

Research and Theory

Cultural diversity between hospital and community nurses: implications for continuity of care

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Abstract

Introduction: Health care systems and nurses need to take into account the increasing number of people who need post-hospital nursing care in their homes. Nurses have taken a pivotal role in discharge planning for frail patients. Despite considerable effort and focus on how to undertake hospital discharge successfully, the problem of ensuring continuity of care remains.

Challenges: In this paper, we highlight and discuss three challenges that seem to be insufficiently articulated when hospital and community nurses interact during discharge planning. These three challenges are: how local practices circumvent formal structures, how nurses' different perspectives influence their assessment of patients' need for post-hospital care, and how nurses have different understanding of what it means to be 'ready to be discharged'.

Discussion: We propose that nurses need to discuss these challenges and their implications for nursing care so as to be ready to face changing demands for health care in future.

Keywords

continuity of care, discharge planning, hospital and home care nurses' interaction, interaction challenges

Introduction

The quality of the interaction between hospital and community health care systems must improve if the health care system is to meet future demands related to an increased number of elderly and chronically ill people [1, 2]. According to the World Health Organization [3], the disease-oriented approach currently used in health care is not adequate to meet the demand for long-term care in the future. The World Health Organization suggests new approaches to service delivery, with home care showing promise as a means of ensuring sustainable long-term care. The idea of caring for

patients outside institutions has been discussed for many years. For example, in the UK community care has been a broad political goal since the late 1980s [4]. In Norway home care has been classified as health and social care since 1984 [5]. Growing numbers of patients receive home health care after an episode of hospitalization [2]. Many patients will experience one or more transitions among care providers across hospital and community health care [6]. The overall aim of health care is to ensure a seamless provision of care, i.e. continuity of care throughout the entire health care system [7]. However, deficits in communication and information transfer and lack of coordination when patients are

transferred between different health care organizations and providers result in patients not receiving effective care [8, 9]. Such ineffective health care systems complicate hospital discharge [9], threaten patient safety [1], lengthen hospital stays [11], increase the number of re-hospitalizations [12], and contribute to the patient's feelings of powerlessness [13, 14].

Continuity of care is considered a prerequisite for quality care [15]. It is also recognized as a significant factor affecting patient satisfaction and the key to reducing hospitalization and clinical errors [9]. However, discontinuity has become the unintended consequence of the modernization of health care, now characterized by specialization, differentiation and fragmentation. Philipsen and Stevensen [16] define discontinuity as unavailable services, lack of consensus among providers, lack of plans and lack of predictability. During the last decade, the role of discharge planning in enhancing continuity of care has been discussed in numerous papers [12, 17, 18]. However, the problems with discontinuity still remain. Continuity of care has been discussed mostly as a one-to-one relationship between the patient and one provider within one organization [19, 20]. We argue the need for changing the perspective of continuity of care from the traditional intra-organizational approach to one that is inter-organizational [21]. Within this perspective, two aspects must be addressed: the individual and the organizational. At the individual level, we need to consider the informal networking, communication and information flow that occurs among health care providers, and between patients and providers. Hence, the organizational perspective shifts from a one-to-one relationship to many-to-many relationships and considers both informal and formal structures and regulations [21]. To compensate for discontinuity, the introduction of information and communication technology is regarded as an important tool to connect and inform those who are involved in a patient's health care across different organizational levels [2, 10].

The purpose of this paper is to highlight and discuss three identified key challenges nurses in hospital and home care have to manage in their interaction when patients are in transition, illuminating the complexity in ensuring continuity of patient care. The identified challenges are (1) local practices circumventing formal structures, (2) nurses' different perspectives when assessing patients' care needs, and (3) nurses' different understanding of 'ready to be discharged'. The challenges are extracted from studies where the overall aim was to explore interaction between hospital and home care nurses [21–23]. We chose these specific papers because they provide reasons that highlight both theoretically and practically how cultural diversity must be taken into account when planning for future

delivery of integrated care across different boundaries. The first paper [21] is a literature review that explores the expectations and promises about enhanced continuity of care following the introduction of the electronic patient record. The analysis of the literature showed that conflicting rationalities and values and asymmetry between different organizations influence information processes across health care boundaries. Nurses have taken a pivotal role in discharge planning for patients, and with expectations of increased numbers of patients being cared for in their homes in future it is crucial to develop knowledge that can contribute to continuity of care. The second and third papers [22, 23] report findings of studies in which 287 hospital and 220 home care nurses were invited to complete questionnaires about their assessment of the information they exchange and their collaboration from the time of patients' admission to discharge. Although these studies are from a Norwegian perspective, the findings reflect general and global problems nurses face. When considering the increasing number of patients in transitions between locations and levels of care, according to Coleman and Berenson [24] multiple and complex factors need to be addressed. The three papers contribute to the discussion of this complexity with regard both to international and national literature.

Challenge 1: local practices circumvent formal structures

The formal structure of organizations is designed to achieve defined goals, regulate the division of labour and direct the differentiation of work [25]. Local practices reflect how formal structures are implemented and depend on the people involved. Health care policies determine organizational structures and deploy strategic plans or formal documents to present the official version, but what really happens may be different. The organization of health care, legislation and regulations are mainly formal structures decided at a nation's political level with the overall aim of improving health services. In a literature review, Reed et al. [7] identified that, internationally, strategies at macro, mezzo and micro levels have been developed to address collaboration and interaction issues between sectors, professions, settings, organization types, and types of care. The macro level reflects principles of the welfare system. For example, in Norway characteristics of the welfare system include a high degree of decentralization with local financing and decision-making. Long-term care in the community is an outcome of such strategies. The Norwegian health care system is separated into specialist health care services located in hospitals, and community health care (primary health services, nursing homes and home health care) located in

municipalities. The two systems have different responsibilities, administrative and financial structures for ensuring overall health care services [8] and they are characterized by different cultures [26]. The separation between different levels of care impacts on how providers interact with one another regarding implementation of formal structures. The relationship between formal structures and local practices expresses the tension between espoused theory and theory-in-use [27].

To illustrate such tensions, we will use two examples from one university hospital and its affiliated home care agencies in Norway. The first illustrates the implications of organizational models for nurses' interaction and the second is about formal guidelines. Hospital nurses are organized mainly in teams, primary nurse systems or as hybrid models [28], while principles of New Public Management usually underpin the organizational structure used for home care nurses. New Public Management is a purchaser–provider split [29]. The purchaser unit assesses individual needs, formulates contracts, orders services and controls outcomes while the provider unit delivers care specified and decided by the purchaser. The organizational models used by the hospital and municipalities are intended to clarify the division of labour and the provider's responsibilities in their interaction. However, for Norwegian nurses it was not always obvious with whom they should collaborate in the discharge planning process. Between 65% and 72% of hospital nurses reported that they were sometimes given the name of a specific contact person in a municipality in the discharge planning process, while 70–81% of home care nurses reported that they received the name of a contact person in the hospital [23]. Hospital nurses reported that they preferred to collaborate with the nurse in the municipality who had most knowledge about a specific patient. However, because of the New Public Management system, their wishes about with whom they collaborated were not always respected [23].

According to the Reed et al. [7] typology, the mezzo level strategies focus on how organizational structures and processes are linked across health care boundaries. The development and implementation of guidelines throughout the entire health care system is one example of efforts to underpin coordinated care. The second example from Norway illustrates how two types of formal guidelines are implemented, one guideline initiated at the governmental level and one established at the aforementioned university hospital. The Norwegian government has given hospitals and municipalities responsibility for developing guidelines for the interaction between a hospital and a municipality and for designating formal points of contact. In an evaluation of the impact of the central directives on local framing of guidelines, it was found that the government directives

led to an asymmetric relationship occurring between hospitals and municipalities in the local development and implementation of such guidelines [30]. Municipal representatives believed that they did not participate on an equal basis with hospital representatives.

The formal guidelines initiated by the university hospital aimed to structure and regulate coordination and collaboration between nurses in the hospital and municipalities in their local and daily discharge planning process. According to the guidelines, hospital nurses were expected to use two formal documents to inform home care nurses about patients who needed post-hospital health care in municipalities. These two documents were considered adequate to regulate nurses' collaboration and coordination when patients were in need of post-hospital nursing care. One document was an early alert to inform home care nurses about when a newly hospitalized patient was *expected* to be in need of home health care after discharge. The other document was to be sent to *confirm* that the patient needed post-hospital home care and to notify the date of discharge. In reality, these documents proved inadequate to allow nurses to exchange reliable information and make decisions about patients during discharge planning. Therefore, nurses used informal coordination mechanisms. The telephone was the most common medium used to coordinate and plan discharge. When home care nurses found they had insufficient information they sometimes visited the hospital to assess patients' health problems or to discuss the situation with nurses on the ward. The use of these informal practices in the implementation of the guidelines demonstrated that the formal structures were too superficial for ensuring safe and individualized patient care in daily practice. Therefore, nurses initiated and implemented their own local practices to compensate for deficiencies in the formal structures [23].

It is reasonable to question how formal structures in health care take into account asymmetric relationships, how they support and promote continuity of patient care in general and specifically the extent to which they support nurses' work processes. Furthermore, how are nurses' assessments of patients' care needs influenced by the two-tier system of care and local practices? This question will be examined in the next section.

Challenge 2: different perspectives in assessing patients' care needs

According to Glouberman and Mintzberg [31], practices in health care both within and across health care systems are characterized by separate systems. Even

where they are interdependent they act as ‘enveloped’ systems [32] or ‘silos’ [33]. Nurses within each system are committed to quite different values and aims. Their different perspectives influence how they assess patients and their needs, and what they regard as feasible and necessary preparation before a patient can be discharged from hospital. Norwegian home care nurses state that hospital nurses do not assess patients from a holistic perspective but have a more technical approach [34]. When home care nurses receive information about a potential patient, they visit the patient in hospital if they do not have confidence in the information. Home care nurses said that they had to make new assessments of patients’ care needs because they had found that hospital information was imperfect or inaccurate [22]. In home care nurses’ experience, hospital nurses may underestimate or overestimate a patient’s need for nursing care [6]. Older people can undergo up to 20 separate assessments from different sectors in health care, with 80% of the content of each assessment being common across all organizations. To reduce this duplication a single assessment process has been developed in the UK, where both health and social services use the same tool. The aim is to avoid information duplication and to ensure a comprehensive assessment. Carpenter et al. [35] found more completeness in recording older peoples’ needs when the single assessment process was deployed, while MacNamara [36] found that cultures and roles complicated the clarity of each group’s responsibility in the assessment process.

In general, nurses emphasize that their unique body of knowledge is holistic care. However, Hyde et al. found that documentation by hospital nurses in patients’ records reflected medico–technical details, the patient’s body was reduced to its parts and the ‘voice of medicine emerged strongly’ [37, p. 70]. In addition to using encounters with patients to obtain information about their needs, it is important for hospital nurses to gain information about medical diagnoses and knowledge of diseases and medical tests in the initial phase of assessing newly admitted patients [38]. Hospital nurses who have not worked in home care may lack knowledge about patients’ holistic needs after an episode of hospital stay, and this lack of insight may impact on their assessment of patients’ post-hospital needs [39]. A statement from a home care nurse illustrates the differences between the two groups of nurses regarding patients’ needs. She stated: “when the hospital has done what they have to do, the technical I would say, then the patient is discharged to another world” [34, p. 62]. This nurse had experienced how the hospital nurses’ perspective affected their assessment of patient needs as well as what aspects they addressed when the patient was hospitalized.

Hospitals reflect the medical discipline and also hold an acute illness and treatment perspective [40]; in consequence, hospital nurses use a disease model to inform patient treatment [41]. In municipalities, health care has to ensure a longer-term perspective [42] and home care nurses need to approach patient care from an illness management perspective also [41, 43]. The inclusion of a long-term, illness management perspective means that nurses need a broader, multifaceted approach to meet patients’ needs in their own homes. Even though home care nurses tried to emphasize a longer-term perspective for patients, they were not very successful in penetrating hospital nurses’ terminology.

Procter et al. [44] found a tension also existed between instrumental values based on nurses’ evidence-based knowledge and expressive values based on patients’ experiences. These authors state that the discharge planning process from hospital to home health care is influenced by instrumental values [44]. Other studies have shown that patients are told about the health bureaucracy and rules they need to know to manage the system, instead of how to manage their everyday life with their illness [45, 46]. In another study, it was found that the substance and structures for discharge planning are executed principally from a medical and organizational perspective [14]. Patients who need post-hospital care report that they are not adequately informed about following up recommendations to improve their health care and prevent rehospitalization [47].

Since the early 1970s, nurses nationally and internationally have worked to develop standardized terminologies for nursing, with the aim of having a common language containing uniform definitions for nursing activities [48]. The advent and introduction of electronic patient records in health care has increased the focus on standardization. The use of predetermined standardized terms for recording patient information is designed to be a culture-free means of informing colleagues. However, it raises questions about what consequences the discrepancies in nurses’ different perspectives on patients’ needs will have for nurses’ production of information. Further questions arise about the terms nurses choose to exchange, receivers’ interpretation of information, and the effects, if any, on the nursing care patients receive. According to Bowker and Star [49], in an exchange of information experiences acquired within one time and space are set against experiences developed in another time and space. This implies that information developed in one context and exchanged to another one requires coding and decoding. Hospital nurses provide the information they judge is necessary from their acute and medical perspective to define the patient’s need for continuing care. Home care nurses, on the other hand, read the

information from their contextual experiences with a long-term perspective on the patient's needs. A possible explanation for studies that have reported that home care nurses lack accurate and relevant information from hospitals might be related to this contextual reading. Consequently, a great deal of informal communication occurs between hospital and home care nurses to obtain, discuss and decode additional information [34]. The discrepancy in perspectives with regard to patients' care needs is reflected in the nurses' understanding of the term 'ready to be discharged'.

Challenge 3: different understanding of 'ready to be discharged'

Hospital and home care nurses do not have a common understanding of what the term 'ready to be discharged' means [30]. Hellesø [34] identified a tension between the two groups of nurses with regard to when a patient was assessed to be ready to be discharged. According to the home care nurses' view, the hospital discharged patients too soon while hospital nurses argued that home care nurses took too long to prepare safe post-hospital care conditions. Hospital nurses had to consider the need to discharge patients for the purpose of releasing beds. They spoke of the patients that they considered to be ready for discharge as 'not our responsibility any longer'. Payne et al. [1] also found in a review study that home care personnel were concerned about arranging and assessing the ongoing provision of safe care, including support from informal carers, while hospital providers were more focused on discharging patients and ensuring bed availability.

In the modern health care system, the availability of hospital beds is regarded as a critical management tool that is used to monitor and control health care providers' effectiveness. The bed space in hospitals is a controlled hospital resource and hospital nurses now play a central role in organizing the occupying and vacating of beds so they are ready for incoming patients [50]. In addition, hospital units have been organized according to medical specializations and have 'provided the location for the development and enactment of the art and science of medicine' [51, p. 22]. Nurses have always had problems in releasing hospital beds but the terms used to describe patients occupying hospital beds have changed over time. In 1966, patients were characterized as an 'evacuation problem' [52]. From the late 1980s until recently patients were described as 'nursing care patients' or 'medical treatment completed' and now the terms 'ready to be discharged' [53, 54] and 'medically fit for discharge' [18] are used. Patients who from a hospital nurse perspective are ready to be dis-

charged are therefore often referred to as 'bed blockers' or 'a discharge problem' [50].

It seems reasonable to ask whether this use of general terms reflects an objectivizing of the individual as a result of the establishment of the hospital as an institution [55, 56]. In the modern health care system, beds have been transformed from concrete objects that are a resource for the healing process and have become economic units that nurses have the responsibility for coordinating. To some extent, it seems that nurses have become disciplined by managerial technologies to account for bed occupancy, which is reflected in the terms they use for patients [50]. However, nurses' freedom to act holistically and autonomously is limited. Hospital nurses have been put under pressure and caught between hospital managers and physicians, according to Glouberman and Mintzberg [57]. Physicians, although absent from wards, emphasize they are responsible for care of hospital patients. Managers state they have control over wards even though they keep a significant distance from them [31]. These situations limit nurses' freedom for action and also influence their decisions. This is in line with nurses' feelings of striving for flexibility, and loss of their sense of professionalism [18].

Home care nurses have also been put under pressure in the last ten years because of demographic changes and the increase in chronic illness. In Norway, people who need health care have the right to receive this in their homes instead of being institutionalized [10]. The proportion of people who receive home health care has increased by 150% over the last ten years. In the same period, the number of hospital beds has decreased by 10%, and the number of emergency hospitalizations increased by 14.6% overall, but by >30% for people aged 80 years and older [58]. New Public Management has become the managerial model in municipalities. The influence of this on future home care nurses, their models of care and perspectives on patients should be further elaborated.

A significant question is the extent to which the increasing coordination role nurses hold influences their ability to deliver holistic nursing care for patients during discharge planning and in post-hospital care.

Discussion

The challenges described in this paper illustrate how nurses represent and must take into account multiple perspectives in their efforts to enhance continuity of care. Applying aspects of informational (challenges 2 and 3) and management continuity (challenge 1) [15], we will discuss significant aspects of these challenges for nursing interaction across organizational boundaries.

Informational continuity is related to nurses' accumulation of knowledge about the patient [15] which influences the production of patient information for transfer across levels of care. The transfer of information among providers is intended to coordinate patient care. Use of standardized terminologies [59] is expected to ensure accurate patient information for exchange across boundaries [60]. We have shown that hospital nurses tend to hold a medical perspective that may influence their use of terms and the information they record and exchange with their colleagues in municipalities. It is reasonable to ask who is collecting knowledge about patients, and whose perspective has the strength and power to determine and validate what is accurate information content. Informational continuity limits or excludes informal and undocumented information and details, for example patients' preferences and values are often left undocumented [61]. It has been shown that the authorial recording process is contextual and providers' voices have priority over patients' voices [47, 62].

By adopting a humanistic information-filtering perspective we can illustrate and broaden insight into aspects that nurses must be aware of in their communication and interaction across boundaries. The patient's situation, the context nurses are working in, and characteristics of nurses themselves all seem to be significant for a nurse's assessment of a patient and for the information that nurses *acquire* about a patient [63]. The available information is *processed*, i.e. nurses filter the information both consciously and unconsciously based on their professional competence, values and experiences, and the information available about the patient [64, 65]. These aspects have implications for nurses' perceptions of what information they regard to be valid, accurate and essential in a specific situation. We propose that issues related to contextual accumulation of knowledge must be considered in efforts to enhance continuity of care and standardization of nurses' work, thus ensuring that information and communication technologies will be useful tools for nurses' interaction.

Management continuity focuses on service standards and protocols [15]. The use of formal regulations, such as guidelines together with standardized and comprehensive discharge planning and individualized care plans is designed to structure knowledge accumulation about patients. Nurses have a long tradition of developing and implementing different organizational approaches and models to ensure quality in discharge planning for patients, as shown, for example, by the use of advanced nurse practitioners to ensure transitional care [66], case management models, dedicated discharge programmes and clinical pathways. These models all represent approaches designed to standardize nurses' practice so it becomes predictable and efficient. Daiski [67] points out that organizational

structures and programmes that aim to make patient trajectories more efficient have relegated nurses to the status of technicians and inspectors, responsible for ensuring that protocols and standards developed by the organization are carried out. She claims that this approach is not feasible for ensuring professional nursing. Nurses themselves feel that patients sometimes are being systematized and regimented within a system that is in itself dehumanizing [18, p. 554].

The existing discharge planning system has been shown to create problems for chronically ill patients and their carers because their voices are not being heard and they do not have the strength and power to penetrate institutionalized solutions for patient care. The ongoing discussions about when a patient is ready to be discharged illustrate one aspect of the asymmetry and power relations among actors involved in discharge planning. Problems arise because the patient, nurses and physicians interpret the patient's problems differently and have different opinions about the best solution for them. A tension is identified between the health care system's demand for efficiency and patients' needs and wishes about what is important for them in their discharge planning. It is not clear whether the different models of nursing have taken into account the diversity of perspectives among nursing settings. This should be elaborated further.

It seems reasonable to ask whether nurses who claim to take a holistic approach to nursing care need to redefine their understanding of what nursing care should and can be in modern health care. The tensions between hospital and home care nurses described in this paper should not be regarded as distinct and mutually exclusive. Rather they need to be considered along a continuum from being distinct to vague. Because nurses' roles are distributed in time and space, nurses should be aware of the implications of multiple perspectives in their care models, and the implications for their ability to enhance continuity of care in their interaction across boundaries. Becoming aware of the challenges may help nurses to discuss their ability to influence their practice and to look for new ways of interaction in their efforts to enhance continuity of care.

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