Exploration of hospital and home visiting nurse experiences and vision for the transitional care of carers: A qualitative study

Short title: Exploration of hospital and home visiting nurse

Michelle LOBCHUK, RN, PhD

Leslie DRYBURGH, RN, MN

Nicole SHEAD, RN, BN

Lisa HOPLOCK, PhD

1Associate Professor, University of Manitoba, Rady Faculty of Health Sciences, College of Nursing, Room 315-89 Curry Place, Winnipeg, Manitoba Canada R3T 2N2

2Clinical Nurse Specialist, Grace Health Campus, 300 Booth Drive, Winnipeg, Manitoba Canada R3J 3M7

3Graduate Student, University of Manitoba, Rady Faculty of Health Sciences, College of Nursing, Room 315-89 Curry Place, Winnipeg, Manitoba Canada R3T 2N2

4Post-doctoral research fellow, University of Manitoba, Rady Faculty of Health Sciences, College of Nursing, Room 353-89 Curry Place, Winnipeg, Manitoba Canada R3T 2N2

Correspondence

Michelle Lobchuk, University of Manitoba, Rady Faculty of Health Sciences, College of Nursing, Room 315-89 Curry Place, Winnipeg, Manitoba, Canada R3T 2N2. Email: Michelle.Lobchuk@umanitoba.ca

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Exploration of hospital and home visiting nurse

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**Conflict of Interest**

The authors declare that they have no conflict of interest.

**Author Contributions**

The research team consisted of one senior researcher (ML) with 16 years of research experience, an advanced practice nurse (LD), a post-doctoral research fellow (LH), and an undergraduate nursing student (NS). Study design and plan: ML and LD; data collection: ML and LD; data analysis: ML, LD, and NS; manuscript drafting and comment: all authors; agreement of the inal version of the manuscript: all authors.

**ORCID**

Michelle Lobchuk ID orcid.org/0000-0002-1893-5010
Abstract

Aims and objectives: To capture hospital and home visiting nurse experiences and vision for the transitional care of family carers of adult patients.

Background: Transitional care is a time-limited approach to avert overlooking family carer and patient needs during ‘hand-offs’ of care from hospital to home. Despite nurses’ key role in transitional care, we have scant knowledge of hospital and home care nurse experiences and suggestions to better support family carers during their care transitions.

Design: A qualitative design underpinned by interpretive description.

Methods: As part of a larger study, a convenience sample of seven hospital and five home visiting nurses participated in December 2015 and January 2016. A semi-structured interview schedule was developed from Appreciative Inquiry. Data were extracted from two focus group interviews conducted separately with hospital and home visiting nurses. The study was reported according to the COREQ guidelines.

Results: Content analysis revealed two main themes from transcribed focus group data and handwritten responses to survey questions about workplace philosophy of family care and additional comments: Current Care of Caregiving Families and Vision for Care of Families in Transition.

Conclusions: The degree and type of transitional care for caregiving families by nurses is dependent on the organizational setting. Nurses agree that more direct communication between care sectors at “hand-off” as well as the provision of cohesive messages by nurses that foster realistic expectations held by families regarding roles and responsibilities of formal and family caregivers across care sectors are required. Opportunities for nurses across care sectors to meet
and dialogue about their roles and expectations for caregiving families across the care trajectory are needed.

**Relevance to Clinical Practice:** Nurses’ recommendations reflected transitional care concepts of continuity, expectations, and resources that can guide clinicians, policy-makers, health care leaders, and researchers to promote enhanced transitional care for family carers.

**Keywords:** family carers, care transitions, home visiting, hospital, nurses, collaboration, communication, qualitative, focus group
Exploration of hospital and home visiting nurse experiences and vision for the transitional care of carers: A qualitative study

INTRODUCTION

“How well do we support caregiving families as they transition with adult patients across our health care system?” Worldwide, nurses and other multidisciplinary team members focus on helping patients and their family carers to transition more quickly out of high cost settings (e.g., hospitals) to lower cost care settings (e.g., the home) – these actions are known as transitional care. However, a recent Canadian report revealed that older individuals who started in the community and were discharged to the ‘community with home care’ had the highest rate of hospital 30-day readmissions (compared to individuals who started in the community and were discharged to long-term care; Gruneir et al., 2018). Speculation is that home care needs by patients and family carers are not being adequately assessed to match required home care services (Gruneir et al., 2018).

Transitional care is a time-limited approach that aims to avert the risk of patient and family carer (aka carer or family) needs from being overlooked during quick ‘hand-offs’ of care from hospital to home. Without optimal transitional care, medical errors, lack of care coordination, dysfunctional communication between carers and professional caregivers across settings, poorly timed care, and challenges in accessing requisite home and community-based services can occur (Gibson, Kelly & Kaplan, 2012). In their critical review, Gibson and colleagues (2012) recommended more research on health care professionals’ approaches toward family carers and barriers encountered while trying improve transitional care processes and family engagement. Despite hospital and home care nurses’ key role in supporting carers in transitioning from hospital to home, limited information exists on their experiences and vision to better support carers during these transitions.
Exploration of hospital and home visiting nurse

**BACKGROUND**

Support for caregiving families is a vital component of transitional care (Toye et al., 2016) -- this is a vulnerable time for older patients and families (Gibson et al., 2012). As patients continue to be discharged sicker and more dependent with more complex care, hospital stays present pivotal opportunities to support families in new or existing carer roles. However, families do not always view discharge planning favorably due to inadequate assessment of their needs, skill level, and health status (Bauer, Fitzgerald, Haesler, & Manfrin, 2009). When viewed by health care providers only as a resource, carers feel left out due to: not being recognized at time of admission, limited liaison with staff at discharge, discharge instructions that exclude them, and poor identification of their key role in home-based care (Toye et al., 2016).

Nurses frequently encounter carers during life-altering health-illness transitions (as they traverse hospital and home care settings) and situational transitions (role changes; Schumacher & Meleis, 1994). Preparing the patient and carer to maximize safe patient care and recovery is an ethical obligation of registered nurses (Canadian Nurses Association, 2017). Training in holistic and relational care makes nurses well suited to promote healthy transitions: i.e., their training includes attention to carers’ subjective wellbeing, role mastery, and relationship well-being (Schumacher & Meleis, 1994). Nurses as ‘transition coaches’ facilitate patients’ and carers’ self-management which contributes towards reduced re-hospitalization rates and cost savings to the health care system (Donald et al., 2015). But our healthcare systems have been slow in helping nurses to realize their full potential to take the lead in demonstrating ‘partnerships’ with transitioning families (Berger, Flickinger, Pfoh, Martinez, & Dy, 2014).

Successful “holistic transitional care” cannot occur without careful inpatient and home care discharge planning, support, and follow-up across care sectors (Allen et al. 2014).
et al. (2013) conducted a review of common care models that assist health care systems to optimize transitional care. These models differ by design and in how to manage and coordinate care across settings and carer-patient partnerships; e.g., the Transitional Care Model by Naylor (1990) focuses on hospital to home transitional care. Yet, gaps still remain on how to improve collaborative, transitional care from nurses’ perspectives across care sectors (Petersen, Fogel, & Norholm, 2019). For instance, home care case managers noted that hospital nurses are not often involved in the process of how to design better care for family carers (Giosa, Stolee, Dupuis, Mock, & Santi, 2014). Others argued that the experiences and needs of home visiting nurses may not be “visible to hospital clinicians” (Foust, Naylor, Bixby, & Ratcliffe, 2012, p. 125).

Essentially, due to their proximity to family carers, hospital and home visiting nurses have practical insights on how to avoid communication breakdowns that lead to ill-informed patients and carers, and a lack of continuity of care along the care continuum (Hirschman, Shaid, McCauley, Paul, & Naylor, 2015). Knowing nurses’ perspectives is significant to: (a) increasing the visibility of nurses’ respective roles and needs in transitional care across care settings and (b) serving as experiential evidence that should drive clinically-relevant strategies to reduce carers’ unmet needs and lower patient readmission rates, re-hospitalization days, and long-term institutionalization (Nagel, 2008).

The present research was part of our larger project where we aimed to quantitatively capture hospital and home visiting nurse attitudes toward family care, and their qualitative accounts of experiences and vision for care of transitioning carers. Questionnaires were employed to capture nurse attitudes toward family care (measures are reported in Author Blinded, 2019). Focus groups enabled our ability to capture nurse experiences and vision for transitional care of carers. The present paper focuses on nurse experiences and vision for the
Exploration of hospital and home visiting nurse transitional care of family carers as captured in focus groups. The survey results on nurse attitudes toward care of family carers can be seen in (Author Blinded, 2019).

AIM

Our aim was to address limited information that exists on hospital and home visiting nurses’ experiences and vision to better support family carers during care transitions. Our research question was: “What is the experience of hospital and home visiting nurses in caring for carers and their vision to better support carers in care transitions?”

METHOD

Design

To address our research question, we employed interpretive description analysis techniques with semi-structured digitally-recorded focus group interviews held with hospital and home visiting nurses about their experiences with and vision of care for transitioning family carers. Interpretive description involves qualitative interview techniques to collect data and leverage our clinical reasoning and expertise to interpret meanings in clinicians’ narratives of their experiences (Thorne, 2008; Thorne, Kirkham, & MacDonald-Emes, 1997). This qualitative technique was also employed to analyze participants’ responses to two open-ended written survey questions (described more fully below). The Consolidated Criteria for Reporting Qualitative Research (COREQ) was used for comprehensive reporting of our study (Tong, Sainsbury, & Craig, 2007).

Data Collection

As part of the larger project, convenience sampling was used to recruit hospital and home visiting nurses in direct patient care. At the 251-bed community hospital located in the provincial City of Winnipeg in Canada, 546 full-time, part-time, and casual nurses (including Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses, and Nurse
Exploration of hospital and home visiting nurse practitioners) were invited to participate. Sixty-four full- and part-time home visiting nurses (including Registered Nurses and Licensed Practical Nurses) with the provincial government home care program office located near the community hospital also received a study invitation. Eligibility criteria and the recruitment protocol are described elsewhere (Author Blinded, 2019). Nurses had the option of volunteering to complete only the survey. They were told that there would be no penalty if they decided not to participate in the focus group. Nurses who agreed to participate in the focus group provided their name and contact information on the informed consent form and were later contacted by ML. Survey participants were able to enter an early bird prize draw for a $250.00 grocery gift card, and two additional draws for $100.00 grocery gift cards. Focus group participants received a $25 cash honorarium.

Participants completed and returned written informed consents prior to completing the survey and focus groups. Participants completed an investigator-developed, pen and paper demographic survey and the 26-item Families' Importance in Nursing Care--Nurses' Attitudes (FINC-NA) tool (Saveman, Benzein, Engsrom, & Arestedt, 2011; see Author Blinded, 2019) between May 2014 and November 2015. As part of the demographic data survey, participants were asked to provide their response to the open-ended question, “Is there a philosophy or a general approach to the care of family at your place of work?” At the end of the FINC-NA tool there was an open-ended ‘Comments’ prompt for additional voluntary responses.

Digitally-recorded one-time focus group interviews were held in December 2015 and February 2016. ML led the focus groups in a private communication lab located near the hospital and home care office (she had no relationship to study participants). As the hospital’s sole clinical nurse specialist, LD was the only author who had a direct relationship with hospital nurse participants. With ML, LD co-led the focus group only with home visiting nurse participants.
The focus group is a facilitated group interview technique that we used to clarify and extend our comprehension of nurses’ experiences and vision for care for caregiving families (Jackson, 1998). We selected Appreciative Inquiry to stimulate reflection and dialogue among participants, and guide our development of four core open-ended focus group questions (Table 1). This method helped participants to envision positive images of care of carers, what is working well, and possibilities for improvement in their support of carers (Barrette, 1995; Browne, 2017). A trained research assistant with a social psychology background was a non-participant observer who kept handwritten notes on the interaction and tone of responses. Hospital and home visiting nurses participated in separate focus groups, which took 1.5 hours to complete.

Data Analysis

Interpretative description was used as a methodological framework to explore participants’ experiences with and vision for family care. Content analysis of handwritten responses to the open-ended survey questions was conducted by the authors (ML, LD, NS) and the research assistant. Digital recordings of the focus groups were fully transcribed verbatim, de-identified, and analyzed in the following six steps. The transcripts were not shared with participants but study findings were presented by ML and LD at two invitational sessions to hospital and home visiting nurses, respectively at a later date. In Step 1, ML, LD, and the research assistant did several readings of the transcript from the first focus group with hospital nurses to obtain a general impression of content. Step 2 was an independent line-by-line review of the transcript by ML, LD, and the research assistant who used content analysis to identify initial codes. Step 3 involved author discussion of their codes which were then grouped into categories of primary patterns in the data (Elo et al., 2014; Sandelowski, 2000). Disagreements were resolved through discussion. Step 4 involved creating an initial coding template which was then independently
Exploration of hospital and home visiting nurse applied by ML and LD to the home visiting nurses’ transcript. Step 5 involved ML and LD meeting again to discuss their analyses using the coding template and achieve consensus in the coding of this transcript. Some new codes were added to the template reflecting home visiting nurses’ unique responses. Step 6 involved comparing: (a) code categories that were then organized into themes and (b) similarities and differences in code categories between both groups of nurses.

Rigour was achieved through various ways. Credibility was established by recruiting a sample of nurses in direct patient care and using field notes and excerpts (Elo et al., 2014). Dependability was enhanced by having the lead investigator (who is experienced in qualitative techniques; ML), the second investigator (LD), and the research assistant review the coding process and agree on analyses. We addressed confirmability through dialogue among the investigators (Graneheim & Lundman, 2004). Audit trails were employed to record decision-making about coding, categories, and themes (Saldana, 2009). By thick description of the data collection process and sample characteristics plus incorporating written-recorded observations that were referenced when coding the transcripts, we enhanced transferability (Graneheim & Lundman, 2004). Use of digitally-recorded transcripts with coding memos addressed reflexivity (Birks, Chapman, & Francis, 2008). To ensure authenticity, the researchers conducted the focus groups in a private setting and used icebreaker opening questions (Holloway & Wheeler, 2010).

**Ethical Consideration**

Ethics and access approvals were received from the university (Protocols #E2013:033 and #E2015:042) and hospital where this research was conducted.

**RESULTS**

**Open-ended Survey and Focus Group Responses**
For the open-ended survey questions, 41 hospital and 18 home visiting nurses responded to the workplace philosophy question; 14 hospital and six home visiting nurses responded to the additional “Comments” prompt. All focus group participants (n = 7 hospital; n = 6 home visiting) were female with nursing experiences ranging from two to 23 years. Hospital nurse participants in the focus group worked in medicine, ICU, acute psychiatry, surgery, oncology/palliative care, and orthopedic surgery. Two main themes emerged: **Current Care of Caregiving Families and Vision for Care of Families in Transition** (Table 2) and nine underlying categories with 8 sub-categories: **Core Values**, **System- (nurse-system conflicts, poorly resourced)**, **Staff- (nurse-manager conflicts, reliance on other disciplines, opinions ignored and being caught in the middle)**, and **Individual- (choices made regarding family involvement, family dynamics, family expectations)**) level factors, **Improving relationships**, **Helping novice nurses to help families**, **Focusing upcoming**, **Bridging the gap**, and **Improving families’ expectations** which are presented in Table 2. We found an overlap in main themes by hospital and home visiting nurse participants. Some differences in the underlying categories of main themes existed between hospital and home visiting nurses and are noted. Note: ‘#’ indicates a survey response and ‘FG’ indicates a focus group response. Two focus groups were digitally recorded and lasted between 1 hour and 1.5 hours after the nurses’ work day was completed.

**Current Care of Caregiving Families**

This first theme provides some insights into nurse participants’ values, general approach, and experiences in family care. Hindrances and facilitators for family care are reflected in categories of **core values, system-, staff- and individual-level factors** (hospital nurse participants only), and **family expectations**.
Core values reflect deeply-seated tenets that pilot nurses’ gravitation towards family support. Home visiting and hospital nurses held similar humanistic values of respect, empathy, and sensitive understanding when co-jointly tackling patient care issues with families. One hospital nurse described the importance of cultivating good family relations:

“I think a lack of bias... an open-mindedness for us is a core value and being able to relate for us is important” (FG Carla, Psychiatry).

Caring for families as if they were their own family and imagining that it was them in the same situation were dominant commentaries of home visiting nurses.

System-, staff-, and individual-level factors reflect hospital nurses’ perceptions of obstacles that thwart their ability, confidence, or motivation to engage in family care. At the system-level, nurse-system tensions arise with the periodic ‘lack of fit’ between administrative priority for patient flow (i.e., an individual’s movement through the health care continuum) and respect for patients’ and families’ unique situational needs.

“We see the tension that it creates on families ... picking them up and bringing them home and bringing them right back and wait in Emergency” (FG Laura, Surgery).

Being poorly resourced reflects the lack of time afforded to interact meaningfully with families.

“Often too busy to support family or look at the big picture” (#34, Medicine/Surgery).

Families are in the background and come into focus only when patient information needs to be garnered or shared by the nurse. In addition to a lack of time, some nurses described crisis situations (e.g., the psychological impact of being confronted with a sudden drop in patient well-being) where the family member’s needs exceed what the system can offer for support.
Exploration of hospital and home visiting nurse

At the staff-level, **hospital nurse-manager conflicts** address nurses’ periodic confusion and conflicts with managers. One nurse had lasting memories of having been chastised by the nurse manager for telling “*a daughter that her mother had a good night*” that left her with the perception of having breached the privacy law:

> “the nurse manager jumped on me … don’t you dare answer [families’ questions]” (FG Laura, Surgery).

Sometimes privacy regulations were perceived as being too restrictive and insensitive toward dilemmas that nurses face when needing to allay families’ anxieties or help them make realistic decisions about transitional care.

**Reliance on other disciplines** refers to some hospital nurses who thought their limited role in family care was appropriate. They believed that they had inadequate knowledge to extend proper emotional, psychological, or spiritual supports to families or help families to garner certain caregiving skills. These nurses were satisfied with making referrals to other skilled health team members (e.g., social work) who could offer out-of-scope support.

**Opinions ignored and being caught in the middle** captures hospital nurses’ perceived powerlessness in averting inappropriate discharges because their professional opinions are not taken seriously by the discharge team:

> “that was the stupidest discharge and it shouldn’t have been done but you’re kind of limited… you can voice your opinion and it will be ignored or told no, no, no” (FG Shirley, Medicine).

Nurses instead adopted a wait-and-see approach about the success of discharge outcomes.

At the individual-level, **choices made regarding family involvement** reflect decisions made by patients or families about the degree of desired family involvement in patient care.
Exploration of hospital and home visiting nurse

Hospital nurses see societal shifts in values where some family members decide not to identify as the primary carer. This causes dissension between nurses and families:

“We’re really in kind of a society right now where that care of our loved one isn’t valued the way it is other cultures and I think the way it maybe was years ago…I think that’s where we get some friction” (FG Anita, Medicine).

**Family dynamics** depict how poor family relationships negatively impact nurses’ interactions with families:

“There are times when the [patient-family] relationship is not good…causes stress and in these situations, I would respond very differently than I would in a good relationship situation” (#24, Medicine/Surgery).

While nurses in acute care settings described an avoidance response toward conflicted families, hospice nurses remained engaged but often without proper safeguards against emotional contagion or becoming distracted in meeting patients’ needs.

**Family expectations** reflect both hospital and home visiting nurse experiences when confronted with families’ varied frames of reference for: expectations of patient care and professionals’ positive regard for families’ opinions, preferences, and degree of engagement.

Hospital and home care nurses held strong impressions of families’ reactions, attitudes, or behaviors toward them. They interpreted these in relation to how families see their position in the health care system and with care providers. One hospital nurse stated:

“...I think they come into the hospital with the attitude that it’s almost like a hotel environment that they expect service...” (#FG Shirley, Medicine).

Interrogative families challenged hospital nurses on the tardiness of their responses resulting in defensive or fearful nurses. There was an awareness that some families’ questions stemmed from
a need for reassurance that their input as guardians was valued. Other families were seen as
being uninformed about the patient’s status resulting in families’ frustrating, unrealistic demands
at discharge.

Home visiting nurses also saw variation in family expectations due to personality types
and different histories of care experiences. Some expressed dissatisfaction with families’ false
expectations which they believed stemmed from incorrect information transmitted by hospital
nurses:

“Nurses in the hospital are not educated about what home care does” (FG Chico, Home
Care).

Families’ problematic understanding of care boundaries creates confusion about their
responsibility for certain tasks in the home. Home visiting nurses were adamant about cultivating
a shared health care team approach. This approach entails hospital nurses being involved early in
the care continuum to help families in “moving forward” to garner realistic expectations and
“overcome their anxieties” (FG Diva, Home Care) about their care roles and responsibilities
before discharge to home care.

Vision for Care of Families in Transition

This second theme focuses on categorical descriptions of ‘where’ nurses felt that most impact
can be made to overcome hindrances and advance their vision for improving quality transitional
care.

Improving relationships reflects nurses’ desire to engage more confidently in
relationship-building within the health care team and with families for their empowerment. For
hospital nurses, this entails an ideal system where they are able to: revisit patient privacy
regulations to achieve congruent team understanding on information-exchange with families;
Exploration of hospital and home visiting nurse

possess better knowledge of professional and community-based resources; and spend allotted
time endorsed by leadership to educate, consult with, and respond sensitively to families’
questions. Hospital nurses expressed their need for more self-assurance in taking the lead to
engage with families from admission onwards:

“I think if families are told in the beginning of what to expect with care, this could help
some circumstances” (#9, Hospice).

Hospital nurses also believed that team member hierarchies in discharge rounds need to be
dismantled to ensure better relations and partnered decision-making; this would involve the
team’s recognition of the nurse as a trusted advocate and key collaborator with families.
However, this would require a major shift in the multidisciplinary discharge team’s thinking:

“there’s got to be a paradigm cultural shift to do this” (FG Carla, Psychiatry).

For home visiting nurses improving relationships, within and across care sectors, meant
engaging in collective efforts to empower families:

“Importance of a united front again in selling the role of home care is to empower...and
you get to a place of, you know, independence” (FG Pat, Home Care).

Regional health authorities could sponsor forums for hospital and home care staff to relate,
dialogue, clarify, and jointly work at achieving mutual understanding of, and a commitment to
impacting consistent messages for families. Team-building activities could strengthen congruent
messages about expected care partnerships in transitional care.

Both nursing groups described helping novice nurses to help families as essential to
building novice nurses’ sureness and motivation to engage with families, and as a priority for
basic and continuing education. Hospital nurses described novice nurses as appearing more
interested in interacting with mobile technology than families. Participants believed that
Exploration of hospital and home visiting nurse expanding opportunities for senior nurses to role model good family care warrants attention.

Home visiting nurses described a “huge learning curve” (FG Diva, Home Care) to learn about community resources and intersecting health and social service programs. Being able to recognize what is ‘not normal’ in the home as a signal for timely intervention and/or appropriate referral is important for novice nurses to grasp from senior nurses.

Hospital and home visiting nurses described focusing upstream to prevent harm or bolster families’ strengths in the long-term. For hospital nurses, focusing upstream meant greater use of structured care plans and expected length of stay so that they can: impart essential information to anxious families, clarify families’ expectations about the hospital stay, and initiate early and open lines of communication to launch favorable impressions and grow trust in the health care team. For home visiting nurses, focusing upstream entailed leadership support for formal ‘check-ins’ with families to prevent or ameliorate carer burn-out plus broker connections across health care sectors and community resources. One nurse said:

“...when we’re having a bad day and we’re really busy, we need to focus and remember that all the time, definitely knowing number one and upstream thinking... just continuously trying to do better with what might happen and prevention” (FG Mya, Home Care).

**Bridging the gap** captures participants’ petitions for more efficient and accurate information-exchange between direct care staff across sectors. Home visiting nurses said:

“I need a true appreciation of what happened in the hospital cause this is what I’m seeing here and then you get a better story” (FG Mya, Home Care)
Exploration of hospital and home visiting nurse

“...when we have admissions, that admission paper and the discharge history and what you have sometimes is very very lacking... there’s lots of holes...” (FG Finnegan, Home Care).

For similar reasons, a hospital nurse said:

“I think maybe at some point it would be nice if the nurse could somehow talk to someone in the community end” (FG Shirley, Medicine).

There was also the realization that this could be challenging due to the inconsistent core of care providers who are assigned to patients in hospital and home care settings.

Home visiting nurses described their desire for centralized electronic records that foster timely access to accurate information. The use of technology could also avert the need for families to recount the patient’s medical history to health care professionals across care systems:

“...like if it were all centralized...then we could just fluidly share information...because I think what frustrates a lot of families too is the retelling, the regurgitation of the same story” (FG Finnegan, Home Care).

One nurse expressed doubts that e-charting will become a reality due to infrastructure costs and fears surrounding the risk of privacy breaches.

**Improving families’ expectations** about health care services may ease nurse relations with families. Hospital nurses felt that greater public education about patient privacy regulations could encourage individuals to determine - in advance of a healthcare encounter - appropriate family members to receive sensitive patient information. Families also need guidance on how to initiate effective conversations with hospital staff to clarify their expectations. Home visiting nurses felt that clear explanations on family responsibilities for caring for the patient should be provided in acute care settings as part of discharge teaching:
Exploration of hospital and home visiting nurse

“Part of the discharge planning team, you know it could be education there saying, you know we’ll send homecare out initially to educate and try and get you… you know so that they don’t have the expectation of it being lifelong for some stuff…” (FG Pat, Home Care).

This would involve coaching families on their care role to initiate self-reliance and not dependence on the home health care team.

**DISCUSSION**

Our aim was to address the gap in comprehending hospital and home visiting nurses’ experiences with and vision for what is needed to support families in care transition. The main theme of *Current Care of Caregiving Families* revealed that nurses across hospital and home care sectors were influenced by core values, personal beliefs, and practice setting patterns in family care. Generalized accounts of practicing empathy and open-mindedness, while being attentive to the administrative mandate “to get them and keep them [patients and families] out of hospital” is in sync with efficiency efforts to improve patient flow and to get and then keep patients safe in their homes (Hudson, Comer, & Whichello, 2012, Petersen, Foged, & Norholm, 2019). Hospital nurses spoke most directly to factors that negatively impacted their provision of family care. For example, nurses working on medicine units tended to encounter families at the periphery of their care due to complex organizational (e.g., time limits), staff (e.g., communication breakdowns), and individual (e.g., family disharmony) circumstances. These factors are echoed in related research (Delicado Useros, Espin, & Parra, 2012; Kable Chenoweth, Pond, & Hullick, 2015; Petersen, Foged, & Norholm, 2019; Toscan, Mairs, Hinton, & Stolee, 2012). On the other hand, home care nurses addressed more of a holistic focus in their care of patients: they felt obligated to provide family care as reported elsewhere (Petersen, Foged, & Norholm, 2019). These
Exploration of hospital and home visiting nurse

findings are similar to those by Zurmehly (2007) who described community-based nurses’
“flexibility” and “coordination” of total care (including resource management) for both the
patient and the family.

In the second theme, *Vision for Care of Families in Transition* and its underlying
categories, participants proposed strategies to thwart barriers (i.e., system-, staff-, and
individual-level, and family expectations) identified in the first theme. We will discuss
practice implications for addressing these barriers while making reference to key transitional care
concepts of continuity, expectations, and environment or resources (e.g., Giosa et al., 2014).
Continuity of care is defined as the “orderly” and “uninterrupted movement of patients” who
access services in and across healthcare and community-based organizations (Adair et al., 2003).
As captioned in category, *Bridging the Gap*, participants desired hand-overs of accurate
information between direct care providers across sectors to ensure a consistent care plan is
enacted during transitions -- otherwise called “informational continuity” (Naylor & Berlinger,
2016). Petersen, Foged, & Norholm (2019) and Powell et al. (2016) also identified the need for
similar reform efforts in care coordination and communication between care settings. External
facilitative resources were perceived by participants as vital to advancing their vision of *Bridging
the Gap*. For instance, participants recommended investments in infrastructure and
organizational processes that enable communication between direct care providers across care
settings, as well as timely access to accurate information via information technology and
centralized electronic records. Petersen et al. (2018) reported on the use of an electronic
messaging system in Denmark to enhance the provision or exchange of useful information
between care sectors.
Because home care is generally interim, fostering continuity of care means early strength-based efforts to empower competent carers for future care as described in the category, *Focusing Upstream*. As one remedy, also identified in previous work (Toscan et al., 2012), home visiting nurses felt that a point person is needed to do both case coordination (negotiating appropriate services within the home care program) and community coordination (brokering connections across care systems); this is an approach that Naylor and Berlinger (2016) dubbed as “management continuity.” Home care nurse participants also felt regular check-ins or assessments were vital to preventing carer burnout; thirty to forty percent of family carers experience distress in the role (Turcotte, 2013). A recent government report revealed a similar strategy to develop a care plan for the family carer (i.e., apart from the patient’s care plan) based on a regular assessment that allows for a prompt response to changing circumstances and identification of appropriate strategies to avert distress and promote a good quality of life for the carer (Toews, 2016). Of note, some hospital nurse participants also identified the need for protected time to identify family strengths, deficits, and needs through formal, routine assessment that was also identified in related literature (Glenny, Stolee, Sheiban, & Jaglal, 2013).

In the category, *Improving Family Expectations*, participants described how families’ rigid or unrealistic expectations about families’ input and decision-making negatively impact nurses’ approach in family care. Expectations are defined as “the anticipation or the belief about what is to be encountered in the healthcare system” (Lateef, 2011, p. 163) and are a key influence of the transition experience (Schmacher & Meleis, 1994). For example, when expectations are unrealistic, families can experience feelings of uncertainty or naïve thoughts on what to expect. This category reinforces others’ (Powell et al., 2016) descriptions of the important link between good communication and realistic expectations in and across care
settings. Participants believed that healthcare teams need to initiate early dialogue with families and create opportunities for them to learn how to dialogue with their health care teams. Both sectors of nurses expressed that consistent, accurate, and repeated public messages to families can help improve their expectations about: (a) the role and responsibility of nurses and family as partners-in-care, (b) information-sharing as bounded by patient privacy regulations, and (c) the availability of formal and informal community resources to engender independence and strength in caregiving families.

Findings in the related category, *Improving Relationships* speak to the importance of building relationships with not only health care team members but also family carers. First, participants identified how inconsistent messages from nurses about their roles, in and across care settings, can create a mismatch between expectations that are ‘realistic’ and ‘false’ and leads to mistrust and tension in families as described by others (e.g., Nosbusch, Weiss, & Bobay, 2010). In the current study, bonding and commitment to ‘family-as-partners’ by home visiting nurses were less evident in hospital nurse accounts where ‘family was in the periphery’ of their care. Without systematic efforts to heighten nurse perceptions of these differences, nurses across care sectors remain ill-prepared to engender realistic role expectations of each other, carers, and patients (Petersen, Foged, & Norholm, 2019; Zurmehly, 2007). Team-building interventions are vital to helping cross-sector nurses understand respective roles across settings and create collective or united messages about family care that accommodate these distinct, yet dependent roles (Petersen, Foged, & Norholm, 2019). Team building activities also help nurses to commit to consistent message delivery resulting in concordant, realistic stakeholder expectations (Schumacher & Meleis, 1994).
Second, similar to Hudson et al.’s (2012) findings, participants did not feel like their professional opinions were valued by their team members. Nurses may have felt inhibited to negotiate or follow-through with their recommendations due to perceptions of not feeling trusted by the team, a lack of confidence in their professional judgment, poor communication patterns, or limited team collegiality. Toles et al. (2016) described these behavioral outcomes as “circumvented conversations” due to power differentials and competing priorities (Nosbusch et al., 2010) that culminate in tensions and resistance (Toscan et al., 2012). However, these tensions can be attenuated in team communication and trust-building interventions (e.g., Brennan, Olds, Dolansky, Estrada, & Patrician, 2014; Hellier et al., 2015).

Third, supporting Glenny et al. (2013), our hospital nurses experienced conflicts with other team members who prioritized patient privacy regulations over sharing information with carers. Participants recommended strengthening organizational structures, processes, and opportunities for staff to: (a) directly dialogue, learn, and resolve moral dilemmas due to tensions between professional obligations and privacy regulations and (b) cultivate respectful inter-professional dialogue, as well as a respect for each team members’ equal and unique roles and responsibilities.

Nurses’ professional transitions are also shaped by available and appropriate resources in the workplace environment (Schumacher & Meleis, 1994). In the category Helping Novice, nurses identified mentors as an essential workplace resource to help novice nurses attain mastery and comfort in communicating with families. Home visiting nurses identified that novice nurses could benefit from senior nurse mentors’ knowledge of key warning signs for poor coping by families, as well as how to identify and coordinate appropriate supports for families in the community. Participants were clearly concerned with care not only
Exploration of hospital and home visiting nurse

experienced by families but also provided by novice nurses who had limited workplace supports
to attain role mastery in family care.

**Strengths and Limitations**

The experiences and vision of home visiting and hospital nurses who worked in one urban
regional health authority may not represent the responses of nurses working in other settings.
Nonetheless, and in particular, we managed to recruit hospital nurses who practiced across varied
patient units, especially those who worked in busy acute medicine and surgical units (a gap exists
in understanding their experiences of family care). Data saturation might not have been achieved
due to this being a small study with limited funds. Regardless, we captured detailed accounts that
touched on and provided valuable insights on how to achieve ‘consistency’ of care, address
realistic ‘expectations’, and redress ‘resources’ as part of advancing transitional family care.

Although responses might have been biased because nurses were aware that this was a study on
transitional care, we believe this was mitigated by our triangulation of data sources: i.e., nurses
were afforded the opportunity in a focus group to qualitatively supplement their open-ended
survey responses.

**CONCLUSIONS**

Internationally, attention is being paid to effective transitional care to reduce expensive hospital
stays. An important contribution of the present study is that it captured both hospital and home
visiting nurse experiences with and vision for the transitional care of caregiving families.

Previous studies had not captured the perspectives of nurses across care sectors in one report; it
was difficult to have a complete picture of transitional care provided by nurses to caregiving
families at either end of the care continuum. Due to their “embedded involvement” in all aspects
of care transitions (Naylor & Berlinger, 2016), we were able to tap into how nurses envision
Exploration of hospital and home visiting nurse

overcoming barriers and advancing transitional care of families across sectors and at system-, staff-, and individual- levels of care.

RELEVANCE TO CLINICAL PRACTICE

Nurses were positive about supporting transitioning families. They offered insights on strategies involving committed resources by management and reforms in health care organizations; e.g., to support direct communication between direct care providers across care settings, provide mentoring environments for novice nurses, etc. Nurses desired team building exercises that bolster their understanding of respective roles across care sectors and allow them to create collective or united messages about family care that accommodate their distinct, yet collaborative roles. Future research needs to systematically test these strategies to produce evidence on the best system- or setting-level conditions conducive for optimizing quality transitional care of families.
References


Exploration of hospital and home visiting nurse


Exploration of hospital and home visiting nurse


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Exploration of hospital and home visiting nurse


https://doi.org/10.1177%2F1074840707312716


Exploration of hospital and home visiting nurse


What does this paper contribute to the wider global community?

- Despite their key roles in transitional care, nurses across care sectors pay different types and degrees of attention toward the support of transitioning family carers.

- Hospital and home visiting nurses both desire enhanced communication: for hospital nurses, this involves enhanced discharge team communication and better skills in communicating early with family carers; for home visiting nurses, more direct information-exchange between direct care nurses across sectors was desired.

- Favorable attitudes toward family carers does not translate unequivocally across care settings or necessarily shape optimal nurse-family carer interactions that depend also on available and appropriate workplace resources.
Table 1. Interview items and probes

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Introductory question – begins discussion topic</strong></td>
<td><strong>“When you hear the term ‘families’ of individuals in your care what comes to mind?”</strong></td>
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<tr>
<td><strong>Discovery</strong></td>
<td><strong>“What do you believe is good about your care of families in your setting, and why?”</strong></td>
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<td></td>
<td>• Tell me about a time when you were able to do your best care and support to families. You can describe the situation by describing what was happening and what did you do? What did others do? What made it possible for this experience to occur?</td>
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<td><strong>Dream</strong></td>
<td><strong>“What do you want to achieve in your care of families, and why?”</strong></td>
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<td>• Imagine a time in the future when people will look to your practice as an exceptional example of how to provide the best care and support to families.</td>
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<td>• Tell me how you envision you and your colleagues are engaged in care of families.</td>
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<td>• Tell me what positive core values make it possible for you and your colleagues to achieve this vision.</td>
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<td>• Tell me what kinds of systems or structures would most encourage nursing care of families.</td>
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<td>• Tell me what you would be most proud of in having helped families in your care.</td>
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<td><strong>Design</strong></td>
<td><strong>“What are the areas where you feel you need to focus on that could have the most impact on improving the quality of care for families?”</strong></td>
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<td></td>
<td>• What do you feel are the most promising areas in which to expand your skills in providing care to families? Why? What family care topics would you like to learn more about?</td>
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<tr>
<td><strong>Destiny</strong></td>
<td><strong>“What is needed to make your vision in caring for families more of a reality in your care setting?”</strong></td>
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<tr>
<td></td>
<td>• For the future, what three things would make it possible for you and your colleagues to do more best care of families more of the time? What do you wish? What resources will be needed?</td>
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<td></td>
<td>• What small changes could you make right now to make your vision in caring for families more of a reality?</td>
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<td></td>
<td>• Tell me more about how you and your colleagues will know that caring for families has become more of a reality in your patient care unit? What are the indicators?</td>
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TABLE 2. Categories / Subcategories and Themes from Content Analysis

<table>
<thead>
<tr>
<th>Categories/sub-categories</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Core values</td>
<td>Current Care of Caregiving Families</td>
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<tr>
<td>System-level factors</td>
<td></td>
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<tr>
<td>Nurse-system conflicts</td>
<td></td>
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<tr>
<td>Poorly resourced (e.g., time)</td>
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<tr>
<td>Staff-level factors</td>
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<tr>
<td>Nurse-manager conflicts</td>
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<tr>
<td>Reliance on other disciplines</td>
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<tr>
<td>Opinions ignored and being caught in the middle</td>
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<tr>
<td>Individual-level factors</td>
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<tr>
<td>Choices made regarding family involvement</td>
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<tr>
<td>Family dynamics</td>
<td></td>
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<tr>
<td>Family expectations</td>
<td></td>
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<tr>
<td>Improving relationships</td>
<td>Vision for Care of Families in Transition</td>
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<tr>
<td>Helping novice nurses to help families</td>
<td></td>
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<tr>
<td>Focusing upstream</td>
<td></td>
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<tr>
<td>Bridging the gap</td>
<td></td>
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<tr>
<td>Improving families’ expectations</td>
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