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EMPIRICAL STUDIES

Hospital and homecare nurses' experiences of involvement of patients and families in transition between hospital and municipalities: A qualitative study

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Abstract

Background: Involving patients and families in nursing care is essential to improve patients' health outcomes. Furthermore, families play an essential role in supporting patients by helping nurses understand the patient's everyday life. However, families also need support. Involvement of patients and families is especially important when patients are transferred between hospital and home as transitions heighten the risk of compromising quality and safety in care. However, no consensus exists on how to involve them. Consequently, this may challenge a systematic approach toward patient and family involvement.

Aim: To describe hospital and homecare nurses' experiences with involving patients and their family members in nursing care in the transition between hospital and municipalities.

Method: Focus group interviews were conducted in the Gastro unit at a large university hospital in Denmark. Participants included 10 hospital nurses from three wards at the Gastro unit and six homecare nurses from one of three municipalities in the hospital catchment area (total $n = 16$). Data were analysed using qualitative content analysis. The study is reported according to the Consolidated Criteria for Reporting Qualitative Research.

Findings: Our analysis revealed one overall theme – "The complexity of involvement" – based on four categories: gap between healthcare sectors increases the need for patient and family involvement, lack of time is a barrier to patient and family involvement, involvement is more than information, and involvement as a balancing act.

Conclusion: The nurses experienced patients' and families' involvement as essential, but a discrepancy was found between nurses' intentions and their actions. Aspects related to a gap between healthcare sectors and various understandings of involvement challenged the systematic involvement of patients and families in the transition between healthcare sectors. However, the nurses were highly motivated

to achieve a close cross-sectoral collaboration and to show commitment towards patients and families.

KEYWORDS

continuity of patient care, family, focus group, involvement, nurses, qualitative research, transitional care

INTRODUCTION

Growing research has emphasised the importance of involving patients and families in nursing care [1, 2]. Likewise, the political focus on involvement is becoming stronger due to an ageing population with multiple chronic conditions in need of healthcare services from both hospital and homecare [3]. Among healthcare professionals, there is shared underlying understanding related to the importance of patients and their family members' role shift from passive recipients to more active parties in the care process; however, no consensus exists on how to involve them [4]. Consequently, this may challenge a systematic approach towards patient and family involvement [5, 6].

Studies show that involvement improves patients' health outcomes and well-being; increases their knowledge about conditions, diagnosis, and treatment; and encourages adherence to treatment [7, 8]. Furthermore, studies have found that patients and families prefer to be involved in nursing care and that the contextual information they possess is essential for quality nursing care [9, 10]. The benefits of patient involvement are reciprocal; when patients are involved, their satisfaction with their care and with health-related outcomes increases [11, 12]. At the same time, patient involvement enables nurses to identify patients' individual needs and preferences [13]. However, for various reasons, patients do not feel involved, for example, if the information is given hastily and in noisy surroundings and therefore becomes difficult to understand [14] or if the discharge is planned by healthcare professionals and presented at short notice [14]. Patients may also not feel involved if nurses' approach to involvement is unstructured; this make patients feel that their individual needs are insignificant to nurses [11].

Additionally, families play an important role in supporting patients by helping nurses understand the patient's everyday life and home environment [3]. Often, it is the family members who receive and give information to the nurses, and, to some extent, initiate a dialogue about patient preferences and care plans [10]. However, it is well-known that families also need support. Caring for a loved one can be both rewarding and stressful. When family members contribute to the care of their loved ones, they may feel empowered and experience personal growth [3, 15]. However, caring often requires extra time and energy, and can be physically, emotionally, and socially demanding [16, 17]. Nevertheless, families struggle to be involved and often experience hospitalisation and discharge processes as turbulent [10, 18].

Nurses' perspectives on involvement have a profound effect on how and to which degree patients and families are involved. If they engage in a relationship with patients and families characterised by trust and respect, this will encourage patients to participate more actively in their own care and treatment [10]. When nurses support patient and family preferences by considering their individual needs and possibilities, the dialogue becomes more equal, and it is more likely to encourage patient and family involvement [19]. Generally, nurses acknowledge the importance of families in nursing care. However, less compassionate attitudes towards involving the family have been related to younger nurses with basic education only, short-range hospital employment, and no experiences with illness within their own families [20]. On the other hand, positive attitudes towards family involvement have been associated with a longer working career, older age, higher level of academic education, education in family nursing, and employment in primary healthcare or a department with an open attitude towards family involvement [21]. To involve patients and families in nursing care is especially important when patients are transferred between hospital and home as transitions heighten the risk of compromising quality and safety in care [13]. A meta-analysis including 3964 elderly patients found that nursing discharge planning did not reduce the readmission rate or improve patients' quality of life [22]. The authors concluded that the management and procedure of nursing discharge planning should include links between hospital-based and post-discharge home and homecare services. Furthermore, well-organised discharge planning may enhance satisfaction with healthcare for patients and professionals alike [23]. The complexity of care transitions, unclear responsibility transfer between nurses across sectors, and a vague understanding of patient and family involvement may affect nurses' collaboration across sectors and challenge attempts to create a smooth healthcare transition between sectors. Several studies have investigated nurses' experiences of patient and family involvement in various healthcare settings. However, few studies

have investigated involvement in a cross-sectoral setting from the nurses' perspective [3, 24]. A deeper understanding of hospital and homecare nurses' experiences with patient and family involvement may generate new ideas on how to strengthen coherence between hospital-based and homecare-based services. Hence, the aim of this study was to describe how hospital and homecare nurses' experiences involving patients and their family members in nursing care in the transition between hospitals and municipalities.

MATERIALS AND METHODS

Study design

A descriptive design using focus group interviews was conducted. The study is reported in accordance with the COREQ (Consolidated Criteria for Reporting Qualitative Research) guidelines [25].

Setting and participants

This study was performed at the Gastro unit at a large university hospital in Denmark from which approximately 36% of patients were referred to homecare services after discharge (local estimation). A group of 10 nurses from three wards at the Gastro unit and six homecare nurses from one of three municipalities in the hospital's catchment area were divided into two groups for focus group interviews (Table 1). The participants knew the first author from prior meetings at which the study was presented in the Gastro unit and the municipalities. Purposive sampling was used for selecting participants [26]; that is, the participants were approached by email based on suggestions from their managers in collaboration with one of the researchers. They had to be employed as a nurse in one of the three wards of the Gastro unit or as a homecare nurse in one of the three municipalities in the hospital catchment area, having various years of nursing experience and having an interest in the research topic. They all agreed to participate. The number of participants in the focus groups was based on reflections that smaller groups would give more time to the individual participants, whereas larger groups may provide a wider range of responses. The literature recommends 6–10 participants in each group [27]. The participants were mixed in the focus groups to encourage discussion and obtain rich descriptions [28]. The hospital nurses knew each other, as did the municipal homecare nurses, but the two groups did not know each other. A total of 15 women and one man participated in the interviews. Their mean age was 40 years, and they had, on average, 15 years of experience as a nurse (see Table 1).

Data collection

The study was conducted between January and February 2018. Data were collected using focus group interviews conducted in a hospital conference room during working hours [27, 29]. The simultaneous participation of hospital nurses and homecare nurses in focus groups encouraged rich discussion and provided insight into a wide range of experiences and perspectives. A semi-structured interview guide was developed in accordance with the aim of the study and inspired by current literature on patient and family involvement. The interview questions were broadly formulated to facilitate discussion. Examples of questions were *"How would you describe your experiences of involvement of patients and families in nursing care?"*; *"Can you think of examples from your daily practice?"* The interview guide was followed to maintain focus on the aim and to keep the schedule. However, a discussion with open-ended questions was used to encourage multiple perspectives in the discussion [30]. The focus groups were

TABLE 1 Characteristics of participants

	Hospital	Municipalities	Total, mean (SD)
Focus group 1			
Participants, *n*	6	2	8
Age, years, mean (SD)	34.5 (13.8)	47.5 (13.4)	37.8 (14.0)
Experience as a nurse, years, mean (SD)	10.2 (13.7)	18.5 (4.9)	12.3 (12.4)
Focus group 2			
Participants, *n*	4	4	8
Age, years, mean (SD)	51.8 (11.1)	34.3 (4.0)	43.0 (12.2)
Experience as a nurse, years, mean (SD)	25.3 (11.0)	8.5 (3.9)	16.9 (11.8)

facilitated by the first author (JJP), a PhD student, who was responsible for asking questions and keeping the discussion going and ensuring that the topics raised were relevant. JJP had 10 years of nursing experience in the field of gastroenterology. When caring for the patients, she experienced how the patient trajectory affected the family members, and she developed a growing interest in family nursing. The last author, a PhD and professor experienced in conducting focus group interviews, asked additional questions to ensure nuanced and detailed descriptions. The two focus group interviews were digitally audio-recorded and lasted 108 and 123 min, respectively.

Data analysis

The data were analysed using qualitative, inductive content analysis involving qualitative-interpretive steps to analyse the extensive text data; a single overall theme emerged [31]. The interviews were transcribed verbatim, and the following six-step analysis was performed in Word: (1) the interviews were read and reread several times to get a sense of the whole; (2) the text was condensed into meaning units, focusing on aspects relating to the study aim. In the process of condensing, the text was shortened into meaning units but still preserved its core meanings; (3) the meaning units were labelled with codes; (4) the codes were condensed into subcategories; (5) the subcategories were again condensed into categories; and, finally, (6) the categories were condensed into an overall theme relating to the study aim. During the analysis, the data were read and reread several times to ensure coherence in the interpretation between the different steps. Investigator triangulation was performed when analysing the data to ensure agreement of data saturation and to enhance the credibility and trustworthiness of the interpretations [32].

Ethics

Approval was obtained from the Danish Data Protection Agency (ID no.: AHH-2017-067; i-suite no. 05790). The local ethics committee assessed that no further approval was required since the research involved no biomedical experiments (ID no.: 17007271). All participants received written and oral information about the study and were informed that their participation was voluntary. The participants were guaranteed confidentiality according to the Helsinki Declaration [33]. Finally, written informed consent was obtained. Data were stored in a secure file drive on the hospital server.

RESULTS

Thematic results

One overall theme emerged from the data: *Complexity of involvement*. The theme included four categories: (1) gap between healthcare sectors increases the need for patient and family involvement, (2) lack of time is a barrier to patient and family involvement, (3) involving is more than information, and (4) involvement as a balancing act. The theme with categories and subcategories is illustrated in Table 2.

Gap between healthcare sectors increases the need for patient and family involvement

Generally, the hospital nurses found it crucial to involve patients and families in care transitions across the hospital and municipality, for example, plan discharge, inform about changes in medicine, agree/understand which tasks primary care would provide, and ensure safety and coherence in the patient pathway. However, care transitions were sometimes unsuccessful; the nurses felt frustrated, and at the same time, they could not explain what happened:

> It's like a gap where you lose them (the patients)
>
> (hospital nurse).

Care transitions between hospital and municipality were especially complicated in the case of frail elderly patients with multiple care needs. The nurses emphasised the importance of working closer together across sectors:

> We have to involve the hospital ward and primary care to optimise patient transfer across sectors. Often good care transition fails because something happens at the crossover between the sectors
>
> (hospital nurse).

The nurses experienced that their collaboration and ability to create coherence in the care transfer was challenged by their limited knowledge of each other's work tasks and work conditions in the other sector, and lack of knowledge-sharing and unclear responsibility in care transfer. They agreed that a closer collaboration related to each patient would make it easier to involve patients and families because they would have knowledge about each other's work tasks and have a common plan for the patients

TABLE 2 Overview of theme, categories, and sub-categories

Theme	Categories	Sub-categories
Complexity of involvement	Gap between healthcare sectors increases the need for patient and family involvement	Involvement would encourage patient safety
		Knowledge gap between sectors
		Short notice discharge
	Lack of time is a barrier to patient and family involvement	Time–pressure and workloads
		Focus on physical aspects
		Involvement increases job satisfaction
	Involvement is more than information	Various understandings of involvement
		Providing information
		Engaging in the patient situation
	Involvement as a balancing act	Struggle to cope with illness
		Burden of the family members
		Supporting the patients

in relation to, for example, rehabilitation, facilities at the patients' home, and the need for a homecare nursing. The nurses suggested that meetings between nurses across sectors to share knowledge and discuss the transfer of patients with multiple care needs could be a way to improve coherence in care pathways across sectors. Or that the homecare nurse could visit the patient during their hospital admission, and, in that way, bridge the gap. Even so, the nurses were aware that patients were sometimes discharged at short notice because the hospital needed a bed for newly admitted patients.

> Sometimes patients are discharged suddenly because we need the hospital beds for other patients. Then it is really challenging to make sure that the care transfer between hospital and municipality is okay...(...) it is also much more problematic to involve the family members ...
>
> (hospital nurse).

The homecare nurses in particular felt that they needed more information about patients' hospital stay to gain an overview and meet patients' needs.

> We don't know the diagnosis of the patient or the plan, so we depend on the patients or their family to tell us what happened during the hospital stay
>
> (hospital nurse).

They experienced a gap between the healthcare sectors which made involvement of patients and families even more crucial to ensure consistency in the transfer between hospital and municipality. Also, aspects such as nurses' lack of knowledge about each other's work tasks and work conditions, including incompatible electronic communication systems, increased nurses' experience of a gap between sectors and increased the importance of involving patients and families.

The hospital nurses often made an effort to write a thorough care plan in the electronic system, but they were unsure which information the homecare nurses needed, and they were surprised to learn that the homecare nurses did not receive all the information. A nurse with work experience from both sectors stated:

> When I worked as a homecare nurse, I realised that the information written by the nurses in the hospital was first received by a discharge coordinator in the municipality who reduced the information to a minimum before forwarding it to the homecare nurses
>
> (hospital nurse).

The nurses suggested that having a shared communication system would seem like a way of promoting continuity in healthcare transitions.

Furthermore, the nurses found that families played an essential role in care transitions between sectors since they were present during the hospital stay and after discharge but, generally, the nurses felt that they involved patients more than they involved families.

Lack of time is a barrier to patient and family involvement

Time and workloads determined how and to which degree nurses involved patients and families. When nurses found time to listen to patients and families and involve them in nursing care, they experienced this as

educational and positive, and it increased their job satisfaction. However, even though they worked hard and did their best to provide high-quality nursing care, they found that time pressure and workloads constrained the possibility of involving patients and families. The hospital nurses in particular emphasised that the focus was on the patients' physical condition and that they had only a little time to engage in conversation with patients or families about their thoughts and concerns regarding the illness.

> You get credit for non-existentialistic aspects... (...). It's just that focus is on the patient's physical condition, and there is no time for anything else
>
> (hospital nurse).

They believed that patients and families had unexpressed needs for talking about severe illness or thoughts relating to the future; needs that the nurses did not have time to fulfil. The nurses felt that they were more appreciated by the organisation when they worked fast, and that their managers focused more on efficiency than on the quality of nursing.

> (...) they evaluate the length of patient hospitalisation and not the quality of the nursing care you provide. I think that work conditions with time pressure and workload where you always focus on working quickly and efficiently are not always the most efficient in the long term
>
> (hospital nurse).

The homecare nurses explained how the patients were grateful when they took the time to follow up on the patients' hospitalisation and assisted them in getting an overview of their hospital appointments.

> I often experience...when we visit the citizen the day after discharge, they say: "Oh I'm so grateful that you have come by... All information from the hospital is here." Then they open an envelope full of papers and ask me: What is going to happen now?
>
> (hospital nurse).

However, only little time was available to involve patients and their family members after a hospital stay.

> We are four nurses responsible for 200 citizens...or something like that. (...) We do not have the time to call the family members to inform them about the condition of, e.g., their mother
>
> (hospital nurse).

Generally, all the nurses requested more time with patients and families. They believed that more time could improve the quality of nursing care, increase their work satisfaction and even save resources in the long term.

Involvement is more than information

The nurses acknowledged the importance of involving patients and their family members to meet their needs and increase the quality of nursing care. However, their understanding of how to involve patients and families varied. Some nurses described how they involved the patients as a natural part of daily nursing care where they informed patients about aspects such as medication, wound care, nutrition, and a plan for their medical treatment. Others found involvement to include more holistic aspects as well.

> Many (nurses) think that involvement is the same as giving information, but for me, it's not. (...) Real involvement takes more...(...) It means that you really engage in a conversation with the patient to find out what is important for him
>
> (hospital nurse).

The nurses also experienced that more and more families requested to be involved. The nurses mainly understood the families' request for involvement as a request for information. They provided family members with the information that they considered to be relevant from their professional point of view and agenda. However, they did not feel entirely sure that the information was enough to meet families' needs. Especially the homecare nurses found it challenging to meet the family members' need for information because, often, their only contact with the family members (except the spouses) was by phone.

> In the municipality, we only have brief contact with the family members. Sometimes, we don't know who they are. At the same time, they expect to be fully informed...that is challenging
>
> (hospital nurse).

Involvement as a balancing act

The nurses experienced how especially elderly hospitalised patients struggled to cope with the illness situation, to understand the reason and indication for medical examinations and to remember information. The unfamiliar situation caused many elderly patients to be passive and hesitant, which made it difficult for the nurses to get a clear picture of their resources and gain insight into the person behind the patient.

> In here, they (the patients) are all anonymous and dressed in hospital clothes. You don't know who they are unless you see them in their everyday environment. (...), but I think the patients have a lot more resources than they show here
>
> (hospital nurse).

Caring for the citizens in their homes gave homecare nurses a clearer picture of the patient's everyday life and his/her physical and mental resources. The nurses provided specific nursing tasks that had been referred by the visitation.

> We involve the citizens in almost everything, e.g., treatment of wounds, medication, etc. Then, I involve them... at some level... If I think that we should change the treatment of the wound from every other day to once a week, then I ask them (the citizens) if it's okay, and I give them my professional explanation
>
> (hospital nurse).

The nurses acknowledged the families' need to be involved. They observed that many family members carried an enormous responsibility for the patient, providing emotional support, remembering information, spending many hours at the hospital, taking care of the patient, and sometimes carrying out nursing tasks after discharge. The nurses valued the care and emotional support that the family members provided. However, they also expressed a concern that the family members may be burdened and emphasised the importance of supporting families' needs. Though, at the same time, they found themselves not considering family needs in their daily practice due to their workload and a patient-centred focus. When the patient was discharged, families sometimes took responsibility for complicated nursing tasks that turned out to be too overwhelming, resulting in the readmittance of the patient to the hospital. Basically, the nurses considered the families a valuable resource, and they often involved family members in nursing tasks that they assessed they could manage.

> I think that we are good at delegating tasks to family members. E.g., measuring blood sugar, giving insulin...I think that the family members appreciate that they are able to participate. (...) We try to see how family members can be a resource
>
> (hospital nurse).

The nurses explained that involvement of families and considering their needs were huge tasks, but supporting families could also be a way of supporting patients:

> I think we should be better at inviting families into our nursing practice and asking about family relations. It's time-consuming but time well spent to show interest in the families
>
> (hospital nurse).

The nurses found that the involvement of patients and families was always an individual matter, and the crucial issue when involving patients and families was finding the right balance between involving and considering their needs.

DISCUSSION

The present study describes hospital nurses' and homecare nurses' experiences of involvement of patients and families in healthcare transitions between sectors. The analysis revealed one main theme, *The complexity of involvement*. This theme included the following four categories: (1) gap between healthcare sectors increases the need for patient and family involvement, (2) lack of time is a barrier to patient and family involvement, (3) involvement is more than information, and (4) involvement as a balancing act. The main theme and the categories reflected the nurses' experiences of working in separate sectors with insufficient communication, time pressure, and various experiences of involvement; aspects that added to the nurses' experience of complexity when involving patients and families in nursing care across healthcare sectors.

In our study, the nurses described their work in each sector to be separate from work in the other sector, and they had only a little knowledge and understanding of each other's work tasks and work conditions. These results are consistent with those of a previous study which found that nurses from hospital wards and municipalities described their work as belonging to "two worlds" with different cultures and perceptions of the nursing profession [34]. Cross-sectoral collaboration can be seen as a collaborative chain [35]. In that chain, after having completed specific tasks and responsibilities, each

member transfers responsibility to the next member in the collaboration chain – in this case, from hospital nurse to homecare nurse. A collaborative chain where information is lacking in the healthcare transition between sectors may contribute to nurses' experiences of a gap between sectors. Additionally, the nurses perceived the electronic communication system as non-transparent. However, using this system was the only way to pass information from hospital nurses to homecare nurses when patients were discharged. Likewise, previous studies have found that electronic communication systems create obstacles in cross-sectoral communication, notably because they have replaced personal interaction [12, 24, 36]. The nurses in our study requested a shared electronic communication system across sectors, a request that has also been confirmed by nurses in hospitals and municipalities and by general practitioners and managers [12]. Naylor and Keating (2017) emphasise that gaps in care during transitions between healthcare sectors may lead to adverse events and unmet needs of patients and families [37]. Additionally, shorter hospital stays and more advanced primary sector care underline the need for better patient and family involvement in care transitions between healthcare settings [11, 12]. This perspective is also underpinned by Bell (2013), who emphasises that systematic involvement of families would decrease errors made by healthcare professionals and increase satisfaction with nursing care [38].

The nurses in our study found involvement to be complex and that it is unclear how best to involve patients and families in care transitions. The nurses' understanding of involvement varied from providing information to engaging in conversations with patients and families to understanding what was essential for them. However, if nurses provide information without considering the patients' capability, then patients may not necessarily understand the information they receive or be able to adhere to nursing advice. Furthermore, this information may conflict with the patients' understanding of their health problems or daily lives. Therefore, it is essential to show interest and consideration for patient preferences and capabilities so that nursing care can be tailored to individual patients [39]. Nurses in our study would have preferred more time and resources with patients and families to meet their individual needs. Lack of time and resources was their general explanation for a lower-than-intended level of involvement of patients and families, even though the nurses also stated that they involved patients at some level in their everyday practice. We found that aspects of involvement, such as tailored interventions and engaging in partnership with patients and family members, exceeded the possibilities in everyday practice where time pressure and a one-sided focus on physical health dominated. This suggests that nurses' intentions regarding patient and family involvement clash with the constraints of the present healthcare system, leaving patient and family involvement in limbo, stuck between intentions and actions. This is emphasised by Hoblock et al. (2019), who found that a positive attitude towards patient and family involvement can facilitate strong partnerships but might clash with workplace values if the workplace focuses mainly on efficiency and task completion [3]. This situation raises questions about the contemporary nursing paradigm and how nurses' time is and should be allocated [40].

The past decade has seen growing recognition that illness affects not only patients but also their family members [41, 42]. In our study, the nurses observed how elderly patients, in particular, struggled with illness when trying to gain control over their lives and bodies. This is consistent with a study that found that elderly patients felt worthless, anxious, and not in control of what happened to them during their hospital stay [43]. Furthermore, illness could lead to worries, feelings of insecurity, and stress in family members, causing them to struggle to maintain an everyday life [44–46].

The nurses in our study recognised that families needed support to comply with their needs and that feelings of responsibility and emotional stress were sometimes too overwhelming. They may have considered families to be a resource but had no time to consider the family members' needs. However, the balance between involving families, considering their needs, and finding time was a challenge with which the nurses struggled on a daily basis. One of the nurses in our study suggested that they should be better at inviting families into nursing practice and asking about family relations. Wright and Leahey have presented a systematic way of involving patients and families [42]. Here, the family is defined as the unit of care, and they are offered family conversations to alleviate suffering and support well-being and resilience [42, 47]. In a recent study, we found that family conversations conducted in a cross-sectoral setting had the potential to support families and increase coherence in care transitions [48]. Wright and Leahey argue that even a brief family conversation of 15 minutes or less can support families struggling with illness and illness-related challenges in daily life [49]. However, nurses' attitude towards including families in nursing care is also decisive for if – and to which degree – they involve families in nursing care. Nurses who respect and acknowledge families' significance for patients' recovery are more likely to take the initiatives to involve families in nursing care [38, 50].

Our findings are largely consistent with those of previous studies. However, the nurses in our study came up with ideas to overcome some of the obstacles they

experienced in their daily practice. Furthermore, they expressed an underlying interest in each other's work and shared a common concern and commitment towards patients and families. This suggests that there is unexplored potential for close cross-sectoral collaboration where patient and family needs are met. Such knowledge may inform the development of the future healthcare system.

Strengths and limitations

The study is limited to nurses' perspectives on patients' and families' involvement. The patients' and families' views were not included, which could have added data providing a more comprehensive picture. However, nurses with variable tenure and experience from both sectors were present in the focus groups. This ensured a wide range of experiences and perspectives in the data, contributing to the credibility of the study [31].

To increase the credibility of the study, the last author, who was an experienced interviewer, participated in the focus group discussion to ensure detailed descriptions and saturation of the topics. Furthermore, researcher triangulation between the first and the last author was conducted during the process of analysing the data, which helped to capture different interpretations of the phenomena and ensured that no relevant data were excluded, which also strengthens the credibility of the study [31].

The nurses could have been asked to confirm the results afterward. However, interviews are always conducted in the context of a specific moment [51]. Therefore, data were presented in detailed descriptions with quotations representing perspectives from nurses in both sectors and from both focus groups, which strengthens transferability [52]. The study was conducted in a specific national setting. However, the setting with hospital nurses from a large university hospital and homecare nurses from three municipalities is representative of healthcare settings in Denmark.

CONCLUSION

This study deepens our understanding of the complexity that arises when involving patients and families in nursing care across healthcare sectors. The nurses described patient and family involvement to be essential, but a discrepancy between their intentions and actions involved was identified. Our findings suggest that systematic patient and family involvement was challenged by aspects such as a gap between healthcare sectors with a lack of knowledge-sharing, incompatible communication systems, time pressure, and various understandings of involvement. Although the nurses expressed ambivalence regarding their intentions and actions in nursing care, they were also highly motivated to achieve a close cross-sectoral collaboration and to show commitment towards patients and families, revealing the potential value of considering coherence in the healthcare system in future policies.

AUTHOR CONTRIBUTIONS

JJP, AB, and BØ contributed to the study design. JJP and AB contributed to data collection and analysis. JJP drafted the first version of the manuscript with assistance from AB and BØ. AB, BØ, EKS, and MP contributed to the critical revision of the manuscript. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

ETHICAL STATEMENT

Approval from the Danish Data Protection Agency is described under Ethics in the manuscript. It is also described that no further approval was required since the research involved no biomedical experiments (ID no: 17007271).

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