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# Social-Interaction Knowledge Translation for In-Home Management of Urinary Incontinence and Chronic Care\*

Lynn Jansen,<sup>1</sup> Carol L. McWilliam,<sup>2</sup> Dorothy Forbes,<sup>3</sup> and Cheryl Forchuk<sup>2</sup>

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## RÉSUMÉ

Bien que l'incontinence urinaire peut être géré d'une manière conservatrice, c'est une cause principale de la dégradation des soins de famille dans la maison. Cette étude a examiné les processus d'interaction sociale et de l'application des connaissances (AC) se rapportant à la façon dont la gestion de l'incontinence urinaire (IU) peut être traduit dans les soins à domicile. Les données provenant des entretiens approfondis ont été recueillies auprès d'un échantillon théorique des 23 aidants familiaux, des bénéficiaires âgés et des prestataires de soins à domicile. Les comparaisons constantes et les critères d'analyse de Glaser ont été utilisés pour arriver à traduire les connaissances à travers une théorie de fond. Dix sous-thèmes sont inclus: comment vivre avec le problème; le renforcement de connaissances expérientielles; le développement du confort; l'assouplissement dans une relation de travail; la mutualité nourricière; facilitant l'échange de connaissances; le renforcement de la confiance; l'affinage de connaissances; mettant tous ensemble, et la gestion de soins à domicile. Les résultats sont instructifs pour l'AC au sujet d'IU à la fois dans la théorie et la pratique des soins à domicile, grâce à avoir éclairé comment l'intersubjectivité et les interactions bi-directionnelles sont indispensables à l'application des connaissances des soins à domicile chroniques, ce qui sont largement tacites et empiriques.

## ABSTRACT

Although urinary incontinence (UI) can be managed conservatively, it is a principal reason for the breakdown of in-home family care. This study explored the social interaction processes of knowledge translation (KT) related to how UI management knowledge might be translated within in-home care. In-depth interview data were collected from a theoretical sample of 23 family caregivers, older home care recipients, and home care providers. Constant comparison and Glaser's analysis criteria were used to create *translating knowledge through relating*, a substantive theory with 10 subthemes: living with the problem; building experiential knowledge; developing comfort; easing into a working relationship; nurturing mutuality; facilitating knowledge exchange; building confidence; fine-tuning knowledge; putting it all together; and managing in-home care. Findings inform both theory and practice of in-home UI KT, illuminating how intersubjectivity and bi-directional relational interactions are essential to translating in-home chronic care knowledge, which is largely tacit and experiential in nature.

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## Introduction

Research has afforded little understanding of the process of knowledge translation (KT) among family caregivers, home care recipients, and interdisciplinary home care providers to manage in-home older persons' care. Such knowledge might promote evidence-informed approaches to professional practice and family caregiving for in-home elder care. This is particularly so for the management of chronic conditions such as urinary incontinence (UI). Urinary incontinence, defined as the unintentional excretion of urine (Abrams et al., 2003), is a principal cause of the collapse of informal in-home elder care arrangements and care recipient admission to long-term care (Farage, Miller, Berardesca, & Maibach, 2007). Forty-six per cent of elderly home care recipients experience symptoms of UI (Du Moulin, Hamers, Ambergan, Janssen, & Halfens, 2008), and this is anticipated to increase with an aging elderly population (DuBeau, Kuchel, Johnson, Palmer, & Wagg, 2009). Urinary incontinence can be addressed conservatively (Fader, Bliss, Cottenden, Moore, & Norton, 2010) within the home. However, caregivers, herein referred to as family caregivers, have significant problems managing UI (Brittain & Shaw, 2007). While these unpaid family caregivers provide personal, social, and health care for 98 per cent of older adult family members and friends receiving home care services (Canadian Institute for Health Information [CIHI], 2010), they often lack knowledge about continence promotion and management (Jansen & Forbes, 2006).

Knowledge translation has been defined as a process that includes the creation, exchange, enactment, and application of knowledge within an interactive context to promote health (Canadian Institutes of Health Research, 2009). The KT process is informed by pre-existing personal knowledge, experiential learning, and preferred sources of information, all often linked to social interaction (Nutley, Walter, & Davies, 2003). Although research findings to date have suggested that family caregivers experience in-home KT through social interaction (Jansen, McWilliam, Forbes, & Forchuk, 2012), social process perspectives based in the organizational and professional KT literature (Ferlie & Dopson, 2005; Graham et al., 2006; McWilliam et al., 2009; Sales, Estabrooks, & Valente, 2010) have not been applied to the study of the social enactment of KT by health care providers and health care recipients (Gagliardi et al., 2011) within community settings (Kothari & Armstrong, 2011). This gap creates uncertainties about knowledge creation, exchange, enactment, and application in this context. Hence, how to go about doing KT is inadequately informed.

We have limited knowledge of how the social enactment of KT may unfold, and ultimately how it might

be promoted, specifically for UI management between and among in-home care professionals, personal care workers, and unpaid family caregivers, and those receiving home care. Not only are both client and family caregiver health ultimately undermined by the strain of unsuccessful UI management (Brittain & Shaw, 2007), but also UI results in annualized expenditures for families of \$2.6 billion in Canada (Canadian Continence Foundation, 2007) and \$14.2 billion in the United States (Hu et al., 2004).

The aim of this study was to enhance understanding of the social interaction process of KT between and among paid care providers such as professional nurses and unregulated care providers, unpaid family caregivers, and home care recipients confronting the challenges of continence promotion and UI. The research question was: How do paid home care providers, family caregivers, and home care recipients enact UI KT within the context of in-home care?

### *Relevant Literature Review*

Limited investigation has explored the process of in-home KT for the management of chronic UI symptoms. However, a review of the literature regarding the investigation of KT within an in-home chronic care setting revealed three major themes. These themes included role enactment, caregivers' expectations of social interaction, and paid providers' social interactions. Research that focused on role enactment relevant to social interaction KT included qualitative descriptive (Benzein, Johansson, & Saveman, 2004), multi-case (Guberman, Lavoie, Pepin, Lauzon, & Motejo, 2006), and critical ethnographic (Ward-Griffin, 2001) studies. Findings from these studies revealed that nurses perceive their role as that of the expert provider with expectations that family caregivers would provide care and receive prescriptive task-focused education to enable elder care.

In contrast, two qualitative studies (Heinrich, Neufeld, & Harrison, 2003; Sims-Gould & Martin-Matthews, 2010) found that in their role enactment, family caregivers instructed and collaborated with paid providers, functioning in roles similar to those of the home care providers. Thus, to date, studies of role enactment relevant to KT for in-home elder care suggest that both professionals' task-related instruction and expectations of family caregivers' involvement may be part of the social interaction process of KT. Findings also reveal that family caregivers ascribe their provider role expectations to themselves, although they describe more proactive collaborative roles with providers. However, these studies do not elaborate upon how paid providers', and family caregivers', role enactment may have transpired to create social interaction KT within the context of in-home UI management.

Family caregivers' expectations of social interaction in KT was the second theme of the literature review. In an ethno-nursing study, Van den Brink (2003) found that family caregivers may refuse to use assistive devices if home care education is provided in a prescriptive didactic way that is incongruent with the family's desire to work and learn through collaboration with paid providers. Findings from a descriptive exploratory sub-study (Schumacher et al., 2002) suggested the essentiality of social interaction as part of family caregivers' ongoing in-home education, while one-time professional didactic teaching was not effective. Findings from a phenomenological investigation (Jansen et al., 2012) suggested that social interaction, particularly within working relationships, is an important component of family caregivers' experience of UI KT. None of these studies, that illuminated family caregivers' expectations of social interaction specific to KT, addressed *how* family caregivers, paid care providers, and home care recipients together relate to socially construct KT.

Paid providers' social interaction relevant to KT, the third theme of the literature review, was investigated in two studies. In a qualitative observational sub-study of 42 family caregiver–care recipient dyadic interactions during bathing care, researchers (Mahoney, Trudeau, Penyack, & MacLeod, 2006) found that family caregiver practice sessions and knowledge-sharing with paid providers may co-create approaches to bathing as well as KT processes for in-home chronic care management. While findings suggested a few social interaction strategies and issues relevant to KT, questions about KT, particularly how to enact KT relevant to UI management, were not investigated.

Findings from a quasi-experimental intervention study (Colling, Owen, McCreedy, & Newman, 2003) that tested social interaction relevant to KT, specifically professional teaching and family caregiver coaching to manage in-home bladder training, demonstrated significant improvement of client-relative UI symptoms and UI care. These findings suggested that the KT approaches used, specifically unidirectional transfer and sharing of knowledge by the paid care providers, were effective. However, the authors reported that these family caregivers were not always able to follow the instructions provided due to other physical and psychological demands of caregiving. Furthermore, this investigation did not describe any bi-directional social interaction KT that may have transpired between the nurses and family caregivers to manage UI. Further family caregiver consultation was recommended to inform approaches to in-home UI KT.

Overall, research findings relevant to social interaction KT to date suggest the relevance of social processes to in-home KT. However, the literature does not provide

an extensive account of how paid care providers, home care recipients, and family caregivers interact to create KT, specifically for UI management. The grounded theory research reported herein addresses this knowledge gap, describing how the social enactment of KT may unfold between and among family caregivers, paid care providers, and home care recipients.

### *Research Methods*

Grounded theory method, which aim to generate a theory that accounts for social interaction patterns (Glaser, 1978), was chosen to investigate the in-home social interaction patterns related to UI KT in this study. The theoretical perspective of grounded theory research, symbolic interactionism, was applied with the aim of promoting reflection and understanding specifically focused on how social interactions, as enacted among paid providers, unpaid family caregivers, and home care recipients constructed the process of UI KT. Participants were selected for their direct involvement in UI management and their willingness and ability to reflect on and report their experiences of learning about UI. Applying Glaser's (1978) grounded theory method, as data collection proceeded, constant comparative analysis was undertaken to allow data and theory to emerge without the application of any preconceived theoretical frameworks. Coding themes identified and refined from the data were used to guide constant comparative interpretive analysis of interviews and observations of social interaction in process. Linkages made between refined themes ultimately informed the pattern constituting the grounded theory presented herein.

The research protocol in its entirety was approved by the Health Sciences Research Ethics Board of Western University and the Behavioral Research Ethics Board at the University of Saskatchewan.

### *Study Context*

This investigation was conducted within a rural home care setting of one of the 12 health regions in Saskatchewan, namely the Health Authority Board that is accountable for the health services provided to the 56,000 residents of this region. Home care, a sub-service of continuing care, is provided to 2,500 clients through an integrated single point of access model for team-based continuing care services. Home care services include (a) needs assessment and care coordination, (b) home nursing, (c) home health aide services, (d) volunteer services, (e) physiotherapy, (f) occupational therapy, (g) palliative care, (h) respite, (i) intravenous therapy, and (j) Meals on Wheels. Home care team members (i.e., nurses, physiotherapists, home health aides, social workers, case managers, and occasionally, physicians) are represented on regional and provincial

care, human resource, financial, and information management quality improvement teams to facilitate evidence-based care and service. The health region is committed to the inclusion of family caregivers and care recipients in team-based quality improvement initiatives to increase the quality of life of those who experience UI, and ultimately, the reduction of long-term care admissions and the costs associated with UI management. Approximately 70 per cent of those receiving home care services in the health region experience symptoms of UI. Thus, the health authority that comprised the context of this investigation was committed to working with the researcher to explore KT related to the provision of in-home UI care for older adults.

#### *Recruitment and Sampling Strategy*

The sampling strategy is not pre-determined in grounded theory (Glaser & Strauss, 1967).

From an assessment database of the health region's home care recipients and family caregivers, case managers selected care recipients over the age of 65 who managed UI care and were able to share their experience of learning about in-home care. The case manager then contacted these potential client-family caregiver participants and determined if they were willing to be contacted by the researcher. Contact of the home care paid providers was facilitated by home care office staff who placed an introductory study letter in the home care mail boxes of all home care nurses, community therapists, social worker case managers, and home health aides. Those client-caregiver participants and home care providers who consented to release their names were contacted by the researcher, who further explained the study and sought formal informed consent for their participation.

Sampling began by purposely selecting family caregiver, care recipient, and paid care provider triads from the sampling frame of family caregiver-client dyads who also had involvement of consenting providers. To build a grounded theory study of the social process of UI KT, theoretical sampling followed, engaging other participants with the potential to provide greater depth of data related to key concepts and constructs. The intent of theoretical sampling is to identify and refine categories of data through a process of constant comparative analysis throughout the data collection process (Glaser, 1978). Theoretical sampling also promotes appropriateness of the sample selection to inform the *answer to the research question*.

The total sample size of people representing the three groups of participants was determined by the adequacy of data, that is, the extent to which the collected data saturated the categories and components of the

grounded theory derived (Glaser, 1978). Sampling ceased when constant comparison of the properties of the emergent categories revealed theoretical saturation.

The theoretically driven sample from this study ( $n = 23$ ) comprised six family caregivers, three home care recipients, and 14 home care providers. Family caregivers (four females, two males) were the spouses and adult children of the home care recipients, ranging in age from 60 to 88 years ( $M = 76$  years), and living with the care recipients. Three male care recipients, who varied in age from 65 to 84 years ( $M = 74$  years) required toileting assistance related to UI and mobility issues. One of these participants was cognitively stable, and two were diagnosed with mild to moderate dementia. Three female care recipients, who ranged in age from 70 to 94 years ( $M = 74$ ) were diagnosed with late-stage dementia. These care recipients did not contribute verbally to the study; however, they were present during their family caregiver's interviews. Home care service for personal and nursing care had been provided over periods of one to four years ( $M = 2.5$  years) and was provided by paid home health aides ( $n = 7$ ), registered nurses ( $n = 3$ ), social workers ( $n = 2$ ), or physiotherapists ( $n = 2$ ) of both sexes (12 females, two males), who ranged in age from 21 to 65 ( $M = 45$  years). Of the home care providers, 21 per cent had an undergraduate degree, 21 per cent had a diploma, and 58 per cent had special-care aide certification. Participants represented the predominately Caucasian population of the geographic area and had work experience (1 to 30 years) in urban and rural areas of the health region.

#### *Data Collection*

Two audio-taped interviews of one to two hours were conducted by the first author with each participant in a home or private interview setting within the health region. Initial discussion about how participants managed elder care evolved to how UI care, often referred to as bladder control by home care recipients and their family caregivers, transpired within an in-home setting. A semi-structured interview guide was used to elicit data explaining what was going on, who was involved, how they were involved, how activities were organized, how the UI KT process unfolded, and what knowledge was contributed by whom, when, where, and how. Specific questions included the following: "Can you tell me about others involvement in bladder control care for whom you provide care?" "Could you tell me how (if at all) sharing knowledge about bladder control management has occurred for you?" How (if at all) has sensitivity been a part of this experience? and "How did you use this shared knowledge in bladder control care?"

One triad of family caregiver, home care recipient, and home care provider – and two dyads of family

caregivers and home care recipients – were interviewed together. If potentially relevant observations of KT interactions transpired within the in-home context among the three categories of participants, the researcher also used a semi-structured interview guide to ask participants questions such as: “What are your needs and understandings at this moment – how is this occurring for you?” All interviews were audiotaped and transcribed verbatim for analysis. Field notes explicating subtle nuances of the context – in particular, the researcher’s questions and observations regarding behaviors, intents, thoughts, understandings, expectations, social interactions, and evidence of tacit knowledge – were made during each visit.

#### *Data Analysis*

Data were analyzed through the constant comparative method of analysis that promoted fit, a criterion of qualitative rigor, that supports the extent to which emergent data categories comprise the basic social process of the grounded theory (Glaser, 1978). Initially, the data were explored line-by-line through open coding to identify the properties of each unit of data. Next, units of data were compared across content within each interview, across interviews with each participant, and across interviews of all participants. The dimensions of core concepts and categories were generated by constantly comparing concepts and incidents and by seeking the main theme or category revealed by the units of data. Selective coding then was used to identify the basic social process or core variable, to code variables that related to the core variable, and to undertake an ongoing comparison of incidents with the properties and dimensions of these variable categories and the core variable (see Table A1 in the appendix).

Theoretical coding involved examining relationships among categories (Glaser & Strauss, 1967). The criterion of work, defined as the ability of the grounded theory to provide predictions of what occurs in the topic area through explanation of the relationship of categories, was promoted through the use of participants’ language to develop the themes. As theory emerged from the data, constant comparison was used to compare the data with the emergent theory to define dimensions of categories further and to determine if the data supported the categories, core variable, and the relationships of the categories with the core variable.

The researcher also searched for data that did not support the emergent categories and theory. Possible exceptions to the theory that may have entered into the process of KT were monitored by increasing diversity of the sample, thereby expanding an understanding of the actual categories and dimensions and enabling refinement of an interpretation of the findings

(Glaser & Strauss, 1967). For example, emergent findings suggested that the process of KT may have differed according to the age of the care provider. Therefore, providers of varied age were purposively selected to explore how age might enter into the process of social interaction KT.

Categories were considered to be theoretically saturated when no new dimensions of a category emerged through constant comparative methods. Examination of the literature also occurred during the analysis to inform the emerging theory.

The criterion of modifiability was achieved as new data emerged, and the researcher modified emerging or established analyses as conditions changed. All participants also had the opportunity to review the study findings, further inform the themes, and authenticate study findings through member-checking, thus supporting the criterion of relevance. *Relevance* refers to the extent to which the theory, which is based on theoretical explanation of the relationships between and among categories, informs the key concerns of the respondents, rather than any pre-existing notions of theoretical constructs and relationships (Glaser, 1978). During the member-checking process, the researcher listened to participants’ experiences associated with the sensitivity of learning about UI and chronic care management to promote understanding about how to articulate study findings as part of in-home social interaction UI KT processes. The theory ultimately described has the potential for modifiability in subsequent investigations when new relevant data are uncovered and compared to the existing units of data.

Continual reflection during data collection and analysis entailed the researcher asking her own questions about fit, workability, relevance, and modifiability of emergent categories, thus generally promoting the criteria of qualitative rigor and concurrent analysis of the data. Auditability was addressed by maintaining raw data, field notes, and memos, providing an audit trail of the various steps taken throughout the research process. Memoing encouraged critical reflection regarding the meaning and assumptions underpinning data and codes as well as definition and linkage of the properties of categories identified to formulate the theory. Memoing also provided guidance for further coding and theoretical sampling, thereby enhancing the authenticity of the theory discovered through the research process (Glaser, 1978).

#### *Findings: Translating Knowledge through Relating*

The core variable of *translating knowledge through relating* constituted the basic social process of in-home KT among family caregivers, home care recipients, and paid home

care providers. Figure 1 represents the study participants' dynamically evolving and inextricably linked, intertwining relational and translating interactions relevant to KT to manage UI within in-home care. The sub-themes of *relating* included (a) living with the problem, (b) developing comfort, (c) nurturing mutuality, (d) building confidence, and (e) managing in-home care. Sub-themes of translating knowledge included (a) building experiential knowledge, (b) easing into a working relationship, (c) facilitating knowledge exchange, (d) fine-tuning knowledge, and (e) putting it all together. This substantive theory of social interaction KT theory consisting of its constituent thematic patterns is presented in the following subsections.

*Relating*

Study participants enacted the process of translating knowledge to manage in-home care through relating to one another. As one home health aide stated: "It's all about the relationship so that we can help each other learn about in-home care." Similarly, a family caregiver explained: "We [family caregivers and paid providers] have a relationship. I can share just about anything with them ... We ... learn how to give the best care together." Five relational sub-processes emerged from the data as enacted by the study participants.

*Living with the Problem*

Family caregivers and care recipients socially constructed knowledge for the daily management of UI through their experiential learning of living with the problem and sharing their learning with paid

home care providers. One home care recipient described how this knowledge was created through social interaction processes: "We [caregiver and care recipient] refer to this [information shared by physicians and hospital staff prior to receiving home care] *everyday* to learn about my condition [UI and mobility issues] ... We share this information with the home care people."

Similarly, paid providers' experiential learning, acquired through the social process of their clients' living with the problem, constituted this learning through relating. As one registered nurse explained: "They [care recipients and family caregivers] can be very creative ... because they are living with the problem ... and I will say ... I really learned [UI management] ... from what they shared with me."

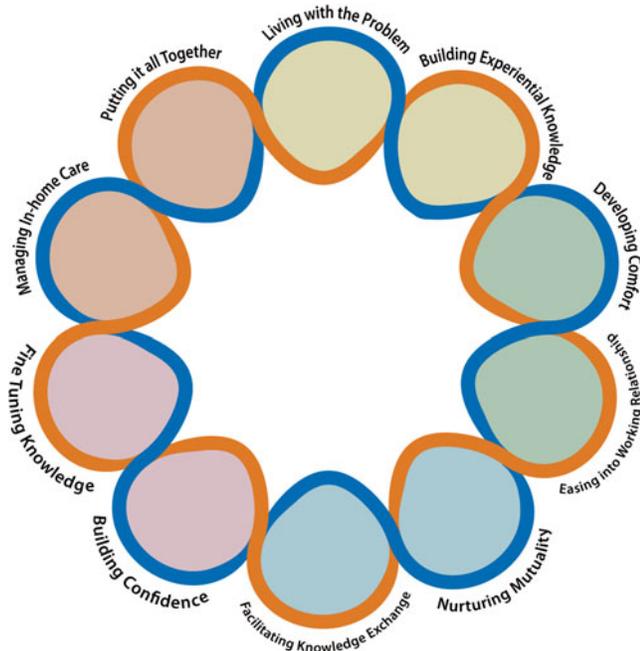
*Developing Comfort*

Family caregivers and paid providers described developing comfort as an essential component of a bi-directional relational process that was mutually beneficial to family caregivers, care recipients, and paid providers in translating knowledge. One case manager emphasized how it was possible to socially construct comfort within the context of in-home KT for chronic care as follows: "If the family caregiver is entering into the sharing and learning process ... you really have to listen to them to promote their comfort and learning."

Similarly, a registered nurse explained that paid providers can promote comfort in UI management by discussion: "It [UI] can be addressed .... [We] talk about how to do this so that we promote their [family caregiver and care recipient] comfort."

Paid providers' comfort with family caregivers also evolved within the relational interactions of developing knowledge about in-home learning and care processes. As one family caregiver commented: "The new providers are more stressed than we are as caregivers .... The more they come, the more relaxed they become with me. They came to know my ways."

Participants described the importance of a deep relational connectedness which was foundational to the social construction of comfort and the inextricably linked social enactment of KT: As one home health aide shared: "She [family caregiver] is one that I would like to think of as my friend right now. There is a deeper relationship and comfort [between us] ... as we worked together ... we learned how to relate." Another family caregiver described not only the in-depth relating and knowledge-sharing enacted with paid providers, but also how she and the home care recipient desired a close personal relationship with these providers to promote learning:



**Figure 1: Translating knowledge through relating**

I have thought of moving, but the home care staff are our [family caregiver and care recipient] friends – we love them all – I can tell them anything. I don't want to leave these people. We look forward to them coming in the morning and working with them [to manage UI and chronic care].

One registered nurse shared her observations about another component of comfort, that is, how clients engaged in the relational construction of trust to promote KT for in-home UI management:

Sometimes clients will have a lot of trust in a home health aide ... because the home health aide becomes very familiar with them and the client is comfortable with the home health aide ... and they know what works [to manage UI]. They [home health aides] are just so much part of their life ... like a friend.

#### *Nurturing Mutuality*

The relational process of nurturing mutuality also very much contributed to *translating knowledge through relating*. According to one family caregiver, nurturing mutuality was socially constructed through the equitable exchange of care knowledge:

Each person [caregiver and paid provider] contributes [to work together], "I'll do that if you will do that" .... Then next time each knows what to do, and we build a little more each time as each of us is familiar with what and how the other does something. It's a mutual thing because each of us is equal.

One home health aide also described how nurturing mutuality was a relational aspect of KT that promoted learning about the co-facilitation of KT: "As I worked with the family caregiver and shared my knowledge [of UI care], I learned that she really knew what she was doing. I did well to take the knowledge that she had to offer."

#### *Building Confidence*

The social construction of confidence emerged as part of *translating knowledge through relating*. One home health aide described how building confidence in their own care knowledge was essential in also building family caregivers' confidence in the providers' potential for sharing this knowledge: "Providers have to be confident and show family caregivers that we do have knowledge and that we will explain the rationale [for UI management] and listen ... and build their [caregivers] confidence." One home health aide shared her social construction of building confidence for what constituted KT for the management of UI: "Just make them [family caregivers] feel like they are doing a good job [of learning how to manage UI] ... So I will say, you are doing an excellent job."

#### *Managing In-home Care*

Managing UI and more general in-home care through the relational process of working together was part of *translating knowledge through relating*. Family caregivers and home care recipients were supported through working relationships to be in control of and manage a chronic condition. One home health aide shared the following insight:

We work with them [family caregivers and care recipients] to support them in the management of UI. For example, I might say: "You can manage ... your condition ... and this is how to do it." So they are empowered. They take back the control that they have lost.

In summary, these five sub-processes between and among family caregivers, care recipients, and paid care providers constituted the process of relating, an inextricable component of the core variable, *translating knowledge through relating*. The social construction of relating to engage in KT was mutually and affectively enacted through being "relationally" with others.

#### *Translating Knowledge*

The social construction of translating knowledge was created by building on relational interactions within working relationships. Five sub-themes comprised the sub-processes of translating knowledge: building experiential knowledge, easing into a working relationship, facilitating knowledge exchange, fine-tuning knowledge, and putting it all together.

#### *Building Experiential Knowledge*

Participants' experiential knowledge evolved through integrating in-home care experience with tacit know-how knowledge illustrating the complex and multi-dimensional nature of the social construction of KT. One home health aide described her preferred way of creating and applying knowledge: "I learn best by doing and experience". Another home health aide described how she combined her formal and experiential knowledge and then applied this knowledge through in-home interactions: "I combine my experience or what I have seen across many homes with what I learned more formally. Then I apply this information as I work with people in the home."

A family caregiver explained how she learned experientially by observing and then performing a care technique:

I learn by doing – I figure out how to do it just by watching ... I was doing it [UI care] in a different way ... But I learned better techniques by watching the care worker so then I could help him [spouse] with moving and skin care.

*Easing Into a Working Relationship*

Participants emphasized the importance of managing time to ease into social interactions that support learning about and working to co-create approaches to manage UI. As one family caregiver described: "As I ... ease over time into what needs to be done and how I go about it [learn about UI], I involve and work with home care."

One home health aide described how managing time for learning through social interaction afforded opportunities for the family caregiver to become comfortable with the paid provider, further illustrating how processes of translating knowledge are intertwined with socially interactive processes of relating:

It's hard because I may not have enough time to engage in the social aspect [sharing UI information] and ... work with them to make them [caregiver and care recipient] comfortable.... So I will tell them that I will be back to see them tomorrow.

Paid providers also used communication strategies as part of working together to approach the topic of UI. One social worker described a strategy for how to ease into an in-home working relationship through discussion:

I start with broad assessment.... It assists us in easing into conversation about UI so I commence with questions about mobility, nutrition, etc., as we work with them [family caregiver and care recipient].

Study participants stated that the use of humour with paid providers, family caregivers, and care recipients created relational connections as part of working together to create approaches to care. One home health aide shared how to promote this affective component of KT:

As we work together ... I realized it was important for him [care recipient] to have a laugh ... it's like connecting with him and giving him a little bit of hope that something can be done to manage his condition.... So I tried to make his day a bit brighter by sharing a bit of humour with him ... and then we would talk about how to do his care.

Similarly, a family caregiver emphasized the importance of incorporating humour as a way of creating relational intimacy, illustrating the inter-connected nature of relating and translating knowledge: "We [caregiver, care recipient, and paid provider] always have a laugh while we work. It gets us to work a bit closer to make the best care for my spouse."

*Facilitating Knowledge Exchange*

Paid care providers created opportunities for family caregivers and home care recipients to be part of relational

exchanges of care knowledge. One case manager described a strategy she used to promote the contributions of home care clients to UI KT:

I share my observations [about in-home signs of UI] with them [family caregiver and care recipient] and invite them to contribute to the conversation about how to manage UI. ... I also teach the clients and then ask them to share with me how that teaching information might work for them.

One home health aide shared how she proactively facilitated knowledge exchange for care management, engaging family caregivers in the process: "I said ... Is something not working? Is there anything we can do differently [to address how to learn]?"

*Fine-tuning Knowledge*

The fine-tuning of knowledge for chronic care was socially enacted by the bi-directional efforts of the study participants to promote learning about in-home tacit "how to" care knowledge. One family caregiver commented on the process of tacit learning as a component of KT: "They [paid providers] know and learn my habits [for in-home care] and I learn their habits."

One home health aide stated: "I said, 'As I work with home care clients, I am explaining as I go' ... I explain the reason for doing something [care technique]." Another home health aide also illustrated how the refinement of care information transpired through working with a family caregiver and care recipient to co-create a bathing procedure [for UI care]: "This is what we can do. This is what we can't do. So let's see how we can get to where we need to go [with lifting into the tub]."

A family caregiver described how she fine-tuned the knowledge she needed to promote continence for her spouse and ultimately assisted the paid providers in understanding how to assist her spouse with toileting:

When home care came in, I always explained to them the situation [what signs the care recipient made when he had to go to the bathroom] and that they would have to help him to the bathroom, ... and so they were able to support him in this regard.

*Putting It All Together*

Interpersonal interaction was used to build on care knowledge and discover innovations for UI and other chronic care conditions. A family caregiver explained how she and a paid provider together co-constructed and applied integrated knowledge through "putting it all together":

I had an idea about what I thought would work [to manage UI]. She [care provider] came up with another idea but it was not working totally.

I expanded on the design of the material by creating a wick to draw the urine away from the skin ... We learned together and put it all together right.

A care recipient described how he and his family caregiver were able to co-create care management knowledge through social interaction with several paid providers:

We compiled a little booklet that talks about the problems with my condition and all of the various things that could go wrong and then refer to this information everyday to learn about my condition, so we put it all together.

In summary, the substantive theory of *translating knowledge through relating* revealed bi-directional social construction of KT between and among family caregivers, home care recipients, and paid providers in their relating to manage everyday living with UI and other chronic conditions. Sub-processes of relational interactions and translating knowledge were inextricably linked and continuously evolving to create the process of KT. In addition, two factors within this study contextualized the social enactment of KT: continuity of assignment of paid provider and personal attributes of the KT participants themselves. These contextual elements are described in depth elsewhere (Jansen et al., 2012).

## Discussion

The interpretive and contextually specific nature of this study limits generalizability of the study findings beyond the context of in-home care. In addition, limitations of the study may arise from the researcher's ability to represent the themes that emerged from participants' interview data, as well as participants' ability to describe how in-home KT was socially constructed. Nevertheless, the substantive theory of social interaction KT created from this study provides insights into the social enactment of KT, particularly revealing the relational and subjective nature of KT between and among paid care providers, family caregivers, and care recipients involved in managing in-home care specifically with respect to UI.

Study findings invite consideration of the significance of relationship in building the KT theory. The findings of this study portray paid providers', family caregivers', and home care recipients' social enactment of KT shaping the social structure of in-home KT, which reciprocally shaped in-home care participants' social enactment of KT. This illumination suggests the potential relevance of *structuration theory* (Giddens, 1991), which posits that social structures – for example, in-home care settings – create social interactions, which in turn, through their enactment, also dynamically shape the social structure of which they are a part, a process

known as structuration (Giddens, 1991). This potential theoretical linkage suggests the merit of further in-depth investigation attending in greater depth to the context and its relevance in further refining social interaction KT. Rycroft-Malone et al. (2004) identified context as an essential consideration in KT, further supporting this study's insights regarding the relevance of the consideration and manipulation of context in building the theory and praxis of social interaction KT.

Consistent with the participatory action knowledge translation model developed in research of KT among paid home care providers in an organizational context (McWilliam et al., 2009), study findings also provide insights into how tacit and experiential relational "ways of being": (Doane & Varcoe, 2008) are socially constructed within in-home settings and further support the notion that social interaction KT, in and of itself, may constitute experiential and affective relational enactment of "how to" or craft knowledge (McWilliam et al., 2009; Yorks, 2005). These findings therefore add to the theoretical understanding of evidence, defined in the PARIHS model (Rycroft-Malone et al., 2004) as scientific, experiential, and preferred client treatment knowledge. The reported gap in the use of research knowledge may in part be attributed to a focus on codified knowledge to the exclusion of other forms and ways of knowing (Scott-Findlay & Pollock, 2004). As craft knowledge constitutes a significant component of professional practice, further in-depth investigation of the translation of this type of knowledge may be particularly important to building the theoretical foundation of KT, particularly to inform in-home chronic care for conditions such as UI.

Study findings also illuminate the facilitation of KT as a mutual process among professional and unregulated paid providers, family caregivers, and home care recipients. This enactment of facilitation of KT contrasts with that described in the PARIHS model, in which facilitation is described as the professional's role (Meijers et al., 2006) within organizational settings. The conceptualization of the co-facilitation of KT merits further investigation and testing to build the theory and evidence-informed practice of social interaction KT.

Participants portrayed an affective and intersubjective stance throughout the co-facilitation of KT, in which developing comfort, nurturing mutuality, evolving relational connectedness, socially constructing trust, and easing into working relationships were all inextricably essential to knowledge creation and exchange. On-going attention to this detailed explication of the nature of relating may inform both the social construction of KT and its content for how to affectively enact KT for the management of UI and other chronic conditions.

Study findings also suggest that home care clients and paid providers experience the practice of relating more intimately within the context of working relationships as desirable and productive. The importance of professionals' intentionality regarding how they relate with others in therapeutic relationships has been described previously (Forchuk & Reynolds, 2001). Similarities between KT-related working relationships and therapeutic relationships include a "sharing of oneself" (Gantert, McWilliam, Ward-Griffin, & Allen, 2009) and knowing of another (Forchuk et al., 2000; McWilliam et al., 1997) that transpire through developing comfort (Forchuk et al., 2000), trust (Welch, 2005), and a deeper relational connectedness (Caroline, 1993; Stoltz, Lindholm, Uden, & Willman, 2006). These linkages to theory on therapeutic relationships also merit further investigation.

However, it should be noted that KT-related working relationships and therapeutic relationships may differ in the area of professional boundary setting. In therapeutic relationships, the limited sharing of personal information is encouraged to promote attention to clients' needs rather than the needs of the professional (Peplau, 1997), thereby promoting unidirectional client information-sharing in which professionals apply prescribed expert knowledge (McWilliam et al., 2009; Zoffmann & Kirkevold, 2005). Professionals' therapeutic empathetic understanding of a client's health conditions (Egnew, 2009; Gantert et al., 2009) also may differ from intersubjective understandings co-created by clients and professionals together. In the grounded theory developed in this study, the paradigmatic perspective of intersubjectivity, reflected in the co-construction of knowledge and mutual enactment of KT, constitutes being with the other, as opposed to providing therapeutic care to and for them. This insight adds depth to previously articulated theoretical (Doane & Varcoe, 2008) and empirical (McWilliam et al., 2009) understandings of the relevance of mutuality and reciprocity in care relationships, in this instance throughout social interaction KT.

In keeping with the findings of this study, the relevance of the art of "relational inquiry" (Doane & Varcoe, 2008) and mutual conscious attention to connecting "at the hyphen" (Buber, 1958) throughout care has been explicated by others (McWilliam, 2009). However, the empirical and theoretical literature also illuminates how paid provider-client connectedness may be constrained by traditional health care practice that creates and maintains relational boundaries with clients (Gantert et al., 2009), a process known as professional "distancing" and "othering" (Boreus, 2006). Insights into how to go about the bi-directional processes of *translating knowledge through relating* may enable home care providers to enhance their own

subjective understanding and intersubjective "knowing" (McWilliam, 2009) and practice skills, and clients to know how to go about in-home care related to needs such as UI management. Overall, application of the insights gained from the grounded theory developed in this investigation may promote relational connectedness in social interaction KT, ultimately optimizing informal care for UI and other chronic care management.

The findings of this study also have implications for system and organizational policies and procedures. Policies and procedures related to in-home services delivery need to take into consideration the essentiality of relationship-building to achieve KT among providers' caregivers and clients, which demands attention to the continuity of assignments of providers to any one client. For example, policies and procedures for hiring practices and work assignments, currently directed towards minimizing human resource costs and efficient provider time allocation for specific tasks might be revised to accommodate conscious attention to promoting the affective component of care through optimizing continuity of relationships between paid providers and clients.

Another consideration relates to informal caregivers, who have been found to be vulnerable to social exclusion and health issues (Jansen, 2008; O'Rourke, Cappeliez, & Guindon, 2003) and lack of social support for home care clients (Forbes, Montague, Gibson, Hirdes, & Clark, 2011). The findings of this study suggest that financial and human resource policies that support paid providers' time and educational resources for relational enactment of KT, particularly within in-home working relationships may help to redress such problems (Jansen et al., 2012).

Overall, the substantive theory developed in this study supports the observations of other nursing scholars that nursing curricula, as well as interdisciplinary curricula that are inter-professional, need to focus on the social process of relational interactions (Doane, 2002), both in preparatory and continuing professional education. Professional education may be refined by placing greater emphasis on affective relational interactions in addition to communication techniques, traditionally the focus of education regarding professional/client relationships (Lussier & Richard, 2008). Relational practice to create equitable knowledge exchange (Graetz & Smith, 2009; McWilliam, 2009) is required so that clients' experiences and perspectives on care can be more fully a part of the KT process. Formal and continuing education for unregulated providers, family caregivers, and home care recipients should similarly attend to relational interactions, and the application of the substantive theory of *translating knowledge through relating* in practice, thus facilitating practitioners'

ability to integrate tacit, experiential, and research knowledge related to relational interactions and the social construction of knowledge.

Ultimately, *translating knowledge through relating* may promote the co-creation and enactment of “power with” approaches for care in general rather than the traditional transfer of health responsibility and information as “power to” home care clients. Clients and paid providers may then consciously and equitably attend not only to the social construction of KT but also, simultaneously, to the promotion of health as a resource for everyday living. Thus, *translating knowledge through relating* is illuminated as being, in and of itself, health promoting (Doane, 2002). As little is known about these KT-related approaches among family caregivers and home care recipients specifically for the management of UI, further exploratory research also may advance understanding of both the theory and practice of relational health promotion.

## Conclusion

The findings from this substantive grounded theory of *translating knowledge through relating* suggest that relational interactions are inextricably interlinked in and essential to translating in-home knowledge of UI management, which is largely tacit, “how to”, and experiential knowledge in nature. The core process and sub-processes of this theory illuminate how an intersubjective affective stance works as an essential component of social interaction KT within in-home settings. This theory adds to the theoretical and practice knowledge about in-home knowledge translation among interdisciplinary home care providers, home care clients, and family caregivers. Professional relational practice was illuminated as essential to foster mutual and equitable client social construction of in-home UI KT.

Insights gained from this investigation hold particular relevance for community-based care of older people, and, in general, an aging population. But these insights may also apply in evolving client- and family-centered KT strategies related to the co-creation and co-facilitation of evidence for UI care in all health care contexts, as well as chronic care management in general. The practical application of this work may constitute an important component of promoting health as a resource for everyday living with UI and minimize costs associated with adverse UI-related outcomes. Hence, overall, this grounded theory of in-home KT among family caregivers, older home care clients, and home care providers affords thought-provoking understanding that may be useful in advancing the art of knowledge translation and, ultimately, the quality of community-based care for older people.

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## Appendix

**Table A1:**

Supporting Interview Data	Categories	Social Process
□ "I learn best by doing and experience".	Building Experiential Knowledge	Translating Knowledge
□ "I combine my experience or what I have seen across many homes with what I learned more formally. Then I apply this information as I work with people in the home."		
□ "I learn by doing – I figure out how to do it just by watching ... I was doing it [UI care] in a different way ... But I learned better techniques by watching the care worker so then I could help him [spouse] with moving and skin care."	Easing into a Working Relationship	
□ "As I ... ease over time into what needs to be done and how I go about it [learn about UI], I involve and work with home care."		
□ "I start with broad assessment.... it assists us in easing into a conversation about UI so I commence with questions about mobility, nutrition, etc., as we work with them [caregiver, care recipient]."		
□ "It's hard because I may not have enough time to engage in the social aspect [sharing UI information] and ... work with them to make them [caregiver and care recipient] comfortable.... So I will tell them that I will be back to see them tomorrow."		
□ "As we work together ... I realized it was important for him [care recipient] to have a laugh ... it's like connecting with him and giving him a little bit of hope that something can be done to manage his condition.... So I tried to make his day a bit brighter by sharing a bit of humour with him ... and then we would talk about how to do his care."		
□ "We [caregiver, care recipient, and paid provider] always have a laugh while we work. It gets us to work a bit closer to make the best care for my spouse."		