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Stakeholder perspectives on transitions of nursing home residents to hospital emergency departments and back in two Canadian provinces

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ABSTRACT

Major gaps exist in our understanding of transitions in care for older persons living in nursing homes. The purpose of the study was to identify key elements, from multiple stakeholder perspectives, that influence the success of transitions experienced by nursing home residents when they required transfer to a hospital emergency department. This interpretive descriptive study was conducted in two cities in the Canadian provinces of British Columbia and Alberta. Data were collected from 71 participants via focus groups and individual interviews with nursing home residents, family members, and professional healthcare providers working in nursing homes, emergency departments, and emergency medical services. Transcripts were analyzed using constant comparison. The elements contributing to the success of transitions reflected a patient- and family-centered approach to care. Transitions were influenced by the complex interplay of multiple elements that included: knowing the resident; critical geriatric knowledge and skilled assessment; positive relationships; effective communication; and timeliness. When one or more of the elements was absent or compromised, the success of the transition was also compromised. There was consistency about the importance of all the identified elements across all stakeholder groups whether they are residents, family members, or health professionals in nursing homes, emergency departments or emergency medical services. Aspects of many of these elements are modifiable and suggest viable targets for interventions aimed at improving the success of transitions for this vulnerable population.

Introduction

As in many other member countries of the Organisation for Economic Co-operation and Development (OECD), almost half (43%) of Canadian seniors will be residents of nursing homes (NHs) during their lives and will spend 3 to 4 years there, with one in five staying more than 5 years (Council on Aging of Ottawa, 2008; OECD, 2005). Almost half (45%) of Canadians in NHs are frail elderly 80+ years of age (Statistics Canada, 2010). Three quarters are women (Statistics Canada, 2008); the majority (approximately 70%) suffer from age-related dementia (Doupe et al., 2011; Gruber-Baldini et al., 2010); and virtually all are highly dependent on others to meet their daily needs. The

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standards by which nursing home staff deliver such care, in Canada, are set by the respective provincial governments and no single standard exists (see Berta, Laporte, & Valdmanis, 2005; Harrington et al., 2012; McGregor et al., 2005). The quality of care received and health outcomes for NH residents has thus become an area of intense research interest (Berta, Laporte, Zarnett, Valdmanis, & Anderson, 2006; Boult et al., 2009; Kuske et al., 2007; Loganathan, Singh, Franklin, Bottle, & Majeed, 2011; Spilsbury, Hewitt, Stirk, & Bowman, 2011).

One area gaining prominence is the experiences of NH residents as they move between health services. Commonly occurring changes in health status – often triggered by events such as infections, falls, and geriatric syndromes – can result in frequent transfers from NHs to hospital emergency departments (EDs). Early research reported up to 1 in 4 NH residents experiencing a transfer to the ED each year (Bergman & Clarfield, 1991), and recent reports suggest that rates have not significantly changed: 19.0% (Gozalo et al., 2011) and 23% (Gruneir et al., 2010). We have defined the entire process of transferring a resident from their NH, to the ED (and inpatient care unit, if needed), and back to their NH as a transition in care. Transitions in care have been recognized as an important area for inquiry (Arendts, Reibel, Codde, & Frankel, 2010; Gozalo et al., 2011; McCloskey, Campo, Savage, & Mandville-Anstey, 2009; McCloskey & van den Hoonaard, 2007; Mitchell & Young, 2010) and have prompted the exploration of related health care needs (Coleman & Boult, 2003).

Transfers to ED among the NH population are: a) recognized to often place residents at significant risk for poor health outcomes and decline (Hustey, 2010); b) often prompted by weak evidence and poor decision making; c) plagued by operational inefficiencies that are reinforced by health system fragmentation (Terrell & Miller, 2006); and d) also extremely costly to the healthcare system (Boockvar, Gruber-Baldini, Stuart, Zimmerman, & Magaziner, 2008; Terrell & Miller, 2006). Residents can experience care that is delayed, not evidence-based, potentially unsafe and fragmented, and possibly unnecessary (Hustey, 2010; Saliba et al., 2000; Terrell et al., 2009). Few studies have reported on the entire process of transitions in care but instead have focused on discrete aspects of the process such as transfers of the elderly from hospital to NH (Newcomer, Kang, & Graham, 2006) or experiences in a single setting (e.g., the ED). Further, the multiple perspectives of all involved stakeholders, including residents and family caregivers, have not received systematic attention (McCloskey & van den Hoonaard, 2007). International and national reports describe sub-optimal quality of care in NH settings and in pre-hospital and ED settings (Keating, 2008; National Advisory Council on Aging, 2005; OECD, 2005), which may exacerbate the problems associated with transitions in care for NH residents. In summary, major gaps exist in our understanding of these complex transitions.

The objective of this qualitative study was to identify key elements influencing the success of transitions in care for residents moving between NHs and EDs from multiple perspectives (i.e., residents, family members, and professional healthcare providers) within the three settings of care (NH, Emergency Medical Services [EMS], and ED). For the purpose of this research, *elements influencing success* were defined as those aspects of the transition in care that were perceived to contribute to a transition 'going well.'

Design and methods

The interpretive descriptive study (Thorne, 2009) reported here is the first phase of a program of research: the Older Persons' Transitions in Care (OPTIC) project. The goal of this program of research is to identify modifiable factors to improve the care of residents experiencing transitions between NHs and acute care EDs. Two participating Canadian study sites – a large city in Alberta and a small city in British Columbia – are involved in this research. Thirty-seven NHs and multiple EDs exist in the larger city, and fewer than 15 NHs and a single ED in the smaller city. Participating EMS providers in each city are publicly operated. Ethical approvals were obtained in both provinces from the participating universities and health authorities.

Sample and data collection

Participants were recruited from three groups in each province: 1) NH residents who had experienced a recent transition in care to a hospital ED and a return back to the NH; (2) family members of those residents; and 3) professional healthcare providers (registered nurses, licensed practical nurses, paramedics, physicians, and administrators) involved in transitions from three settings—NHs, EMS, and EDs. The resident/family samples are described in Table 1 and the health provider sample in Table 2. Residents were eligible to participate if they were aged 60 or above, had an emergency transfer (911 calls only) to the ED within the last 12 months, and a Cognitive Performance Scale (Morris et al., 1994) score between 0 and 2. When compared to the Mini-mental State Examination, the Cognitive Performance Scale was found to be a valid measure of cognitive function in NH residents (Smart, Herrmann, & Lanctot, 2011). For ease of recall, we recruited residents and their involved family members in relation to their most recent transition. We did not attempt to match health professionals and residents/family members in relation to the same transition experience. Common reasons for NH transfers to the ED in the study sites included: fractures and lacerations related to falls, cerebrovascular events, cardiac problems, and infection (e.g., pneumonia and bladder).

Data were collected from residents (7 participants) and family members (20 participants) via 24 semi-structured interviews guided by open-ended questions focused on a recent transition to the ED and back to the NH. Residents and family members were given the option of individual or group interviews. Two families chose to be interviewed as a group (one family included 2 participants; the other family included 3 participants). Interview times for residents averaged 30 min while times for family members averaged 45 min. Participants were encouraged to describe what prompted the transition, the sequence of events (including family involvement) at each step of the transition, patient/family expectations regarding the transition, and perceived outcomes. Participants were asked to provide an overall assessment of the success of the transition they experienced as well as advice for responsible healthcare providers. Despite our best efforts to include the perspective of residents who met cognitive capacity criteria, we found that they struggled to recall transitions and provided extremely limited responses to open-ended questions. Family members, on the other hand, were able to provide detailed and reflective reports regarding their relatives' transitions.

Table 1
Resident and family member sample individual interviews.

Participant type	Resident	Family
Participants (n = 27)	7	20
# Interviews	7	17
Female	4	17
Mean resident age (range 72–87)	79	
Relationship to resident		
Spouse/partner		3
Daughter		14
Son		1
Other relative		3

Data were collected from healthcare providers via 6 context specific focus groups (37 participants) and 7 semi-structured individual interviews. Focus groups were determined to be the most efficient way of collecting rich data from a wide range of busy professional providers (Sandelowski, 2000) and lasted an average of 80 min. Individual interviews were offered to healthcare providers who were unable to attend focus group interviews in order to maximize participation and the diversity of perspectives. These seven interviews lasted an average of 50 min. The same healthcare provider interview guide was used for both methods of data collection. Questions were framed to prompt narratives of two types of transitions: those perceived to have 'gone well' (successful) and those perceived to have gone 'not so well' (unsuccessful). Additional questions were included to encourage participants to expand descriptions, fill gaps and draw comparisons. They were also asked to make recommendations about how transitions could be improved. All interviews and focus group discussions were audio-recorded, transcribed verbatim and accuracy checked.

Data analysis

Data were analyzed using the method of constant comparison (Thorne, 2009). The research team began analysis by close and repeated reading of the transcripts in order to identify preliminary themes. We compared the data from the large and small cities to determine if place was an influencing factor. No differences were found so data were combined for further analysis. Attention was paid to differences and similarities in perspective among the stakeholders. Comparisons were also made across various types of transitions, for example related to the urgency of transition, time of day, and setting. A coding framework was developed through consensus and was oriented toward elements that were perceived to influence the transition experiences and outcomes. We purposely adopted the focus of resident and family members in our approach to interpreting the data. Our decision to privilege the perspectives of residents and family members regarding optimal transition outcomes was based on the belief that transitions in care are meant first and foremost to serve the best interests of residents. Family members' perspectives were privileged because of their close involvement with residents and to ensure representation for those residents whose cognitive impairment was too great to allow participation in the study. Transcripts were subsequently coded using NVivoQRS 8.0. Constant comparative strategies were then used to review the coded data and further elaborate the elements that were perceived to contribute to the success of transitions.

Table 2
Health care provider sample.

Health care setting	Nursing home	Emergency medical services	Emergency department
Participants (n = 44)	23	11	10
Total # focus groups	2	2	2
Total # focus group participants	18	11	8
# Individual interviews	5	0	2
Worker category			
RN	5		4
LPN	3		
Care aide or unit clerk	6		
Physician	1	1	2
Leaders/managers	6	2	4
Unknown	2		
Paramedic/EMT		8	

Findings

The context of transitions was complex and challenging. Throughout the focus groups and interviews, participants pointed to factors that created unique challenges to effectively meet the health care needs of vulnerable NH residents. These included: compromised cognition among many residents, system constraints such as inadequate staffing mix and ratios, staff turnover, varying levels of family involvement, compromised physician availability, barriers to seamless communication, and differing priorities among health care providers. Five elements that were perceived to influence the success of transitions in this context were identified: knowing the resident; critical geriatric knowledge and skilled assessment; positive relationships; effective communication; and timeliness. When one or more of these elements was absent or compromised, the success of the transition was also perceived by participants to be compromised. Each of these elements is described below.

Knowing the resident

'*Knowing the resident*' was critical because it was the foundation on which transition decisions were made and the process unfolded. All stakeholder groups indicated the importance of having information about who the resident was as a person. This included knowledge about the resident's values, preferences, and day-to-day way of being as well as having a clear grasp of the resident's health history and current health status. The participants who were best positioned to have this knowledge were NH staff and family members. Others relied on knowledge of the resident gleaned from NH staff and family members because residents were often unable to convey this critical information themselves due to confusion and/or dementia. Knowledge of what was 'normal' for the resident (behaviors, symptoms, co-morbidities) while living in the NH setting provided a critical reference point for assessing often subtle, but important, changes in health status and the need for transfer to the ED.

> They [nursing aides] … don't have the professional ability to do a really thorough assessment—although they have the intimate knowledge of the resident. So they know that Mrs. Jones isn't quite right. There's something wrong there. They may not know what it is but they know that person better than anybody else because they're there every day. So they come to the nurse or the LPN [licensed practical nurse] and say there's something wrong. I don't feel good about… what's happening with [resident's name]. [NH participant]

Not surprisingly, personal knowledge of the resident increased healthcare providers' confidence with assessment and decisions regarding transfer. Knowing the resident's personality, preferences, and his or her medical baseline could also facilitate the transition for the resident, with the NH staff (and family) providing ‘little tips’ for other healthcare providers to tailor their approach to the resident as exemplified in the narrative below.

> The nurse who … is ready for them [EMS] when they come to give them the complete story of what happened, has all the documentation ready, is so knowledgeable about that resident that even can give those little tips, not just what happened but, “This person you know they're very easily agitated by this and that and you need to know that.” You know those little things that she can tell them that may not be pertinent to the injury or the reason you're sending them out but that can help the paramedics in their roles and maybe they can pass even on to the receiving facility [ED]. [EMS participant]

When personal knowledge of the resident was absent, the transition was often reported to be negatively affected. For example, this could occur when family were absent, or NH staff were new and/or unfamiliar with the resident (e.g., if working part-time or ‘on call’). Under these circumstances there was evidence that assessment and decision making could be compromised and result in unnecessary transitions or transitions that put the resident at increased risk for such things as distress, disorientation and physical decompensation. Examples were given of residents transferred for long-term existing problems, such as shortness of breath, which did not require emergency attention.

Critical geriatric knowledge and skilled assessment

Healthcare providers in each context of care recognized that care of the elderly is often exceptionally complex and that without adequate geriatric education and training, inappropriate decisions could be made related to transfer, diagnosis, and treatment.

> Well if anybody's going to be misdiagnosed, it's going to be a geriatric patient; and clearly in studies and subjectively that's what's going to happen. They've had a fall. Why did they fall? Why are they like that? What led to the fall? How has the care been up to the point where they got like that so they ended up falling? And when you talk about receiving at the hospital, of course right, report is so vital and if nurses at the hospital are really, really busy then there's more chance of this misdiagnosis with the geriatric patient, right? ‘Well of course he's like that, he's old.’ You know people are still saying that. Even if they're not busy, the lack of understanding about gerontology will lead to mistakes being made. [EMS participant]

While in-depth geriatric knowledge was identified as an important influence on the success of transitions, it was incomplete if not combined with resident-specific information. This is highlighted in the following quote from a NH staff member who cued the EMS attendants with critical information regarding the resident that enabled them to tailor their approach:

> Well, from start to finish they [EMS] understood.... They got down on his level because he was in a wheelchair and from start to finish and they knew he was going to get mad, I warned them. They [EMS] knew and they said “Yeah” and they didn't get upset when he got upset. They didn't try to rush him and even though we had to sedate him, they kept talking quietly. [NH participant]

Problems related to lack of geriatric knowledge in combination with resident-specific knowledge and skilled assessment included the following: a) inability to recognize resident problems early when measures could be taken to address them before the resident's condition deteriorated and required a transfer (i.e., nipping something in the bud); b) lack of ability to deal with co-morbidities of aging residents to prevent acute incidents (e.g., preventing falls); and, c) general lack of confidence in determining whether a particular resident's health and safety were truly compromised. Such problems had significant consequences for decision making. For instance, a delay in decision to initiate a transition could result in serious deterioration of an already acute situation for the resident and put providers in the position of responding to a crisis.

> Recognizing that it's acute quickly which makes it much more successful. A lot of our transfers …they might have been sick for one or two days, and now it's an acute transfer and it could have been a routine transfer. [NH participant]

In addition, family members were often left with the final decision to initiate an admission to the ED for their relative, a role many were uncomfortable with, especially when they too lacked sufficient knowledge.

> I think it's good to involve the… family; however they—they [NH staff] seem to hesitate to make decisions that… should be in their domain.... That's what [the NH staff are] there for is to make those kind of decisions. They should be advising me that “yes your mother's had a fall and we think she should go to emergency and we're going to send her.” You know—I should be informed, not…they shouldn't be asking my permission. [Family member]

Health provider participants noted that health system resource limitations sometimes constrained their ability to appropriately respond to knowledge of residents' needs. For example, ED staff were well aware of residents' rapid physical and cognitive decline when immobilized on a stretcher in a busy ED for any length of time, but reported that they were often unable to provide a more appropriate context of care because resources were unavailable. When the ED had access to clinicians with geriatric expertise, they noted that dealing with the complexity of care was often enhanced; for example, the identification and organization of necessary resources occurred in a more timely fashion.

Positive relationships: the relational context of care

Transitions in care occurred in a relational context; as a result, the quality of relationships was perceived to be a contributing factor to the success of transitions. In addition to relationships that centered on the resident and resulted in personal knowledge that underpinned transitions discussed above, relationships between two stakeholder groups were also important: first, healthcare providers and family members; and second, relationships among healthcare providers.

Family–provider relationships

Family involvement was viewed by all participant groups as an essential element in a successful transition and involvement was influenced by the family–provider relationship. For the most part, relationships between family members and providers were characterized as positive and supportive with family members being viewed as key team members. NH providers reported that 'knowing' family members was important for effectively involving them in resident transitions; this took time and attention. This knowledge guided provider decisions about when to call family members and what to expect in terms of family involvement. Family members viewed involvement that respected their preferences for information, consultation, and decision making as optimal. When family members observed healthcare providers treating their relatives with compassion, dignity and respect, their relationships with healthcare providers were supported by trust, confidence and admiration. Compassionate, gentle care that included humor offset concerns that naturally arose during transitions and inspired a sense that the resident "was in good hands." One participant talked about responding to a resident's apprehension with patience and humor this way: "It depends on how you handle it. You know I tend to be, 'Oh, so you're going for a trip in the ambulance; you're going to check out all the good looking guys over there, huh.' I found that it was easier to kibbitz with them a little bit and just try to be as up about it for their sake and you know just give them that little extra time and just be there for them."

When tensions in family–provider relationships occurred, it was typically around interpretation of the resident's best interests and discrepancies in perspective. For example, sometimes family members were hesitant to support a transition recommended by healthcare providers when residents stated they "didn't want to go back to hospitals any longer." At other times, family members were at a geographic distance and wanted 'everything done' but lacked the personal knowledge of the resident that the NH staff had. Here, tensions arose when NH staff believed it was in the resident's best interest to remain 'at home' in the facility. These situations were reported as infrequent and were usually resolved by initiating a transfer to the ED, one that may or may not have been necessary. The better the family–provider relationship, the greater the likelihood of negotiating decisions surrounding transfer that all stakeholders agreed upon. When a rule bound approach was taken, for example when NH staff took the stance that it was the family's role to decide whether to transfer, family–provider relationships suffered.

Relationships among healthcare providers

Study participants clearly identified the importance of mutual respect and understanding among healthcare providers in different settings to the transition process. Ideally, this required system level understanding and acknowledgement of each others' "worlds" along with a firm belief in everyone's underlying motivation to provide "good care." These trusting relationships were based on a belief that everyone was oriented to the resident's best interests and supported giving each other the 'benefit of the doubt.'

Despite the commitment to supporting each other in the provision of optimal care to residents, there was evidence that this ideal was difficult to achieve. Respectful relationships among healthcare providers across settings were undermined by negative assumptions and judgments about each other and about what constituted appropriate care for the older person. For example, both NH and EMS participants identified problems with EMS attendants aggressively questioning NH staffs' judgment and decision to transfer a resident to the ED. When EMS attendants took on a gatekeeping role, relationships with NH staff were undermined leading to concerns about how the resident would be cared for, both during transfer and in the ED. NH staff remarked on the influence of ageism on healthcare provider relationships—in particular, the belief held by some healthcare providers that older people should not be seen in the ED. When problematic relationships between healthcare providers resulted in dismissing the NH staffs' personal knowledge of the resident and casting doubt on their assessment, then transitions in care were perceived to be negatively affected.

Communication of information

Clear, effective communication of information was perceived by all participant groups to be a central element contributing to the success of transitions. Critical information included knowledge about the resident as a person, assessment data, treatment and process information (i.e., what happened or was happening in each phase of the transition). When communication was effective, it served to organize the transition and facilitate a smooth, efficient and seamless experience where everyone understood what was happening and why. Communication of critical information enabled accurate interpretation of the 'facts.' For example, if shortness of breath was present, was this an important symptom, or was it normal for that resident? As mentioned earlier, EMS and ED healthcare providers relied on NH staff and family to communicate their knowledge about the resident as a person. Three patterns of communication were noted in the data from all three settings: notification, explanation, and conversation.

Notification

Notification was the briefest form of communication and consisted of accurate, verbally conferred facts. For example, notification took place when NH staff informed family members that a resident had been sent to the ED. Ideally, from the family perspective, notification should happen before a transition was initiated, but it was often considered acceptable if it happened immediately afterwards, particularly if the situation was urgent. NH staff reported that the person most often left out of the notification loop was the resident's family physician. From the EMS perspective, the facts to be communicated by the NH needed to be chosen carefully, since notification of a resident with shortness of breath automatically resulted in "lights and sirens," a degree of urgency that could be inappropriate if the shortness of breath was longstanding. Notification was considered optimal when it enabled appropriate care during each phase of the transition.

Explanation

Explanation involved more detailed and comprehensive communication that focused on the resident and the situation. Ideally, the explanation was organized, consistent, understandable, concise, easily accessible and tailored to the needs of the recipient of the information. Healthcare providers required this information verbally and in writing, while family members received the information only verbally. A standardized form for communication of written information that accompanied the resident was viewed as helpful but even when forms existed, participants reported that they were seldom used. A good explanation provided essential context for decision making (e.g., what equipment EMS should bring or how triage should proceed in the ED). Having all the 'pieces of the puzzle' was viewed as particularly important by all stakeholder groups when residents suffered from dementia or confusion and could not speak for themselves.

Conversation

Conversation was the most complex pattern and was characterized by reciprocity, negotiation, and mutual involvement in decision making. Participants reported that a systematic chain of communication was ideal although infrequently followed. Conversation was typically required in situations where the problem was "not patently obvious," requiring more involved, complex decision making and advance planning. While participants agreed that this pattern of communication was highly desirable, it occurred infrequently.

When any of the patterns of communication was fractured, absent, or inadequate, serious consequences related to the success of transitions were reported. Without communication of necessary information, those involved could not do their jobs effectively, the resident may not receive adequate and timely care, and relationships between healthcare providers were negatively affected. Participants agreed on these common communication problems:

- EMS participants were frequently unable to find someone who knew the resident and who was able to give a comprehensive report when they arrived to receive the resident.
- Both NH and ED participants agreed that the resident's return to the NH was often complicated by inadequate (or no) information about what had occurred in the ED and, consequently, resulted in unclear expectations for continuing treatment.
- Advance notification of the return of the resident to the NH did not typically occur, which impeded NH staffs' ability to prepare.
- All participant groups identified the problem of "chasing" or "digging" for essential information that was not readily available. In one extreme example, an ED physician talked about receiving a resident with no accompanying information; unable to determine why the resident was in the ED, the resident was transferred back to the NH untreated.

Fractured communication occurred both within and between contexts of care. The pressure points in the system that negatively affected communication included short staffing, policy requirements surrounding staffing complements (e.g., one RN per NH facility who might not know the resident but who was responsible for overseeing transitions), as well as casualization of staff, particularly in NHs. Family members were vital links in the process filling the communication gaps between healthcare providers. For example, family members were critical to helping ED providers 'know' the resident and sometimes provided the only report to NH staff about what happened in the ED.

Timeliness

Not surprisingly, timeliness figured as a key element contributing to the perceived success of transitions. This was reflected in participant data about the importance of a quick response time related to identification and assessment of resident needs and problems, decision making regarding the need for transfer to the ED, and initiation of the transition. EMS participants emphasized the importance of balancing speedy transfers with slowing down in order to attend to residents' comfort and alleviate confusion, facilitate communication, and compile complete documentation.

The most vocal participants about the issue of time were family members and the focus of their attention was the ED. Being seen quickly in the ED was linked to quality of life for residents and families in two ways. The first related to simply being assessed quickly to determine what was wrong—this relieved stress and anxiety. The second related to 'being on the hospital's radar,' evidenced by awareness that ED staff knew the resident was there and had performed an initial assessment, provided comfort—even if residents then had to wait a long time for further treatment or for admission to an inpatient unit. In contrast, family members regarded not being seen quickly as a failure.

Perception of the waiting time was a major determinant of how residents and family members perceived the success of a transition in care. Residents and family members reported that being informed about estimated waiting time for diagnosis and treatments in the ED provided them with a timeframe, easing their anxiety. Although some family members and residents indicated that the wait time spent in the ED was quick, this perception may have been influenced by their expectation that it would go very slowly. For instance, some family members were advised by EMS that the wait would be long and they should "bring a book." As one family member reported, "Mom was seen in an hour, but we expected to wait 5 h." Virtually all family members who felt that things went quickly expressed surprise. At the other end of the spectrum, family members who waited very long periods (12–24 h) for initial care in the ED were also surprised at how long it took. An assessment of the quotes of family members suggests that acceptable wait times appear to cluster around specific thresholds. Care that took less than 1 h was "marvellous," and 1–3 h was very quick, while 3–6 h was to be expected. More than 6 h was slow and disappointing. ED staff clustered their comments around unacceptable and "horrifying" waits of 8 + h.

Clock routines (day of the week and time of day) also influenced expectations surrounding timeliness. Family members noted that Saturday evenings were notoriously busy in the ED. However, evidence of a rationale for, or fairness to, the waiting process, and communication about the wait, made it acceptable to many. Family members did not seem bothered that residents often had to wait considerable periods of time between being treated and being returned to the NH. On the other hand, they expressed frustration when they waited unseen in the ED for many hours with no communication from ED staff about what was happening. The seriousness of the health condition, the perceived busyness of the ED, and the discomfort of the resident also influenced family members' assessments and satisfaction. Efforts to make the resident comfortable, such as not leaving them on a stretcher for long periods awaiting a bed, or feeding them at mealtime, were reported to ameliorate these negative perceptions.

ED staff recognized that delay in receiving required care in the ED was associated with increased risk of resident decompensation. In addition, it was reported that the longer a resident waited for care, the higher the likelihood that ED staff would admit them simply due to the increasing discomfort of the resident. Furthermore, the timeless nature of the ED (always daytime with continuous light, absence of routines that normally mark time such as bathing, continuous noise and activity) was recognized by ED participants to contribute to resident decline, especially for those with dementia or limited mobility. Healthcare providers identified that transferring these residents out of the ED quickly and into a calm, comfortable environment with structure and routine was important.

> Within 24 h, they're going to have some degree of delirium because we don't have night and day. We don't have quiet; we don't have one location. They may, in that day, be in three different locations, moved from a [triage room] … into a hall to a cast room back to whatever, so we can almost guarantee we're going to make them delirious. [ED participant]

Timing of discharge back to the NH was important and system tension around this element was evident. Not surprisingly, ED staff and family members desired the earliest possible discharge; however, this was sometimes complicated by "long waits" for EMS transfer back to the NH. EDs were under considerable pressure to discharge residents as quickly as possible due to overcrowding. Discharge delays also impacted the availability of EMS who reported waiting for long periods with patients who could not be admitted to the ED due to the lack of available beds. Concurrently, NH staff participants agreed that residents' quick return to their 'homes' was optimal, but they had difficulty receiving residents at particular times. Due to limited staffing and/or resources, late evening or weekend discharge times were considered undesirable. For example, some NHs did not have access to pharmacy services during the night or on the weekend, so residents transferred back at these times needed to be discharged from the ED with enough medication to sustain them until normal business resumed; however, this requirement was often not met.

Discussion

The study findings provide a nuanced understanding of elements contributing to the success of transitions in care that involve NH resident admissions to an ED. Based on the perspectives of multiple stakeholders, five elements were identified (knowing the resident; critical geriatric knowledge and skilled assessment; positive relationships; effective communication; and timeliness). These elements worked together synergistically, to support a patient- and family-centered approach that was reported to contribute to resident transitions 'going well.' On the other hand, when elements were compromised, transitional care was negatively affected and influenced the perceived success of these transitions. Although the findings support previous research identifying challenges in transfers from hospital to NHs, our findings indicate that transfers from NH to the ED are equally challenging and also deserve our attention. By examining the entire process we have been able to identify common elements that contribute to successful transitions that are applicable to all three care settings (NH, EMS, ED). Many of these common elements are amenable to interventions to improve care during transitions and, therefore, are potential targets for enhancing health care outcomes for residents.

One of our most important findings was the centrality of family members to the transition process and the system reliance on them to 'fill in the gaps.' Family members contributed to enhanced coordination and continuity of care, which have been described as important aspects of transitional care (Coleman & Boult, 2003). The key position of family members in 'knowing the resident' and the influence of this knowledge on the perceived success of transitions for residents reinforces the importance of actively involving family members throughout transitions in care. The literature on family involvement suggests that despite a distinct shift in care responsibilities on resident admission to NHs, family members remain keen observers of their relatives' care and often continue to oversee the care provided by NH staff (Friedemann, Montgomery, Maiberger, & Smith, 1997; Gaugler, 2005; Whitaker, 2009). Family member involvement, including their insight into the resident's historical background, participation in decision making and advocacy have been linked with improved caregiving and enhanced resident wellbeing, (Bowers, 1988; Gaugler, Anderson, Zarit, & Pearlin, 2004; Kellett, 1999; Maas et al., 2004; Nolan & Dellasega, 1999).

There is growing support for health system changes that are aligned with patient-centered care. Our finding that 'knowing the resident' was an important element in the success of transitions in care is in alignment with this goal. However, the centrality of family is not readily apparent in patient-centered care models such as the Institute of Medicine (IOM) framework (Committee on Quality of Health Care in America on behalf of the Institute of Medicine IOM, 2001). Our findings indicate that, especially for older persons experiencing cognitive decline or impairment, family involvement enhances the likelihood of successful transitions and warrants explicit recognition as a means to improve quality of care.

Nevertheless, system reliance on family members can be problematic. Some residents may not have close family members to call upon which raises concerns about the ability of the health care system to meet the needs of these residents during transitions. The element of 'knowing the resident' did not just depend on family involvement. Sustained relationships between residents and health care providers enabled the development of in-depth knowledge of residents that contributed to successful transitions in care. We found that staffing patterns in NHs (e.g., use of on-call staff vs. full-time, regular staff) could undermine 'knowing the resident,' and thereby influenced transitions. These findings point to the importance of system changes to support staff–resident relationships as an avenue to enhance transitions in care.

The importance of the element of 'essential geriatric knowledge and skilled assessment' in our transition framework has some support in the literature. Staffing NHs with nurses who have advanced knowledge and skill has been associated with reduced ED admissions (Boockvar et al., 2005; Fried, Gillick, & Lipsitz, 1995; Hammer, 2009; Konetzka, Spector, & Limcangco, 2008). Although our data did not allow us to evaluate how knowledge and skills contributed to the appropriateness of transitions, our findings indicate that health care provider knowledge and skill contributed to the perceived success of transitions when they were deemed necessary.

In relation to the element of 'effective communication,' when care is comprised of a series of hand-overs, the need for good communication is well established (Terrell et al., 2009). Some studies suggest that 10% of NH residents are transferred to the ED with no information at all, and the remainder are transferred without some critical information (Cwinn et al., 2009; Jones, Dwyer, White, & Firman, 1997; Terrell et al., 2009). We found that problems of communication and documentation occurred in all phases of the transition process, and underscored the lack of continuity in information systems across the health services continuum. Standardized communication strategies have been recommended to improve continuity and reduce injury and errors (Amato-Vealey, Barba, & Vealey, 2008; Pesanka et al., 2009; Wijetilleka & Toma, 2010) as well as the use of technology to bridge knowledge gaps (Hustey & Palmer, 2010).

Our third element, 'positive relationships,' captured the multiple relationships that contributed to transitional care. The importance of healthcare provider relationships across settings has been described in the literature (Arendts et al., 2010; McCloskey, 2011). Our findings suggest that system understanding and appreciation of "each other's worlds" among healthcare providers are needed in order to build bridges that support successful transitions. The importance of physician presence on treatment decisions has been noted (Helton, Cohen, Zimmerman, & van der Steen, 2011) but our data indicate this is sometimes difficult to achieve. Further this element highlights the need to attend to health care provider–family relationships as another strategy to support the success of transitions. Overall, the significance of the relational context of care to the transition process is a noteworthy finding of this study.

Although findings may be influenced by the characteristics of a publically funded health care system in Canada, perceptions related to successful transitions were consistent across the two study settings despite differences in ED services (i.e., one locale with one ED, and another with several EDs). Nevertheless, the findings may not be generalizable to other settings functioning under different models of health service delivery. Qualitative findings like those reported in this study not only provide new insights, but raise questions that cannot be answered with the qualitative data collected in this study. For example, designing and conducting quantitative studies to explore and identify system-level factors (e.g., NH characteristics, regulations and staffing patterns) that influence the elements in this framework of transitional care could contribute to building our understanding of these transitions and evaluate the usefulness of the model.

Conclusion

The elements that contribute to the success of transitions provide a framework for evaluating health care delivery systems and practices. As such the framework holds potential for augmenting and refining evaluation tools to track transitions across settings of care, identify where elements are compromised and associated modifiable factors, and determine system-level focal points for intervention. The nuanced findings about each of the elements in this framework can also be used to guide the development of specific strategies to enhance transitions.

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