Older patients in transition

– from home care towards emergency care

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"Every system is perfectly designed to produce the results it does, if you do not like the results then you must change the system" *(Paul Batalden 2002)*

To Linn, Anna, Niclas, Carl, Emma and Johanna

CONTENTS

ABSTRACT

The overall aim of the thesis was to study the praxis of referrals to the emergency department (ED) from different community health care settings and the caring process of older adults in the ED (**I-V**). With this knowledge prerequisites needed to provide older adults with better care can be provided. The thesis focuses on the older adults and the nurses' involvement in the referrals and the caring process.

Study **I** focused on the extent and reasons that 719 patients $\geq$ 75 years old, residing in sheltered housing, utilized the emergency department during one year. Observations of and interviews with 20 patients $\geq$ 75 years old and relatives were conducted to study the conditions and the events that took place during their stay at the ED (**II**). Ten ED nurses' narrated experiences were analysed to illuminate what constitutes good nursing care for older patients (**III**). The factors and aspects that influence the community RNs' decisions when referring older patients to the ED and what kind of support may be required to facilitate this decision-making process was studied in narratives from 10 nurses (**IV**) and 30 persons in management that were nurses, physicians or home care assistants(**V**).

The inclusion area encompassed two counties with 24 sheltered housing units from one county and a university hospital, two smaller hospitals and 30 Primary Health Care Centres from the other county. Four methodological approaches were utilized in the studies: descriptive statistics (**I**), grounded theory (**II**), thematic content analysis (**III, V**) and latent content analysis (**IV**).

The main results in this thesis showed that a group of older adults (**I**) have in one year visited EDs to a great extent and the main reasons for referrals were falls, cardiovascular and cerebrovascular problems, infections and gastrointestinal disorders. Waiting at an ED (**II**) was a long and unpleasant experience in many different ways. For them, not only was it important that they were cared for, but also the manner in which the care was given. Many patients did however express feelings of trust in the staff's medical expertise and had a positive attitude towards them. For ED nurses (**III**), it was necessary to be knowledgeable, have an understanding of the older person's situation and be willing to take responsibility for them. Prioritisation of medical procedures, everyday chores and routines impeded good nursing care and the nurses expressed their sentiments that the ED is not always the appropriate place to meet the needs of these patients. Study **IV** and **V** showed that the community nurses needed to feel secure in their professional role since several aspects influenced their referral decision. The nurses needed faith in their own competence, knowledge about the patient as well as a supportive environment. The different managers had different views regarding what they thought was important in order to facilitate the decision making process for nurses.

Changes in the older patients health (**I**) and their transferral created a process of transition for them. The transition might make them even more vulnerable, which became apparent during the long and uncomfortable wait at the ED (**II**). It seems that even nurses and the organisation went through a state of transition due to the considerable changes that occurred.

The major findings in this thesis (**I-V**) illuminate the vulnerability among older patients in transition when visiting an ED and among the nurses that care for them. It seems as that in Sweden, have been developed a what might be called "a in between syndrome" for older adults that deteriorates.

Keywords: older adults, transition, health care organisations, management, nurses' decision making, responsibility**.**

ORIGINAL PAPERS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals:

I. Kihlgren A., Mamhidir A-G., Wimo A. Older' adults visits to emergency departments – a descriptive Swedish study. Manuscript.

II. Kihlgren A.L., Nilsson M., Skovdahl K., Palmblad B., Wimo A. (2004) Older patients awaiting emergency department treatment. *Scandinavian Journal of Caring Sciences* 18, 1-8.

III. Kihlgren A.L., Nilsson M., Sorlie V. Caring for older patients at an emergency department – emergency nurses' reasoning. *Journal of Clinical Nursing.* Accepted.

IV. Kihlgren A.L., Fagerberg I., Kihlgren M. (2003) Referrals from home care to emergency hospital care: Grounds for decisions. *Journal of Clinical Nursing* 12, 28-36.

V. Kihlgren A.L., Forslund K., Fagerberg I. Managements' perception of community nurses' decision making processes when referring older adults to an emergency department. Submitted.

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INTRODUCTION

Older patients are a vulnerable group often diagnosed as having several illnesses and various functional impairments resulting in complex needs (Akner, 2004; National Board of Health and Welfare, 2005b). They are often transferred back and forth between the different levels in the health and social care system (Hansagi et al., 2001; Murphy et al., 1999). A change in an individual's health creates a process of transition, and persons in transition tend to be more vulnerable, which may in turn affect their health (Meleis et al., 2000). The older patients meet organisations in transition that are reorganising and enacting cutbacks. The responsibility for older adults in Sweden is shared between the county councils and the communities, as well as between different professions (National Board of Health and Welfare, 2005b).

Transition

The concept of transition is characterised by: process, disconnectedness, perception, awareness and patterns of response (Meleis et al., 2000). When you are in transition, you are somewhere in-between (Olsson & Ek, 2002). Meleis et al. (2000) describe it as a process of adaptation to and development of a new situation. The time span between an ending and a new beginning of the process can vary from a short period of time to many months, or even years, depending on the intensity of the breaking point. How an individual perceives the situation determines how the process will continue. Society, culture and closely related groups can influence this perception. A person cannot be in a state of transition if they are not to some extent aware of the situation. Without this insight, they are still in the phase preceding the actual transition. During the ongoing transition, changes in self-perception and self-esteem will occur. Signs of such changes may be disorientation, distress, anxiety, and elation. The types of transition identified by Schumacher & Meleis (1994) are developmental, situational, health-illness and organisational.

The transition to old age is an example of developmental transition. Situational transitions can be exemplified as enrolment in educational programs or making professional role changes. Health-Illness transitions occur when a person becomes ill, regains their health or the illness becomes chronic. It also occurs when persons are transferred from one type of care setting to another, when discharged from the hospital, or when they are referred between health care and social care systems. Transitions in the organisations environment can be precipitated by changes in the wider social, political, or economic environment or by intraorganisational changes in structure or dynamics. When organisations experience transition, the lives of the people working in them as well as their clients are affected. Interactions among persons and subsystems within the organisation facilitate or impede the process. Collaboration, teamwork, effective communication, and support from key persons and groups contribute to an environment in which the transition can be managed effectively (Schumacher &

Meleis, 1994). The authors held that within the wide range of emotions that accompany transition are anxiety, insecurity, frustration, depression, apprehension, ambivalence and loneliness.

Older patients in transition meeting different organisations

The organisation in the community

Older patients receiving community care are living in sheltered housing or are cared for in their own homes by Home Care Service (HCS). They are meeting a system in transition that is experiencing cutbacks, new employment practices, new routines and a new form of organisation in the community (The National Board of Health and Welfare, 2005b). One form of organisational transition began when the Swedish government implemented a reform impacting the care of older adults, in 1992. The intentions of the new system were to provide and ensure medical care and home care services to older adults, but now due to an ever-increasing number of persons in this group and cut backs, it is over burdened (Gurner & Thorslund 2003; The National Board of Health and Welfare, 2005b). In 1998, 118,700 persons lived in sheltered housing and by 2003 these numbers had decreased to 110,900 (The National Board of Health and Welfare, 2005b). In addition, the hospitals considerably reduced their number of beds by 55% (from 58,000 to 26,000) between the years of 1992 to 2003 and the length of each hospitalisation decreased (The National Board of Health and Welfare, 2005b). Demographically the age group 80 years and older has increased by 81% between the years 1980 to 2003 (263,000 to 476,000) (Statistics Sweden, 2005) and the increased costs for these older adults can be seen as an economical challenge in the future (Wimo & Jönsson, 2001).

Perkel (2002) reported that in times of uncertainty and change, a transformational leadership is important since the leaders empower and provide a unified vision consistent with the values expressed by the organisation. Albinsson (2002) found that most of the problems in the public sector were associated with a lack of leadership. Rantz et al. (2003) found that the more experienced leaders in sheltered housing produced good outcomes associated with basic care. The organisation of patient care within the health care setting depends on what is valued and the varying underlying dimensions in the nursing care systems (Adams et al., 1998). Community RNs in this new system are to supervise and ensure that all persons are given proper care (Westlund & Larsson, 2002). The way in which the communities have carried out and organised this undertaking has varied, for example the responsibility for the HCS has been assumed by approximately half of them. The other half is still a responsibility for the county councils. The RNs' responsibility during daytime hours can include one to several wards at a sheltered housing facility, increasing afternoon hours and holidays to include several sheltered housing facilities and persons residing in their own homes within a prescribed area. This implies that in this organisation they can have 500 older persons that they are responsible for during their shift. In cases of emergency, the RNs are responsible for referring older adults to the EDs. During the daytime they can consult a physician on duty at the local Primary Health Care Centre (PHCC) or

e.g. a geriatrician if such are on contract. At nighttimes, the district physician on call can be reached by calling 112 (SOS-alarm).

The organisation at the county council emergency department
The EDs in Sweden are hospital based acute care settings administered by the county council. They are designed to care for emergencies and are often divided into sections such as internal medicine, surgical, orthopaedics, infectious diseases, and paediatrics, depending on the size of the hospital. The ED is a large department, both in number of persons working there and physical area. Older patients in transition often arrive by ambulance and are assessed by an RN at the entrance where they are further triaged to one of the sections and a new priority assessment is made. Staffing consists of physicians from different medical specialities, RNs and enrolled nurses.

The number of visits to the ED increases dramatically as people age with the oldest patients, those over 85 years of age often visiting the EDs at least twice a year (MacLean et al., 1999). At a university hospital in Sweden with 41, 601 visits one year to the ED, 25% of the patients were 75 years and older and 20% of these were admitted from community sheltered housing facilities (University Hospital Statistics, 2002).

Older patients in need of acute care
Older patients often present complex problems, with multiple system involvement, and needs that are specific to the geriatric patient. In addition to their seeming to be more sensitive to new environments (Watson et al., 1999), they require higher levels of health care service in terms of nursing care, intervention and hospitalisation (Akner, 2004; The Swedish Council on Technology Assessment in Health Care, 2003). This means that there is a greater need of a well-educated and competent staff within community care for older people (Thorslund et al., 2001).

Older patients that have immigrated to Sweden from other countries can be seen as even more vulnerable as illness, health beliefs and practices are culturally bound (Leininger 1991; Meleise et al., 1992). Ericsson & Saveman (2002) show that nursing care is further complicated in acute care settings when a patient also has dementia. It is assumed that 30% of older patients referred to EDs have some form of dementia disease (Aevarsson & Skoog, 1997).

Wade (1999) maintains that care for the older patient requires a different kind of environment and pace than that found in the ED today. Geriatric wards are more specialized in caring for older adults (Latimer, 1997) and have a milieu quite different from the highly medical-technical one found in the ED. Older patients frequently have to wait for several hours in the ED (Eagle et al., 1993; Ryan, 1996), often having low priority (Drory et al., 2000). It has been clinically experienced and reported by Nyström et al. (2003), that many of the patients referred from sheltered housing to the ED could have been cared for at a lower level of care. Saliba et al. (2000) reported that in the USA inappropriate transfers are a potentially large problem and that some may be associated with poor quality of care in

sheltered housing. These authors showed that 36% of transfers from sheltered housing to EDs were inappropriate and the resident could have been cared for more appropriately and securely at another lower level of care. No figures can be found regarding inappropriate referrals in Sweden.

Nurses' conditions when meeting older patients in transition

Nurses' mission and functions

The nurses' mission in society is to assist individuals, families and groups to determine and achieve their physical, mental and social potentials. This endeavour is to be accomplished within the challenging environment in which they live and work. By ensuring the active involvement of the individual, their family, friends, social group and community, as appropriate in all aspects of health care; they encourage self-reliance and self-determination (Salvage, 1993). Elements of advanced nursing practice encompass many sub-roles: clinician, educator, researcher and consultant (Cattini & Knowles, 1999).

The Health care system in Sweden was reorganised in the 1950's using the military organisation as a model. The 'life world' and the RNs values are influenced and have been formed by their education and by their work experience in the highly regulated hospital milieu (Fagerberg, 1998). RNs still have their background and their education in a world with specific roles and a hierarchical system as older colleagues have brought up younger generations. The RNs are accustomed to working in professional teams, often as the team leader. Beavan & Stephens (1999) show in a study that the RNs are often exposed to working situations that are highly emotional and challenging. It is a challenge for the leaders to create a milieu that deals with these issues to ease and facilitate the decision-making process for nurses.

Community nurses

The Elder Care Reform in 1992 that resulted in that the communities took over the responsibility for long-term health care affected the RN's role and presented a challenge for them (Tunedahl & Fagerberg, 2001).

RNs that are more familiar with the medical culture of the hospital had to adapt to a more home oriented medical culture, if they were to meet the expectations inherent in the new reform. They found themselves working in an organisation with few decision making levels, and fewer contacts with physicians and colleagues (Fagerberg, 1998). Weman et al. (2004) reported in a study that almost half of the RNs were not satisfied with their work situation. In order to meet the complex demands found by community nurses in the study by Tunedal & Fagerberg (2001) suggested four requirements that were needed to raise their competence levels. These requirements were expertise in medical and nursing knowledge, pedagogical abilities, genuine interest in older patients, and mental strength as well as self-confidence when dealing with older adult patients.

ED nurses

In Sweden one prime clinical responsibility of ED nurses is to organize the total and appropriate care of the patient (Nyström et al., 2003). It is the ED nurses that make the initial decision as to which category of urgent care and speciality the patient should be referred, and what the patient's situation requires. Furthermore it is also the emergency RNs' responsibility to make sure that the patient receives care while waiting in the ED (Bucknall, 2003). Studies show that the staffs at the EDs exhibit great interest, enthusiasm and involvement in their work (Lee et al., 2003; Raingruber, 2001). When asking ED nurses in Sweden about their working situation, Nyström (2003) reported that nurses preferred working in a stimulating environment such as in an ED rather than working on a general nursing ward. Most stimulating was that they were able to work within several specialities, the days were unpredictable and they were allowed to perform advanced medical skills. The nurses meet patients with complex needs requiring specialists from many areas in healthcare.

A later report by Nyström (2003) revealed, however, that the nurses felt undue demands were placed upon them. They felt that demands from the patients and their relatives had increased. Those placed upon them from other sections of the hospital caused them to feel pressure and anxiety, especially regarding the risk for potential incidents. The physicians wanted them to prioritise their work beyond what they felt themselves competent to do.

Decision making

Decision making is regarded as an essential component of the nursing role and can be defined as a process that nurses use to gather information about patients, evaluate it and make judgements that result in the provision of nursing care (Bakalis et al., 2003). Often in nursing practice, decision making is a complex process (Ellis, 1997) with some situations being more complex than others as they involve unknown factors and uncertainties. Studies have shown that decision making strategies are dependent on experiences when complexity is involved (Cioffi & Markham, 1997; Cioffi, 1998). Knowledge and clinical experience are the most important factors influencing clinical decision making (Benner et al., 1996; 1999; Bucknall & Thomas, 1997). Benner (1984) found that the expert nurse was able to focus on the problem directly without needing to consider alternatives. Dreyfus et al. (1986) called this intuition.

Complexity is considered to be present in the decision making situation, such as deciding whether or not to refer a patient whose condition has deteriorated to an ED. This includes identifying the patients' problems, accessing resources, and patients' autonomy. "Knowing the patient" is an important concept in nursing (Radwin, 1998) and an essential prerequisite in planning and providing high quality care (Carpenter et al., 2000; Luker et al., 2000; Ruland, 1998). Orme & Maggs (1993) suggest that decision making must be based on sound knowledge, may involve risk-taking and can only flourish in a supportive environment. A good sense of self-esteem is critical for the work community nurses do (Fagerberg, 2004) as well as an ability to work autonomously (Breda et al.,

1997). A human being needs to believe that those around them want the best for them if they are going to be able to feel secure and develop autonomy (Erikson, 1982).

RATIONAL FOR THE STUDIES

The literature review shows that the research about older patients cared for in EDs and regarding the referrals to EDs in Sweden is limited. Older adults often present complex problems with a multiple disease history that increases their vulnerability. They are frequently present with acute and serious medical and psychosocial problems that require referrals to more intensive medical and caring levels. During that transfer, a transition begins in which older adults cannot always contribute to the decision making process. They are exposed to new organisations, new environments and new people that can lead to unique problems for them. Questions that can arise are why and to what extent are older adults being transferred, what are the grounds for the decisions being made, and how are they cared for during their transition.

There seems to be many aspects involved when making a decision of whether to refer an older adult to an ED. The systems and attitudes that exist in the society influence everyone; patients, relatives, physicians, and nurses when decisions are made. By illuminating some of what occurs when older patients are in transition between the different branches of the Swedish health care system, a dialogue can begin on how the system can be improved (cf. Akner, 2004).

AIMS

The overall aim for this thesis was to study the praxis of emergency department referrals and the caring process in an emergency department of older adults from different community health care settings.

In order to achieve this, five studies comprise this thesis and had the following aims:

I. To study to what extent do patients aged 75 or older, residing in sheltered housing, utilize the emergency department during one year and for what reason.

II. To describe, through observations and interviews with patients $\geq$ 75 years old and the relatives who accompanied them to the hospital, the conditions and the events that took place during their stay at the ED.

III. To use the experiences of emergency nurses to illuminate what constitutes good nursing care for patients 75 years of aged and older transferred to EDs.

IV. To illuminate the factors and aspects that influence the community RNs' decisions when referring older patients for emergency treatment. Furthermore to illuminate what kind of support may be required to facilitate this decision-making process.

V. To understand how persons in management conceptualised the decision-making process employed by community nurses when referring older persons to EDs. This was done to also determine whether perceptual differences and/or similarities exist among persons in management that are nurses, physicians or home care assistants.

METHOD

The studies (**I-V**) involved patients and their relatives in community health care settings and in the ED, nurses in the community and the ED, and managers with backgrounds as nurses, physicians, and home care assistants (Table 1). The inclusion area encompassed two counties with twenty-four sheltered housing units from one county and a university hospital, two smaller hospitals and 30 Primary Health Care Centres from the other county.

Four methodological approaches were utilized in the studies: descriptive statistics (**I**), grounded theory (**II**), thematic content analysis (**III, V**) and latent content analysis (**IV**).

Table 1. Overview of participants and research methods with study focus, sample, data collection, and analysis.

Study	Focus	Sample	Data collection	Analysis
I	Frequency and reason for 719 older patients' transfer from community care to EDs for one year	719 patients $\geq$ 75 years from 24 sheltered housing units randomly selected, in one county	RAI/MDS Nursing-documentation	Descriptive statistics Logistic regression
II	How older patients are cared for at an ED and how the visit is experienced by them and their relatives	20 pat. $\geq$ 75 years	Non participant observations Interviews	Grounded Theory
III	What nurses at the ED consider to be good care of older patients	10 nurses at an ED	Narrative interviews	Thematic Content Analysis
IV	What influences the community nurses' decision to refer a patient to the ED	10 nurses from 4 communities, 4 physicians from 4 PHCs	Narrative interviews	Latent Content Analysis
V	What influences community nurses' decisions when referring patients to the ED	30 managers in the elderly care randomly selected from one county	Narrative interviews	Thematic Content Analysis

Design

The approach used to reveal the extent and cause for referrals from sheltered housing to the ED was quantitative (**I,** a cross-sectional follow-up study). A qualitative approach was used to obtain knowledge from patients, their relatives and nurses regarding ED experiences (**II-III**), and from nurses, physicians and managers on what might have influenced the community nurses' decision-making when referring older adults to the ED (**IV-V**). The choice of methods and the number of

participants was made in an attempt to reach a deeper understanding of the care given at the ED and the factors that influenced the decision-making processes for the referral. Using both quantitative and qualitative approaches in the thesis was intentional since the aim was to get increased generalised knowledge (**I**) and deeper understanding of what might influence the decision to refer an older adult to an ED (**IV-V**) (Burns & Grove, 2001). The thesis focuses on the old patient's transferral, the care given and the referral decisions made by nurses.

Sample

Study I

From 24 randomly selected sheltered housing units, 800 older adults from one county, representing 18% from each community (N=10) were included. A survey was conducted in the autumn of 1999, which revealed a total of 4,480 older adults living in some form of sheltered housing. Inclusion criteria were adults that were aged 75 or older and living permanently in community sheltered housing units. The units were placed in alphabetical order and assigned the numbers 1 or 2. Those receiving the number 2 were included in the study until the 18% resident quota per community was reached. The staff, patients and their relatives from these units were informed about the study and asked to participate. Three housing units declined participation and were replaced by others having the number two. About 600-700 persons would be required, if power is set to 0.9, with an expected standardized difference to 0.25, which is based on expected standard deviations in various scenarios. So additionally in order to reach the number of participants required based on the statistical power considerations on potential analyses, we estimated that a sample size of 800 people would be sufficient. A random selection (Altman, 1999) of patients from units containing a larger number of individuals than the quota required was performed. From those initially recruited for the study, a number withdrew or died before data collection began. Included in the first evaluation from 24 sheltered housing units were 719 older adults (16%), with an average age of 85.8 years, and of whom 71% were women. A year later at the time of a second evaluation, 503 patients remained resulting in 216 (30%) dropouts, (26% deceased, 2% moved, 2% assessment not completed). Acute referrals to the ED were followed between the first and second assessments.

Study II

During a three month period 20 older adult patients (14 women and six men) aged 75 or older who had been transferred to the ED were included in the study. Patients that had been clearly diagnosed as having fractures were excluded, as they often went directly from the ED to the X-ray department. Patients with suspected myocardial infarction were also excluded, due to the severity of their condition. Fifteen of the 20 patients were accompanied by relatives at arrival. No patient or relative declined participation.

Study III

During study **II** all of the nurses at the ED were contacted and asked if they would be willing to be interviewed. The first ten that agreed to be interviewed were included in the study. Their work experience in the ED ranged from 10 to 17 years.

Study IV

Interviewed in the study were ten nurses and four chief physicians from four different communities and four PHCC areas. The nurse managers from the four different communities were informed about the purpose of the study and provided a list of the community nurses responsible for making decisions regarding the referral of patients to EDs. The RNs were selected in alphabetical order from the four different lists, until the total number was reached.

Study V

Thirty managers concerned with the care of older adult patients from physician, home care services and nursing backgrounds were interviewed in the study. The PHCC areas were listed in alphabetical order and assigned the number 1, 2 or 3. From the areas receiving the number 1, eight chief physicians were asked to participate. Two additional chief physicians were by lot chosen randomly from the medical departments of two local hospitals. Ten home care services managers were recruited from the PHCC areas receiving the number 2 and were asked in alphabetical order if they would agree to participate in the study. From those areas numbered 3, eight managers with nursing backgrounds were recruited in the same manner, together with two nurse managers that were chosen randomly from two medical wards of a hospital. This was done to determine whether perceptual differences and/or similarities exist among persons in management that are nurses, physicians or home care assistants.

Data Collection

The Resident Assessment Instrument RAI/MDS 2.0

Patients' functional abilities, previous reasons for emergency care, resources and needs were evaluated using the RAI/MDS instrument (**I**). The RAI/MDS-system was developed in the USA to assist in measuring the needs of older adults, developing their patient care plans and evaluating the quality of care given in sheltered housing (Morris et al., 1990; Rantz et al., 2003). In this study the revised RAI/MDS 2.0 version was used. This version has a new set of assessment items developed by Morris et al. (1997). The RAI/MDS has been tested for its validity (Morris et al., 1990; Mezey et al.,1992) and reliability, with an average inter-rater reliability (intraclass correlation) of .67 (Hawes et al., 1995), and with the new 2.0 version .79 (Morris et al., 1997). The instrument, which was translated into Swedish by Hansebo (2000), consists of 16 sections, with categories and defined codes. The sections are expected to capture the core elements, which are the minimum needed for a comprehensive assessment of the individual older adult patient (Morris et al., 1990).

Nurses' documentation

All occasions of patient transfer to the ED were documented (**I**). The nurses copied their documentation and faxed it to the research unit. The documentation was numbered and the information checked by a research assistant.

Observations

Upon arrival to the ED (**II**) a nurse met the patients and obtained their informed consent to be observed and interviewed. From the time of their arrival at the reception to their discharge from the ED, open non-participant observations (Denzin & Lincoln, 1994; Patton, 2002) were performed. Patients were also followed to other departments such as X-ray. Four researchers performed one observation each in a pilot study. The focus of the observations was to concentrate on what took place in connection with the care of the patient and the surrounding environments influence. Observation data was documented in the form of field notes (Denzin & Lincoln, 1994; Patton, 2002). During the actual study (**II**), data collection and analysis was conducted in the same manner as in the pilot study but with two observers. The observations and interviews took place afternoons and evenings when the observers' schedules allowed and continued until saturation was obtained. There were 20 observations in total, 4 from the pilot study and 16 from the main study. The field observations lasted between two to seven hours with a total of 80.25 hours. After each observation the researcher tape-recorded their impression of the data collection as a memory aid. An experienced secretary transcribed these verbatim. The two researchers performing the observations continually discussed the data in general during the collection and analysis phases.

Narrative interviews

All interviews (**II-V**) took place in accordance with the wishes of the interviewees, at the hospital, in their homes or at their place of work. The observations (**II**) were followed by interviews with the patients or their relatives if the patients were unable due to confusion before they left the ED. Sixteen patient interviews were conducted lasting 15 to 30 minutes each. The observer posed one open question *"How did you experience your visit to the ED"*. The observer kept written notes of the interview.

In study **III** one open question was asked " *Can you please tell me about a situation where you felt that an older adult patient received good care?"* Several of the nurses found it difficult to describe such a situation, and were asked instead to *"Describe what good nursing care for older adult patients in the ED should consist of"*.

In study **IV** the nurses and physicians were encourage to speak freely about *what factors influence the decision to make referrals to the ED*. They were also requested to talk about what would have *been required to maintain the ill person in their own home,* if this wish had been expressed.

In study **V** the managers were encouraged to discuss freely which *factors or aspects they as managers felt influenced an RNs' decision to refer an older adult to an ED in those situations when they might feel hesitant over which action to take.* The interviewees were also requested to talk about what they thought could facilitate the nurses' decision-making process.

Follow up questions in all studies were: *"Please tell me more about that",* or *"What did you think about that"* (Mishler, 1986).

The interviews in study **III-V** were tape recorded with the respondents' permission and lasted 30-90 minutes. An experienced secretary transcribed all interviews verbatim.

Analysis

Statistical analyses

The nurses' documentation (**I**) was read several times and different causes for referrals were marked and counted. It was the nurses´ view of a medical problem for referral that was of interest, not a specific medical diagnosis. The data was then sorted into 15 diagnosis/symptom groups, most common in the text. The results were analysed with the statistical package SPSS 12.0 together with the RAI data regarding the residents' functional abilities, resources and needs. Descriptive statistics as well as logistic regression methods were used to describe the pattern of ED visits and potential explanatory factors for referrals to the ED.

Grounded theory

Grounded Theory, as described by Glaser & Strauss (1967) and Glaser (1978; 1992) based on non-participant observations and interviews was utilised (**II**). The theoretical basis for this sociological method is Blumers' (1969) symbolic interactionism. In symbolic interactions, `meaning´ is a major element for understanding human behaviour, interactions and social processes and was useful in study **II** when studying the interactions between the patients and nurses. The intention with the method, however, was not to develop a theory of how a visit to an ED is experienced, but to describe what it can involve.

In grounded theory, the participants are selected based on their presumed knowledge of the topic and the emerging theory. This process is called theoretical sampling, and implies that data is collected in order to generate a theory. The researcher collects, codes and analyses the data simultaneously and decides which additional data is required and where to search for it (Glaser & Strauss, 1967; Glaser, 1978; Coyne, 1997). The sampling process continues until saturation is attained, which occurs when no further information is discovered that can be added to the categories. The researcher is aware that saturation has been reached only after it has occurred which means some data collection may continue after it is reached in the analysis. Consequently, the sample size cannot be planned and is not known until saturation is reached and the sampling process has been concluded (Glaser, 1978; 1992). It is up to the researcher to decide when saturation has been attained (Morse,

1991). Data can be gathered in different ways (Benoliel, 1996) and in study **II** data was collected through interviews and observations.

The analysis phase in grounded theory follows a specific structure. The field notes from each interview, observation and the tape-recorded impression (**II**) were analysed line-by-line, in the pilot study by the four researchers and in the main study by the first and third author, and compared. Sentence after sentence was analysed and coded according to Glaser's scheme of open coding (1978, p. 56; 1992, p. 38). Each code was continually compared, contrasted and empirically grounded. Codes were conceptualised into categories. In the next step the researchers wrote down ideas and thoughts that developed during the coding to serve as memos. These memos were included in the analyses of the next phase, selective coding. The selective coding was concentrated on discovering the core variables and the categories related to them.

Qualitative content analysis

Qualitative content analysis is a research method that focuses on meanings, intentions, consequences, and context to delimit and describe categories (Downe-Wamboldt, 1992; Graneheim & Lundman, 2004). The method was used in this thesis to give a systematic description of the manifest and latent content of the interviews. In study **III** it was used to describe what constitutes good care of older patients in an ED. In studies **IV** and **V** it was used to describe the factors that influenced the decision to refer older patients from the HCS to the ED, and what support would be needed if the patient had wished to remain in their residence. An interpretation was made of both the manifest and latent content, which differed in depth and level of abstraction (Graneheim & Lundman, 2004). Manifest content analysis implies an analysis of what the text says, a description of the manifest substance in the text (Downe-Wamboldt, 1992; Kondracki et al., 2002; Graneheim & Lundman, 2004). Latent content analysis implies an analysis of the underlying meaning in the text. The analysis is based upon how the different aspects in the text relate to each other (Downe-Wamboldt, 1992; Kondracki et al., 2002; Graneheim & Lundman, 2004).

In studies **III-V** the interview text was read several times to grasp a sense of the whole. The text was then divided into meaning units, which can consist of a sentence, or an entire paragraph. The meaning units were condensed into descriptions of the manifest content and an interpretation of the latent content was made.

A thematic content analysis was performed in studies **III** and **V** (Baxter, 1991; Burnard, 1991). Thematic content analysis is an interpretative content analysis, which is more complex because the researcher's interpretations are based on a holistic analysis of the text and must be performed on more than one domain. The themes that are developed are threads of meanings that recur in domain after domain (Baxter, 1991).

Categories (**IV**) and sub themes (**III** and **V**) were abstracted from the manifest descriptions and latent interpretation (Baxter, 1991). From the categories and sub themes the themes were created

and finally the main theme was developed (**III-V**). All steps in the analysis were made as closely to the text as possible, while at the same time perform a critical interpretation of the text (cf. Graneheim & Lundman, 2004).

Independent assessment

Independent assessments of the observations and interview text were made in studies **II-V** to increase the credibility of the analysis (Kvale, 1997) and to reduce possible bias emerging from the researchers' expected or desired results. According to Ricoeur (1976) there is always more than one way of understanding a text, you can always argue for or against an interpretation, but all interpretations are of equal credibility. The role of an independent assessment is to discuss if there is support in the text for the developed themes and to question the researchers interpretation since the probability of developing the same themes is low (Kihlgren & Thorsén, 1996).

Study **II**: The four observers together discussed the codes that emerged in the pilot study in general, in order to find similarities and differences relevant for further study. In the main study the two researchers who performed the observations continued to discuss the data in the same manner. This was done throughout the data collection and analysis phases.

Study **III**: In order to validate the sub themes that emerged from the analysis the authors discussed, reflected and after reaching a consensus, decided on them (Downe-Warmboldt, 1992).

Study **IV**: First, the second author read five randomly selected interviews, with the purpose of approving or rejecting the proposed themes. The same interviews were read again in order to determine if the theme was adequately and appropriately described. It was concluded that the level of agreement between the researchers was high.

Study **V**: A total of nine interviews, selected randomly, which included each of the management groups were examined and analysed by a different researcher who confirmed or disagreed with the assessments. In order to reduce the risk of bias resulting from the expectations of the researcher, a co-assessor from another field (social work) was brought in. The small disagreements that arose were discussed on a continuing basis until a consensus was reached.

Ethical considerations

The Regional Research Ethical Committee granted permission for study **I** (99310-17) and for studies **II-III** (544/97). After thorough consideration, the secretary of The Regional Research Ethical Committee granted permission for the interview studies **IV-V**. Information regarding studies **II** and **III** was presented at ED staff meetings where the staff had the opportunity to ask questions. Staff, patients and relatives (**I-V**) were given verbal and written information regarding all of the studies. The participants were informed that their participation was voluntary, confidentiality was guaranteed and that they could withdraw from the study at any time without having to give an explanation.

It became problematic when the patients did not seem to be able to comprehend the situation nor the information they were given before the observations in study **II**. Ethical problems arose when the research involved older adults with dementia, as they have to be dealt with carefully and with respect for their autonomy and integrity (cf. Norberg et al., 1985). When an ED nurse (**II**) felt the patient was unable to give informed consent, it was obtained from the accompanying relative(s). Halimaa (2001) maintains that it is important that the researcher examines all possible alternatives and is certain that the information is being given in the most appropriate manner. During recent years the focus of 'informed consent' has shifted from the researcher's obligation to disclose information, to the patient's ability to understand information and give consent. Beauchamp & Childress (2001) point out a number of difficulties in this regard. Questions that can arise are how is the patient's competence assessed, how is the amount of information determined that constitutes an adequate basis for making a decision, how valid is consent if it is suspected that it has not been fully understood and how can a decision based on coercion, persuasion or manipulation be avoided.

No competence assessment was made before the observations in study (**II**) but by asking questions and trying to establish good contact with the patient and their relative(s); the nurses could get an opinion of how much the patient understood. The researcher who made the observations could form her opinion of how much they understood by studying the interaction between patient, relative and the nurse. The consequences of the nurses being observed can be discussed. The nurses were informed that no individual' actions would be evaluated or pointed out and that the material would be described as objectively as possible. None of the nurses refused to have the researcher present during the different procedures nor did the patients or the relatives.

RESULTS

Study I

No significant differences were found regarding the baseline characteristics between referred and non-referred persons except that there were fewer with cognitive impairment among those who were referred. This is also reflected in the diagnoses. Significantly fewer persons with dementia were referred in contrast to persons with allergies, cancer and renal insufficiency. There were no significant differences regarding drug use and referrals.

Of the 719 persons, 209 (29%) were referred to an ED 314 times during the study year (1.5 visits per referred person). There were no gender differences. The main reasons for referral were falls, fever/infections, cardiovascular and cerebrovascular diseases and gastrointestinal problems. For women, falls were the most frequent reason, while for men, falls, cardiovascular and cerebrovascular problems were most common. Most referrals took place weekdays during the daytime. In 38% of the referrals, no contact with a physician was identified. Telephone contacts were more frequent than physician visits to the sheltered housing units.

Potential background factors for referrals to a hospital were included in a logistic regression model with referred or not as the dependent variable. The covariates that were measured at baseline were age, gender, staying time in sheltered housing, different diagnose groups (thirteen), multiple morbidity, BMI, number of drugs, types of drugs, previous episodes of falls, infections, different clinical symptoms and problems (twenty one). The r^2 of the model was 0.07, which indicates that the explanatory value of the model was low. Nevertheless some covariates were significant ($p<0.10$). Allergy, cancer and renal insufficiency were associated with a higher risk for referral to an ED, while dementia, treatment of pain, oedema, and use of sedative drugs and antidepressants were associated with a lower risk.

Study II

The waiting time at the ED was long (average= 4 hours) and characterised by a lack of privacy, a noisy milieu, and an uncomfortable stretcher. However, many patients expressed feelings of trust in the staff's medical expertise and had a positive attitude towards the staff.

A considerable part of the waiting period involved waiting for test results to be seen by the doctor. Problems arose when the staff did not have access to previous information regarding the patient such as medical records or sufficient information in the letter of referral from the community. Several of the patients were hungry, shivering because they were cold, and had a longing to be seen instead of feeling like they were forgotten. Pain was usually dealt with, but not when it resulted from lying too long on the stretcher in the wrong position. The patients were not always informed of the reason for the long waiting time and this increased their need to be seen. The results illustrated the importance of how nursing care is performed which the observations revealed could be performed in different ways. According to the patients what mattered was not only what the nurses actually did, but also the nurses' manner in which they did it was important, i.e. showing patience and kindness. Upon arrival some of the patients were totally lucid, but became increasingly confused during the course of the waiting period. Patients that arrived in a confused state became even more confused and did not cooperate during examinations.

Study III

From the ED nurses' point of view it is necessary to have a good basic knowledge of various illnesses in order to provide good nursing care. They need to be able to observe symptoms, understand improvement or deterioration in the patient's condition and react adequately and effectively in emergency situations. It was important for them to try to understand and have insight into the older patient's situation. They also underlined the importance of assuming their responsibility for guaranteeing good nursing care. The nurses shifted focus from describing the central content of good nursing care to describing what hinders the provision of such care. All emergency nurses agreed that good nursing care is impeded when there is simply not enough time. It was difficult to find time to do

the work required and they felt that sometimes nursing care was not appropriately prioritised. Prioritisation of medical procedures, everyday chores and routines impede good nursing care for the older adult in the ED and the nurses felt that the patients had to wait for hours for the doctors' decisions. The ED nurses expressed their sentiments that the ED is not always the appropriate place to meet the needs of these patients.

Study IV

The interviewed nurses expressed a need to feel secure in their own profession, when making decisions concerning referrals. In order to make this possible, they needed faith in their own competence, knowledge about the patient and a supportive environment. Lack of knowledge about the patient led to communication difficulties, caused a feeling of uncertainty and contributed to hasty decisions in the referral of patients to the ED. The communication with the consultant physicians on duty was of crucial importance, according to the nurses. Leaders' lacking understanding for the nurses' work, and unclear roles for nurses in the community could exemplify a non-supportive environment. Furthermore can long distances to the consultant physician, co-workers' lack of competence and lack of co-operation within the organisation lead to a non-supportive environment. Such an environment leads to uncertainty in the decision-making process. An increased understanding from the leaders within the organisation with reference to nursing roles was requested.

Study V

All the managers thought that the nurses needed to feel trust in themselves as nurses when making their decisions. The extent of insecurity was influenced by the presence of deficiencies in the organisation and/or competence levels of the staff. An increased feeling of insecurity on the part of the nurses might influence the physicians, remaining staff, older adults and their relatives. In turn, their uncertainty is reflected back to the nurses which managers felt could lead to the development of a vicious circle that culminates in sending the older adults to the ED.

Nurses' decisions to refer older adults to an ED could be easier when competent staffs develop a care culture. This should be based on the needs of the older adult patients as well as a desire for cooperation and trust between the professionals. The managers thought that the nurses needed more backing from the physicians.

The various managers had different views regarding what they thought was important in order to facilitate the decision making process for nurses. Physicians spoke more about a good working environment and individual development. They saw themselves as consultants in the process and focused more on `how to support´. They acknowledged a need to be closer to the patients and nurses but did not discuss their medical competencies in specialised fields such as geriatrics. Managers from home care services discussed administrative work, staff planning and work distribution. They felt it was necessary to be a supportive leader that creates a sense of security for the entire group in the

different situations. Those from nursing focused more on weaknesses in the organization than lack of competence among the nurses. They asked for understanding, guidelines and more support. They saw themselves as being more active, out in the field, leading and delegating. Being a good role model was important for them.

METHODOLOGICAL CONSIDERATIONS

In this thesis focus has been on the older adults and nurses' involvement in the referral and the caring process. Both quantitative and qualitative methods have been used to illuminate factors that lead to the transfer of older patients to an ED (**I, IV-V**) and the experiences from the care given (**II-III**). The combinations of the methods used to give a deeper understanding of the process (Burns & Grove, 2001). Downe-Wamboldt (1992) maintains that it is no longer a question if a quantitative or a qualitative method is the right method, what is more important is to let the aim of the study determine the method. Sandelowski (1997) holds that this discussion is still going on. To be able to generalise is often the goal in quantitative research while in qualitative research the goal is to illuminate and raise the understanding of the phenomena. There are different approaches used when collecting the data, but they share the same goal of measuring what should be measured. To describe this, the concepts of validity and reliability are used. Good validity and reliability are requirements in order to generalise the findings. There are differences but also similarities in how the concepts validity and reliability are used in quantitative and qualitative research. In a study with a quantitative approach, the researcher uses methods that are a known to have acceptable validity and reliability. With a qualitative approach, validity and reliability are an ongoing process throughout the entire project (Burns & Grove, 2001, pp. 406-408).

Study I

This quantitative cross-sectional follow-up study was performed in order to reveal the extent and cause for the referrals from sheltered housing to EDs. A random selection (Altman, 1999) of patients from units containing a larger number of individuals than the quota required was performed. From 24 randomly selected sheltered housing units, 800 older adults aged 75 or older from one county, representing 18% from each community (N=10) were planned to be included. Some declined to participate, withdrew or died, which resulted in 719 older adults being included in the study. Over a period of one year all acute referrals to the ED were documented and followed. The main sources for this study were the nurses' documentation (faxes) in connection with the referral occasion and the baseline RAI/MDS assessment. The RAI/MDS has been tested for validity (Morris et al., 1990; Mezey et al., 1992) and reliability, achieving an average inter-rater reliability of .67 (Hawes et al., 1995). The new 2.0 version has an average inter-rater reliability of .79 (Morris et al., 1997).

In spite of the internal drop out for some important variables such as information about referral patterns, which to some extent may make the conclusions questionable, the results are nevertheless of great interest due to the large database and the high number of referrals. Even if some factors in the RAI database had an association with visits to EDs, the r^2 in the logistic regression was low. The time span between the baseline assessment and the event or situation that lead to the referral was crucial. Two interpretations are possible. The baseline assessment itself may have highlighted problems against which actions have been taken. Another explanation is that reasons for referrals to EDs are so acute and complex that instruments such as RAI cannot predict them. We cannot from this database distinguish between these two interpretations. RAI is a care-planning instrument with a focus more on daily care than the prediction of acute events. The number of diagnoses (2.9) was rather low. The Swedish Council on Technology Assessment in Health Care (2004) showed that the subjective occurrence of diseases in this group was 80% musculoskeletal, 60% circulatory, and 30% neurological/sensory. For the RAI instrument to be effective, criteria filled in by the staff regarding diagnoses needs to be relevant to the patients' present condition. Problems with the faxed documentation was that it did not include all information that was of interest for this project, or sometimes the documentation was poor or the fax came without any documentation copied. Inquiries were made afterwards in person to supplement data that was missing.

The strengths of this study are the prospective design and the large sample and the detailed information of the referral patterns. The weaknesses are the internal drop out in some of the items, that the fax sheet could have been more structured and that perhaps the appropriateness of the referrals could not be analysed.

Study II-V

According to Sandelowski (1995) the sample size in qualitative research should be large enough to achieve a variation of experiences and also small enough to permit a deep analysis of the data. It is also important to choose participants with a wide enough variety of backgrounds such that the focus of interest will be covered (Kvale, 1997). The number of participants was limited in studies **II-V** and if the sample (**III-IV**) had been randomly selected the findings might have been different. Being that the observations and interviews provided rich information the researchers determined that the number of participants was adequate (Patton, 2002, p. 40). Leininger (1985) held that people who act together on an identified place or milieu are going to learn, share, transfer and form patterns that characterise the specific working place.

The 20 observations at the ED (**II**) were randomly selected since they took place when the researchers had the possibility of being there. The caregivers' situations and methods of working might have been effected by the observers' presence (Dahlberg, 1997). A positive quality of the co-assessment was that thoughts that arose during the data collection and analysis could be validated or

falsified by the four co-researchers in the pilot study. The two observers that continued had discussions with each other throughout the whole collection of data.

Narrative interviews (cf. Mishler, 1986) were carried out by the author of the thesis in studies **III** and **IV**, and together with a co-researcher in study **V**. We had no previous relationship with the interviewees; therefore the risk of being too familiar with them might be removed. However, being two interviewers in study **V** might have had an influence on the material as such since it is not likely that two different interviewers conduct their interviews in the same way.

Qualitative studies emphasise the understanding of lived human experiences and involve the researcher in the interpretation and analysis of data, and thus may be regarded as subjective (Polit & Beck, 2004). The trustworthiness of the findings in study **II-V** is, according to Graneheim & Lundman (2004), related to credibility, dependability and transferability. Credibility relates to the focus of the research and refers to confidence in how well data and processes of analysis address the intended focus. Critical issues are the decision about the focus of the study, selection of context, participants and approach to collect data. Another critical issue during the analysis process is to select the most suitable meaning units, how well categories and themes cover data and how to judge the similarities within and differences between categories. One way is to show representative quotations from the text, another way is to seek agreement among co-researchers, experts and participants. Graneheim & Lundman (2004) describe dependability as the degree to which data change over time and alterations made in the researcher's decisions during the analysis process. According to Polit & Beck (2004), transferability refers to 'the extent to which findings can be transferred to other settings or groups' (p. 717). Throughout the studies the researchers have tried to be as thorough and faithful as possible to the method when conducting the data collection, analyses and the reporting of findings.

Thus, the findings can be transferred to other groups and settings. In the qualitative studies of this thesis, an effort was made to illuminate the research process by explaining how the descriptions and interpretations were constructed and by giving representative quotations from the text. According to Bailey (1996) from the narratives there is not one correct interpretation of the meanings. Ricoeur (1976) states that it is always possible to argue for and against an interpretation, to confront interpretations and to mediate between them. Using two or more researchers to analyse and interpret the interviews and observations is done to further demonstrate credibility and reduce interpretation bias (cf. Polit & Beck, 2004). In studies **II-V** one or two additional co-researchers analysed and interpreted parts of the material.

Pre-understanding

Central in this thesis is the authors' personal pre-understanding within the field of study. The questions and reflections generated in these studies stem from the different events that have been experienced from within the author's clinical field as an RN in both the county council acute care and the community health care sectors. It is impossible to avoid looking at the material subjectively (Lindseth

& Norberg, 2004) even if the intention of the researcher was to do so by employing different methods such as, co assessment by others from different professional backgrounds or presentation of the material at seminars. It is necessary for the researcher to have both an 'inside and outside' perspective. It is important to distance themselves in order to avoid influencing the data yet at the same time maintain closeness to the clinical field and the knowledge necessary to understand it (Sandelowski, 1998). Sandelowski (1995; 1998) maintains that in qualitative research the researcher often has limited knowledge of the field being studied, which can make it difficult to put the results in the right context. In this sense, personal clinical experience is a strength.

REFLECTIONS OF THE RESULTS

Transition

The results seem to indicate that when referring an older adult to the ED, three transitions seem to be occurring during the process. These transitions according to Meleis et al. (2000) are Health-Illness, Organisational and Situational. The adaptation to and development of a new situation due to a transition seems to be influenced by several aspects (Meleis et al., 2000).

The change in the older patients' health status and subsequent transferral created a process of *Health-Illness transition* for them (**I**). This group of patients is more vulnerable than younger ones and have needs that are specific to the geriatric patient (Akner, 2004). The transition might make them even more vulnerable (Meleis et al., 2000). The patients' vulnerability became apparent (**II**) during the long and uncomfortable wait at the ED, which is in accordance with several authors (Nyström et al., 2003; Nyström, 2003; Wade, 1999). The older patients waited in a highly technical milieu that was not always easy to understand. Older patients need to be aware of their situation, which according to Chick & Meleis (1986) can be difficult since surroundings can influence the patients' perception. The staff at the ED gave information, but the patient' and their relatives could not always understand it. Providing information in an ED can be a challenging task, which can easily become just a routine (Moons et al., 2003). Communicative abilities are essential requirements (Caris-Verhallen et al., 1997) as well as active listing (Eckes 1996) in the nursing care of older adults. It was important for the patients and their relatives to be seen and listened to as well as being involved in the decisions regarding the patients' health (**II**). This is similar to the results reported by Nyström (2003) and Sahlsten et al. (2005). The older patients and their relatives felt a need for trust and security. The manner in which the nursing care was performed became important which is in accordance with other studies (Bruce et al., 1998; Watson et al., 1999). In order to give good care, it was necessary for the ED nurses (**III**) to be knowledgeable, have understanding and take responsibility for the older patients. Moons et al. (2003) maintain that it is extremely important for ED nurses involved in the care of older adults, either clinically or from management, to have an insight into the consequences of the care that is given in terms of content, economics, and organisation. As an aid for understanding the patient's

new situation, according to Chick & Meleis (1986) nurses need to construct profiles of how the individual perceives her/his transition.

Organisational transition (Schumacher & Meleis, 1994) could be seen in terms of the cutbacks and reorganisations that complicated the decision making process among the nurses (**IV-V**). Less is known about the impact of the organisation and the care culture (Sarvimäki & Sandelin Benkö, 2001) but Schumacher & Meleis (1994) propose that the interactions among persons and subsystems within the organisation facilitate or impede the process of transition. Collaboration, teamwork, effective communication, and support from key persons and groups all contribute to an environment in which the transition can be managed effectively (Schumacher & Meleis, 1994) and was asked for in study **IV** and **V**. In accordance with Dencker (1992), the feeling of inertia in relation to changes might be enough to create frustration. Management plays a significant role when it comes to the point of turning a possible resistance to change into a positive force, something that was earlier reported by Curtin (1997) and Schneller (1997).

The community nurses themselves seem to go through a Situational transition (Schumacher & Meleis, 1994) and it is reasonable to believe that this transition makes it even more difficult when making decisions (**IV**). This request for security in their professional role, faith in their own competence and knowledge about the patient exemplifies their transition (**IV**). That was further confirmed when they requested guidelines and support to assist them in adapting to and developing in the new situation, as nurses in community elder care (Meleis et al., 2000). It seems reasonable to believe that it is not enough to have trust in oneself if trust in the organisation does not exist (**IV- V**) or visa versa.

In these ongoing transitions, nurses care for patients and make their decisions, and when possible, together with the patient, relatives and physicians (**III-V**).

Decision making

The results show (I, IV-V) the complexity in the decisions made by community nurses. Several aspects such as the physical condition and knowledge about the patient influenced their decision. Furthermore, the wishes of the patients and relatives, the nurses' faith in their own competence, and a supportive environment were influential. To make or participate in decisions in times of uncertainty is one of the major roles for professionals (Bakalis et al., 2003). A problem arose when the nurse's uncertainty became so great that they projected their uncertainty to others who in turn mirrored it back creating a vicious circle, which culminated in sending an older patient to the ED (V). The nurses pointed to the lack of documentation about the individual patient as a cause for not being able to make the right decision (IV). Evidence suggests knowledge and clinical experience to be the most important factors influencing the clinical decision-making process (Benner et al., 1996; 1999). Hoffman et al., (2004) found that experiences and educational level alone did not strongly influence decision-making. The value of the professional role was more significant, which the interviewees expressed in studies

IV-V. Patient's and relatives' wishes were important when deciding whether to refer or not (IV) although, knowing the patient's wishes can be difficult. It became more difficult to decide when the patients, relatives and staff differed in their opinions (Weman et al., 2004; Lauri et al., 1997). Participating in the decision making process was important for the patients and their relatives at the ED (II). This concurs with Häggström et al. (2005) in their study of older adults and the involvement of family members in their care.

Decisions to refer and discharge older patients were discussed (**III-V**). ED nurses felt that the decision in the community to transfer the older adults was due to their unwillingness to take responsibility for them. The community nurses saw this from another point of view, and felt the decision to discharge the older adults was made too early and placed too heavy a responsibility upon them.

Responsibility

An interpretation of the results of this thesis can be that the older adult that becomes ill is somewhere 'in between' the different organisations and staffs' responsibility. Responsibility for a patient implies completing the tasks assigned a member of the staff in a given situation, no matter where in the organisation they are working (National Board of Health and Welfare, 2005a). Being responsible has ethical as well as human aspects. When the responsibility involves another person, it also has a moral one (Lögstrup, 1956). The very fact that someone depends on you, gives you responsibility. That someone depends on you, requires you to care, and caring is the response given to those depending on you. Lögstrup (1956) maintains that it is impossible for us to clarify the situation in its entirety solely by using our intellectual capacities.

Nurses are legally responsible for the nursing care (**II-IV**) according to law (1998:531) and ordinance (1998:1513), (National Board of Health and Welfare, 2005a). The nurse is responsible for her actions that are to be based on nursing science, ethics, and professional experience in accordance with the law. Reports of adverse incidents were something the nurses feared (**III- IV**) which was linked to their implicit and explicit feelings of responsibility for good nursing care. They felt their responsibility had increased after the reform and the cutbacks had been enacted (**III-IV**), which is similar to other studies (Thorslund et al., 2001; Weman et al., 2004; Westlund & Larsson, 2002).

Community nurses (**IV**) met the patients face to face and were able to see the whole person, which might increase their feeling of responsibility. ED nurses also met the patient face to face but due to the acute care setting were not privy to the whole person in the same sense the community nurse was. Sörlie et al. (2005) wrote that nurses join a patient's life when they meet them professionally. The ethical aspect that cannot be avoided further increases the nurses' responsibility. Lögstrup (1994) writes that ethical demands are increased when you meet a person face to face and occurs not only with what is said but also what was left unsaid. The consultant physicians on call are ultimately responsible for the medical treatment and make their assessment from nurses' pre-assessment. The

nurses are depended on this contact with the physician (**IV-V**). As the physicians' decisions are based upon the nurses' pre-assessments, the nurses' are therefore also partly responsible for the decisions made (Norberg et al., 1996).

The results show that there was criticism raised against the way in which the organisation responsible for older adult care took responsibility (**II-V**). The organisations consist of a number of structures in which formal decisions are made and have the ultimate responsibility for providing the means and environment to assure good care (Health and Medical Service Act, 1982:763). This is in accordance with the formal goals mandated by the politicians and within the economical limits. Gurner's observations regarding the fragmented care of older adults, indicates that the care organisation is not working efficiently (Gurner & Thorslund, 2003) and older patients are moved between different clinics and wards (Akner, 2004). Anell & Hjortsberg (2001) found that most of all, it is the older patients, that are affected by the changes in the health care system. Today, the care for older adults has been shifted from the hospital to the community or their relatives (Rahm Hallberg et al., 2002). Anell & Hjortsberg (2001) found that changes have created gaps in the chain of responsibility for these patients. The changes were a result of a large amount of individual decisions on different levels in the health care system and by different leading persons. Akner (2004) states that the faults in the elder care system creates conflicts which prevent good care and suggests that care should be provided based on the patient's perspectives of what is important. Furthermore Akner proposed that more focus needs to be placed on the older adults' well being rather than on the system. The patients' and relatives' (**II**) also questioned the responsibility of the organisations, when they blamed the leaders and politicians for their long unpleasant wait at the ED. They felt that something should be done to improve the routines and ease the heavy workloads at the ED. The ED nurses felt the ED-milieu was not adapted to the needs of the older adult patients (**III**). The nurses and physicians (**III-IV**) were sceptical of the responsibility of the organisations when they illuminated the weaknesses surrounding the decisions to transfer patients. They wanted better cooperation and discussed the importance of effective communication between the two caring systems (**IV-V**). Axelsson (2000) found in her study that the leaders in the health care system had different backgrounds, education and culture, which led to the use of different languages per se, as was seen in study (**V**). In a decentralised organisation responsibility and authority at the managerial level can imply conflicts between medical decisions, financial constraints, and administrative policies (Axelsson, 2000). Nurses (**III, IV**) and managers (**V**) felt that the workload had worsened and cited lack of resources, cutbacks and reorganisation as causes for the difficulties in the organisation and this is in accordance with several other studies (Axelsson, 2000; Häggström et al., 2005; Palme et al., 2003; Wimo & Granholm, 2003).

Patient in transition meeting the system world

When the health of an older adult deteriorates, a change occurs such that they seem to fall somewhere 'in between' the responsibility of two organisations. The care given in this situation can partly be

understood by the state of tension that exists between the life world and system world perspectives (Eriksen & Weigård, 1999). In the context of the results of this thesis, one can see the central concept of the system world as routines in the organisation and care relationships as the concept of life world. When nurses are caring for patients (**II-III**), the patients have a life world perspective and if the nurses have a system world perspective, that causes a state of tension. Since the character of nursing care has a life world perspective, this could cause tension for the nurses and could explain why they shifted focus from describing the qualities of good nursing care, to describing the conditions necessary for it (**III**). The community nurses (**IV**) work closer to the patients in their residences which brings them closer to a life world perspective and thus they become more sensitive to the patients' situation. This made even the nurses vulnerable.

Habermas criticizes a one-sided understanding of society and the idea of only a life world or system world perspective (Habermas et al., 1990; 1994; Eriksen & Weigård, 1999). The life world perspective can be seen as too idealistic. In this sense it is not possible to only have a life world perspective in acute care situations. A balance is needed. Looking at society as only a part of the system will make us lose the meaning aspect of social life. The meaning aspect of social life can only be understood by a hermeneutic interpretation of how the actors' use their symbols. Both perspectives are important, but the problem as Habermas see it, is when routine oriented attitudes take over (**II-III**) and characterize the relations in the life world.

For patients' in transitions, it seems important to discuss how routine oriented attitudes influence their situation during the transition, and affect their care (**II-IV**). If only a routine oriented perspective is allowed, the actions that follow might take place without reference to the patient' well being. The essence of the life world, the interaction in the relation, will be over run by the ideals of the system world (cf. Nyström et al., 2003). Older adult patients are going to be transferred between the levels of care based on what is best for the system such as resources, available beds and staff competence (**IV-V**). The older patients' care is going to be based on the routines that are created by the system which best serve the system (**II**). In such a situation the patients' identity can be lost and they become a task instead of a person. Ethical problems can arise when staff members displace moral issues onto the system and thereby relinquish their sense of responsibility for the patient. Habermas states that human values are important in human actions, and not for making the norms pathological (Habermas et al., 1990; 1994; Eriksen & Weigård, 1999). The ED nurses (**II**) were aware that the older patients were uncomfortable while waiting, but saw it as an organisational problem. Sörlie et al. (2004) reported that en-rolled nurses saw many ethical problems in their work, but shifted the responsibility to their leaders and the politicians, by saying we cannot do anything about this, it is our politicians' and leaders' fault. In this sense it is possible to see how community nurses felt frustrated by what they considered to be an undue burden of responsibility. They did not want to allow the system world values to take over and by doing that they open up for changes.

IMPLICATION

The major findings in this thesis illuminate the vulnerability of the older patients in transition and of the nurses caring for them. In Sweden, what might be called an 'in between syndrom' has developed where a gap occurs in the chain of responsibility for older adults that become ill.

Older patients do indeed need acute care and should not be denied it. The fact that the transition itself causes further problems for these patients indicates that we should if possible avoid the transfer process. To make that possible, physicians need to come closer to the patients and nurses and the care planning requires further development. More geriatric competence would be advantageous among the entire staff working with older adults.

The ED milieu needs to be more adaptable to older patients' needs without loosing its capability for advanced acute care.

Today two organisations share the responsibility of care for an older adult whose health has deteriorated. More focus is needed on the consequences this shared responsibility brings.

There should to be more focus on the influences of the systems on clinical praxis.

The older population is growing but the resources seem to be decreasing. More knowledge about older patients is necessary, but that is not going to be enough. We are going to need an improved understanding of the system if we are to avoid the apparent rigidity that seems to exist today; an examination of health care priorities is required. For the old patients in transition it seems necessary that the ongoing dialogue concerning routines continues, and in an increasing rate, to meet the challenge of their needs.

Patienters förflyttning från kommunal äldrevård
till vården på akutmottagning

Stora förändringar har skett inom kommunal äldreomsorg under de senaste 10-15 åren med en reducering av antalet platser i särskilda boenden från 118 700 år 1998 till 110 900 år 2003 och en successivt minskad serviceivå för majoriteten av de äldre. Den starka inriktningen mot att i första hand hjälpa de allra äldsta och mest hjälpbehövande har bl.a. inneburit att de personer som finns inom hemsjukvård och särskilda boenden har stora behov av sjukvårdande insatser. Samtidigt med denna utveckling ökar kommunernas problem med att finansiera offentlig omsorg. De äldre har ofta en komplex sjukdomsbild och stora omvårdnads-, rehabiliterings- och sjukvårdsbehov. För vårdpersonalen medför detta att arbetet blivit tyngre och kravet på mer professionellt kunnande ökar. För närstående har det inneburit att de tar på sig nya uppgifter när gapet mellan behov och resurser sviktar. Den låga medicinska bemanningen i kommunerna bidrar till en förflyttning av de multisjuka äldre och förflyttningen sker ofta fram och tillbaka mellan olika vårdnivåer. Förflyttningen i sig ökar deras sårbarhet. De möter nya organisationer, nya miljöer och ny personal. Den geriatriska patientens sjukdomar och behov är specifika och deras möjlighet att ta till sig en ny omgivning är mer begränsad.

Det formella ansvaret för den äldre människan är delat, dels i huvudsak mellan landsting och kommun, dels mellan olika professioner. För kommunernas sjuksköterskor har det ökade antalet multisjuka äldre och Ädelreformens införande förändrat arbetssituationen, rollen och ansvaret, radikalt. Många aspekter är involverade i beslutsfattandet omkring remitteringen av de äldre till akutvård. För att den kommunala äldreomsorgen ska kunna möta framtidens krav, där fler äldre behöver avancerad vård och omsorg, är det viktigt att öka kunskapen om processen runt patientens förflyttning mellan vårdformer och vården i ett akut skede.

Avhandlingsarbetet syftar till att belysa den praxis som finns vid remittering av äldre patienter från eget boende till akutmottagning; vad som påverkar beslutet att remittera (**I, IV, V**) samt omhändertagandet där (**II, III**).

Delarbete I syftade till att få svar på i vilken omfattning vårdtagare, $\geq$ 75 år vid särskilt boende, utnyttjar akutvården under ett år och vilka orsaker som kan ligga bakom remitteringen till akutmottagningen. I Gävleborgs län inkluderades 719 personer från 24 särskilda boenden fördelade på samtliga kommuner. Personerna följdes sedan under ett år med funktionsbedömning och vårdbehovsmätning, som gjordes vid studiens start och efter 1 år med ett etablerat instrument

(RAI/MDS 2.0). Vid eventuell överföring till akutsjukvården under året granskades dokumentationen genom att remitterande sjuksköterskor kopierade sina anteckningar och faxade dem till forskningsenheten. Dokumentationen sorterades in i 15 diagnos-/symtomgrupper och analyserades i SPSS. Vid vart tionde remitteringstillfälle intervjuades ansvarig sjuksköterska/läkare och patient, under förutsättning att patienten hade förmåga att verbalt uttrycka sig, om hur remitteringstillfället upplevts. Närstående intervjuades om synen på vården och deras möjlighet att vara delaktiga i olika beslut. Resultaten från intervjuerna redovisas i senare rapporter. Resultaten utifrån RAI/MDS och sjuksköterskornas dokumentation visar att av de 719 äldre vårdtagare som deltog i studien besökte 209 (29%) AKM 314 gånger på ett år. Det fanns inga skillnader mellan kvinnor och män. De vanligaste orsakerna för remittering var fall, feber/infektioner, hjärt-/kärlsjukdomar och symtom från magen. I 38% av remitteringarna fanns ingen anteckning om att sjuksköterskan kontaktat läkare. Telefonkontakt med läkaren var betydligt vanligare än läkarbesök hos patienten.

Delarbete II syftade till att studera omhändertagandet på en akutmottagning och hur äldre patienter och närstående upplever vistelsen där. Observationer av omhändertagandet av 20 patienter, 75 år och äldre, genomfördes. Femton av de 20 patienterna hade närstående med till sjukhuset. Patienter med klara diagnoser som t.ex. frakturer och hjärtinfarkt ingick inte i studien. Datainsamling och analys följde strukturen i Grounded Theory. Resultaten gav svar på hur det kan vara att som gammal vänta på AKM. Patienterna uttryckte ett stort behov av trygghet. Otryggheten uttrycktes i rädsla för att t.ex. inte bli trodd, inte få smärtlindring, bli bortglömd och att inte kunna påkalla uppmärksamhet. Vidare uttrycktes den i att förlora kontrollen över sig själv och att inte kunna påverka in- respektive utskrivning. Att vänta upplevdes i studien som ett av de största problemen med att vara på AKM. Väntan var i medeltal fyra timmar. Den präglades av ovisshet i en många gånger påfrestande och opersonlig fysisk miljö, ovisshet över när läkaren skulle komma/återkomma, och vad som kunde ske härnäst. En önskan om att bli sedd och lyssnad till framträdde starkt samt att få vara delaktig i sin egen väntan. Trots att vistelsen på AKM kunde vara svår visade patienter och närstående tilltro till läkare och övrig vårdpersonal. Den kritik som framkom riktades mot organisationen och politiker.

Delarbete III. Det är sjuksköterskor som gör den initiala bedömningen vid patientens ankomst till en akutmottagning och beslutar om prioritering och den specialitet som patienten skall sändas vidare till. I syfte att belysa vad sjuksköterskorna anser vara en god vård för äldre på en akutmottagning intervjuades 10 sjuksköterskor. Materialet analyserades med hjälp av tematisk innehållsanalys. Av intervjusvaren framgick att för att kunna ge bra vård till äldre människor på AKM krävdes att vara kunnig inom olika områden, ha förståelse för den gamles situation, ta ansvar och att inte alltid prioritera medicinska insatser och rutiner. Sjuksköterskorna hade lättare för att beskriva vad som hindrade en god omvårdnad än att beskriva situationer när en god omvårdnad gavs. De ansåg att AKM

inte var utformad för att alltid kunna möta gamla människors behov och ifrågasatte ibland varför dessa blivit inremitterade dit från kommunen.

Delarbete **IV** syftade till att studera närmare vad som påverkade beslutsprocessen före remittering till akutvården och vilket stöd som behövdes för att undvika en förflyttning. Fyra vårdcentralschefer och 10 sjuksköterskor inom den kommunala hemsjukvården intervjuades. Berättelserna analyserades med hjälp av latent innehållsanalys. Resultaten visade att kommunens sjuksköterskor ansåg att en av de stora svårigheterna när de kom till ett boende eller till patientens hem var att få fram aktuell kunskap om patienten. Den skriftliga dokumentationen var ofta dålig eller otillgänglig. För att åstadkomma handlingsprogram inför eventuell försämring efterlystes utarbetad vårdplanering och bättre samarbete mellan vårdcentral, kommunens verksamhet samt akutsjukvård. Läkarna efterfrågade bättre rutiner för hur besluten kunde följas upp. Vikten av att samma språk talas mellan sjukhus och primärvård betonades. Svaren handlade även om utbildningsnivå och fortbildning av personalen, vem som ska ansvara för personalgrupperna och om olika tekniska hjälpmedel. Anmälningsfallen skrämde sjuksköterskorna och det var problem med att delegera tillsyn över, eller våga lämna kvar försämrade patienter. På grund av stora personalgrupper blev personkännedomen dålig. Professionsstrid och avsaknad av förståelse från omgivningen skapade osäkerhet i beslutsprocessen. Det var inte ovanligt att akuta beslut fattades under stress över annat ogjort arbete. De ansåg att tid inte fanns för att återkomma och se hur situationen utvecklats. Läkarna betonade behovet av ökade resurser utan att ange specialitet. Intervjupersonerna upplevde att utskrivningen från sjukhusen skedde för tidigt och vilket ökade deras ansvarsbörda ytterligare.

Delarbete **V** syftade till att belysa ledares syn på remitteringen av äldre till akutvården och jämföra resonemang hos ledare med social, omvårdnads- respektive medicinsk bakgrund. Intervjuer med områdeschefer, medicinskt ansvariga sjuksköterskor (MAS) eller avdelningsföreståndare och klinikchefer/motsv. i kommuner och landsting inom ett län, totalt 30 intervjuer, genomfördes. De narrativa intervjuerna analyserades med hjälp av tematisk innehållsanalys. Samtliga ledare ansåg att sjuksköterskorna behöver känna trygghet i sina beslut, men skiljde sig åt om hur det skulle uppnås. Läkarna talade om arbetsmiljö, lön och personlig utveckling, chefer med social bakgrund lyfte mer fram gruppens utveckling och personliga egenskaper hos sjuksköterskan. Ledare med omvårdnadsbakgrund talade om mål, riktlinjer och om svagheter inom organisationen. De olika budskap som gavs om vad som bör prioriteras kan ses som en förklaring till varför kommunsjuksköterskorna saknade förståelse och stöd från arbetsledningen, vilket i sin tur kan leda till den osäkerhet som sjuksköterskorna uttryckte.

Sammanfattning

Avhandlingen har fokuserat på den äldre människan och sjuksköterskan i den process som följer på en förändring i den äldres hälsa; sjuksköterskans beslutsprocess, den förflyttning som sker och upplevelser av omhändertagandet på en akutmottagning. Den kombination av metoder som använts har fördjupat förståelsen av de pågående processerna. Resultaten visar komplexiteten i kommunsjuksköterskans beslutsprocess. Många aspekter influerar besluten som patientens fysiska kondition, kunskapen om patienten som finns tillgänglig, medarbetares och kommunsjuksköterskans egna kunskaper och patientens och anhörigas önskemål som inte alltid överensstämmer. Genom förflyttningen försätts patienten i ett "transition"- tillstånd (se Meleis m.fl. 2000) som ytterligare kan öka sårbarheten. Den gamla människan möter organisationer i förändring med nedskärningar, nya rutiner och ett delat huvudmannaansvar. En tolkning av resultaten i avhandlingen är att processen den gamle befinner sig i inom systemet kan betecknas som "in-between-syndromet".

Såväl etiska som humanistiska aspekter kan läggas på att ha ett ansvar. När ansvaret involverar annan person finns också den moraliska aspekten med (Lögstrup 1956). Det faktum att någon är beroende av dig ålägger dig ett ansvar menar Lögstrup. Sjuksköterskan är, utifrån lagar och förordningar, ansvarig för den vård hon/han ger. Hon/han möter patienten öga mot öga och förväntas fatta ett beslut om den bästa möjliga vård där den etiska aspekten inte kan förbises. Det ökar hennes/hans ansvar ytterligare. Av ekonomiska skäl är risken stor att kommunerna anställer personal med lägre utbildning för de svåra uppgifter som vården av äldre och handikappade innebär. Det kan ge vårdarna en känsla av att deras arbete är mindre värt och att vem som helst kan utföra det. Känslan av att vem som helst kan utföra ens arbete kan få som följd att vårdarna förlorar motivation och engagemang och upplever att det sätt på hur arbetet utförs saknar betydelse.

Antalet gamla, sårbara personer i samhället blir fler och risken ökar att medicinskt omhändertagande och omvårdnaden baseras på rutiner som mer passar systemet än de gamla, med ett förtingligande som följd. För patienten i ett tillstånd av förflyttning ses det ytterst nödvändigt att dialogen om rutiner som skapats utifrån den gamles behov får fortsätta och i en ökad takt.

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