

## Research Article

# Nurses' Conceptions of Elderly's Participation in Coordinated Discharge Planning from Hospital Wards

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The discharge care planning (DP) is a complex assignment and challenging. Research shows that aspects of patient participation in DP are often ignored or neglected and assessments are rarely coordinated by nurses. The aim of the study was to explore nurses' conceptions of elderly's participation in the DP. Fifteen registered nurses were interviewed. A phenomenographic analysis by Åkerlind was used. Categories of description showed that the elderly's participation is prerequisite and it requires grounding. Themes of awareness highlighted the nurses' insight to undertake the role of advocacy and to take on ethical responsibilities. Complex ethical issues arise in DP and the difference between what is beneficial for the elderly and the elderly's autonomy is a key issue and should be constantly discussed.

**Keywords:** Discharge Planning; Participation; Nurses' Conceptions; Phenomenography**Introduction**

In the health care system worldwide of today there have been changes in elderly care, which have led to a reduced number of available beds in health services [1,2]. These studies also showed that older patients discharged from hospitals were in a worse condition and more dependent than before. Further, the elderly's role has changed from passive recipient of care to more active and informed co-producer of health [3]. Discharge planning (DP) from hospital to home care is a complex commitment and a challenge with different organizational contributors [2]. Problems are shown in the literature e.g; inadequate assessment, failure in communication and information transfer between hospital and community care [2,4]. This can lead to unnecessary readmissions which can be life threatening for the patients [5]. According to [6] DP facilitated with a structured, systematic and coordinated procedures ensures a smooth patient transition from hospital to the community and improved patient health outcomes. DP is a process for identifying and organizing the services and prevents problems after discharge that a person with diseases and other vulnerabilities will need after hospital discharge [7,8]. However, DP does not always satisfy patients' and relatives' rights to express their personal wishes in a dignified manner, which may result in their needs not becoming evident [9].

The goal of DP is to reduce the length of stay in the hospital and unplanned readmission to the hospital, and improve the coordination of services following discharge from the hospital [10]. A meta-synthesis by Waibel, Henao, Aller, Vargas and Vázquez [11] focused on patients' experiences of continuity of care showed that communication and information transfer across care settings and holistic information about the patient promoted continuity of care.

In the rhetoric in European countries about patients' possibilities to take an active part in their own health care, a prominent argument has been that social protection and social inclusion is crucial for reducing inequalities in health. Patient participation is fundamental

for implementing nursing interventions in all types of nursing care [12,13] and to avoid readmissions, increase satisfaction, reduce anxiety, complications and mortality [14]. However, health care professionals do not always focus on elderly's participation in planning for discharge [15-17]. The following factors have been described as important; information for elderly patients such as; time for discharge, use of medication, factors related to the community service, degree of information, and finally, how their practical problems could be solved [18]. Larsson, Sahlsten, Segesten and Plos [19] found that patients participating in DP experienced barriers in participation their experiences were facing own inability, meeting lack of empathy, meeting a paternalistic attitude and sensing structural barriers. On the other hand factors that contributed to the elderly's participation in the DP were related to their; 'knowledge about their changed life situation, how to regain health' and positive interaction with the staff [20].

The concept participation has been studied in different contexts within nursing science since 1980 [21]. In this study, we used the definition "patient participation is an established relationship between nurse and patient, a surrendering of some power or control by the nurse, shared information and knowledge, and active engagement together in intellectual and/or physical activities" [21]. Findings in studies by [22,23] suggested that clarifying the roles of the professionals together with cooperation between the caregivers can contribute effectively to the DP process. To promote and stimulate patients' active participation in the DP process Nilsson, From and Lindwall [24] indicated that nurses should see the patient as an equal partner and balance obstacles for patient's participation. Further, studies show that nurses' conceptions of the patient's participation in DP are characterized by a good relationship between the patient and nurses, satisfactory information and that the patient's resources are being used [13,20,25]. Communication problems could be a major factor that hindered an effective DP [26]. Interviews with nurses [25] showed that aspects of patient participation in DP were often ignored

or neglected and assessments were rarely coordinated. Lack of time was reported to be the greatest barrier that affected the coordination of assessment. According to Norheim and Gutormsen Visnes [27] nurses' express difficulties in meeting all obligations to enable the patient's participation due to cutbacks in finances and staff.

There is a growing body of research on the DP process related to elderly's participation, which is often found to be complicated and problematic. The importance of mutual communication and cooperation between caregivers and elderly's participation has been highlighted as a key to effective DP. However, there is a lack of studies showing Registered Nurses (RN) in hospitals own experiences of their roles and responsibilities for patient involvement in decision making during DP.

This study aimed to explore registered nurses' conceptions of elderly's participation in the discharge planning process and to identify the structure of awareness underlying the nurses' varying experiences of participation.

## Methods

This study is a part of the research project "Elderly and Discharge Planning (DP)", which aims to describe different perspectives related to discharge planning for elderly persons from hospital to home or residential care facilities. The present study focuses on nurses' conceptions of the elderly's participation in DP.

### Design

The present study has a phenomenographic approach with semi-structured interviews to describe the qualitatively different ways in which individuals experience, conceptualize, perceive and understand different aspects of the world [28,29]. The aim of phenomenography is to detect and describe different ways of conceptualize phenomena in the surrounding world, and there are only a limited number of qualitatively different ways a phenomenon can be experienced [29]. The term Conception is defined as different ways in which people discern and experience various phenomena in the world around us. Phenomenographic analysis seeks to explore the Conceptions, which are implicit in the descriptions of a particular phenomenon [30].

According to Åkerlind (2008, 2012) the different conceptions are seen as structurally related in a hierarchy of inclusiveness. Different ways of experiencing a phenomenon i.e. Conceptions are compared regarding similarities and summarized into different Categories of Description. These Categories of Description are logically inclusive structures representing different ways of experiencing. These ways of experiencing can be ordered in terms of inclusivity of awareness, where more inclusive ways also represent more multifaceted descriptions, indicated by an increasing breadth of awareness of different aspects of the phenomenon being investigated. The more complex views includes awareness of the dimensions of growth and development in the process to articulate the conceptions of the phenomenon under investigation. The expansion of individuals' awareness includes discernment of additional aspects of the phenomenon, presented as Themes of Expanded Awareness [31,32].

The logical structuring of the relationships between Categories of Description and Themes of Expanded Awareness composes the structure of the Outcome Space in a holistic way [33]. The Outcome

Space represent the full range of possible ways of experiencing the phenomenon in question. Categories of Description intertwined with Themes of expanding awareness, in this particular point of time, for the population represented by the group collectively outline the Outcome Space [34].

### Informants

Fifteen Registered Nurses (RN) working in four of seven medical wards and three of five surgical wards in one hospital in Sweden were included in the study. Inclusion criteria were; informants that mastered Swedish language and had at least one year's experience working as a nurse and experience of discharge planning. Information about the research project was given to the medical director of the medical and surgical wards by the authors and informed consent was obtained. The head nurse at each ward was asked to forward an information sheet about the study by e-mail to RNs who met the inclusion criteria. The master students involved in the project visited the wards weekly to receive information about RNs who had participated in any DP. These nurses were then contacted and asked for consent to participate in the study. Agreement of place and time for an interview was obtained within seven days after the DP. Of the fifteen informants, one was a man. The length of their professional career varied between 1.5 to 38 years (median 5 years).

### Study context

Different laws regulate community care, The Swedish Social Service Act [35] and The Health Care Act [36], The National Board of Health and Welfare is the regulating authority for the care of elderly people in Sweden. The county council in each region is responsible for health and medical care in primary and hospital care and the municipalities are responsible for long-term elder care, such as home-based care and nursing homes. The county council and municipalities are responsible for drawing up the procedures in cooperation for the discharge planning [37]. DP conferences should be organized as a cross-professional meeting that includes the patient and/or next of kin [37].

The concept "clinically ready for discharge" is applied when the investigations of the patient's disease and medical status are finished – when further medical treatment is no longer needed [36]. The regulation stipulates a policy to promote and support the elderly's continued needs of care. When patients are clinically ready for discharge, the municipalities have five business days to plan for elderly homecare or other care facilities [38]. Otherwise, the municipalities must pay a fee to the county council from the sixth day [38]. As stated in the regulation, the health care providers are required to collaborate during the DP process and information about the patient can be obtained before the DP meeting. However, the organizations sometimes use different administrative systems for patient documentation, leading to missing or discrepancy in information [39]. This was the current circumstances in time of the present study. In 2017 the National Board of Health and Welfare has changed the regulation

### Data collection

Fifteen semi-structured individual interviews were conducted with RNs, who were asked to describe their experiences and thoughts about DP that they have been involved in with focus on elderly

patient's participation. Before the interview, the nurses' were asked to think about an average elderly person, 80 years old or elder, and was to be transformed to their home or municipal health care services. During the interviews, the nurses were also asked to elaborate on their answers, such as: "How do you mean?" or "Can you describe more?" The interviews were digitally recorded and lasted between 20-45 minutes. The interviews were performed by two master students and were preceded by three test interviews. These test interviews were transcribed and discussed in the research group, the interview guide was reformulated and reorganized and the two master students were given feedback on their performance in order to learn interview technique.

### Data analysis

A phenomenographic analysis described by Åkerlind was used. The analysis was carried out by the two authors. In the data analysis, Åkerlind argues that the different ways of experiencing are not constituted independently, but in relation to each other, ordered in terms of inclusivity of awareness. This analysis model is based on the arguments of Marton and Booth, who claim that the experience of any phenomenon may be seen as involving both a 'what' and a 'how' aspect. The interview was transcribed verbatim by the interviewers and analyzed by the authors. The following three steps were used in the analysis process [32,33].

The first step was to read each transcript three times, and during the third reading, notes were made about what emerged in the context of the other transcripts. Key questions and themes that emerged were summarized in relation to the uttered conceptions of the phenomenon. The second step involved grouping similar transcriptions together after repeatedly rereading the transcripts and notes. The third step involved rearranging the groups of data after further reading, searching for similarities in the overall meanings within the emerging categories and differences between the categories, so called "categories of description" [33]. Next step in the analysis was to search for Themes of awareness running through the set of categories of description, every theme linked to a set of different dimensions of variation. The themes of awareness may then be hierarchically ordered on the basis of increasing breadth of awareness, as a more complex way of understanding. The categories of description constituted by the researchers to represent different ways of experiencing elderly's participation, and the themes of expanding awareness are thus seen as representing a structured set. The logical and hierarchical structuring of the relationships between the categories of description and the themes of expanding awareness constitute the final outcome space [32,33].

Åkerlind emphasizes the importance of those categories being allowed to emerge from the data and not being decided in advance. To strengthen the trustworthiness, the authors worked together in a critical dialogue through all steps. Preliminary categories were discussed and re-analyzed until consensus was reached. The final outcome unavoidably reflects both the data and the researchers' judgments' in interpreting the data.

### Ethical consideration

The Regional Committee for Medical Research Ethics in Uppsala, Sweden, approved the study (registration number 2012/028). The

study was carried out in accordance with the Ethical guidelines for nursing in the Nordic countries [40]. The RNs who participated in the study were given oral and written information and informed consent was obtained in writing. The informants were also informed of the voluntary nature of the study and that they could withdraw at any time without negative consequences. The digitally recorded interviews and transcriptions were kept separate and stored in such a manner that only authors and students had access to them.

## Results

The result contains three sections; Categories of Descriptions, Themes of Expanding Awareness and the Outcome Space. The first section show nurses qualitatively different ways of conceiving the phenomenon of elderly's participation in care planning. The Categories of Description that emerged were: Elderly being present and taking part - a prerequisite, The requirement of preparing and orienting the elderly to reality, Occasional inability to actively participate, Disparities in whether family members act supportive or discouraging, Imbalance of power in facilitating active participation. Each Category of Description is described in more detail below with a description of key aspects of the categories and with quotations and written in italics. Quotes are used to exemplify the variation within the categories, not to validate the analysis that is not possible because one quote could not represent the category of description, which reflects the total group (Table 1).

### Elderly being present and taking part - a prerequisite

The idea of participation was based on a real aspiration to do something for the elderly, i.e. prepare the elderly in advance and create a trusting relationship. There was an endeavor from both the nurses and community care staff to involve the elderly in the planning process and most of the time the elderly took part in the conference. Informing the elderly in advance about the conference and what was going to happen seemed to be a requirement for participation. The nurses' conceptions were that the planning conference was seen as positive and was in the elderly's interests. When they have to know the elderly by establishing rapport and attempting to generate feelings of trust before the conference, and when they were well prepared, the planning of the transition could go very well. However, a stressful work situation and if they did not know or had not cared for the elderly, create a sense of being disorganized.

When the nurses knew the elderly, they had more opportunity to take action and also to be attentive and make sure that the elderly understood what was going to happen. The nurses tried to have an open dialogue, give feedback and give time for the elderly to react. But they also experienced difficulties when making an effort to include the elderly in the dialogue, when the elderly held the opinion that it had already been decided for them what help they could receive. It did not matter what the elderly said or wished. The nurses felt that there was an attitude of "we versus them" from the community staff. There seemed sometimes to be no focus whatsoever on the elderly's situation and needs, according to the nurses.

Restriction of license to act, which interfered with participation, implies that nurses could neither intervene too much nor too little, as they had to hold back information to the elderly about possible arrangements. They had the authority to talk about the time at the

ward, but nothing about what would happen outside the health care section. The community staff claimed that it was their decision to make. There were difficulties for the nurses to agree with the scope of activities they could operate in. The nurses felt that they had no say in the matter “It is not your case”. Their experience was that they could not always speak up for the patients and their participation in decision-making during the conference.

The elderly’s ability to express what they thought about their situation and what they needed help with depended on the elderly’s cognitive status and awareness. To encourage the elderly to express their needs and wishes entails attempts to involve the elderly in the conversation. The nurses made sure that the elderly understood what was going on and tried to ask questions that were possible to respond to. Listening to each other and meeting perceptive staff were important factors for the nurses. The goal was always that the elderly were the ones to decide for themselves before an agreement was made.

“You had to try to listen to the elderly and perhaps the close relatives who they were surrounded by and put everything together. Doing one’s best. Yet it is clear that the patient always should be present, sort of” [9].

### **The requirement of preparing and orienting the elderly to reality**

To present the medical and nursing history in a basic way, suggested that the elderly could recall what they had been through in order to understand their situation. It was an opportunity for the elderly to get a coherent story about their illness and increased their possibility to participate. After the nurses had delivered their nursing and medical story they felt neglected by community staff and felt excluded from the conversation. They felt as if they did not have ownership of the process.

Not humiliate the elderly by pointing out his/her mistakes, was an issue for the nurses. They tried to involve the elderly in the care planning despite the elderly’s difficulties to comprehend and to hear what the professionals said. It was essential for the nurses not to “talk over the head of the elderly” [6]. They found it difficult to sit in front of the elderly and talk about forgetfulness, as they did not want to point fingers, but nevertheless the elderly had to be informed to be able to participate.

Balancing interference between the elderly and the community care staff was a concern for the nurses. The nurses felt strongly that they had to act on behalf of the elderly that they had to represent them. The nurses felt that they had to balance between the elderly’s shortcomings and the community staff’s demands not to interfere too much. On the other hand, the community staff challenged them and wanted answers about medical issues that the doctors should have answered.

The nurses’ professional role in the discharge planning process was to clarify current and forthcoming nursing and medical needs. Sometimes the elderly had no insight into their nursing needs and thought they could manage better than they actually could. It was sometimes difficult to talk about the elderly’s status, because the elderly was not informed about the severity of their illness. However, the nurses tried to be as honest as they could be, without discouraging the elderly and family members. In difficult situations, i.e., elderly with

psychiatric problems in combination with other severe illness, the planning took place without the patient present and not participating, with the intention of protecting the elderly’s self-esteem.

“I can just be as precise as possible, to clarify the medical needs and nursing needs that we have seen here, and which should continue at home. That is all I can do. I am not supposed to put words into community staff’s mouths. I only have authority to talk about the time here at the ward – to be clear towards the elderly” [2].

### **Occasional inability to actively participate**

Protecting the cognitive impaired elderly from a stressful situation. Some elderly did not know who they were or where they were, and in cases like that, it is not worth the effort to involve them in the process. The elderly was sometimes too ill to participate in the conference. They did not care what happened to them, they just wanted to be cared for. Even family members had the opinion that it would not be decent for the elderly to participate in the conference.

The elderly’s inability to understand their situation made it difficult for the nurses to discuss arrangements and what support the elderly required. Sometimes the solution to the problem was that the nurses and community staff in discussions with family members took over the authority to decide for the elderly. The elderly did not seem to understand their own best interests and could not participate in an efficient way. The elderly refused to get help and thought they could manage by themselves. Then it became very difficult to plan for the transition to home.

Experiences of conflict in when and how to inform in order to avoid anxiety entailed conflicts between the ambitions to accomplish the obligation to inform, which in turn could perhaps create anxiety in the elderly. The nurses tried to establish an appropriate dialogue with the elderly, but they did not find it easy.

In some cases, the nurses came to an agreement without the elderly’s consent. Instead of involving the elderly in care planning, they turned to the family members for agreement with the community staff. Sometimes they informed the elderly person afterwards but did not ask for their consent, which could disrupt the whole planning in the interest of the elderly, although the nurses knew that the law stipulates that the elderly must give consent to the decision. There were situations when they talked with the community staff before the conferences and came to an agreement with them in order to avoid compromising the elderly.

“Yes, there are occasions when the elderly just doesn’t have very good self-perception and they don’t think they need any help, although it is obvious for everyone else that it is needed, both this and that. So it is difficult, tremendously difficult” [13].

### **Disparities in whether family members act supportively or discouragingly**

Family members sometimes had strong demands for arrangement of care for their elderly and did their own thing despite the elderly’s wishes. In these cases, the nurses and the community staff could join and support the elderly and prevent them being trampled on. The family members could be found to be very demanding, as they required concrete arrangements and support for their elderly. Family members did not always ask for the elderly’s thoughts about their

situation but had already decided what was best for their elderly. They ignored them and did not pay attention to the elderly's statements of their needs. The family members thought the elderly's input was irrelevant, as the elderly did not know they were saying and could not participate in the process.

Joining the community staff was one approach when the nurses thought that the family members ignored the elderly and that their demands were unrealistic. The nurses tried to focus on the elderly's own will despite family members' demands. They tried to strengthen the elderly's position by asking where they wanted to live and support them in their participation.

In the care planning, the nurses felt that their role was to balance demands and support from family members in front of the elderly. The nurses understood that family members could feel frustrated and worn out because they had previously helped their elderly, despite perhaps their own fulltime job or other family obligations. The nurses indicated that they had to support family members when the elderly was too much of a burden on them. They had to balance between the elderly's sometimes-unrealistic expectations of help from family members and the family's desire to give help and support.

Part of the work effort nurses had in the care planning process was to empower family members to take an active part in decisions. A component in empowering was to inform. The information was about what kind of arrangement the community had to offer and sometimes the nurses voiced their opinion of what family members could claim for their elderly. The family members sometimes wanted to describe the elderly's situation, what it was like before the hospitalization and the problems they experienced in daily life. They did not want to talk about their difficulties in front of the elderly, but privately with the nurse. The family members supported the elderly to take part in the care planning and to be active about their needs, they wanted the elderly to be in charge as much as possible.

"Sometimes the relatives disregard the elderly and don't ask for what the elderly wants. Nevertheless, it is the elderly we make plans for, not the relatives. But sometimes, on the other hand, relatives burn out, you could almost see this part and then you have to call upon more support" [4].

### **Imbalance of power in facilitating active participation**

To enable elderly's participation in the care planning, information about available support was given. The nurses took time to inform the elderly and family members about community support the day before the conference was scheduled. They discussed the elderly's nursing needs and their problems in daily life, to give them the same understanding of the situation when facing the community staff.

An important issue for the nurses was that family members had the same and correct information, which could strengthen the elderly's cause and participation in the process. The nurses claimed they had the responsibility to argue for care planning in favor for the elderly's participation. They had to stand up for the elderly person, the community gave no alternatives, and the community staff just stated that this is what you have to take on. The nurses tried to fall back on existent rights and laws to help the elderly receive necessary support. If they were well-prepared, they could be more determined. The nurses experienced that the quality of the cooperation differed

between large and small communities in favor of the small ones.

In the conference, there were experiences of difficulties in communication. The nurses experienced not being listened to or respected, at the mercy of one-way communication influencing the elderly's participation. Community staff took over and the nurses felt that the elderly was trampled on. The decision was taken before they even met the elderly person. The nurses' expertise was not taken in account, and they were not taken seriously.

The community staff was not content with the nurses' efforts to take stand for the sake of the elderly. The nurses had to work against the community and not holding back active participation. The experience was that some staff had strong opinions about things and it was difficult to come to an agreement. The nurses found themselves and the community staff stumbling and not acting on the behalf of the elderly and family members having an impact on participation in the process. Nevertheless, when the nurses talked about difficulties, they claimed that for the most part it all went efficiently and resulted in a good decision for the elderly.

"I think it is a lot from the side of the community, what they believe, so to say. Sometimes one can think that they trample on the elderly, sort of. There are limited residential aged care facilities for older persons. The elderly wish not to go home they often want to go to a home for elderly. Then you are offered several hours of home care service, because there are no other options" [6].

### **Themes of expanding awareness**

The themes of expanding awareness are seen as related to one another through an expanding hierarchy of inclusive awareness and running through the categories of description. They are logically linked and separate the different categories of descriptions or the different ways of experiencing. The themes of expanding awareness as a result of the analyses are: Taking on the role of advocacy, Ethical responsibilities to protect elderly's self-esteem, Being restricted in what to communicate and perform and Necessity to conspire in defending active participation. These four themes are presented in detail below and in Table 1.

**Theme 1** Taking on the role of advocacy expanded across the categories of descriptions. In category 1, the analysis showed that nurses had a real aspiration to do something for the elderly, to promote and protect their wellbeing. Creating trusting relationships with the elderly and getting to know them was essential for the nurses in the discharge care planning. Category 2 reveals that the nurses tried to work in partnership with the elderly by explaining and sharing information with the elderly in a basic way. The nurses' desire was to assist and support elderly's decision-making. They thought they had insight into the needs of patients just like any other healthcare professional. Category 3 showed that in order to promote participation, the nurses found it most difficult when they had difficulty establishing rapport with the elderly. This was particularly true for those most vulnerable and at risk, being unable to communicate. The nurses sometimes had to persuade elderly with cognitive impairment or make decisions for them. They acted in what they thought was the best interest of the elderly. In category 4, it was shown that the nurses aligned themselves with the elderly in order to safeguard the elderly person's rights and safety. The nurses could

**Table 1:** The range of variation in ways of experiencing elderly's participation in care planning.

Categories of Description	Cat.1	Cat.2	Cat.3	Cat.4	Cat.5
Themes of expanding awareness	<i>Elderly being present and taking part - a prerequisite,</i>	<i>The requirement of preparing and orienting the elderly to reality</i>	<i>Occasional inability to actively participate</i>	<i>Disparities in whether family members act supportively or discouragingly</i>	<i>Imbalance of power in facilitating active participation</i>
Taking on the role of advocacy	Prepare the elderly in advance and create a trusting relationship.	Present the medical and nursing history in a basic way	Protecting the cognitive impaired elderly from a stressful situation	Support the elderly and prevent them from being trampled on	Information about available support to enable participation
Ethical responsibilities to protect elderly's self-esteem	Make an effort to include the elderly in the dialogue	Not humiliate the elderly by pointing out their mistakes	Taking over the authority to decide for the elderly	Focusing on the elderly's own will despite family members' demands	Responsibility to argue for care planning in favor of the elderly's participation
Being restricted in what to communicate and perform	Restriction of license to act which interfered with participation	Balancing interference between the elderly and the community care staff	Conflict in when and how to inform to avoid anxiety	Balancing demands and support from family members in front of the elderly	At the mercy of one-way communication influencing the elderly's participation
Necessity to conspire in defending active participation	Encourage the elderly to express their needs and wishes	Clarify the current and forthcoming nursing and medical needs	Came to an agreement without the elderly's consent	Empower family members to take an active part in decisions	Had to work against the community and not hold back active participation

also collaborate with others in the professional team to strengthen the elderly's engagement, which they thought protected the rights of the elderly. Particularly in situations where family members insisted on a course of action that nurses knew may be damaging to their elderly's wellbeing. Category 5 showed that the role of advocacy provided nurses with an ideal springboard from which to challenge the authority of community staff, resulting in nurses speaking, fighting and standing up for the elderly. The nurses used their expertise and influence to promote the participation of vulnerable elderly.

**Theme 2** Ethical responsibilities to protect elderly's self-esteem was about nurses' reflections on doing the right thing to facilitate the elderly's participation in discharge planning. In Category 1, it was revealed that nurses tried to respect elderly's rights to participate in decisions about their care planning by assisting in and supporting the elderly's decision-making. The right to make autonomous decisions about their own care planning seemed to be an ethical issue for the nurses. Category 2 disclosed that, to respect the elderly, it was essential for the nurses to view the elderly as an equal part of the team. The elderly has the right to take part in their own health care and should be informed and involved with all communication with outpatient providers and other contacts, despite their difficulties. Category 3 showed that to ensure that the care planning was in the elderly's best interests, the nurses worked together with community staff to come up with the best solution for the elderly. The nurses were concerned with promoting the elderly's interests and continuity of care. Category 4 showed that nurses had to handle increased complexities in ethical decisions facing the family members' demands, while at the same time acting on behalf of the elderly. The nurses' standpoint seemed to strengthen the elderly's position. In category 5, it was shown that nurses experienced a lack of balance in power between themselves and community staff. These circumstances made it difficult for them to protect elderly's participation. The nurses own power and autonomy was restricted when they felt that they must use the full capacity of their voice to get the best decision from their point of view.

**Theme 3** Being restricted in what to communicate and perform exposed that the nurses were not comfortable with their inability to have an impact on the elderly's participation in the discharge planning. In category 1, the analysis revealed that the nurses felt that they had to accept a passive and restricted role towards the elderly's involvement. They felt that they were suppressing the voice of others.

They expressed that it was the community staff who were supposed to inform and advise the elderly and family. It was the community staff that had the authority and the nurses felt marginalized. In category 2, the nurses stated that they had to counteract the attitudes of elderly as vulnerable and encourage elderly to be active. They strove to up-hold the elderly's autonomy and to represent the elderly in the process. Category 3 showed that nurses end up in a dilemma about what the information should consist of, since without information, the elderly could not participate. The nurses had to face the decline in the elderly's cognitive and physical capacities and they questioned the elderly's requirements for knowledge or expertise to make decisions. In category 4, it seemed as the nurses met conflicting wishes, expectations and responsibilities and they questioned whose interests should form the basis for the discharge planning. They had to consider the elderly's needs and wishes and the family members own needs of relief from the burden of care and responsibilities. The analysis in category 5 showed that nurses felt too restricted in their professional roles when it came to regulations and institutional policies. There were occasions with competing organizational priorities, the nurses experienced that they did not have influence on discharge decision-making, and there was a one-sided communication practice. That led to a limitation in maintenance of the elderly's participation in the process.

**Theme 4** Necessity to conspire in defending active participation was about nurses that thought they had to collude against community staff to make sure the elderly could participate in the discharge planning. The analysis in category 1 uncovered that the nurses were committed to that the elderly should be prepared, supported and encouraged to be active in the discharge planning conferences. Their approach was that the conferences should not be perceived as the professional arena for information transfer. Nurses tried to align themselves with the elderly by claiming the role of patient advocate to support elderly's involvement in the process. Category 2 disclosed that the nurses had difficulty informing about the elderly's difficulties in everyday life in a decent way. They thought that they had the necessary knowledge and expertise to contribute to the conference; however, their insecurity was about the elderly's ability to comprehend the situation and actively participate in the discharge planning. Analysis in category 3 showed that there were situations when the nurses created alliances with the community staff in order to make decisions about care planning. They arranged inter-

professional pre-conferences and excluded the elderly, to minimize the risk that elderly decline the proposal. The elderly's participation was prevented, although the nurses thought that they acted in the best interest of the elderly. Category 4 showed that the nurses were engaged in involving family members in the discharge planning. The nurses reported about situations where they cooperated with family members in advance, to even out the balance of power in the discharge planning process. The nurses felt that they did not have the same influence on discharge decision-making as community staff. In category 5, the nurses disclosed that they experienced problems in collaboration with the community staff in the discharge planning. There were problems with the professional hierarchy and insufficient contact among professionals from different organizations. The negotiation was affected by conflicting clinical and organizational priorities and the community staff were in more control of the situation and discouraged the development of a more dialogic talk. This influenced the outcome of the conferences, leading attendees to focus more on professional boundaries rather than what was best for the elderly and elderly's participation.

### The outcome space

Nurses' different ways of experiencing elderly's participation in discharge care planning was found to be that elderly's participation is prerequisite, and it requires grounding. The nurses accepted occasional failure in elderly's participation and detected disparities in whether family was supportive or not along with imbalance of power in facilitating elderly's participation.

The increasing complexity of breadth of awareness across categories highlighted the nurses' insight to undertake the role of advocacy in order to optimize elderly's ability to participate. They understood and took on ethical responsibilities to protect the elderly's self-esteem to stimulate participation, although they acknowledged a restriction in their aspiration and found themselves obligated to conspire in defending the elderly's active participation (Table 1).

## Discussion

The results show that nurses undertook the role of advocacy in relation to both the elderly person and his or her family participating in the discharge care planning. This obligation contained an aspiration to do something for the elderly, working in partnership to assist and support elderly's decision-making, according to the nurses. Advocacy is now established to be central to professional nursing and is generally described as helping the patient obtain necessary health care, defending their rights, safeguarding quality of care and serving as a connection between patients and the health care organization [41].

The present study also showed an ambition to establish rapport, in particular with those most vulnerable and at risk, and the nurses sometimes had to make decisions for these elderly. In the role of advocacy, they aligned themselves with the elderly and collaborated with other professionals to safeguard the elderly's rights and safety. This corresponds to findings from a study by Eklund, Jossebo, Sandin-Bojö, Wilde-Larsson and Petzäll [42], showing that the second level of influencers is the nurse's bond with the patient in getting know the patient and feeling empathy for the patient. But the nurses had to balance between advocacy and making the patient dependent upon

the nurses' personal values and professional skills. There is a thin line between advocacy and paternalism, where paternalism can be seen as overriding individual choices or intentional actions in order to provide benefits for the patient, opposed to a nursing action based on advocacy [43,44].

The nurses perceived that they had an ethical responsibility to optimize the elderly's ability to participate in decisions about their care. The result showed that the nurses tried to respect elderly's rights and the elderly as an equal part of the team. The nurses had to handle increased complexities of ethical standpoints, promoting the elderly's interests and continuity of care, family members' demands and lack of balance in power relationships between themselves and other staff as regards to participating in discharge planning. Previous studies show that nurses in discharge planning can face ethical conflicts between beneficence and patient autonomy [45,46]. Balancing patient safety and autonomy is central in discharge care planning and becomes more ethically complex when issues of mental capacity and proxy decision-making are raised in the 'grey area' between competence and incompetence. The nurses tended to prioritize safety and subjecting the rights, values and interests of older adults in decisions with great bearing on the quality of their lives, according to a study by Durocher, Gibson and Rappolt [47]. Rehmann (2015) stated that health care professionals have an ethical responsibility to create unbiased discharge plans and comprehensive follow-up and that the patient should be an active participant in the development of discharge care planning.

Exercising restriction in what to communicate and perform in their role as nurses seemed to cause frustration as the nurses had to take on a passive and restricted role. They did not have the authority and experienced marginalization in stimulating elderly's participation. In a study on self-rated professional competence, a majority of nurses working in elderly care assessed their level of competence as satisfactory or very satisfactory even though they held the opinion that they required education within elderly care [48]. Nurses tended to take on a more passive role in the multidisciplinary discharge conference [49] and experienced lack of communication with other professionals [50] which is seen as contributing to professional hierarchy and insufficient contact among professionals [51].

In the present study, the nurses tried to uphold the elderly's autonomy, they occasionally had to represent the elderly in the process, questioning whose interests should form the basis of the discharge planning. In the process, there seemed to emerge conflicting organizational priorities. Bångsbo, et al. found that cooperation in discharge planning focused mainly on professional boundaries and hierarchies rather than on the participation of the frail elderly. According to Durocher, et al. common expectations among health care staff were that as older adults aged there would be a natural decline in cognitive and physical capacities, leading to inability to make decisions or actively participate. It was also shown that the structure and process of the discharge planning conferences ensured that the health care professionals' discharge recommendations would be the final discharge decision.

The cooperation between the involved representatives of the different organizations was occasionally complicated. On the one hand, the nurses found it necessary to conspire against the community

staff in order to defend the elderly's right to active participation in their discharge care planning. On the other hand, the nurses created alliances with the community staff in order to make decisions sometimes without elderly's participation. Some of the problems in collaboration were seen to be based on professional hierarchy and insufficient communication between professionals from different organizations. According to Goldman, et al. negotiated order theory says that interactions among groups of health care professionals are often about the ability to argue and create alliances, and they also showed that negotiations were affected by conflicting clinical and organizational priorities. This is in line with the results of the present study. A study by Mabire, Büla, Morin and Goulet [52] among nurses in Switzerland showed that the most frequent intervention recorded was coordination and the least common was patients' participation in decisions regarding discharge.

### Methodological considerations

In this study, a phenomenographic approach was chosen to explore nurses' various conceptions of elderly's participation in the DP process. In accordance with validity demands/trustworthiness, the focus of the present study is on how well the outcomes correspond to human experiences of the phenomenon and that each study is individual and unique [32,53]. In the phenomenographic approach to validity, Åkerlind describes two types. The first one is communicative validity, which means that the researcher's interpretations of the data are made on the collective interview level, but not on the individual interview level. The results in this study were then based on 15 interviews focusing on RNs experiences of DP. This implies that the result can be specific for this group within their context and should be understood from the perspective of the entire group. However, the nurses were a heterogeneous group based on their professional career and age after RN degree, which could strengthen the variation in conceptions of elderly's participation in the DP process.

A limitation in this study could be related to not receiving in-depth narratives, which may have been influenced by the interviewees' skills to conduct interviews. However, the use of thematic questions along with complementary questions enables more elaboration from the informants, which could improve and strengthen the quality of the interviews.

Communicative validity also involves the researcher's ability to argue their interpretation of the data. The aim is to capture the range of understanding within a particular group. This is in line with a suggestion by Marton and Booth that the interpretive process of the data represent the data which the researcher experienced. Further, Rolfe stresses that it is important that the researchers use reflexivity during the research process to enhance all variation in data. There is always a risk of subjectivity when conducting a qualitative analysis, as data interpretation will be influenced by the interpreter's life experiences and ability. To reduce the risk of subjectivity, the authors discussed together during development and interpretation of the raw data into the areas of categories and themes of awareness.

Pragmatic validity includes the extent to which the research outcomes are seen as useful and the meaningfulness for the intended audiences [54]. It is crucial that the sample selected for the study be appropriate and relevant to the central research question under investigation. As variation and recognition are central components, a

broad selection of nurses with experiences related to DP with elderly patients from different settings was strategically selected. The strategic sampling was used to obtain a variation of nurses' conceptions of the elderly's participation. However, the idea that only nurses with an interest in the subject chose to participate could be a limitation. To ensure that the interview guide was valid for the study aim, three pilot test was conducted and resulting in modification of the guide. In phenomenographic interviews, questions are not necessarily as structured as in other forms of interviews. It is often semi-structured with only a few key questions. In our study, the interviews started with an open and thematic question. According to the study context, some limitations should be addressed that this study represented only medical and surgical wards in one hospital in Sweden, however, the data from the interviews gave a large number of conceptions from the nurses, which is the goal in phenomenographic studies.

### Conclusion

This study has outlined registered nurses' conceptions of elderly's participation in the discharge planning process. Nurses constitute one of the largest professional workforces and nurses have a key role in supporting elderly and their families to actively participate in decisions about their health issues in discharge care planning. This could be enhanced through nurses undertaking the role of advocacy, although they need to be aware of the risk of paternalism. The complex ethical issues that arise in discharge care planning, the difference between what is beneficial for the elderly, and the elderly's autonomy is a key issue and should be constantly under discussion. Nurses have a professional duty to represent the elderly and their families and also to facilitate clarity about professional roles, uphold informative communication and share concerns about the elderly's interests and rights. This study demonstrates the complexity surrounding the process of discharge planning, taking into account the elderly's participation in decision-making

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### References

1. Szebehely M, Trydegård GB. Home care for older people in Sweden. A universal model in transition. *Health & Social Care in the Community*. 2011; 20: 300-309.
2. Majeed MU, Williams DT, Pollock R, Amir F, Liam M, Foong KS, et al. Delay in discharge and its impact on unnecessary hospital bed occupancy. *BMC Health Services Research*. 2012; 12: 410-416.
3. World Health Organization (WHO). Exploring patient participation in reducing health-care-related safety risks. Copenhagen WHO Regional Office of Europe. 2013.
4. Wong ELY, Carrie HK, Yam CHK, Cheung AWL, Leung MCM, Chan FWK, et al. Barriers to effective discharge planning: a qualitative study investigating the perspectives of frontline healthcare professionals *BMC Health Serv Res*. 2011; 11: 242.
5. Tazhibi M, Ghaderi L, Tirani M. Causes of readmission of patients to Alzahra Hospital. *Journal of Research in Health Care*. 2011; 7: 101-107.
6. Yam CH, Wong EL, Cheung AW, Chan FW, Wong FY, Yeoh EK. Framework



- and components for effective discharge planning system: A Delphi methodology. *BMC Health Services Research*. 2012; 12: 396.
7. Nurjannah I, Mills J, Usher K, Park T. Discharge planning in mental health care: An integrative review of the literature. *Journal of Clinical Nursing*. 2013; 23: 1175-1185.
  8. Hall MJ, De Frances CJ, Williams SM, Golosinsky A, Schwartzman A. National hospital discharge survey: 2007 summary. *National Health Statistics Reports*, (no 29). US. Department of Health and Human Services. 2010.
  9. Rydeman I, Törnkvist L, Agreus L, Dahlberg K. Being in-between and lost in the discharge process- An excursus of two empirical studies of older persons', their relatives', and care professionals' experiences. *International Journal of Qualitative Studies on Health and Well-being*. 2012; 7: 1-9.
  10. Shepperd S, Lannin NA, Clemson LM, McCluskey A, Cameron ID, Barras SL. Discharge planning from hospital to home. *Cochrane Database Syst Rev*. 2013; 1: CD000313.
  11. Waibel S, Henao D, Aller M-B, Vargas I, Vázquez M-L. What do we know about patients' perceptions of continuity of care? A meta-synthesis of qualitative studies. *International Journal of Quality in Health Care*. 2012; 24: 39-48.
  12. Ding B, Liu W, Tsi SB, Gu D, Biam F, Shao X. Effect of patient participation on nurse and patient outcomes in inpatient healthcare. *International Journal of Environmental Research and Public Health*. 2019; 16.
  13. Tobiano G, Bucknall T, Marshall A, Guinane J, Chaboyer W. Nurses' views of patient participation in nursing care. *Journal of Advanced Nursing*. 2015; 71: 2741-2752.
  14. Vahdat S, Hamzehgardeshi L, Hessam S, Hamzegardeshi Z. *Iran Red Cross Medical Journal*. 2014; 12: e12454.
  15. Dyrstad DN, Testad I, Storm M. Older patients' participation in hospital admissions through the emergency department: an interview study of healthcare professionals. *BMC Health Services Research*. 2015; 15: 475.
  16. Storm M, Siemsen IM, Laugaland K, Dystad DN, Aase K. Quality in transitional care of the elderly: Key challenges and relevant improvement measures. *International Journal of Integrated Care*. 2014.
  17. Foss C, Hofoss D. Elderly persons' experiences of participation in hospital discharge process. *Patient Education and Counseling*. 2011; 85: 68-73.
  18. Foss C, Askautrud M. Measuring the participation of elderly patients in the discharge process from hospital: A critical review of existing instrument. *Scandinavian Journal of Caring Sciences*. 2010; 24: 45-55.
  19. Larsson IE, Sahlsten MJ, Segesten K, Plos KA. Patients' perceptions of barriers for participation in nursing care. *Scandinavian Journal of Caring Sciences*. 2011; 25: 575- 582.
  20. Ringdal M, Chaboyer W, Ulin K, Bucknall T, Oxelmark L. Patient preferences for participation in patient care and safety activities in hospitals. *BMC Nursing*. 2017.
  21. Chagill J. Patient participation: a concept analysis. *Journal of Advanced Nursing*. 1996; 24: 561-571.
  22. Duner A. Care planning and decisions-making in teams in Swedish elderly care: A study of Interprofessional collaboration and professional boundaries *Journal of Interprofessional Care*. 2013; 27: 246-253.
  23. Jones CD, Vu MB, O'Donnell CM, Anderson ME, Patel S, Wald HL, et al. A failure to communicate: A qualitative exploration of care coordination between hospitalists and primary care providers around patient hospitalizations. *Journal of General Internal Medicine*. 2015; 30: 417-424.
  24. Nilsson M, From I, Lindwall L. The significance of patient participation in nursing care-A concept analysis. *Scandinavian Journal of Caring Sciences*. 2019; 33: 244-251.
  25. Oxelmark L, Ulin K, Chaboyer W, Bucknall T, Ringdal M. Registered nurses' experiences of patient participation in hospital care: Supporting and hindering factors patient participation in care. *Scandinavian Journal of Caring Science*. 2018; 12: 612-621.
  26. Kirsebom M, Wadensten B, Hedström M. Communication and coordination during transition of older persons between nursing homes and hospital still in need of improvement. *Journal of Advanced Nursing*. 2013; 69: 886-895.
  27. Norheim A, Guttormsen Vinsnes AG. Factors that influence patient involvement in nursing home: staff experiences. *Nordic Journal of Nursing Research*. 2012; 31: 42-46.
  28. Marton F. Phenomenography: Describing of the conceptions of the world around us. *Instructional Science*. 1981; 10: 177-200.
  29. Marton F, Booth S. *Learning and awareness*. Hillsdale, NJ: Lawrence Erlbaum. 1997.
  30. Marton F. The structure of awareness. In J. A. Bowden and E. Walsh (Eds.) *Phenomenography* Melbourne, RMIT University Press. 2000.
  31. Åkerlind GS. A phenomenographic approach to developing academics' understanding of the nature of teaching and learning. *Teaching in Higher Education*. 2008; 13: 633-644.
  32. Åkerlind GS. Variation and commonality in phenomenographic research methods. *Higher Education Research & Development*. 2012; 31: 115-127.
  33. Åkerlind GS. Ways of experiencing being a university researcher. In J. A. Bowden & P. Green (Eds) *Doing development phenomenography*: Melbourne, Australia: RMIT University Press. 2005; 145-155.
  34. Åkerlind G. Constraints on academics' potential for developing as a teacher. *Studies in Higher Education*. 2007; 32: 21-37.
  35. SFS 2001: 453. *Social Services Act*. Socialtjänstlagen. Ministry of Health and Social Affairs. Stockholm. 2001.
  36. SFS 1982:763. *The Swedish Health and Medical Services Act*. Hälso- och sjukvårdslagen. Ministry of Health and Social Affairs. Stockholm. 1982.
  37. SOSFS 2005:27. *Samverkan vid in- och utskrivning av patient i slutenvård*. (Cooperation in administration to and discharge from inpatient care. Stockholm: Socialstyrelsen (National Board of Health and Welfare). 2005.
  38. SFS 2003:193. *Swedish code of statutes. Act on Payment Liability*. Svensk lag om kommunernas betalningsansvar för viss hälso- och sjukvård. Ministry of Health and Social Affairs. Stockholm. 2003.
  39. National Board of Health and Welfare. *Co-ordinated care and care for the missions and interventions of the most ill-elderly primary care and elderly care*. Stockholm: Socialstyrelsen.
  40. Northern Nurses Federation (NNF). *Ethical Guidelines for Nursing in the Nordic countries*. *Vård i Norden*. 2003; 23: 1-5.
  41. Tomaschewski-Barlem JG, Lunardi VL, Barlem ELD, Ramos AM, Figuiera AB, Formari NC. Nursing beliefs and actions in exercising patient advocacy in a hospital context. *Journal of School of Nursing*. 2015; 49: 806-812.
  42. Eklund AJ, Jossebo M, Sandin-Bojö A-K, Wilde-Larsson B, Petzäll K. Swedish registered nurses' perceptions of influencers of patient advocacy-A phenomenographic study. *Nursing Ethics*. 2014; 21: 673-683.
  43. Cole C, Wellard S, Mummery J. Problematizing autonomy and advocacy in nursing. *Nursing Ethics*. 2014; 21: 575-582.
  44. Water T, Ford K, Spence D, Rasmussen S. Patient advocacy by nurses-past, present and future. *Contemporary Nurse*. 2016; 52: 696-709.
  45. Denson LA, Winefield HR, Belby JJ. Discharge-planning for long-term care needs: The values and priorities of older people, their younger relatives and health professionals. *Scandinavian Journal of Caring Sciences*. 2013; 27: 3-12.
  46. Rehmann K. Ethical considerations in discharge planning on an inpatient behavioral health unit. *Journal of Human Behavior in the Social Environment*. 2015; 25: 723-730.
  47. Durocher E, Gibson BE, Rappolt S. Mediators of marginalization in discharge planning with older adults. *Ageing & Society*. 2017; 37: 1747-1769.
  48. Karlstedt M, Wadensten B, Fagerberg I, Pöder U. Is the competence of Swedish registered nurses working in municipal care of older people merely a question of age and postgraduate education? *Scandinavian Journal of Caring*

- Sciences. 2015; 29: 307-316.
49. Bångsbo A, Dunér A, Dahlin-Ivanoff S, Lidén E. Collaboration in discharge planning in relation to an implicit framework. *Applied Nursing Research*. 2017; 36: 57-62.
50. Goldman J, Reeves S, Wu R, Silver I, MacMillan K, Kitto S. A sociological exploration of the tensions related to interprofessional collaboration in acute-care discharge planning. *Journal of Interprofessional Care*. 2016; 30: 217-225.
51. Greysen SR, Scilliro D, Horwitz Li, Curry I, Bradley H. "Out of sight, out of mind": Housestaff perceptions of quality-limiting factors in discharge care at teaching hospitals. *Journal of Hospitals Medicine*. 2012; 7: 376-381.
52. Mabire C, Büla C, Morin D, Goulet C. Nursing discharge planning for older medical inpatients in Switzerland: A cross-sectional study. *Geriatric Nursing*. 2015; 36: 451-457.
53. Rolfe G. Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*. 2006; 53: 304-310.
54. Uljens M. On the philosophical foundation of phenomenography. In G. Dall'Alba & B. Hasselgren (Eds.), *Reflections on Phenomenography*. Göteborg: Acta universitaris Gothoburgensis. 1995; 130-128.