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Voices of Patients Receiving Home Care and Their Families: A Qualitative Analysis of Their Needs and Expectations

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Abstract

Background/Objectives: Specialist oncology home care can ease hospital attendance for people with cancer, yet patients and families may continue to face substantial practical and supportive care needs. This study explored the needs, expectations, and experiences of this population in Jordan. **Methods**: A qualitative descriptive study used semi-structured interviews with patients receiving specialist oncology home care and their family caregivers. The final analytic sample included 29 participants: 15 patients and 14 family caregivers. All 29 completed interviews were analyzed. Researchers transcribed and analyzed the interviews, developing two analytic categories, eight themes, and 37 subthemes. **Results**: Participants valued clinical expertise, caregiver education, compassionate relationships, continuity, and responsive home visits. However, hospital-dependent appointments, medication-related concerns, transportation and physical-transfer difficulties, and the demands of family caregiving persisted. Participants also described gaps in rehabilitation and equipment support. The analytic categories encompassed systemic barriers and the strengths and perceived impacts of care. Patients emphasized mobility, independence, and meaningful activities outside the home; caregivers sought reliable guidance, practical assistance, and confidence in continuing professional support. Families who valued professional support also described uncertainty about its future continuity. Repeated hospital visits often depended on family members' capacity to organize transport and provide physical assistance. **Conclusions**: Specialist oncology home care offered valued clinical and emotional support but did not fully resolve needs that extend beyond individual home visits. Care planning may benefit from greater attention to patient-defined functional goals, caregiver capacity, medication experiences, and coordination between hospital and home services.

Keywords: home health care; oncology nursing; patient experiences; family caregivers; supportive care needs; community-based care; qualitative research; Jordan

Check for updates

Academic Editor: Felicity Hasson

Received: 11 October 2026
Revised: 12 November 2026
Accepted: 17 November 2026
Published: 27 November 2026

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1. Introduction

Advanced cancer can create substantial and interconnected demands for patients and the relatives who support them. Alongside distressing symptoms and limitations in physical functioning, families often need to organize treatment-related travel, repeated hospital attendance, and assistance with everyday activities. For a person who cannot walk independently, reaching a clinic may involve transfers between bed, chair, and vehicle, negotiating stairs, and coordinating the availability of another family member. These circumstances

are not peripheral to cancer care: they shape whether necessary services can be reached and how burdensome treatment becomes. Reviews of supportive care needs among people with advanced cancer and their informal caregivers describe overlapping physical, psychological, informational, and health-service concerns that cannot be understood adequately in isolation [1,2].

Specialist oncology home care offers a means of delivering selected clinical interventions, assessment, education, and supportive contact in the setting where many of these difficulties occur. Its functions may overlap with supportive and palliative care, although enrollment in home care does not itself imply that a patient is approaching the end of life. Current oncology guidance recommends integrating interdisciplinary palliative care with active cancer treatment and attending to the needs of family caregivers [3]. Similarly, effective symptom management requires consideration of the consequences of symptoms for daily functioning and well-being [4]. Evaluating home care therefore requires attention not only to whether treatment is delivered but also to the practical and personal outcomes that patients and families consider meaningful.

The household context complicates conventional distinctions between clinical care and daily life. Home visits may spare a patient a physically difficult journey and reduce the preparatory work required of relatives; nevertheless, diagnostic investigations, medication collection, admissions, or specialist consultations may continue to depend on hospital-based systems. Support received within the home may also coexist with a desire to leave the home for social contact, shopping, or other ordinary activities. Conversely, an apparently routine hospital appointment can impose considerable physical and emotional demands on the person providing care. Patient experience, caregiver experience, and service accessibility are therefore closely connected, but they should not be treated as interchangeable perspectives or outcomes.

Existing qualitative evidence highlights the importance of interpersonal and organizational aspects of home-based care. Patients and families receiving specialist palliative home care have linked security and continuity to the accessibility of professionals, responsiveness to changing needs, and familiarity with their circumstances [5]. A recent qualitative meta-synthesis similarly identifies trusting relationships and the ability to sustain everyday life as important elements of person-centred palliative home care, although its evidence base is drawn predominantly from high-income settings [6]. Studies addressing transitions between hospital and home further emphasize communication, caregiver preparation, resource availability, and clear professional responsibilities [7,8]. These findings suggest that the perceived value of home care may depend as much on continuity across services as on the care provided during visits.

Family caregivers occupy a particularly important position within this continuity. They may administer or organize medications, monitor symptoms, accompany patients, and coordinate contact with professionals. Being included in clinical conversations can provide knowledge and reassurance, yet practical competence does not necessarily mean that a caregiver has the physical strength, time, or additional assistance needed to undertake every task. Similarly, perceived emotional support from a professional team may be accompanied by uncertainty about how long that support will remain available. Understanding family involvement thus requires consideration of both the benefits of partnership and the limitations of caregiving capacity. Assessments focused exclusively on the patient's clinical condition or on overall service satisfaction may overlook these dimensions [2,9].

The Jordanian context adds relevance to examining these interdependent needs. Studies involving cancer survivors in Jordan have identified unmet informational, practical, financial, and follow-up needs, including differences in reported supportive care needs across national settings [10,11]. Regional qualitative research with people affected by ad-

vanced cancer has also described the significance of information, family support, daily priorities, and involvement in decisions [12]. Specialist palliative care provision has been described within Jordanian oncology services [13]. Nevertheless, evidence about unmet needs in cancer populations does not, by itself, show how patients and caregivers experience an established specialist home care service or which demands persist despite access to home visits.

A more specific understanding of these experiences is needed to distinguish valued features of home care from needs that lie beyond the scope of individual encounters. Patient-reported and caregiver-reported accounts can illuminate how practical barriers, professional relationships, and aspirations for independence intersect in everyday care, including concerns that may not be evident from service activity or a single satisfaction measure [9]. Examining supportive experiences alongside difficulties can also avoid the misleading assumption that appreciation of professional care signifies the absence of unmet need. Accordingly, this qualitative descriptive study aimed to explore the needs, expectations, and experiences of patients with cancer and their family caregivers receiving specialist oncology home care in Jordan, with particular attention to perceived strengths of care, continuing challenges, and priorities for improvement.

2. Materials and Methods

2.1. Study Design and Reporting Approach

This study used a qualitative descriptive design with semi-structured interviews of patients and family caregivers, suited to describing participants' experiences in language close to that used in their accounts [14]. The research team conducted the original qualitative analysis of the interview transcripts and documented its findings in a matrix of themes, subthemes, descriptions, and attributed quotations. The matrix was therefore an output of the completed analysis, rather than a substitute for analysis of the interviews. The study protocol, bilingual interview guides, thematic matrix, and participant register informed the presentation of the findings in this manuscript. Reporting was informed by SRQR and COREQ [15,16].

2.2. Setting, Eligibility, and Recruitment

The study was conducted within a specialist oncology home care service in Jordan, with participants residing in Amman, Zarqa, Irbid, Mafraq, and Salt. The service was primarily nurse-led, with multidisciplinary support from physicians for pain management, physiotherapists, and social workers, provided through home visits or consultations according to patients' needs. Nursing services included symptom assessment and management, administration of prescribed medications, wound and pressure injury care, patient and caregiver education, and clinical monitoring and follow-up. Home visits were typically scheduled once weekly, with additional visits arranged according to clinical needs and individualized care plans. Under the IRB-approved study protocol, eligible patients were adults aged 18 years or older with advanced cancer receiving home care who were able to describe their experiences and provide informed consent; eligible family caregivers were adults who provided more than half of the patient's care. Advanced cancer was operationally defined as metastatic, recurrent, or progressive disease documented in the medical record and assessed by the treating physician as advanced; no single numerical stage threshold was applied across cancer types. The participant recorded with stage II multiple myeloma met the advanced-cancer eligibility criterion based on documented clinical progression associated with disease-related complications or disease burden despite the recorded disease-specific stage. Purposive sampling was used, and the researchers reviewed interviews during data collection to assess saturation separately for patients and caregivers. Saturation was

considered reached when accounts became repetitive and successive interviews yielded no substantively new codes or themes within either group. Thirty individuals initially consented (15 patients and 15 caregivers); one caregiver (F03) withdrew after consent for personal reasons and before interview, and no replacement was recruited. The final analytic sample therefore comprised 29 participants (15 patients and 14 caregivers), including 14 patient–caregiver pairs with interviews from both members and one patient without a caregiver interview. The number of individuals who were initially approached and declined participation before providing consent were not documented.

2.3. Interview Procedures

Twenty-nine separate semi-structured interviews were conducted and analyzed: 15 with patients and 14 with their family caregivers. All 29 interviews were audio-recorded and transcribed in full. The interviews were conducted in Arabic by one data collector specifically appointed for this study who had previous experience conducting qualitative research interviews. The interviewer was not part of the participants' direct home care team and had no prior relationship with them. Open-ended, neutral questions were used to invite participants to describe their experiences; voluntary participation and confidentiality were explained. Patients and caregivers were interviewed separately, although other family members were present during some interviews. Interviews lasted approximately 30–45 min and were conducted in participants' homes, commonly in connection with home care visits. Available interview dates spanned 23 July 2024 to 30 April 2025; dates were not available for every interview, so this range does not establish the complete data collection period. Separate bilingual Arabic–English guides addressed perceived needs, challenges, expectations, trust, communication, decision-making, family involvement, responsiveness and compassion; these guides are provided as Supplementary File.

2.4. Data Analysis and Presentation

The audio recordings were first transcribed in full into written Arabic. A bilingual research-team member translated the complete transcripts into English, and qualitative analysis was conducted using these English translations. A second bilingual researcher compared the English versions against the Arabic transcripts, and a third bilingual research-team member back-translated all English interview transcripts into Arabic to assess preservation of meaning. Within the qualitative descriptive design, an inductive coding approach was selected to allow codes and themes to develop from participant accounts without a predetermined coding framework. NVivo 15.6.0 qualitative data analysis software (Lumivero, Denver, CO, USA) was used to facilitate the organization and coding of interview transcripts. Coding decisions, theme development, and interpretation of the findings were undertaken by the research team. Haneen Abaza, a research specialist who had not participated in the participants' care and had no prior relationship with them, read the translated transcripts, identified meaningful passages and completed the initial coding; related codes were grouped into subthemes and overarching themes. Two additional research-team members, neither of whom participated in the participants' care or had a prior relationship with them, reviewed the codes, subthemes and themes against participants' accounts. Differences in interpretation were discussed and resolved through consensus. The completed thematic matrix comprised two analytic categories, eight themes and 37 subthemes, supported by descriptions and participant-attributed quotations. The analytic structure and participant quotations were retained; selected theme and subtheme labels were refined for interpretive accuracy. P denotes a patient and F a family caregiver. The English quotation wording follows the translated transcripts, with only minor punctuation normalization or contigu-

ous shortening. Participant characteristics were summarized descriptively (Table 1), while findings are presented thematically using illustrative quotations.

Table 1. Participant sociodemographic and clinical characteristics.

Characteristic	Patients (N = 15)	Family Caregivers (N = 14)
Age in years		
Age available, n	15	14
Mean (SD)	66.0 (12.5)	54.2 (18.0)
Median	67.0	50.5
Range	32–79	26–82
Gender as recorded		
Female	9 (60.0)	8 (57.1)
Male	6 (40.0)	6 (42.9)
Not recorded	0 (0.0)	0 (0.0)
Place of residence as recorded		
Amman	9 (60.0)	8 (57.1)
Zarqa	3 (20.0)	3 (21.4)
Irbid	1 (6.7)	1 (7.1)
Mafraq	1 (6.7)	1 (7.1)
Salt	1 (6.7)	1 (7.1)
Not recorded	0 (0.0)	0 (0.0)
Education		
Primary school	6 (40.0)	0 (0.0)
High school	3 (20.0)	5 (35.7)
Diploma	1 (6.7)	0 (0.0)
Bachelor's degree	2 (13.3)	6 (42.9)
Master's degree	0 (0.0)	3 (21.4)
Missing	3 (20.0)	0 (0.0)
Employment as recorded		
Employed	0 (0.0)	3 (21.4)
Retired	0 (0.0)	5 (35.7)
Unemployed	15 (100.0)	5 (35.7)
Housewife	0 (0.0)	1 (7.1)
Not recorded	0 (0.0)	0 (0.0)
Caregiver relationship to patient		
Wife	—	4 (28.6)
Husband	—	3 (21.4)
Daughter	—	4 (28.6)
Son	—	2 (14.3)
Uncle	—	1 (7.1)

Table 1. *Cont.*

Characteristic	Patients (N = 15)	Family Caregivers (N = 14)
Not recorded	—	0 (0.0)
Diagnosis or clinical label as recorded		
Breast cancer	4 (26.7)	—
Brain tumor	2 (13.3)	—
Multiple myeloma	2 (13.3)	—
Anal cancer	1 (6.7)	—
Bladder mass	1 (6.7)	—
Endometrial cancer	1 (6.7)	—
Lung cancer	1 (6.7)	—
Renal tumor	1 (6.7)	—
Sarcoma	1 (6.7)	—
Testicular cancer	1 (6.7)	—
Recorded disease stage		
II	1 (6.7)	—
III	2 (13.3)	—
IV	12 (80.0)	—
Time from home care initiation to interview (days)		
Records with both required dates	8	—
Median	328.5	—
Range	25–1009	—
Missing duration	7 (46.7)	—

Note. Values are n (%) unless otherwise stated. Categorical percentages use the respective interviewed group totals (15 patients and 14 caregivers), not the original number who consented. The caregiver who withdrew before interview is excluded; missing observations, where present among interviewed participants, are identified separately. Age summaries include available observations only and SD denotes the sample standard deviation (n − 1). Employment status was recorded for all included participants; all 15 patients were recorded as unemployed. Diagnoses and stages are reproduced as recorded; staging systems differ by disease. Time from home care initiation to interview is the arithmetic difference in days between recorded home care initiation and interview dates, calculable for eight patients only. Percentages are rounded to one decimal place and may not sum to exactly 100%. A dash indicates unavailable or not applicable.

2.5. Trustworthiness and Ethical Considerations

The analysis drew on all 29 fully transcribed interviews, and the thematic matrix linked coded participant identifiers to illustrative excerpts. Initial inductive coding by Haneen Abaza, review by two additional researchers and resolution of interpretive differences through discussion and consensus supported the transparency of analytic decisions. Both favorable and critical experiences were retained, including contrasting accounts of medication support and service access. To reduce potential interviewer influence, an interviewer with previous qualitative interviewing experience outside the direct care team, with no prior participant relationship, used open-ended, neutral questions. Nevertheless, participants' ongoing reliance on home care could have influenced their willingness to report negative experiences. Approval was provided by the Institutional Review Board of King Hussein

Cancer Center (23 KHCC 129 F; 18 November 2023). Consent materials described voluntary participation, confidentiality and the right to withdraw without affecting care; one caregiver exercised this right before interview and contributed no interview data. The service is not named in the narrative, and quotations are attributed to coded participant identifiers.

3. Results

3.1. Participant Characteristics

Patients were aged 32–79 years (M = 66.0, SD = 12.5); nine were female and six male. All 15 patients were recorded as unemployed. Twelve had recorded stage IV disease, two stage III and one stage II; the stage II entry was for a participant with multiple myeloma whose documented clinical progression and disease-related complications or burden met the study's advanced-cancer eligibility criterion. Breast cancer accounted for four records, brain tumors and multiple myeloma for two each, and seven other diagnostic labels for one each. Among the eight patients with both home care initiation and interview dates, the median elapsed time from home care initiation to interview was 328.5 days (range 25–1009). The interval could not be calculated for seven patients (46.7%) because one or both dates were unavailable.

Fourteen family caregivers completed interviews and were included in the analysis. Their ages ranged from 26 to 82 years (M = 54.2, SD = 18.0); eight were female. Seven caregivers were spouses, six adult children, and one an uncle. The fifteenth caregiver who initially consented withdrew before interview and was excluded from the analytic sample and percentage denominators. Table 1 presents characteristics of the 29 participants interviewed.

3.2. Qualitative Findings and Thematic Structure

The original analysis identified two overarching categories: Gaps, Needs, and Systemic Challenges (Themes 1–4), and Strengths and Impact of Home Care (Themes 5–8). The analysis encompassed eight themes and 37 subthemes (Table 2), with the original structure and ordering retained and selected labels refined for closer correspondence to participants' accounts. Subtheme counts are descriptive features of the analytic organization, not estimates of the frequency, prevalence, priority or relative weight of participants' concerns. The findings reflect reported experiences, perceptions and care priorities rather than independently verified clinical or service outcomes. Patient and caregiver perspectives are distinguished throughout using their quotation identifiers.

Table 2. Analytic themes and 37 subthemes.

Analytic Category	Theme	Subthemes (n = 37)
Gaps, Needs, and Systemic Challenges	Theme 1: Healthcare System and Continuity Challenges	1. Care system improvement recommendations 2. Waiting time and service efficiency 3. Hospital-related burdens 4. Access and admission challenges 5. Patient's potential non-adherence
Gaps, Needs, and Systemic Challenges	Theme 2: Structural and Environmental Barriers	1. Initial skepticism toward home care 2. Lack of awareness—accessibility gap 3. Lack of clear communication 4. Medication and supply concerns 5. Resource and environmental constraints 6. Structural and home environment barriers 7. Transportation barrier due to distance 8. Transportation barriers due to physical status

Table 2. *Cont.*

Analytic Category	Theme	Subthemes (n = 37)
Gaps, Needs, and Systemic Challenges	Theme 3: Support System and Caregiver Burdens	1. Caregiver limitations and physical strain 2. Limited family presence and isolation
Gaps, Needs, and Systemic Challenges	Theme 4: Unmet Medical and Functional Needs	1. Gaps in medical and rehabilitation services 2. Lack of essential equipment 3. Mobility limitation and physical fatigue 4. Emotional impact of limited mobility
Strengths and Impact of Home Care	Theme 5: Caregiver and Relationship Dynamics	1. Caregiver involvement and training 2. Communication and proactive follow up 3. Positive impact on the caregiver 4. Trust based on positive interaction
Strengths and Impact of Home Care	Theme 6: Emotional and Psychological Impact	1. Emotional bond with home care team 2. Provision of psychological support 3. Emotional reliance on home care 4. Encouragement and motivation 5. Importance of empathy and compassion 6. Psychological impact of home care
Strengths and Impact of Home Care	Theme 7: Caregiver Perceptions of Home Care Quality and Responsiveness	1. Perceived flexibility in scheduling care 2. Perceived support during hospital-related care 3. Caregiver-reported satisfaction with home care 4. Caregiver-reported involvement in care decisions 5. Perceived reliability of medication support 6. Perceived timeliness and responsiveness
Strengths and Impact of Home Care	Theme 8: Functional Aspirations and Physical Care Priorities	1. Hopes for functional recovery and independence 2. Physical care and symptom-relief priorities

Note. The two categories, eight themes and 37 subthemes retain the original thematic organization. Selected theme and subtheme labels were refined to better match illustrative quotations without changing participant quotations or the number of themes/subthemes. The 19 subthemes under Category 1 and 18 under Category 2 do not indicate relative importance, frequency, prevalence or empirical weight.

3.2.1. Gaps, Needs, and Systemic Challenges

Theme 1: Healthcare System and Continuity Challenges

This theme captures continuing hospital-dependent work and participants' proposals for improving service coordination.

Care system improvement recommendations

Participants identified coordination and service development priorities rather than reporting completed interventions. F14 stated: "The only improvement, from my point of view, is providing an ambulance for patient transportation, especially for distant areas." (F14). This suggestion linked service improvement to the difficulty of obtaining hospital care across distances.

Waiting time and service efficiency

Repeated prescription renewals and service delays made the continuity of treatment burdensome. F07 explained: "They would prescribe his medications, but every 10 days he needed a new prescription, so he had to go" (F07). F01 also described transporting blood samples; bringing clinical care into the home did not remove all administrative and investigative journeys.

Hospital-related burdens

Caregivers identified barriers associated with hospital-based care, particularly bed access. F07 recalled: "They told me to put my name on a standby list because all beds are taken and it's hard to get one now" (F07).

Access and admission challenges

Access was shaped by the practicalities of appointments and admission as well as availability of services. P03 recalled: "Just last Wednesday, we couldn't find a parking spot." (P03). This difficulty occurred within a journey organized around the availability and family responsibilities of the person providing transport.

Patient's potential non-adherence

Physical discomfort appeared to influence some patients' decisions about prescribed medicines. P03 stated: "I do experiments on myself." (P03). The wider account concerned medicine that felt difficult to tolerate.

Theme 2: Structural and Environmental Barriers

Information, medicine supply, hospital environments, home architecture, and transport were experienced as interacting barriers to care.

Initial skepticism toward home care

Initial expectations of home-based care included uncertainty about what the service could offer. F05 recalled: "We were unsure before, thinking we would only get the same care as in the hospital, but once we started receiving it at home, we were surprised." (F05). F08 additionally associated a palliative referral with end-of-life care, illustrating a perceived misunderstanding rather than establishing prognosis.

Lack of awareness—accessibility gap

Some families learned of the service only after considerable hospital-based care. F09 explained: "I didn't know there was such a thing." (F09). F01 wished that referral had occurred earlier. These experiences point to perceived gaps in timely information about service availability.

Lack of clear communication

Contacting healthcare professionals was not uniformly straightforward. F07 qualified an early difficulty: "Only in the beginning, communicating with them to connect was difficult, but that was it." (F07). F04 contrasted the accessibility of the home care team with difficulty contacting hospital doctors.

Medication and supply concerns

Caregivers expressed concerns about the availability and perceived quality of medicines. F07 stated: "there is excessive rationing of some medications" (F07). F02 also questioned medicine quality. These are participant perceptions and cannot establish actual stock shortages or medication defects.

Resource and environmental constraints

Environmental conditions in hospital were also a source of concern. F08 recalled a shared patient bathroom: "They shared the same bathroom." (F08). The caregiver associated subsequent illness with the environment, but the interview cannot establish the source or cause of infection.

Structural and home environment barriers

The physical structure of the home complicated leaving for care. P03 explained: "our house is all stairs." (P03). P02 similarly linked repeated stair use to pain and difficulty attending appointments. Barriers therefore began before a patient reached transport.

Transportation barrier due to distance

Intercity distance added substantial travel time. F12 described journeys from Irbid to Amman involving "an hour and a half going and an hour and a half coming back" (F12). Such journeys were experienced alongside the time spent at the hospital and the need for practical coordination.

Transportation barriers due to physical status

Moving physically dependent patients required multiple transfers before hospital travel was possible. F07 described having to "lift him, put him on the chair, then take him down again, then put him in the car" (F07). The burden concerned physical handling, not only the length of the journey.

Theme 3: Support System and Caregiver Burdens

This theme distinguishes the physical labor of caregiving from the availability of other family members.

Caregiver limitations and physical strain

Providing transportation and hands-on care placed direct physical demands on relatives. F11 described lifting a patient: "you have to carry him on a stretcher and put him in the car… it's exhausting and painful." (F11). Knowing what care was needed did not mean a caregiver could perform every task without strain.

Limited family presence and isolation

Family availability could be intermittent, complicating plans for care or travel. F10 described needing to "prepare everything, gather family members, take leave from work, make arrangements… it was exhausting." (F10). P03 also described times when the home was empty; family membership did not guarantee the continuous presence of help.

Theme 4: Unmet Medical and Functional Needs

Participants described unmet services and equipment needs alongside the functional and emotional consequences of restricted movement.

Gaps in medical and rehabilitation services

Participants requested rehabilitative interventions that were not part of their perceived service provision. P09 said: "if physiotherapy were included with them, that would be the most important point." (P09). F10 hoped for help with limb movement and strengthening.

Lack of essential equipment

Participants also identified needs for equipment during home care. P13 requested "having monitoring tools such as an oxygen saturation device." (P13). The matrix also included a report of improvised equipment during a visit.

Mobility limitation and physical fatigue

Restricted movement made ordinary activities and travel difficult. P08 stated: "I have impairments and can't walk." (P08). Physical limitation was described as a constraint on both accessing services and leaving the home.

Emotional impact of limited mobility

Loss of mobility carried emotional and social consequences. P09 explained: "I feel stuck at home, no outings, no fresh air." (P09). The broader wish to visit a market or café concerned ordinary social participation, not simply symptom control.

3.2.2. Strengths and Impact of Home Care

Theme 5: Caregiver and Relationship Dynamics

Caregivers valued a role in learning, communication, and decision-making, and described how support shaped trust and burden.

Caregiver involvement and training

Caregivers valued practical teaching that enabled participation in everyday care. F12 explained: "They teach me how to give medications, how to deal with wounds if there are any, and how to use ointments" (F12). F13 also described being consulted before care decisions; these are caregiver accounts of participation.

Communication and proactive follow up

Contact and follow-up were experienced as reassurance that the team remained engaged. F10 highlighted "whether by phone or when they come to visit. They never forget the important things." (F10). Continuity included remembering individual needs, not only completing a scheduled visit.

Positive impact on the caregiver

Home care eased some of the work and worry associated with hospital visits. F02 said: "This has greatly alleviated the burden on us and improved the patient's psychological state, as well as mine as a caregiver." (F02).

Trust based on positive interaction

Repeated respectful interactions supported caregiver trust. F11 valued transparent communication: "They explain everything, and they don't hide things even in front of him" (F11). F06 also described feeling secure when temporarily away collecting medicines; predictable conduct contributed to confidence.

Theme 6: Emotional and Psychological Impact

Accounts emphasized the emotional significance of professional familiarity, reassurance, motivation, and compassionate interaction.

Emotional bond with home care team

Professional familiarity sometimes developed into a sense of personal closeness. F01 valued "how they interact with you as if they're part of the family, not just nurses" (F01). The caregiver used familial language to describe a supportive relationship, without implying literal family roles.

Provision of psychological support

Participants described emotional support as an important function of home visits. F01 stated: "The most needed support is psychological support." (F01). This perspective emphasized the value of contact and conversation alongside procedural care.

Emotional reliance on home care

Emotional attachment could also create anxiety about losing dependable support. F05 asked: "I'm afraid, will they stay with us until the end like this?" (F05). The account continued with reassurance from the team, illustrating how expectations of relational continuity affected the family's sense of security.

Encouragement and motivation

Encouragement from professionals was meaningful to some families. F04 recalled: "They encourage her to move, to go to the bathroom by herself." (F04).

Importance of empathy and compassion

Compassion was communicated through respect, attention, and humane interaction. F02 emphasized "the honesty and respect in their treatment, their sensitivity to the patient's needs" (F02). Such encounters were valued beyond the delivery of a technical intervention.

Psychological impact of home care

Caregivers attributed strong psychological support to home care. F07 stated: "I consider the psychological support they provide to be more healing for the patient than the medication itself." (F07).

Theme 7: Caregiver Perceptions of Home Care Quality and Responsiveness

Caregiver accounts described perceived service flexibility, continuity, satisfaction, involvement in care decisions, medication support and responsiveness.

Perceived flexibility in scheduling care

Adjusting the timing of care helped families fit treatment around other obligations. F06 recalled: "They managed it, and they came, gave her the injection, and we left afterward." (F06).

Perceived support during hospital-related care

Participants also described episodes of timely support across hospital-related care. F01 recalled: "They took her to the hospital and provided first aid." (F01).

Caregiver-reported satisfaction with home care

Caregiver-reported satisfaction included care delivery and the way professionals interacted with families. F05 said: "Their smile alone makes our hearts happy when we see them, and we feel at ease." (F05). Positive evaluations coexisted with the barriers reported in the first analytic category.

Caregiver-reported involvement in care decisions

Caregivers valued consultation and active clinical appraisal. F15 stated: "There is always discussion and shared decision-making" (F15). F07 appreciated clinicians examining the patient rather than relying solely on secondhand accounts.

Perceived reliability of medication support

Some caregivers perceived medication-related support as reliable. F05 stated: "The medicine, they make sure it never runs out." (F05). This account contrasts with perceived constraints reported under the barriers category; the reasons for variation could not be established from the matrix.

Perceived timeliness and responsiveness

Prompt help and additional visits were cited as important service strengths. F01 recalled: "We contacted them, and they were there immediately—within five minutes" (F01).

Theme 8: Functional Aspirations and Physical Care Priorities

Participants described hopes for greater independence and priorities for physical care and symptom relief rather than verified functional outcomes.

Hopes for functional recovery and independence

Patients described hoped-for independence as a future priority. P13 said: "I hope my condition improves and that I can walk and run some errands by myself." (P13).

Physical care and symptom-relief priorities

Families described practical support and specific symptom priorities. F10 stated: "Right now, our main goal is to heal the pressure sores." (F10).

4. Discussion

The central finding is not a simple balance of favorable and unfavorable service ratings. Participants could value knowledgeable, accessible, and compassionate professionals while still carrying demanding tasks across the household–hospital boundary. Home care could relieve the work of accessing treatment without necessarily restoring opportunities to participate in life outside the home. Similarly, caregiver education may improve confidence without providing the physical strength, time, or assistance needed to apply that knowledge. The eight reported themes should therefore be read as intersecting descriptions of continuity, capacity, and personally meaningful goals—not as statistically independent constructs or evidence that any one problem was more prevalent than another.

4.1. Relational Continuity and Practical Access

Participants described continuity through explanations, telephone contact, familiar staff, and dependable responses, consistent with research on availability and relational security in specialized home care [5,6]. Yet F05's concern about losing the team suggests that reassurance is partly contingent on confidence about future access. Clear information about scope, contacts, and transitions may therefore complement compassionate interaction without implying that service withdrawal was planned.

Good relationships did not eliminate stairs, provide transport, or secure hospital beds. The literature on care transitions and rural caregiving emphasizes communication,

accessible resources, and defined professional responsibilities [7,8]. Here those boundaries became visible in renewal appointments, moving physically dependent patients, and transporting samples. Coordinated review of these processes is warranted, although no service-effectiveness or cost conclusion follows from the interviews.

4.2. Family Participation and Caregiver Capacity

Instruction supported caregivers' need for partnership [12], but competence is not capacity: someone may know what to do yet lack strength, time, or assistance. Lifting demands and family availability therefore merit direct assessment.

Patient and caregiver priorities may diverge: avoiding hospital journeys differs from wishing to go out socially. Their accounts should remain distinct [2]. Caregiver interpretations cannot substitute for patient endorsement.

4.3. Functional Goals and the Meaning of Home

P09's wish to sit at a market or café adds a dimension often missed by symptom-centered evaluations: avoiding burdensome treatment travel is not the same as regaining ordinary social participation. Home-based support may reduce the labor of care while mobility restrictions leave patients unable to leave for personally meaningful reasons. Patient-defined activity goals therefore deserve direct assessment alongside comfort and symptoms.

The Pal-Rehab trial found benefits to quality of life from integrated palliative rehabilitation in a different advanced-cancer population [17]. This cannot predict effects in the present service, but it supports considering functional assessment, feasibility, and rehabilitation referral when appropriate. Hopes for walking or neurological recovery remain aspirations, not demonstrated changes. Discussing achievable participation, needed assistance, and uncertain recovery may align care with the person's priorities.

4.4. Understanding Services and Treatment

Unfamiliarity with home care and the equation of palliative referral with dying show why clear explanations matter. Current guidance supports palliative input alongside treatment [3]; F08's concern does not establish referral appropriateness.

Obtaining medication differs from tolerating it. Perceived rationing and quality concerns require pharmacy verification; P03's stomach discomfort calls for clinical discussion. The interviews cannot establish medication failures or adherence rates [4].

4.5. Contribution to Supportive Care Assessment

These findings add patient and family accounts to Jordanian surveys describing information, practical, and psychosocial needs [10,11]. Their contribution is to show why valued service encounters may coexist with a separate set of unfinished tasks and goals. Questions about necessary hospital trips, caregiver capacity, medication experiences, security of follow-up, and activities worth regaining could sharpen individual assessment beyond global satisfaction [9]. Such questions require testing before being treated as validated measures; themes such as spirituality or displacement from other studies [12] cannot be imputed to these participants.

4.6. Strengths and Limitations

The qualitative findings derive from the research team's original analysis of interviews with patients and family caregivers across different diagnoses, ages, and residences. The presentation includes both appreciative and critical experiences; checked participant characteristics improve descriptive accuracy without making the sample statistically representative.

This qualitative descriptive study explored experiences within one specialist oncology home care service. Its findings are context-specific and are intended to illuminate the meanings and practical circumstances of care rather than to estimate the frequency of needs in a wider population. Accounts of medication access, hospital safety, response times, and improvements in clinical or functional status reflect participants' experiences and were not evaluated as independent clinical or operational outcomes. The participants were already connected to home care, so the findings may not reflect the needs of people who cannot access such services.

The sample included different cancer diagnoses and disease-specific clinical stage labels, which require cautious cross-diagnosis interpretation. The study involved one specialist home care service and participants already connected to it, potentially limiting transferability to people without access to home care. Some interviews occurred with other family members present, which may have influenced disclosure. The caregiver F03 withdrew after providing consent but before interview, resulting in 14 complete patient–caregiver pairs and one patient interviewed without a corresponding caregiver interview. Although participants were recruited as related patient and caregiver participants, no formal within-pair analysis was undertaken. Interviews described experiences at particular points in the care journey and did not measure longitudinal change.

4.7. Implications for Practice and Future Research

Clinical review should assess medication experiences and symptom burden alongside the activities patients wish to regain, mobility constraints, rehabilitation suitability, and specific equipment needs. Caregiver teaching should include assessment of lifting demands, competing obligations, and actual availability of help. Cross-service review may consider transport, appointment and prescription coordination, and sample logistics, followed by prospective evaluation of feasibility and patient-defined outcomes.

Referral conversations should clarify what home care provides, whom families can contact, and how continuity is expected to work. Reported medication shortages, adverse effects, or quality concerns warrant clinical assessment and verification. Future research could investigate these priorities across different home care settings, prospectively examine changes in patients' functional goals, and consider linked patient–caregiver perspectives when dyadic analysis is an explicit study aim.

5. Conclusions

Specialist oncology home care was valued in terms of clinical support, caregiver guidance, responsiveness, and reassurance, yet families continued to encounter hospital access barriers, physical demands, medication concerns, and unmet goals for mobility and participation. These findings argue for individual assessment of life beyond the visit, as well as coordination of care across settings. They describe priorities for service development, not evidence of intervention efficacy or the prevalence of particular needs.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/healthcare14234092/s1, Supplementary File S1: Interview Guides for Patients and Family Caregivers (Arabic and English).

Author Contributions: Conceptualization: M.A.-R. and M.S.A.; methodology: H.A., Y.A.-H. and S.A.; formal analysis: H.A.; writing—original draft: A.A. and S.A.; writing—original draft, supervision: R.M. and M.A.-K.; writing—review and editing: all authors. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by the Intramural Research Grants Program at King Hussein Cancer Center (KHCC), Jordan (Research Project No. 23KHCC129 F).

Institutional Review Board Statement: The study was approved by the Institutional Review Board of King Hussein Cancer Center (approval number 23 KHCC 129 F; 18 November 2023).

Informed Consent Statement: The study participant information and consent materials describe voluntary participation, confidentiality, and the right to withdraw without affecting care. Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Interview transcripts and audio recordings contain potentially identifiable personal experiences and are not publicly available because of participant confidentiality. Requests for access to supporting materials are subject to institutional authorization and applicable ethics and privacy requirements.

Acknowledgments: The authors gratefully acknowledge the Office of Scientific Affairs and Research (OSAR) at King Hussein Cancer Center for its valuable support in facilitating data collection and providing assistance for the study interviews. During manuscript preparation, ChatGPT (OpenAI, GPT-5) was used to assist with language editing and manuscript refinement. The authors reviewed and verified the AI-assisted content and take full responsibility for the final manuscript.

Conflicts of Interest: The authors declare no conflicts of interest.

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