Like a Social Breath: Homecare's Contributions to Social Inclusion and Connectedness of Older Adults

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Abstract

The detrimental effects of social isolation on health and well-being bring forward the need for increasing social inclusion and connectedness for older, homebound adults. Homecare services may be a source of social inclusion, but the inclusive dimensions and mechanisms of care have been less explored. This study aimed to develop more knowledge on how homecare can contribute to social inclusion by exploring older adults' experiences with care visits as social encounters. The study utilised interviews with older adults from four municipalities in Norway and Denmark from 2018 to 2019 and drew on a combination of social inclusion theories and Goffmanian microinteractionism. Positive accounts of care encounters comprised three overlapping thematic dimensions: 1) bringing social life into the house, 2) creating connections to the outside world and 3) providing opportunities to participate in a broader array of social roles and identities. Despite variations, care visits could encompass social inclusive and connective aspects that enhanced thriving and wellbeing. Care visits increased opportunities for social participation and support of a valued self and comprised bonding, bridging and linking social capital. Care workers could be important interpersonal network resources at home, providing support and social stimulation, engagement and fun. Moreover, they could bridge to the outside society through conversations or by linking to services (e.g. day centres) that increased social participation and bonding with peers outside the house. The inclusive resources embedded in homecare need to be supported and utilised in policy and practice to increase older people's inclusion.

Keywords: Care work; older adults; homecare services; day centre; social inclusion; social capital; social connectedness; Goffmanian microinteractionism

Introduction

Over the last decades, focus on the need to increase the social inclusion and connectedness of older adults and to develop new policies and innovations that reduce the negative impacts of social isolation has increased (Kaye & Singer, 2018; Morgan et al., 2019; Warburton et al., 2017). Older adults (especially those in the fourth age) are at a greater risk of social isolation and disconnectedness (Galiana & Haseltine, 2019; Herron et al., 2020; Macleod et al., 2019; Nicholson, 2012; Warburton et al., 2017). As people age, many experience increasing barriers to meaningful social participation and inclusion within their environments, potentially due to

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frailty, impairments or social losses. These challenges limit their geographical space and shrink their social circles, making them more dependent on their immediate surroundings and family or community support for social inclusion. Loss of and dismissal of previous social roles and identities can also deteriorate a sense of valued social self, as they are reduced to being merely 'care recipients' or 'old' (Burns et al., 2012; Herron et al., 2020). Older adults do not necessarily need to perceive shrinking social networks and 'aloneness' in a negative way. Nevertheless, objective social isolation has been shown to have detrimental effects on their health and well-being and to increase their mortality (Annear et al., 2017; Emlet & Moceri, 2012; Galiana & Haseltine, 2019; O'Rourke & Sidani, 2017). Therefore, reducing social isolation and increasing inclusion and (re)connectedness with others and the wider society are warranted.

Social inclusion is often defined as the opportunity to participate in the key functions or activities of society (Pinkert et al., 2021). Social participation and social engagement (i.e., the extent to which individuals participate in a broad array of social roles, relationships and activities) have been shown to be important for fostering social citizenship, feelings of belonging, personal growth and wellbeing. Subsequently, one way to increase inclusion for older adults is to provide new sources of fulfilment and opportunities for social participation (Dahlberg, 2020; de São José et al., 2016; Emlet & Moceri, 2012; Herron et al., 2020; Lee et al., 2020). Another approach is to increase access to social capital and utilise these resources in the most optimal way (Briggs & Harris, 2017; Nyqvist & Forsman, 2015). Social networks and the social environment are key elements in the social capital of older adults. Thus, many have underlined the need to investigate various resources in older people's neighbourhoods and communities (Nyqvist & Forsman, 2015). Homecare services as such are possible daily resource. Care workers are in the front-line position in these people's homes, which allows them to recognise the people's social life situations and to serve as key social contacts (Barrett et al., 2012; Nicholson, 2012). However, prevailing research from institutional and community care settings shows that experiences of formal caregiving and relationships with staff are complex and can be experienced as exclusive or inclusive. Staff that voice more family-like feelings towards residents build more positive relationships that increase the residents' sense of inclusiveness (Ferguson, 2021). Although family usually represents a stronger network, older adults may also experience staff and peer networks (even with strangers) as ways to reciprocate emotional support and a sense of social connectedness (Torres, 2019). Research also finds that older adults actively use social interactions with others to build social connectiveness (Morgan et al., 2019). Nevertheless, how older adults use their support networks and stronger (family and friends) or weaker (staff) ties to gain support and improve their social connectedness remains unclear (Ferguson, 2021).

Although a considerable body of literature has addressed the relational qualities of care or social capital at the community level, research focusing explicitly on inclusive dimensions of homecare is scarce. This finding resonates with research that brings forward the need for more detailed knowledge of the mechanisms and the meaning of the concept of inclusion in health and care settings (Briggs & Harris, 2017; Cardol et al., 2021). This includes a need for more knowledge of how professionals in long-term care can address inclusion and contribute to more inclusive policies and practices.

One way to gain a deeper understanding of inclusive aspects of homecare is to explore if and how visits from care workers and the social interactional processes that may unfold in the daily encounters can comprise social participation opportunities and social capital that can contribute to old-age inclusion. This study aims to add knowledge to this subject by scrutinising inclusive aspects of care visits as social encounters based on interviews with older adults from four municipalities in Norway and Denmark. Noteworthy, the study does not aim to provide a full or representative picture of homecare practices, care relations or experiences of care visits. Rather, it focuses on explicating constitute inclusive and connective dimensions of homecare that can have the potential to positively impact older adults' health and wellbeing and to inform

and improve inclusive policies and professional practices.

Study context

In Norway and Denmark, homecare is mostly public, and municipal homecare is arranged through the local council or private agencies. Denmark and Norway have many similarities but differ in the organisation and specialisation of care work. For example, Norwegian nurses more often take part in practical care work, while Danish nurses are more specialised towards medical tasks. In Denmark, practical home help and personal care are also more combined as "social care work". However, these differences are not sufficient enough to render the countries incomparable for this study concerning social inclusion qualities of home care. For this study, the services delivered at home included practical home help, personal care and health services, such as nursing and reablement. The personnel mainly included nurses, licenced practical nurses, healthcare assistants and physical/occupational therapists. Herein, they are broadly referred to as 'care workers', given that all these occupational groups may contribute to inclusive and connective care.

Like national trends (Drange & Vabø, 2021), the staff situation was characterised by shift work scheduling and part-time employment with high staff turnover. In all municipalities, homecare was characterised by short visits. The frequency of care visits to users varied substantially from, for example, every fortnight or once a week to six times a day. The frequency was mainly based on assessments of practical care needs and partly on (short-term) psychosocial support, such as safety visits and co-eating. Daily care visits typically lasted from 5 to 20 minutes but could last 45 minutes or longer in rare cases. The number of visits for each care worker during a shift varied from 8–28, depending on the time of day, caring tasks and staff situation. These contextual and organisational aspects of care were reflected in the older adults' experiences given below.

Theoretical perspectives

The study drew on common theories of social inclusion in terms of overlapping and interrelated concepts, such as social participation, social networks, a valued self and social capital (Briggs & Harris, 2017), combined with Goffmanian micro-interactionism. This was used to identify inclusive elements and to increase understanding of inclusive processes on the micro level while expanding the traditional focus on dyadic care relationships by incorporating inclusive processes on the meso and macro levels.

For this paper, social capital is understood as norms which includes social trust that refers to the values and the quality of human interaction, and networks that reflect the many social relationships that people maintain and from which they gain needed resources, support, feedback and guidance (Nyqvist et al., 2013; Putnam, 2000). Social capital includes structural (institution/networks) and cognitive elements (interpersonal or sense of belonging). It operates at the interpersonal level (micro), at the neighbourhood or community levels (meso) and at the governmental and institutional levels (macro). Social capital can support old-age inclusion through three main dimensions: 'bonding' (intra-group ties between individuals sharing common characteristics, such as age), 'bridging' (ties between heterogeneous groups) and 'linking' (relations between people of unequal wealth, power and status).

Goffmanian micro-interactionism focuses on social interaction in everyday, face-to-face encounters, as well as on the importance of social interaction and embeddedness for human life in general and the production and maintenance of social self and identities (Goffman, 1961, 1981, 1982). Furthermore, Goffman's (1961) concept of social encounter offers insight into how care visits may constitute socially dynamic and interactional processes that influence

social participation and belonging. Ritual aspects of interactions can generate encounters that are saturated with meaning and loaded with energy (Collins, 2014; Goffman, 1982, 1983). Another important contribution is that inclusive processes can occur in diverse 'social situations' (i.e. a situational perspective). Care encounters comprise several micro-level social situations that may have a wider social impact. While recognising the importance of close relationships, interactionism also shows that a 'close' or long-lasting care relationship is not presumed for the work to be inclusive. Moreover, the interactionist perspective highlights the importance of actions and practices. Inspired by this perspective, this study searched for aspects in the interactions during care encounters and care practices that facilitated a sense of inclusiveness and nourished worthy identities.

Methodology

This study was part of a research project called 'Context' supported by the Research Council of Norway. The project was based on a layered case study design (Quinn Patton, 2002), which provided several possible focal points of analysis and was inspired by rapid multi-site ethnography (Armstrong & Lowndes, 2018). Intensive fieldwork was conducted in four urban and rural municipalities in Norway and Denmark over one week each from 2018–2019 by a collaborative team of ten researchers with multi-disciplinary backgrounds from both countries. Data from the project were published in various papers but not stored in open archives because of the project's qualitative and confidential nature.

Ethics and Consent

The study was conducted in accordance with the Helsinki Declaration, and informed oral and written consent was obtained. Ethics approval was granted by the National Data Protection Official for Research (NSD, 18 September 2018, ref. number 128713). Furthermore, anonymity was preserved in the text. All names are fictitious.

Sample, recruitment and data collection

The sample criteria for the cases were size, rural/urban dimensions and organisational traits. The participants were recruited by staff on behalf of the researchers and were mostly older users of homecare services and/or home rehabilitation/reablement or day centre services. Given their vulnerable situation, they were informed orally and written that participation is voluntary, and that non- participation will not lead to any negative consequences for receiving care. The researchers were also sensitive to non-verbal signals and chose to withdraw if the older adult seemed reluctant when visiting.

This study utilised transcripts from 42 semi-structured interviews from all three services conducted by the research team, which contained the older adults' descriptions of their experiences with care visits at home. The interviews included individual interviews (N = 29), interviews paired with spouse/one daughter (N = 7) and group interviews (N = 6), including a total of 57 older adults. Most group interviews were conducted at the day centre. The distribution of interviews across cases and services is shown in Table 1. Twenty men and 37 women participated in the interviews, and most were between 70 and 100 years old and had diverse health issues and care/rehabilitation needs. The participants received care visits from one to six times per day to once per week, over a short period (e.g. weeks) to many years.

Table 1. Distribution of interviews across cases and services.

Country/Case	Homecare*	Home reablement /rehabilitation	Day centre
1 Norway (small city)	5	4	4
2 Denmark (rural)	3	4	3
3 Denmark (city)	10	1	1
4 Norway (city)	2	3	2
Total:	**20**	**12**	**10**

*Nursing, medical and practical support

The interviews varied from 30 minutes to one hour in duration and were recorded and transcribed verbatim. The main interview questions included the adults' life situations, use of home care services, experiences with those services and possibilities for influencing the kind of services they received. Questions about their use of other health and community services and their social networks and contact with others were also included.

In addition, the analysis was drawn on the first author's informal interviews with older adults during 81 homecare visits over a period of in total four weeks, based on one week of participant observation in each of the four municipalities. The researcher participated in staff meetings and interviews with care workers and followed in total six nurses and five licenced practical nurses/ healthcare assistants for around five to six hours during their shift including home care visits. The researcher observed the social interactions during the visit and conducted informal interviews with the care worker and older adult (sometimes also next-of-kin). During the visit, the older adult often commented on how they experienced the care visits. These conversions thus added valuable insights to their views and experiences. In addition, some of them participated in formal in-depth interviews. The second author supplied relevant data from informal interviews during additional home visits, and especially from day centres. Detailed fieldnotes of the social interactions and conversations were written between visits and in the end of the day.

Data analysis

The data analysis was directed towards making the often implicit inclusive dimensions of homecare work more explicit. The interview data and fieldnotes were analysed via thematic analysis (Braun & Clarke, 2021), which focused on the inclusive aspects of care visits by moving between empirical data concerning the older adults' experiences and theoretical perspectives on social interaction and inclusion.

In practice, all interviews were read first to obtain an overall impression of the variations and complexities of care encounter experiences. The transcripts were then coded into eight categories in NVivo by the first author. These categories were developed by the research team to identify important aspects of their experiences. To grasp the context and social meaning of the care visits, we first explored categories related to the life context of the older adults, social networks and social inclusion in later life. Thereafter, the adults' experiences with care visits were further scrutinised by drawing on 'systematic meaning condensation' (Malterud, 2012), which included the following steps. First, interview data from the eight relevant categories were

subjected to systematic meaning condensations. Then, matrices for systematic comparison were set up and transformed into broader categories of respondents' accounts of care visits. Lastly, the data were analysed through theory and previous research, generating the identified thematic dimensions presented in the Findings section. Contrasting exclusive, intruding or indifferent experiences of care encounters were used as an analytic strategy to explicate significant contextual or interactional aspects of the encounters. The quotes came from men and women from all cases and were chosen based on their ability to increase understanding of inclusive dimensions and not representativeness.

Findings

The interviews display a broad span of social life contexts amongst older adults, from social participation to isolation. Many participants spoke about a shrinking social life due to reduced mobility, weakened social networks or busy family members. Their broader life contexts were important to how they experienced and utilised the social interactions during the care encounters.

The overall findings confirm previous research displaying diverse and mixed experiences of care visits. Dissatisfaction was often related to hasty and instrumentally oriented visits, high staff turnover and low professional or language skills. This could induce a sense of non-responsive relationships, de-humanisation, alienation and, subsequently, social exclusion. The positive experiences with care visits as social encounters represented three partly overlapping thematic dimensions: 1) bringing social life into the house, 2) creating connections to the outside world and 3) creating opportunities for participating in a broader array of social roles. Each is elaborated on below.

Bringing social life into the house

One important inclusive aspect of the care visits was that they brought social life and energy into the older adults' homes. This contribution was especially important for the most isolated and disconnected older adults. However, care visits also generally contributed to thriving in daily life. The short visits were, for example, described as a pleasant breath in their daily life: 'Oh yes, it is so nice, it feels so nice to get such a breath'.

Care visits could reduce the participants' sense of loneliness and social liminality at home: 'Otherwise, it would have been—especially during the wintertime—very lonesome if nobody came [to the house]. My nieces and their husbands are working, you know, and my sister is so old that I don't expect her to come [visit me].' For some of the most isolated older adults, the care encounters were pivotal for their sense of social belonging: 'Yes, it is very nice that they come, then I have someone to talk with (...) If nobody had come, I would just be totally alone.' Regular care visits could also encompass a predictable opportunity for social contact and interaction during the day. For example, care visits that occur four times a day could be important for reducing a sense of social isolation and creating safety:

> Interviewer: 'Socially, is it of any help that they pop by?'
> 'Elsa': 'Surely, and I am looking at my watch to see if they will be here soon.'

The possibility of social contact in an isolated social situation could be so important that they were willing to forego ordinary daily rituals:

> Someone says, "Don't you find it as hopeless that they are coming when you are eating your breakfast?" No, that doesn't mind me at all. Because, for the most time being, you are just sitting here, alone.

The positive social energy conveyed by the care workers' demeanours was often described as being 'nice', even if they were busy. For example, by the way they introduced the encounter; 'They are coming in and shining.' Through such introducing rituals (Goffman, 1982), the care workers often contributed to a joyful atmosphere in the house and provided social situations that increased well-being: 'They are sweet people and good persons. And I also think they are good at keeping a cheerful spirit.'

Some participants also described interactions during the care encounters that seemed to hold a greater symbolic meaning of inclusiveness. These situations occurred in different ways but were often characterised by receiving or contributing something extra—that is, the care workers transcended routine-based care interactions. For example, they provided more time than usual: 'It is especially one, she uses time even if she doesn't have time, as she says.' Inclusive situations could also occur through extra personal care or attentiveness to their needs and well-being:

> She washes my hair when she showers me, so I am very pleased when she gets the showering. Because, then she rolls up my hair, and I look so good at my hair. (…) Yes, the little extra. And she is very clever, and she notices things and remembers things. And she understands what I need. It was she who started with these cups of instant soup that she puts here [on the table]. Yes, she is so very kind.

Another important contribution of care visits was enabling meaningful and enjoyable social engagement with others. Many of the participants missed opportunities they had experienced in earlier parts of life to socialise with others during the day. Rewarding care encounters were thus often related to opportunities for 'talking' with the care workers. The care workers' ability to socialise was thus crucial: 'Well, they are talking. That is why I think they are so clever. Whom helps you with the stocking, that can be unimportant. But it's nice when it is persons that you can talk with.'

The older adults also related positive experiences with care visits to the 'fun-making' part of the care encounter: 'Yes, and then they are here for a while and talk with me and joke.' Joking and 'playing games' with care workers during the encounter were thus important sources of joy and amusement, and these encounters were also used by the participants as a means of social stimulation. In line with Goffman's (1961) description of human interaction in general, playful care encounters could provide possibilities for social agency and engagement in reciprocal interactions that contributed to a sense of connectedness and thriving. As described by one older, nearly blind lady:

> Yes, they mean a lot to me. And, then there are so many of them, and I must try to remember all their names. But I do have some fun with them also because I can joke with them, and we are kidding and fooling around, and laughing. And sometimes somebody tries to fool me and say, 'Who do you think is coming this time?' And then I must guess, because I need to recognise the voice, and then I must see the silhouette of them to be able to guess who is coming.

The use of humour could also enhance the participants' sense of valued self and positive energy in disabled situations that felt humiliating. Although the participants' recognised the care workers' professional (or instrumental) use of humour, it was still appreciated. This was illustrated by a physiotherapist session in a participant's home:

> The eldest, faithful [care workers], they do a huge piece of work. We are talking football and joke, and then she is suddenly finished, and say goodbye (…) We are

> joking, kidding, and laughing. It seems to me that many times she does it on purpose to increase my 'guts', so to speak. So, there are some of these [care workers], and they deserve praise.

Creating connections to the outside social world

Another positive experience of care visits related to social inclusion was that the encounters created connections to the outside world and provided opportunities for participation in social life outside the house. As mentioned, many of the participants experienced social isolation and confinement in the house because of their physical inability to move around freely. They enjoyed partaking in social life but were dependent on assistance to get outside the house. Care visits could therefore support inclusion in situations where care workers contributed opportunities for social participation and the development of new social relationships in arenas outside the house. This could, for example, be when the care workers enabled social participation in the local community by assisting the participants' in doing practical tasks and social activities, such as going to the shopping centre or getting dressed for the day centre.

Several participants also described the importance of how the care workers had recognised their sense of loneliness after the death of a spouse during their care visits and assisted the participants in receiving day centre services:

> When my husband died, it was so sad sitting home alone. So, the homecare services asked several times if I would like to start going to the day care centre. And this is something I don't regret. I am here every Thursday, and we are having such a good time. […] I am so happy that I said yes. […] It was the nurse who asked […] and got me out here. (…) I am so much alone day and night. Alone all the time, then I must get out and see people.

Furthermore, older adults could experience the care encounters as socially stimulating because they enhanced their sense of belonging to society and being part of the outside social world:

> I find it a bit fun to learn more about how long they have come [in their studies], and now they have started to talk about things. And that is nice for me, of course. I think they are very open and nice. I often ask them, and they allow me to learn a bit about their family, the kids, and I really appreciate talking with them about it. (…) I think it is just a bit fun, and I don't mind that there are many different who are coming. It gives a bit variation.

Likewise, encounters with migrant care workers could be experienced as socially stimulating because the workers served as social connectors to the outside global world.

> I have had much help and benefits [from the care visits] just socially seen. It is exciting each day, to talk with them [migrant care workers]. Someone to talk with, and to learn more about other people's life and how they are.

Social interactions with the care workers during the encounters could also enable opportunities to (re)connect to their local community and previous life contexts.

> Like [name of the care worker], who was here yesterday evening. Then, I had a visit from my brother and sister-in-law. And then she said in the hallway, 'I know him' [the brother], she said. […] And then it turned out that she had a son who was working there [in his shop] as a summer temp. So, she knew them.

These small mutual connections between the care workers and the participants' social life

could enhance a sense of reciprocal relationships and social belonging.

The connective contributions were often supplied through the meaning making that the older adults ascribed to the encounter with the various care workers, especially in smaller communities.

> I have been doing genealogy, so when they come and say that their name is this and this. Then, who is the father, who is the grandfather? Then it is their grandfather whom I very often know, and then I can place them, where they are coming from. (…) Yes, it is a bit amusing. And the worst thing is that when they have left, I start thinking about it. Who was that family really? Where did they live? (…) And then my brain starts working.

Creating opportunities for participating in a broader array of social roles

As previously described, old-age exclusion is often characterised by the loss of previous social roles and identities, which deteriorates social identity. Positive care encounters were therefore often characterised by social situations in which care workers created opportunities to engage in more contributory roles. This allowed the older adults to take on former social roles and live out a broader spectrum of roles and identities that supported their sense of being an ordinary, active and valued social persons. This came to light in two kinds of situations.

First, as touched upon earlier, the older adults appreciated situations in which the care workers broke out of routine-based care and provided opportunities for partaking in their private lives. Such social situations provided the participants with more access to ordinary social life and human fellowship than they otherwise had:

> Mathilda: There is one [care worker]. He is 28 years old. It is very nice that we have developed a very familiar relationship. Because he is a partner, and now they are expecting a baby. And I have been informed about that. And he has promised me that I can hold the baby. It is a girl expected to be born on the second of May. And just to get that kind of relationship to a man, in that way. Genuinely good. […]

The care worker's act of invitation into his life ('holding the baby') could thus support a sense of being 'somebody' in other people's life and create a sense of 'togetherness' that provided a bridge to the wider social world that supported self-worth (Goffman, 1982).

Second, the participants described positive care situations in which they contributed as an 'expert' or 'supervisor', for example, for young students who asked for their advice. Such care situations reconnected the participants to previous social roles and competencies with higher social status and could reenergise 'lost' social identities. As described by a former teacher, Karen, 'Then [when advising the care workers], I feel like a teacher [again].' Likewise, inexperienced care workers who expressed openness and interest in learning from the older adult could support a sense of competency by acknowledging and using the participants' expertise in practical care situations: 'I like very much the young girls coming because they appreciate my information and how to do that and that, let me teach you, see?'

Discussion

This study aimed to gain more knowledge on if and how homecare can contribute to reducing isolation and increasing the social inclusion and connectedness of older, homebound adults by exploring their experiences with care visits. Despite variations in care visits, the study found that care encounters can comprise social interactional processes and social situations that contribute to structural and cognitive social inclusion and connectedness. These findings

resonate with previous research but add further details and understanding of the inclusive aspects of homecare. In addition, it indicates a broader inclusive impact of care visits than dyadic relationships.

The study showed that one important inclusive contribution of care visits was enhancing opportunities for social participation at home. The care visits could also have a wider inclusive impact by providing social participation opportunities outside the house and strengthening connectedness to the community, the wider society and biographical life context. Second, interactions with care workers could support a valued social identity by creating opportunities to participate in a broader array of contributory social roles (Emlet & Moceri, 2012; Morgan et al., 2019). Like previous research, inclusive and valued relationships occurred when the care workers had a sharing, open and tuned in way of interacting with the older adult and when they engaged in more equal partnership roles. For example, by inviting them into their private life or by expressing belief in the older adult's skills and knowledge and allowing them to have an educational and supervisory role (Cardol et al., 2021).

Another overlapping contribution (Briggs & Harris, 2017) was that care encounters can encompass social capital resources that support inclusion and connectedness. First, care encounters comprise social capital on an interpersonal level in terms of trusting relationships and by being or supporting social networks that enhance opportunities for social engagement with others, and social and practical support. Inclusive care relations occur when care workers provide opportunities to partake in meaningful, reciprocal and constructive relationships with others and when they feel connected to the outside world (Ashida & Heaney, 2008; de São José et al., 2016; Morgan et al., 2019; O'Rourke & Sidani, 2017). As in previous research, reciprocal relationships support a sense of being acknowledged and valued. These relations with care workers can reduce social alienation for the most marginalised and vulnerable individuals by sustaining a feeling of being socially 'anchored' (Skatvedt, 2017). Nevertheless, practical, routine-based care tasks can also include socially significant situations with connective and confirming symbolic meaning. Moreover, although 'talk' is an important element in inclusive interactions (e.g. Barrett et al., 2012; Skatvedt, 2017), this study displayed the importance of humour, playing games and having fun for social participation and sense of connectedness (Dobbins et al., 2020; Goffman, 1961). Situations with fun and joking created inclusiveness through a sense of human 'togetherness'. Such situations also created positive emotional energy ('a social breath') that increased the connectedness and thriving of the participants, even within the limitation of short care visits.

As mentioned, care encounters can also comprise bonding and bridging capital on the meso level to the neighbourhood and wider society and include the element of linking capital by connecting homebound adults to services and institutions. This linking could reduce the isolated older adults' sense of powerlessness by enabling opportunities for participation in new social arenas (e.g. day centres) and creating new ties with peers that they could not do on their own (Briggs & Harris, 2017). Care workers can thus play an important inclusive role by serving as a 'social mediator' or 'connector' across space and place and by bridging the inner social world of the house and that of the outside world through their regular visits (Morgan et al., 2019; Nicholson, 2012).

Inclusive aspects of care were related not only to the care workers' actions, but also to the connective 'work' of the older adults and to the symbolic meaning they attached to the care encounter. The study showed that older adults actively attributed social meaning to the care visits and 'used' the social interaction during the encounter to create connectedness to previous life contexts (both other people and the broader world). They used the care visits as a means for stimulation by engaging in 'connection games', in which the care workers' response supported these life-giving actions. Through this interactional work, the older adults' increased participation 'beyond spaces' despite a shrinking social world (Annear et al., 2017;

de São José et al., 2016; Morgan et al., 2019; Wiles et al., 2009).

Finally, a surprising finding in this study was the inclusive value of short and hasty care visits for thriving and well-being. The positive significance of even short-care visits can be understood in light of social poverty and the shrinking social worlds of many older adults. Older adults can live a substantial part of the day alone in a socially 'empty' house, despite family networks because the family members may be busy or live further away. This isolation weakens their connections to others and the outside world and reduces the possibility of a sense of social belonging. In such contexts, short visits count 'as very much more than nothing'. The social significance of short visits can also be understood in light of Collin's (2014) concept of the interaction ritual chain, where each care visit can add to the others, thereby constituting 'a chain' that provides emotional energy and reinforces the socially rewarding impact of recurrent care visits during a day. The chain of care visits can also provide a sense of safety for having opportunities for social contact and give older adults a sense of belonging to a shared reality with other people. Care workers can thereby be an important social network resource in daily life despite 'weaker' ties.

Conclusions

This study shows that homecare visits can contribute to increasing social inclusion and connectedness for older, homebound adults by increasing their social participation opportunities, supporting a valued self and self-connective work, and providing access to bonding, bridging and linking social capital. Even short visits can make a huge difference to older adults' social life and wellbeing.

The findings emphasise the need to understand inclusive care from a broader perspective than interpersonal relationships. The political and organisational support for performing inclusive and connective homecare also needs to be strengthened and prioritised for the most disconnected and homebound older adults, as inclusive care boosts older adults' social lives. Increased utilisation requires that homecare services recognise these embedded inclusive capital resources in care encounters, acknowledge the value of inclusive aspects of care and extend their tasks to social participation. Inclusive tasks should also become an active part of care plans. Moreover, a more explicit conceptual framework, policy and knowledge base for inclusive homecare should be developed, and collaboration across services and sectors should be increased to reduce social isolation and promote social wellbeing. Public health policies for older adults that focus on increasing social inclusion must be translated even more into and integrated with care policies and social care.

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Author Contributions

Two authors were involved in data collection in home care services (RN) and day care centres (CS). They participated in the conceptualisation of the study, analysis of the data and editing of the manuscript. The first author (RN) was mainly responsible for data analysis and writing, and the other authors participated in drafting the manuscript. The third author (AS) participated in the theoretical analysis and writings in the later stage of the process based on her expertise in the field.

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