot that is not our job. So interior décor and window cleaning and to cook some of the food. And so. All-in-all haha, no but there is a lot that is so, there is so much time taken from the care of the resident that is taken to do many other things, there is cleaning the unit and common spaces.
[Group 1, Residential Care]

Participants felt additional work needed to be done directly with the older persons, which they felt responsible for, but they were pulled away from this to complete seemingly less relevant tasks. Participants from homecare put this dilemma in the context of time:

Anna: Yes, but it really is, and you have just 45 minutes, does not matter where the store is located, and how much the client needs to buy and which day it is. It is only 45 minutes. […] Yeah, those who live close to the lake and want to shop at the ICA supermarket, with just that 20 minutes have gone. And then maybe it's a public holiday, then you have all the other people. So then, no, it's a waste.
Maria: No, homecare should not have that service, it should just be nursing care and quality.
Anna: Yes, exactly, help so that they can live at home.
[Group 4, Homecare]

The tension raised illustrates a shift in meaning depending on whether the relational values of care and collaboration are in focus or completion of rationalized time allocated tasks. The invisible often unpredictable frustrations met when navigating a task checklist was experienced as attempting multiple puzzles or riddles. Participants contended that certain day-to-day decisions and actions might not be seen by others as part of their job, despite being integral to the

care of residents and therefore their work. The next quote features renewing prescriptions, which is not included in their job scope.

Anna: Say they need medicine, then we must call the general practitioners office. Even though it actually is not on our plate. But the client is in a jam. So we must, there are so many musts we must do.
[Group 4, Homecare]

The way the participants view their work means that this kind of care coordination is a "must" to prevent something important from falling through the cracks. However, coordination is not made explicit as valued tangible work. Further, tension was expressed around the older person as a purchaser of services. In certain situations, the need for services may be unavoidable, yet as the participant shared no one wants to pay for them:

Maria: And then it is this with getting the decision on care, they say like this "no but I don't need that" because they see how the cost adds up. But then when you come to them…
Group: *sounds of agreement*
Maria: …they coax it out of you and will have more anyway but they will not pay for it. And that there I think is why one ends up being so incredibly late during the day, because you do not, you do not want to deny them anything and say that you do not have time for that.
Elina: no (in agreement)
Maria: so you do the thing and then it becomes a stressful moment when you are out working.
[Group 4, Homecare]

Participants felt a moral drive to take responsibility for needs that are not being met – even if it's "not their job" – because they felt someone must do it, and if not them, who? For participants, care work included significant frustrations navigating between tasks they felt were expected of them and tasks they felt were necessary – like picking up a 94th birthday cake for sharing over coffee – but invisible, and not valued as part of their work.

The participants reached consensus that the cost for blurred boundaries in terms of what care means and what care is needed is often at the expense of the NA.

Discussion

This study explores how care, in the context of worker perspectives, is understood and experienced in home or residential care facilities. Participants in this study understood care in different ways as (1) a *sense of responsibility that goes beyond remuneration*, (2) the act of *getting to know the person they serve*, and (3) *caring actions that lack clarity on how they align to official work.*

(1) *As a sense of responsibility that goes beyond remuneration*, participants described that their work cannot be done on autopilot; it is not an assembly line job. They described it as a practice of tinkering and adapting.[10,15] The responsibility felt towards older persons at a professional level, even when the work is rationalized, links to the NA's sense of self, who they are as a profession, and who belongs, or not, to that profession. The participants expected themselves and other NAs to genuinely "care about",[49] not only for the older persons. Meaning that they are responsible for getting to know the older person to understand the person's needs and preferences. "Caring about" comes from four components of care: "Caring about involves paying attention to our world in such a way that we focus on continuity, maintenance, and repair".[49] Further, "Taking care of" as a component of care "involves responding to these aspects – taking responsibility for activities that keep our world going".[49] The way NAs adjust their practices in residential care to meet the needs of older persons has been argued to be a way to make sense of their work, enriching it with what are seen as humane practices.[50] While participants expressed feeling a responsibility for their work, the boundaries of that responsibility are vague.[36]

Counter to this responsive and reactive understanding of care, study participants suggested an incongruence in appropriate values among fellow NAs, raising concern about persons being pushed through a neoliberal model suggesting that anyone can "work". The aim of work or paid employment is not necessarily accomplished by placement in paid employment. Care work also needs to be based in a deeper meaning that aligns with one's sense of self and belonging.[51] The neoliberal model does not recognize that the work of NAs may not have similar meaning for everyone, and a responsibility to care about the older persons is not guaranteed, which has implications for quality of care and safety.[36]

(2) *Getting to know the person they serve* can be understood as promoting relational care within their work. Enactment of care as relational can challenge understandings of productive work in western cultures,[51] shifting focus from monetary valuation of productivity to ethics and relations of care. Emotional and relational elements of care are not as easily codified as other aspects of care work.[11] Thus, a challenge in integrating care into work is avoiding attaching monetary value to the emotional and relational aspects of care, which can resemble volunteer or unpaid work.[52]

Despite relational care often being inadequately valued, study participants illustrated the importance of honoring relations to accomplish tasks both effectively and respectfully. Forcing someone to shower is not a viable option, staff must figure out the best approach to support that individual. "Good care" requires navigating two different models of care ethics (rationalized versus relational logics), which require in-the-moment adaptations of care to address situations as they unfold.[53] These aspects relate to participants' descriptions of work, which highlight establishing personal relations that allow them to provide rationalized care continuously and safely. There is agreement that care should align to the older person's needs,[23] which demands the ability to provide relational care and requires adaptability. Other studies have discussed this weighing of options from the perspective of whether staff have the opportunity to narratively reason with interprofessional colleagues about one's work.[54] The ability to "redefine and renegotiate" activities and routines is argued as essential to care work for NAs, as well as other professionals.[55] Future organization of work for NAs should reconsider how staff can impact their daily work planning to meet spontaneous needs and reflect on challenges with older persons, colleagues and relatives,[26] as well as to be part of organizational innovation and shaping new methods.[50] For example, reablement is an increasingly multidisciplinary working approach, driven by the older person's personal goals rather than a task orientation, that has been implemented in Nordic countries and is being explored in Sweden.[56,57]

(3) Having *caring actions that lack clarity on how they align to official work* was described by participants as puzzling out an approach in order to "do" the work. On one side of the spectrum were tasks lacking alignment to the participants' sense of what it means to care for an older person, like navigating traffic and long lines on holidays to do shopping rather than shifting that task to a digital shopping service.[58] On the other side were actions not labeled as participants' work, but integral to their own care ethics, which entails negotiating the intersection of various goods in the moment.[59] These experiences of doing the "little extra" or being an "invisible fixer" are shared with RNs.[35,60] While these negotiations of either kind may not be seen as directly harmful, they can entail ethical or existential dilemmas potentially affecting the NAs well-being.[61] This finding is consistent with experiences of interprofessional teams balancing between rationalized and relational care.[62] By meeting the client's needs, NAs as well as other professionals, can be covering for what the care organization will not deliver,[9] or take responsibility for. Such actions have been suggested to be a source of burden in their work.[63]

Recent studies addressing homecare have highlighted the unrecognized work in coordination and organizing of care,[41,42] or as discussed in this study as simultaneous mind puzzles. In both settings, the intensification of work has led to multi-tasking such that the relational aspects needed may be occurring while performing another task on "autopilot" such as meal prep.[64,65] There are likely multiple forms of invisible labor layered in work among NAs. Coordinated care for older persons requires skills "in making decisions and judgements, sizing up prospects, and knowing how to influence and persuade – all these remain invisible!"[66] These are skills needed for interpersonal relationships, valued among those in executive leadership, but taken for granted by those acting in domestic, volunteer and often caring capacities, and falling "outside of bureaucratic rules and obligations".[66] The invisible labor of coordinating and organizing care may also be relevant to explore in future studies how it manifests in multiprofessional settings and in collaboration. Transformation of NAs' work in the future, towards sustainability, will need to allow for care that is accountable to the invisible and relational work of caring for equal, yet unique, individuals.

Limitations

In-person focus groups might provide richer discussions, while online can facilitate equitable distribution provided that there are no technological barriers to participation.[67] This was considered in the analysis; however, similarities across narratives were found in these groups. The study was conducted with staff from an urban area, having decades of experience and therefore their experiences are not representative of other regions or new recruits. It is possible that informant participation was biased by the role that managers had as gatekeepers, either as compelled or in limiting views,

eg, participants had many years of work experience while newer or younger professionals may have differing experiences that were not included. However, based on the rich experiences in the group, the results mirror a breadth within the local context. This study explored care practices through active discussion and no problems were identified, further studies into care practices using observational methods can be recommended.

Conclusion

This study highlights understandings of care in the work of NAs. Without recognition and value of the variety of dimensions of care in NAs' work, the challenges of retention, sick leave and burnout are unlikely to be addressed. Time and agency are necessary to enhance the dynamic care "puzzling" activities within the work, which are essential for coordinated continuative care that builds from a relational practice. Organizations and policymakers can utilize the findings and visual summary to reflect upon the consequences of a rationalized approach to care, when care is understood and enacted relationally in practice. Further research is needed with NAs to learn how the puzzling activities of NAs are practiced in coordination with older persons, as well as multidisciplinary peers. Through a better understanding of the nature and meaning of work for NAs, supportive efforts for health and work sustainability for NAs can be explored.

Abbreviations

NA(s), nursing assistant(s); RN(s), Registered Nurse(s).

Data Sharing Statement

Due to participant confidentiality, original audio and transcripts of focus group discussions are not publicly available.

Acknowledgments

The authors wish to thank the participants for sharing work experiences, colleagues at the Division of Occupational Therapy for input into the manuscript, and Karin Johansson and Simone Felding for their feedback on an early draft.

Author Contributions

First author is a doctoral student at the division of occupational therapy, as well as a certified medical illustrator with a master's degree, as well as a masters in global health. Second, fourth and last author are occupational therapists with doctoral degrees, while the third author is a nurse with a doctoral degree.

Disclosure

The authors report no conflicts of interest in this work. Funding for this study was provided by Karolinska Institutet internal funds.

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