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Marianne Eika

Doctoral thesis

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Contents

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Abstract

Purpose: The overall purpose of this project was to explore the transition into long-term care placement for older residents from different perspectives in order to maintain and enhance health and well-being, and inform practice and improve care.

Methods: An ethnographic design used three sources of data, periodic participating observations, individual semi-structured interviews, and reading of relevant documents. The project comprises three studies. The aim of study I was to describe and explore the experiences of next of kin during the older residents' transition into long term care placement. I interviewed ten next of kin to eight newly admitted residents. The next of kin talked about their experiences during the preparation period, the arrival day, and the first week after placement. The aim of study II was to explore and describe the staff's actions during the initial transition process for the older residents into long-term care facility. In study III, the aims were to explore and describe the staff's interactions during the older residents' transition into long-term care facility, and explore how the staff interactions may influence their assistance and care of the older residents. In studies II and III, I followed through periodic participating observations, the staff who assisted ten new residents during the preparation period, arrival day, and the first week after placement. Moreover, I interviewed sixteen staff and the leader of the institutional services, and read relevant documents. Thematic analyses were used to analyze the data in studies I and III and content analysis inspired the analysis of study II.

Main findings: What happened prior to the long-term care placement as well as what happened in the initial period in the nursing home influenced the experiences of the next of kin and relationships within the family (I). Moreover, it influenced staff's actions and interactions, which ultimately influenced the older residents' transition processes (II, III). The next of kin strove to handle the new situation. They kept on feeling responsible for their older family member, and provided continuity with their past life. Structural arrangements, such as the older family member having to share a private room with a co-resident and being moved about in the nursing home frustrated the next of kin. They did not expect much for themselves, apart from staff notice them and approach them during visits. This seldom happened, and they experienced little support from the staff (I). The next of kin and the staff were distant to each other and members from both groups expected the other to approach them. They appeared shy towards each other in this rural community where they knew of each

other. In study II, staff's actions varied from involvement with the new resident to ignorance. Some powerful influential forces on their actions were the management of the facility, individual staff's formal position, traits, and enthusiasm, resident and staff mix, and local transparency. Both licensed and unlicensed staff were susceptible of performing poor assistance towards the new residents, which may contribute to directing the new resident towards vulnerability and risk. In study III, the staff interactions influenced the new residents' transition process in complex ways. This study captures some descriptions and connections between micro and macro levels, and some power mechanism at play among the participants that may contribute to enhancing or inhibiting a smooth transition for the older residents and their next of kin. Organizational structures, staff's formal position, and informal staff alliances were complex and paradoxical. Some powerful influential forces on the staff's interactions were the previous health care setting, the management of the facility, the strong oral culture, individual staff's formal position, personality and authority, resident and staff mix, the physician's round, local transparency, and the taken-for-granted. The findings demonstrate the significance of every agent in the organization, and how each one may influence the staff's work in unpredictable ways. When happening, the spontaneous staff interactions were "pockets of excellence" and contributed to maintaining the evolving needs of the new residents in the initial period. These interactions depended on dedicated permanent staff who involved everybody present for the best of the new residents, and on the mix of staff at any given time. During holidays with many supply staff, the involved permanent staff were unable to perform their work according to their own standards. Especially the part-time unlicensed supply staff seemed prone at disturbing the work of most permanent staff.

Conclusion: Main areas of concern regarding both the next of kin and the staff were that they needed support and information, and clarify roles between them. Moreover, to maintain the health and well-being of the older residents and their next of kin during the transition involve focus on the playing out of power in staff actions and interactions. In this respect, this project shows some connections and dialectics between macro- and micro levels, which may influence on this: inter organizational level, organizational level, inter professional level, professional level and personal level, as well as contexts and circumstances at any given time. The findings show the importance of involving everybody to the best for the new resident and their next of kin. Combining complexity science with transition theory in nursing provide valuable insights for grass root-, management-, education-, research-, and policy levels how to

improve the assistance of the older residents and their next of kin during transitions into long-term care placement.

Norsk samandrag

Hensikt: Den overordna hensikta med dette doktorgradsarbeidet var å undersøke og beskrive eldre pasientar sin overgang til langtidsplass i sjukeheim frå ulike perspektiv for å oppretthalde og auke deira helse og velvære, og for å informere og betre praksis.

Metodar: Eit etnografisk design brukte tre kjelder av data, deltakande observasjon, individuelle semi-strukturerte intervju og lesing av relevante dokument. Prosjektet har tre studiar. Målet i studie I var å beskrive og utforske erfaringane til pårørande når eit eldre familiemedlem var i overgang til sjukeheim. Ti pårørande til åtte pasientar blei intervjua. Dei snakka om erfaringane sine i tida før flyttinga, flyttedagen og første tida etterpå. Målet til studie II var å utforske og beskrive pleiepersonalet i langtidsavdelinga sine handlingar når ein ny pasient var venta, og kva dei gjorde dagen pasienten flytte inn og første veka. I studie III, var målet å beskrive pleiepersonalet sin interaksjon med kvarandre i den same perioden som i studie II. I tillegg var målet å utforske korleis denne interaksjonen kunne påverke pleiarane sin assistanse og omsorg for den nye pasienten. I studiane II og III tok eg del i ti pasientar sin overgang til langtidsavdelinga. Eg hadde deltakande observasjon og var saman med dei pleiarane som hadde noko med dei nye pasientane å gjere. Eg deltok i førebuinga som pleierane gjorde, dagen pasienten flytte inn, og første veka etter innflytting. I tillegg intervjua eg seksten pleiarar og leiaren av institusjonstenestene. Tematisk analyse blei brukt i studiane I og II, og innhaldsanalyse inspirerte analysen i studie II.

Hovudfunn: Det som skjedde før innlegginga og det som skjedde i den fyrste tida i sjukeheimen påverka erfaringane til pårørande og samhandlingar innan familien (I). Dessutan påverka det pleiepersonalet sine handlingar og samhandlingar, som igjen influerte på den eldre pasientens og deira pårørande sin overgang (II, III). Pårørande streva med å handtere den nye situasjonen. Dei kjente framleis ansvar for den gamle og representerte kontinuitet med det tidlegare livet dei hadde saman. Strukturelle arrangement – at den gamle måtte dele enkeltrom med ein annan pasient, og at dei blei flytta rundt til ulike avdelingar i sjukeheimen - frustrerte pårørande. Det var distanse mellom pårørande og pleiarane. Begge grupper forventa at den andre skulle ta initiativ til kontakt. Dei kunne vere sky overfor kvarandre fordi dei kjende til kvarandre i landkommunen. Pårørande venta ikkje mykje for seg sjølve, anna enn at pleiarane skulle sjå og snakke litt med dei når dei besøkte den gamle. Dette skjedde sjeldan, og pårørande opplevde å få lita støtte i denne tida. I studie II varierte pleiarane sine handlingar frå involvering til ignoranse når det gjaldt assistansen av den nye pasienten. Faktorar som påverka pleiarane var måten avdelinga vart leie på, individuelle pleiarar sin

formelle posisjon, personlegdom, og entusiasme, blandinga av pasientar og pleiarar til ein kvar tid og lokal transparens. Både faglærte og ufaglærte pleiarar kunne assistere den nye pasienten overflatisk, noko som kunne føre pasienten mot risiko og auka sårbarhet. I studie III påverka pleiaranes sine samhandlingar pasienten sin overgang på komplekse måtar. Denne studien teiknar nokre samanhengar mellom mikro- og makro nivå i organisasjonen, og nokre maktmekanismar som bidrar med å fremme eller hemme dei gamle pasientane og pårørande sine overgangserfaringar.

Organisasjonsstrukturar, personalet sin formelle posisjon og uformelle alliansar blant personalet var komplekse og kunne bidra til gode eller dårlege overgangserfaringar for pasientane og pårørande. Sterke påverknadsfaktorar på personalet sine samhandlingar var den tidlegare helseinstitusjonen til pasienten, leiarskapet av avdelinga, ein sterk munnleg kultur, individuelle pleiarar sin formelle posisjon, personlegdom og autoritet, pasient- og pleiar samansetning til ein kvar tid, legevisitten, lokal transparens og det tause og sjølvsagte. Funna viser betydinga av kvar enkelt pleiar i organisasjonen, og korleis kvar enkelt kan påverke arbeidet til kvarandre på måtar som er vanskeleg å forut sjå. Dei spontane samhandlingane var «pockets of excellence», og bidrog til å ivareta dei behova som til ein kvar tid meldte seg hos den nye pasienten. Desse samhandlingane avhang av at involverte, fast tilsette pleiarar inkluderte alle pleiarane som var til stades og samansettinga av personalgruppa. I feriar med mange vikarar, var dei fast tilsette ikkje i stand til å utføre arbeidet sitt slik dei elles gjorde. Særleg dei deltidstilsette i små stillingar forstyrra arbeidet til mange av dei fast tilsette.

Konklusjon: Funna viser at pårørande og pleiarar treng støtte, informasjon og å avklare roller seg imellom, både mellom personalet og pårørande og også mellom personalet. For å oppretthalde helse og velvære hjå den gamle pasienten og deira pårørande, må det i tillegg fokuseras på korleis makt spelast ut mellom pleiarane. På dette området syner dette prosjektet dialektikken, og nokre samanhengar mellom inter organisasjonsnivå, organisasjonsnivå, inter-profesjonsnivå, profesjonsnivå og personleg nivå; i tillegg til kontekst og omstende til ein kvar tid. Funna viser kor viktig det er å involvere alle pleiarar, også dei deltidstilsette vikarane, til det beste for pasienten og pårørande. Å kombinere «complexity science» med «transition theory in nursing» gir naudsynte nye innsikter for grasrot-, leiarskap-, utdannings-, forskings- og politisk nivå om kva som kan betre assistansen av og støtta til gamle pasientar og deira pårørande i overgangen til langtidsplass og langtidsavdeling.

List of papers

This thesis is based on the following three papers, which are referred to in the text with their Roman numerals (I, II and III, respectively). All three papers are published in peer-reviewed scientific journals.

I. Eika, M., Espnes, G.A., Söderhamn, O., & Hvalvik, S. (2014). Experiences faced by next of kin during their older family members' transition into long-term care in a Norwegian nursing home. *Journal of Clinical Nursing,* 23, (15-16), 2186-2195.

II. Eika, M., Espnes, G.A., & Hvalvik, S. (2014). Nursing staff's actions during older residents' transition into long-term care facility in a nursing home in rural Norway. *International Journal of Qualitative Studies on Health and Well-being,* 9: 24105.

III. Eika, M., Dale, B., Espnes, G.A., & Hvalvik, S. (2015). Nursing staff interactions during the older residents' transition into long-term care facility in a nursing home in rural Norway: an ethnographic study. *BMC Health Services Research,* 15: 125.

Abbreviations

LTCF = long-term care facility

LTCU = long-term care unit is a part of the LTCF. There are three LTCUs in the LTCF

LTCP = long-term care placement

Staff = nursing staff

POPs = participant observation periods

Introduction

Advanced age is associated with functional impairments and multiple and chronic diseases, which imply that some people will need residential long-term care placements. Most developed countries face challenges such as an increasing number of older people at the same time as a decrease in the number of people to take care of them (white Paper No. 29, 2012-2013; Hermansen, 2011). The transition into long-term care placement (LTCP) is a major life event for the older persons and their next of kin, which may bring about fundamental changes in their life. The arrival of a new resident also brings changes for the staff, as they relate to the new resident and their next of kin. In this project, I explored the older persons' transition into LTCP in the overnight respite care unit as well as the long-term care facility (LTCF) from the perspectives of the next of kin. Moreover, I explored the transition into the LTCF from the perspectives of the staff. The focus of attention was the preparation period, the admission day, and the first week after arrival. This initial period in the transition into LTCP is important to investigate because what happens here may play a significant role in the next of kin's and the older residents' transition processes. Transition is defined as a passage from one life phase, condition, or status, to another (Meleis & Trangenstein, 1994). It refers to both process and outcome of complex person-environment interactions, and may bring about fundamental changes in the person's view of self and the world.

The research question in this thesis grew partly out of my experiences both as a care assistant and later as a nurse working in LTCFs. As a novice nurse, I wondered if what happened between the nursing staff ultimately influenced the quality of care and assistance towards the older residents and their next of kin. It could be about long oral reports that "stole" time from direct resident involvement, communication patterns, and the authority that were played out between the different staff groups as well as within staff groups. Regarding the next of kin, their involvement was vague to me, and at that time, it seemed self-evident to many staff, me included, that the nursing staff took over the care and assistance of the older residents when they arrived. We neither paid particular attention to the involvement of the next of kin nor their potential needs in this period. At the time of arrival, in line with current policies (white Paper No. 29, 2012-2013), the respective facilities in the nursing home should invite the next of kin's involvement as well as support their needs. The next of kin, however, have no obligation to be involved.

Background

In Norway, it is projected that there will be a strong growth in the percentage of the population over 80 years from 2020 (Hermansen, 2011; Roksvaag & Texmon, 2012). This will demand more health personnel (Holmøy, Kjelvik & Strøm, 2014), and a need for nursing homes (Vinsnes, Nakrem, Harkless, & Seim, 2012; Norheim & Sommerseth, 2014). The projections show that there will be a growing shortage of primary healthcare personnel towards 2035. In particular, the number of auxiliaries is going to be less than needed (Texmon & Stølen, 2009; Hilsen & Tøner, 2013). This differs from other countries where, for instance, the shortage of nurses is of growing concern (Potempa, Redman, & Landstrom, 2009; Campbell et al., 2013). Campbell et al. (2013) identifies several causes for the lack of nurses, midwifes, and physicians, such as an ageing health workforce with staff retiring or leaving for better paid jobs, and not enough young people enter the professions or are not being adequately trained. Moreover, there is increasing international migration of health workers. Furthermore, a big challenge for today's workforce is that it is trained to work within one setting at a time, yet, older people with multi-morbidities need integrated long-term care across settings (Imison & Bohmer, 2013).

The staff in Norwegian nursing homes comprise licensed as well as unlicensed staff. The government policies (white Paper No. 25, 2005-2006; white Paper No. 29, 2012-2013) and researchers (Bing-Jonsson, Hofoss, Kirkevold, Bjørk, & Foss, 2016; Bing-Jonsson, Bjørk, Hofoss, Kirkevold, & Foss, 2015; Romøren, Torjesen, & Landmark, 2011) underscore that there is a strong need for competent staff in the care of the elderly. Yet, the use of unlicensed staff seems unavoidable (Roksvaag & Texmon, 2012; Romøren et al., 2011). There are currently no national standards in Norway how to train unlicensed nursing staff who work in elderly care. Authors (Aamodt & Tjerbo, 2012; Døvig & Tobiassen, 2009) suggest that the municipal- and county authorities collaborate to offer attractive courses to secure basic qualifications among the unlicensed nursing staff. International (WHO, 2013) as well as national (white Paper No. 13, 2011-2012) health policies challenge a profession-only focus on health care practices, and underscore that health care staff need to develop inter professional collaborative competence.

Studies show that there is a need for better collaboration within health care organizations (Hertzberg & Ekmann, 2000; Bauer, Fetherstonhaugh, Tarzia & Chenco, 2014), as well as across health care organizations (Alstveit Laugaland, Aase, & Barach, 2011; Storm, Siemsen,

Laugaland, Dyrstad, & Aase, 2014; Popejoy, Galambos & Vogelsmeier, 2014). Moreover, the national reports (white Paper No. 25, 2005-2006; white Paper No. 47, 2008-2009; white Paper No. 29, 2012-2013) and the Health and Care Services Act (2011) emphasize next of kin as care resources that may represent the residents. In addition, next of kin may have their own needs for help and support (white Paper No. 29, 2012-2013), and knowledge is needed concerning these issues as well as how to involve them.

Many older people and their next of kin are vulnerable when they transition within and between health care institutions, and between health professionals (Gitlin & Wolff, 2011; Lattimer, 2011). The older resident and the next of kin may be exhausted at the time of the LTCP (Fjelltun, Henriksen, Norberg, Gilje, & Normann, 2009; Nygaard, 1991).

Literature on the transition into long- term care placement from the perspectives of next of kin

The concept next of kin refers to a wide range of individuals, including spouses, children, friends, unmarried partners, or neighbors who perform some form of care to an older adult with whom they have a relationship (Gitlin & Wolff, 2011).

During and after the move into LTCP, the next of kin may experience a range of emotional reactions, which are often ambivalent and conflicting with guilt, grief, and relief (Dellasega & Mastrian, 1995; Bern-Klug, 2008; O'Shea, Weathers, & McCarthy, 2014). Publications regarding the experiences of next of kin during an older family member's transition into LTCP reflect the stress that they may experience at the time of decision and admission into the nursing home (Davies & Nolan, 2003; 2004; Sandberg, Lundh, & Nolan, 2001; 2002; Bramble, Moyle, & McAllister, 2009). After placement, studies show that most next of kin remain involved in the lives of their older family member (Sandberg et al. 2001; 2002; Davies & Nolan, 2006; Gaugler, 2005; Drageseth, Normann, & Elstad, 2012). Studies take different perspectives (Gaugler, 2005), and the nature of the next of kin involvement contains complex and multifaceted dimensions (Bowers, 1988; Gaugler & Ewen, 2005; Gaugler & Kane, 2007). Studies appear to focus on what the next of kin contribute with towards their older family member (Gaugler, 2005; Durkin, Shotwell, & Simmons, 2014), and not on the needs that they themselves may have. Yet, some studies have explored changes in the family situation when an older family member moved into LTCP (Young, 1990; Johnson, Morton, & Knox, 1992;

Dellasega & Nolan, 1997). Dellasega & Nolan (1997) underscore the importance to view the admission to care from the next of kin perspective in temporal and contextual processes. Based on their findings they argue that the next of kin may need support of varying kinds in order to move towards a "new beginning" after their older family member has moved into LTCF. Still, more than a decade later, Gitlin & Wolff (2011) underscore that the needs of the next of kin, the challenges they experience, and the implications of transitional care provisions on their health and well-being are poorly understood. The authors also stress that the next of kin involvement during care transitions may involve more than one person, and entail complex divisions of labor among an informal network of family helpers.

Some studies have explored the transition into LTCP beyond the nursing home context, linking the pre-move processes to the post-placement processes (Nolan et al., 1996, Lundh, Sandberg, & Nolan, 2000; Reuss, Dupuis, & Whitefield, 2005; Sussman & Dupuis, 2012). Lundh et al. (2000) explored the experiences of spouses relating to the decision-making process, the move into care and the subsequent period and found that there was a lack of planning for the older resident's entry into the nursing home. They found that a temporal perspective, with four dimensions, was useful in the understanding of the placement process. The dimensions were; making the decision, making the move, adjusting to the move and reorientation. They found potential difficulties in all four dimensions and that they may often be unacknowledged. Likewise, Reuss et al. (2005) found challenges experienced by the next of kin throughout the transition process where several factors contributed to either impede or facilitate a positive transition for them. The identified factors were; the waiting process, preparation for the move, ease of the actual move, control over decision-making, communication throughout the process, support from others, and family-resident perceptions and attitudes. A more recent study by Sussman & Dupuis (2012) explored the next of kin's experiences prior to, during and immediately following their older family members' move into LTCP. They differentiated between what locations the older residents came from prior to the LTCP, for example, from home, from hospital or from other locations, and found that the starting point shaped the next of kin's experiences after placement.

Literature on the relationships between nursing staff in nursing homes

Studies exploring the working relationships between different nursing staff in nursing homes, suggest complex mechanisms at play (Anderson et al., 2005b; Park, 2010; Anderson, Toles,

Corazzini, McDaniel, & Colon-Emeric, 2014). Some studies have explored the working relationships between licensed staff (Wicke, Coppin, & Payne, 2004; Boblin, Baxter, Alvarado, Baumann, & Akhtar-Danesh, 2008; Tran, Johnson, Fernandez, & Jones, 2010; Huynh, Alderson, Nadon, & Kershaw-Rousseau, 2011), and some have explored the working relationships among licensed and unlicensed staff (Cott, 1997; Anderson et al., 2014).

Teamwork often characterizes the staff's work, and studies (Michelle, Parker, Giles, & White, 2010; Anderson et al., 2014) link inter professional team approaches in health care to more clinically effective services and enhanced problem solving. Yet, teamwork is complex and poses challenges on individual, professional, organizational, and cultural levels (McCallin, 2001; Xyrichis & Lowton, 2008). Cott (1997) identified patterns of relationships that developed among the nursing staff as they went about their work in geriatric care units. The findings indicate that although teamwork increased the participation in decision-making, a clearly defined hierarchical order remained for the lower status disciplines. Michelle et al. (2010) found that professional diversity was paramount to multi professional effectiveness and performance of complex tasks. Yet, they found barriers to knowledge sharing, such as, threats to professional identity, lack of similar mental models, and semantic misunderstandings. Likewise, Anderson et al. (2014) show how local interaction strategies among the staff in nursing homes may facilitate or pose barriers to better outcomes for the residents. The authors propose that interaction strategies promoting inter connections, information exchanges and diversity of cognitive schema create the capacity among the staff to provide better resident care. In a Norwegian context, Havig, Skogstad, Veenstra, & Romøren (2013) found a difference between "real functional teams" and "quasi teams". "Real teams" relate to higher levels of quality care whereas "quasi teams" have significantly lower effect on quality of care. To be considered as real functional teams the authors propose three different factors of particular significance, i.e. a high degree of interdependence among staff, membership stability and the team as a social entity in the subunit.

Literature on the interactions between the next of kin and the nursing staff

Studies have explored the interactions and relationships between the next of kin and the nursing home staff (Sandberg et al. 2001; 2002; Hertzberg, Ekman, & Axelsson, 2001; 2003; Chen, Sabir, Zimmerman, Suitor, & Pillmer, 2007). These studies have different perspectives, and the findings are diverse. Regardless of perspectives taken, most studies identify multiple

barriers to good communication between the next of kin and the nursing home staff (Westin, Örn, Danielson, 2009; Kemp, Ball, Perkins, Hollingsworth, & Lepore, 2009; Utley-Smith et al., 2009, Majerovitz, Mollott, & Rudder, 2009; Haesler, Bauer, Geront, & Nay, 2010; Park, 2010; Bauer et al., 2014; Norheim & Sommerseth, 2014). For instance, Majerovitz et al. (2009) included all levels of care providers in their study and found that poor intra-staff communication contributed to poor next of kin and staff communication. Moreover, Park (2010) found that the staff's work situation and scope of practice directly influenced their communication and interaction with the next of kin. The unlicensed staff's relationships with next of kin were worse than the nurses' relationships with the next of kin. Due to the unlicensed staff's foci on accomplishing the many physical tasks of care, they failed to interact with the next of kin.

I have been unable to identify Norwegian studies exploring the next of kin's experiences during older residents' transition into LTCP. Many studies carried out in North America, Australia, the United Kingdom, and Sweden, show diverse challenges that the next of kin face during these times. Furthermore, as the staff play a central role in this period, it is timely to explore the staff's actions and interactions, and their potential influence on the next of kin and the older residents' transition experiences. I have been unable to find studies investigating these aspects.

Purpose and aims

The overall purpose of this project was to explore the transition process into long-term care placement for older residents from different perspectives in order to maintain and enhance health and well-being, and be able to inform practice and improve care.

The specific aims were:

1. to describe and explore the experiences of next of kin during the older family members' transition into long-term care,

2. to describe and explore different nursing staff's actions during the older residents' transition into long-term care facility,

3. to describe and explore the nursing staff interactions during the older residents' transition into long-term care facility, and how staff interactions may influence their assistance and care for the older resident.

Theoretical perspectives

Transition

In this study, transition theory in nursing was used as a perspective (Meleis, Sawyer, Im, Messias, & Schumacher, 2000), and assisted in establishing areas to focus the attention during the exploration of the transition experiences of the next of kin and staff actions and interactions during the older residents' transition into LTCP. During the last four decades, the transition concept has evolved in the social sciences and health disciplines. Kralik, Visentin, & Van Loon (2006) found in their literature review of the concept within the health sciences that the definitions of transition change according to the disciplinary focus. Based on their review, they define transition as "a process of convoluted passage during which people redefine their sense of self and redevelop self-agency in response to disruptive life-events" (p. 73). People in this connection may refer to the resident and the next of kin. Another frequently used definition in the nursing literature (Chick & Meleis, 1986) is that transition is a passage from one life phase, condition, or status to another. Transition refers to both the process and the outcome of complex person-environment interactions. It may involve more than one person and is embedded in the context and the situation.

Schumacher, Jones, & Meleis (1999) focus on elderly persons in transition and their particular needs and circumstances. Late life is a time of multiple transitions where elderly persons and their next of kin experience losses and changes in their life, which may lead to changes in self-perceptions and self-esteem, and a feeling of alienation from what has been familiar and valued. The actual move into LTCP may trigger simultaneous transitions in familial relationships and social networks for the older resident and their next of kin, as both need to develop new coping strategies, new relationships, and new skills.

The LTCF is often the last residence of the older person before he or she dies, although studies show that the residents may experience relocations within as well as across health care institutions after this placement (Naylor & Keating, 2008; Glasdam, 2012). Coleman & Boult (2003) defines transitional care as "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location" (p. 556). Relocations may make the older resident and their next of kin particularly vulnerable to risks that may affect their health. According to studies (Naylor et al., 2004; Naylor & Cleave, 2010) poorly executed transitional care are common

among these patients because of among other things, incomplete communication between providers and across settings. Inefficient transitional care may lead to adverse events, unmet needs, and poor satisfaction with care.

Bridges (2004) developed the concept of transition to involve different kinds of changes in everyday life including work life in organizations and relationships. Bridges describes three phases that a person may go through when experiencing transition. These are, an ending phase characterized by disenchantment, a neutral zone characterized by disequilibrium and disintegration, and a beginning phase characterized by anticipation and the taking on of new roles. Meleis (2010) argues that each of these phases would require different coping strategies and nursing therapeutics. Kralik et al. (2006), however, underscores that transition does not follow a linear trajectory, and that it rather is an ongoing process involving movements in many directions. A central focus of nursing is to assist the residents through transitional processes. Based on empirical research, nursing therapeutics guide nurses in their assistance of residents towards a healthy transition (Chick & Meleis, 1986). These involve strategies enabling the nurses to anticipate points at which the person is likely to reach peak of vulnerability, and act upon that. Moreover, Meleis and colleagues (2010) have developed process and outcome indicators for nurses to be aware of during a transition process. Minimal symptoms, optimal functional status, feeling connected, a sense of successful coping, and identifying with the new role are indicators that may help the health care provider assess that the transition is on the right path. Contrary, indicators of an unhealthy transition process may be if symptoms that may be controlled persist, suboptimal levels of functioning, feelings of meaninglessness, disconnectedness and isolation, loss of control, and inability to make and carry out decisions. According to Schumacher et al. (1999), nursing therapeutics with particular relevance for elderly clients at this stage of the life cycle should focus on the needs for life review and integration into new living environments, as well as paying attention to memory loss and changes in mobility. Furthermore, health care providers should pay attention to the personal and social conditions in which the transition occurs such as personal background, meanings, and attitudes and beliefs attached to the transition process (Meleis et al., 2000). Social conditions refer to social factors, both the broader social environment and the local, that may facilitate or inhibit the transition process.

Davies (2005) and Geary & Schumacher (2012) have made some suggestions to develop the transition theory in nursing further. Davies (2005) interviewed next of kin's experiences of nursing home entry, and she proposes that Meleis' transition theory needs to recognize the

contributions made by next of kin to positive outcomes during nursing home entry. Moreover, she claims that the theory tends to regard the residents as well as the next of kin as "passive recipients" (p. 667) of care. Geary and Schumacher (2012) argue that the context of care is rarely explicit in care transition research. They suggest integrating transition theory and complexity science concepts. These concepts, they argue, will contribute to paying more attention to the dynamic structure of the transition and the context and circumstances of all agents involved. Complexity science may help expand the conceptualization of the transition into long-term care placement from the staff and next of kin perspectives.

Complexity science

The focus on next of kin and the staff in the exploration of the older residents' transition into LTCP brought complex and multilayered descriptions. Particularly, exploring the staff actions (II), and interactions (III), brought complex and paradoxical practices to the forefront, which were difficult to understand and categorize. Concepts and perspectives from complexity science helped me verbalize some of this complexity.

There is no universal definition of complexity science. According to Begun, Zimmerman, & Dooley (2003) complexity science consists of "collective of theories and constructs that have conceptual integrity among themselves" (p. 258). Thompson, Fazio, Kustra, Patrick, & Stanley (2016) found in their review study of complexity studies in health services research that the definitions of complexity science is "elusive" (p. 2) and have varied according to the phenomena of interests.

Anderson and McDaniel (2008), and their multidisciplinary research teams have used complexity science as a framework for their investigation of quality care in US nursing homes (McDaniel & Dribe, 2001; Anderson, Crabtree, Steele, & McDaniel, 2005a; Anderson et al., 2005b). They have explored the nursing home organization from different perspectives in their research, such as the nurse assistants' mental models, sensemaking, care actions and consequences for nursing home residents (Anderson et al., 2005b), patterns of medical and staff communication in nursing homes (Colon-Emeric et al., 2006), and interdependencies between administrative and clinical issues (Anderson & McDaniel, 2000). Based on their findings they suggest that managerial strategies such as learning, improvisation, and sensemaking are useful to manage health care organizations (McDaniel, Driebe, & Lanham, 2013).

Nursing homes are complex organizations, which "are made up of diverse agents who have nonlinear interdependencies and who learn as they enter the world" (McDaniel et al., 2013, p. 4). Central concepts in complexity science are relationships, self-organization, uncertainty, emergence, sensemaking, interdependencies, and cognitive diversity (Anderson et al., 2005a; Anderson & McDaniel, 2008; Geary & Schumacher, 2012; Leykum et al., 2014). Relationships among the agents, rather than individual agents themselves, define complex systems. Not the number of connections but rather the richness of those connections (Singhal, 2007). Anderson et al. (2005b) suggest that the quality of relationships among its members form the capacity of a human system to change and improve. When management focuses on improving relationships among the staff, studies show significantly better patient outcomes (Anderson, Issel, & McDaniel, 2003).

Self-organization is inherent in complex systems and the patterns of organizations that develop are unpredictable (Lanham et al., 2013). The ability to undergo self-organization refers to new behavior or new patterns that emerge from individual agents' reactions to changes within the complex adaptive systems. The overall change and its impact are emergent, not planned. Self-organization is a characteristic of complex systems that helps us understand and constructively deal with variations in local contexts (Lanham et al., 2013). Cognitive diversity, where multiple perspectives exist, enables wider options for self-organization (Anderson et al., 2005a). Patterns of interdependencies influence self - organization. Improving interdependence and sensemaking capacity among the agents may influence self-organization in ways that facilitate a healthy transition. Sensemaking is the "cognitive process that people employ to construct mental models through which they interpret and assign meaning to behaviors and events" (Anderson et al., 2005a, p. 3). Different thoughts and ideas of multiple agents and their cognitive diversity may influence this and provide rich and nuanced perspectives to the sensemaking process.

The characteristics of complexity science outlined above also apply to next of kin and families. According to Nash (2008), five assumptions inform family nursing. These assumptions are: all people are interrelated and nothing can exist outside of a relationship with others, the sum of the parts is more than and different from the whole, change is non-linear and disorderly, new order emerges out of change, and history repeats itself – but not always. Nash emphasizes that nurses need to interact with next of kin and enter into relationships with them, to "come alongside families on their journey through healthcare" (p. 206).

Power as dominance and power as influence

When exploring the staff actions and interactions during the older residents' transition into LTCF, the playing out of power was apparent, and influenced in complex ways the staff' assistance of the older residents in transition and their interaction with or lack of interaction with the next of kin. Power is a complex concept, and in line with the Norwegian philosopher Monsen (1990), I understand it as an existential and influential force in all human relations.

The nursing staff work in a professional hierarchy. The traditional and established understanding of hierarchy is that some persons are above others in an organization. The chain of command (Sennett, 1993) is associated with hierarchy, where some people dominate and command others, and some obey. Characteristics of the relationships between the participants in a hierarchy are their interdependencies and the power held by one group over the other(s) or one individual over the other(s) (Capra, 1997). Yet, other understandings of the concept hierarchy exist. According to ecological science, one outstanding property of all life is the tendency to form multi-levelled structures of systems within systems (Capra, 1997). Each of these forms a whole with respect to its parts while at the same time being a part of a larger whole.

> *"Since the early days of organismic biology, these multi-levelled structures have been called hierarchies. However, this term can be rather misleading, since it is derived from human hierarchies, which are fairly rigid structures of domination and control, quite unlike the multileveled order found in nature"(Capra, 1997, p. 28).*

Capra (1997) argues that the concept of the network, the web of life, provides a new perspective on the so-called "hierarchies" of nature. In this paradigm power as influence on others is more appropriate than power as dominance. Power as influence is associated with integrative values, whereas power as dominance is associated with self-assertive values. This ecological paradigm requires a shift in thinking and values from self-assertive to integrative. Related to integrative values are cooperation, quality, partnership and conservation, while self-assertive values connect to expansion, competition, quantity and domination. The nature of care work is complex, and comprises the integrative approach as well as the self-assertive approach. In most areas of the society, also within health care, the self-assertive paradigm seems to dominate and prevail. According to Capra (1997), power in the sense of domination

over others, is excessive self-assertion. The social structure in which it is exerted most effectively is the hierarchical order, where most have come to see their position in the hierarchy as part of their identity.

Characteristics of long-term care placement in Norwegian nursing homes

The municipalities in Norway are responsible for providing health and social services to everyone in need, and have a judicial duty to offer institutional care (white Paper No. 25, 2005-2006; white Paper No. 47, 2008-2009). The nursing homes have multiple purposes, such as providing 24 hours care and assistance, give medical treatment, and be a home for the residents (Hauge, 2004; Hauge, 2014; white Paper No. 25, 2005-2006). Some residents stay there for a short period while others spend the rest of their lives there.

The current characteristics of LTCP for older residents are that the majority stay in overnight respite care facility for a limited period or for several limited periods before they eventually are eligible for a LTCP (Otterstad & Tonseth, 2007). It is quite common that some stay on in the overnight respite care facility after they are eligible for a LTCP due to lack of rooms in the LTCF.

Overnight respite care facilities provide care and treatment for the resident, and support the next of kin and give them respite from heavy care burdens (white Paper No. 25, 2005-2006). In addition, some overnight respite care facilities offer rehabilitation and palliative care. The intention of these facilities is to keep the flow of residents going so that more residents and their families may get periodic respite and help (Otterstad & Tonseth, 2007; Fjelltun et al., 2009). Moreover, staying in overnight respite care facility may prepare the resident and their next of kin for the LTCP (Zarit, Gaugler, & Jarrott, 1999; Fraher & Coffey, 2011). In many municipalities, there are waiting lists to get an overnight respite care placement and a LTCP, and next of kin may experience periods of heavy workloads (Henriksen, Fjelltun, Normann, & Norberg, 2015).

Characteristics of the staff and the staff's work in long-term care facilities

In Norway, there is relatively high level of staffing and high formal competence of the nursing home staff compared to other countries (Harrington et al., 2012; Jacobsen & Mekki,

2011). Studies underscore that care work in the LTCF is complex and demanding (Ingstad, 2010; Jacobsen, 2004; Stone & Harahan, 2010; Heath, 2010). Older residents in LTCF are multi-morbid, have complex medical and care needs, and they require more assistance than they did a few years ago (Henriksen et al., 2015).

The New Public Management (NPM) ideology, which inspired reforms in the health care services from the 1990s and onwards in Norway (Vike, Bakken, Brinchmann, Haukelien, & Kroken, 2002; Vabø, 2005), influences the staff's work. This ideology aims at using the resources more effectively and deliver better services at a lower cost (Vike et al., 2002). Trygstad (2009) argues that the shift from traditional public administration to NPM involves an increased workload for health care staff due to new tasks, increased responsibility and increased time-pressure. For instance, Ingstad (2010) found in her interview study of female nurses in nursing homes that they had to deal with endless needs with limited resources. They used different strategies to cope with this; some nurses tried to live up to the demands by, for instance, working overtime and dropping breaks. Others accepted that limited resources reduced their ability to live up to the professions' expected ethical standards.

The nursing home staff comprises nurses, auxiliaries and unlicensed assistants. The nurses and auxiliaries have a formal education within health care. The nurses have a Bachelor degree in nursing and the auxiliaries have two years training in high school. The assistants, however, have no formal health care education and may have random courses at the work places. Although care work among the nursing staff overlap, the different categories of nursing staff also have different scopes of practice and work tasks to perform which influence their actions and interactions with the residents, the next of kin, and each other. Moreover, circumstances, contexts and culture at any time influence on this (Gubrium & Holstein, 1997; Jacobsen, 2005).

To assist and help the new residents and the residents in general, the nursing staff often interact during the shift. They have the possibility to consult other nursing staff at any time, they can share and alternate tasks between them and to a certain extent check what colleagues do. Still, inter professional collaboration is a potential threat to professional identity and autonomy (MacMillan & Reeves, 2014). Historically, when the Norwegian Association of Nurses was established in 1912, an important intention was to differentiate between educated and non-educated care providers (Stjernø, 2013). This development was, among other things, triggered by the advancements within medicine at the end of the 1800s. The physicians needed qualified persons to assist their work, and wanted the nurses to take over some of their

previous work. Likewise, after World War II, as the nurses developed specialized skills, there was a shortage of nurses in hospitals and nursing homes. The physicians and nurses collaborated to develop a shorter health care provider education to take over some of the easier nursing tasks, and called them “hjelpepleiere” (auxiliaries). According to Schiøtz (2003), the Norwegian Association of Nurses has attempted to control the auxiliaries’ scope of practice and their education. Yet their work tasks and scope of practice overlap. Although Schiøtz (2003) underscores that in many work places, the nurses and the auxiliaries work well together for the best of the patients, there are some boundaries between them. According to Abbott (1988), special work tasks connect with specific professions, referred to as the profession’s jurisdiction (Abbot, 1988; Fauske, 2008). These tasks mark the exclusiveness of the profession, in addition to legitimating their control and dominance over certain areas of work.

Methodology and methods

Hermeneutic philosophy inspired the methods and influenced the research process. A study inspired by hermeneutic philosophy seeks understanding through interpretations. According to Gadamer (2004), understanding emerges within a fusion of horizons, which is the field of vision seen from certain perspectives. Our horizons do not remain static rather there is a dialectic play between the texts and the interpreter which constitute the fusion of horizons.[1] (Dominici, 2008). The conditions under which a fusion of horizons takes place include attention to the prejudices and pre-understandings brought to the study by the researchers. In order to identify one's pre-understandings, reflection is central. Daily critical reflections help become aware of one's prejudices during the research process, and may prevent the researchers from making too hasty interpretations. Moreover, the pre-understandings are necessary for understanding the phenomenon under study (Gadamer, 2004). The hermeneutic circle signifies the circularity of interpretation as an essential feature of all knowledge and understanding. Continual new information supplements the hermeneutic circle. This can be a messy process, but one that recognizes the complexity of understanding. Habermas (1968/1974) integrates critical theory with hermeneutic philosophy. He underscores the importance of being aware of power relations in communicative practices and everyday life.

The epistemological position is an analytic middle ground between reality and representation (Gubrium & Holstein, 1997). Gubrium & Holstein (1997) discuss the possibility of combining the four idioms naturalism, ethnomethodology, emotionalism, and postmodernism in the further development of interpretative method. In this thesis, I combine naturalism and ethnomethodology. According to Gubrium & Holstein (1997), one should not only focus on the "whats" of a topic of investigation, but also how the constructions came about. The goal of naturalist studies is to represent "subjects' worlds in writing as faithfully as possible" (Gubrium & Holstein, 1997, p. 36), focusing on the "whats", trying to capture experience "up-close". Ethnomethodology however, "steps back" and contributes to the understanding of social life as its capacity to wonder about what is regarded as obvious, given or "natural" (Gubrium & Holstein, 1997). Ethnomethodology emphasizes that the researcher is not able to get the real world in itself, but constructions of realities. The researcher's role as a co-

[1] In this thesis, texts encompass actions, oral and written utterances, and the recognition of our place in the world as embodied participants, as described by Dominici (2008), Implications of Hermeneutic Constructivism for Personal Construct Theory: Imaginally Construing the Nonhuman World. *Journal of Constructivist Psychology,* 21(1): 25-42.

constructor during the research process is important to consider as well as the participants' roles.

Methods

Ethnographic design

An ethnographic design, including participant observation periods (POPs) and individual semi structured interviews (I-III) was chosen for this project. Additionally, I read relevant documents mainly to check the POPs and interview data (studies I-III). The aims of the studies in the project informed which approaches were the most relevant (Fangen, 2010). Since staff actions (II) and interactions (III) were part of the focus of attention, I assumed that POPs would add valuable information beyond formal interviews and reading of relevant documents.

The ethnographic approach is useful to explore a complex phenomenon in context (O'Reilly, 2012; Hammersley & Atkinson, 2007), and well suited to produce rich descriptions and "relational models for interpreting how individuals are situated in cultural institutions" (Pearson, Nay & Taylor, 2003, p. 188). Furthermore, the design allows flexibility, and the possibility of adopting new strategies as the fieldwork evolves. The inductive approach meant that I began the fieldwork with as open mind as possible. O'Reilly (2012) argues that it is impossible to start out with no preconceived ideas, and that the best way to be inductive is to be open about ones' preconceptions, read theories, and be open to surprises. As a field worker, I was a part of the world I studied (Hammersley & Atkinson, 2007), and could not avoid having an effect on the field arena. This position required continuous reflections about my interactions with the participants, the empirical data, the theoretical perspectives and my pre-understandings brought to the project. Transition theory in nursing (Meleis, 2010), influenced to some extent the questions in the semi structured interview guide and the focus of attention during the fieldwork periods and the interviews. I wanted to explore the preparation period, admission day, and the first week after arrival from the perspectives of next of kin and staff to get insights into their experiences, actions and interactions during the older residents' transition into LTCP and LTCF.

Preparing myself for the interviews and the fieldwork

Due to my relative inexperience with interviewing and participant observations, I practiced before the project started. I interviewed my supervisor, and realized, for instance, that I tuned myself quickly to the respondent. Moreover, I understood what she talked about without asking for details, which may be a drawback of doing research within a familiar setting. These experiences contributed to keeping me alert during the interviews and POPs, and follow up the respondents' utterances and body language no matter how familiar they seemed. The ability to tune in seemed to encourage the respondents to elaborate on the issues in question, and freely associate which gave rich data. Having recently been a next of kin myself, helped establish rapport with the next of kin in the interviews, and some staff.

I also practiced being a participant observer in the overnight respite care facility before I started the POPs in the LTCF. Being a participant observer was particularly challenging. For instance, when could I write down what had been said and done? Hammersley & Atkinson (2007) argue that the participant observer should write notes as soon as possible after the observed actions as the quality of the notes diminishes rapidly with the passage of time. They underscore that "the detail is quickly lost, and whole episodes can be forgotten or become irreparably muddled" (p. 142).

Setting

The nursing home is located in southern Norway in a medium sized (6000-20000 inhabitants) rural municipality. There are three main facilities; one for long-term care (LTCF), one combination facility with long-term care and respite care, and one dementia care facility.

Most residents, also those believed to be in need of a long-term care placement, move into the overnight respite care facility before they eventually move into a private room in the LTCF. I chose the participating nursing home for two reasons; it is in a rural area with good nursing coverage. I was curious about how a rural community may influence the older residents and their next of kin's transition processes, and what influence the rural community may have on the staff. The recruitment of nurses in Norwegian nursing homes is a challenge (Gautum, Øien & Bratt, 2016)). Moreover, older residents in nursing homes require skilled care. Many nurses work in this nursing home, and I anticipated that to explore staff actions and

interactions in these circumstances would provide some insights beyond the level of blaming the high number of unlicensed staff for poor care and assistance.

In this nursing home, the work in each of the three long-term care units within the LTCF is organized according to primary nursing model. This means that each nurse is responsible for five residents each, and the auxiliaries normally share responsibility with the nurse for three residents each. Moreover, all the nursing staff performed hands-on care. Staffing ratios and mix varied with the shifts, weekdays and weekends, and holidays. During daytime weekdays, there were three staff to ten residents. Usually there was one nurse to ten residents, and sometimes one nurse to five residents. The auxiliaries and assistants ratio was one staff to three or four residents. In the evenings, there were usually two staff to ten residents, and one nurse in charge of the whole facility (30 beds). During summer holiday and weekends, the use of unlicensed staff was higher.

Recruitment and sample

Table 1. Recruitment and sampling of data

March, April and May, 2011	**June 2011 to January 2012**	**2012**
Contact with the leader of the institutional services and the municipal health authorities	Periodic participant observations following 10 new residents into long-term care placement and long-term care facility	Additional individual semi-structured interviews with staff and next of kin
	Writing of field notes during and after the fieldwork, and daily critical reflections. On average 1,5- 2 hours each fieldwork day	
Preparation: Interviewing my supervisor before the fieldwork and interviews started	Reading of relevant documents, such as care- and medical plans from previous health care setting, care plans and daily written reports in the long-term care facility	
Preparation: Participant observation periods in the overnight respite care facility		
Meetings with the municipal health care authorities, the leader of the institutional services, and the head nurses in the long-term care facility and the overnight respite care facility	9 next of kin interviews. 9 days to transcribe the interviews	1 next of kin interview. 1 day to transcribe the interview
Staff meeting	14 staff interviews; the head nurse in the long-term care facility, 4 nurses, 6 auxiliaries, and 3 assistants. 14 days to transcribe the interviews	Interviews with 2 assistants and the leader of the institutional services. 3 days to transcribe the interviews

To get access to this particular nursing home I contacted the leader of the institutional services, and shortly afterwards she arranged two meetings, one with the municipal health care leaders, and one with the two head nurses in the overnight respite care facility and the

LTCF. They all agreed to participate. Later I informed the staff at a staff meeting. To recruit staff in the LTCF for an interview, written information was on the wall in the head nurse's office where the staff could write their names if they wanted to participate. Many wanted to participate and I chose persons from the list that represented all three categories of staff. I collaborated with the head nurse to find a convenient time to perform these interviews. The nursing home is small, and most staff knew of each other's participation. They may have collaborated and prepared themselves for the interviews on basis of previous interviews.

It was easy recruiting the staff apart from the assistants. The head nurse suggested assistants to ask, and I asked some of them. Yet, as the fieldwork got along, I head hunted staff for an interview. Sixteen nursing staff and the leader of the institutional services participated in an individual interview. These comprised four nurses, six auxiliaries, five assistants, the head nurse and leader of the institutional services (Table 1). The staff participants were females except two. The majority of the licensed staff were in their 40s and 50s, and many had ten or more years of work experience. Most unlicensed staff were in their twenties, had short work experience, and most worked for a short period in between other work career studies.

The next of kin sample was purposeful, and criterion for participation was that they recently had experienced that an older person had moved into LTCP (I). It was difficult to recruit next of kin. My first strategy to recruit potential participants was to approach them on arrival day. If it seemed appropriate to do so at that time, I asked them if they would participate in an interview in near future. Only some of those I asked wanted to participate. After some time, I asked the head nurses to provide names of potential next of kin to recently admitted residents. I contacted most of them by phone, and one by mail.

I did not interview all the next of kin to the older residents I followed during the POPs. Ten next of kin to eight residents consented to participate in an individual interview (I). The sample consisted of three sons, four daughters, two spouses and one niece. Their older family members' last point of departure before they moved into the LTCF varied. Five residents lived in the overnight respite care facility with a LTCP, one came from hospital, but had had intermittent stays in the overnight respite care facility in this nursing home earlier, one came directly from home into LTCF, and one moved from dementia care facility into LTCF.

The participant observation periods in the long-term care facility

During the POPs in the LTCF, I followed the staff who were going to welcome and assist the new residents on admission day and the first week after arrival. Most often, the preparations started on admission day. In the beginning of the project, before the resident arrived, I assisted some of the other residents in their morning care and during times when nothing seemed to happen concerning the new resident. This helped me get to know the various staff and gave access to their embodied everyday work situations, in addition to developing familiarity and trust with some. However, it complicated my focus of attention and was exhausting. I used a lot of energy to get to know the resident(s) I assisted, and may have little energy left when the new resident arrived. Moreover, initially I almost automatically took the role as a care provider, which contributed to blurring the purpose of being in the facility.

Regarding the new residents, I participated in various activities such as morning care, shift reports, meals, and other activities that took place among the staff and the residents in the living room areas, the rooms and the balcony, and between the staff. For instance, I observed who were present, behaviors and conversations – what was said and how, and interactions in the different settings (Pope, 2005; Gubrium & Holstein, 1997). I was in the LTCF daytime, afternoons, weekends and summer holiday to gain insights into the different cultures and circumstances during different shifts (Gubrium & Holstein, 1997). During night shifts and weekends, I sometimes met next of kin. I seldom met next of kin during dayshifts.

Initially during the POPs, it was not easy to take notes during the shift as no staff used pen and paper, and there were people in most places. I sometimes hid in corners to scribble down a few words, or I went into the nurse's station. I realized it was easier for me to remember sequences of actions among participants than what they said. Gradually, the residents and the staff in one unit where most of the new residents moved in got used to me taking notes in all sorts of situations. They knew that I needed to write to remember what was going on.
Each day after the POPs, I wrote field notes inspired by the approach described by Fangen (2010). What I observed and referred to as observations may be understood as "interpreted observations within a frame of reference" (Alveson & Sköldberg, 1994, in Fangen, 2010). I attempted the observational notes to be detailed and limited to recording of observed verbal as well as non-verbal events. After each fieldwork shift, I rewrote the notes taken during the day. While doing this I associated with previous POPs and interviews, which allowed for capturing

the overall impressions of the research so far. I wrote these associations down. I also wrote down feelings and reactions I experienced during the different POPs.

The design of the project meant that I had to re-negotiate my access as a participant in the research setting if it was long since I had last been there. During the periods with no POPs, I arranged interviews with different nursing staff and next of kin. This helped me stay in touch with the staff and develop rapport with some, and get valuable insights from the next of kin's experiences.

A commitment to a dialectic interaction between data collection and data analysis is not easy to sustain in practice and may demand lengthy withdrawals from the field in order to process and analyze the data before returning to collect further data (O'Reilly, 2012). The design of the project allowed for this to happen at times, while at other times it was difficult to do since there was a rush of new residents.

The interviews with the staff and the next of kin

The staff interviews took place in a small room outside the LTCF, and lasted on average one hour each. The interviews with two of the assistants lasted less. Before the interview started, the participants had the time to read the written information about the project and sign the consent form.

The next of kin and I arranged time and place to meet. The next of kin decided where the interviews should take place. Five interviews took place in a small room in the nursing home, three interviews were in the participants' home, and one was in the next of kin's workplace. Each interview lasted approximately one hour. The interviews that took place in the homes lasted longer, between two to three hours. Similar to the staff interviews, the next of kin had the time to read the written information about the project before the interview started, and sign the consent form.

The interview guide comprised three themes: the preparation period, admission day, and the first week or period in the LTCF. The interviews were joint constructions between the interviewer and the respondents (Gubrium & Holstein, 1997). I started with open questions, such as asking the next of kin about their experiences in the preparation period, admission day, and the initial period. When interviewing staff I asked open questions about what they

did in the preparation period, admission day, and initial period and with whom they interacted when they assisted the new resident. The interviews developed from what the respondents talked about initially. I made sure that we talked about all three themes. The respondents were encouraged to speak openly about their experiences and associations as the interviews went along. However, as a co constructor, the way I asked the follow up questions changed as the fieldwork and interviews went along. For instance, I focused on matters that I needed to find out more about and confronted the staff respondents with details from the POPs and previous interviews.

Documents

I read the residents' medical- and care charts at the time of arrival. During the first week, I read the care plans on the computer and in the residents' bathroom, and the daily reports. I did not analyze the written texts in detail. They rather filled in on the data from the observations and interviews (Fangen, 2010), and helped me make sense of and contextualize utterances and actions from the POPs and interviews. For instance, the written information about the new resident's poor vision guided my observations and analysis of staff actions and interactions regarding this resident (II). In addition, how the staff used and related to the written documentation were part of the analyses of staff actions and interactions.

Analyses

Data from the interviews and the POPs were the basis for the analyses. The number of transcribed pages from the staff and the next of kin interviews outnumbered the number of field note pages. These two approaches were texts of equal importance (Atkinson & Coffey, 2002), and the combination provided rich and multilayered material. In line with authors (Gubrium & Holstein, 1997; Fangen, 1999; O'Reilly, 2012), data collection, analysis and writing are not distinct phases but inextricably linked. This recognition influences the following presentation of the analysis.

Study I

The next of kin's experiences were analyzed according to thematic analysis inspired by Gubrium & Holstein (1997). The analysis started at the onset of the fieldwork and interviews. Due to the non linear assembly of data, both the POPs and the interviews with staff (performed so far) influenced the analysis of the next of kin interview data. As I transcribed the interviews, I paid attention to form and content, as they together contribute to constructing the content of the text (Gubrium & Holstein, 1997). For instance, pauses, laughter, and the respondent's body language during some episodes in the interview. At this stage, I searched for experience near concepts understood in the context of the next of kin, for example, "loneliness", and "change of room". If I associated something from the next of kin interviews with fieldwork periods or interviews with staff, I jotted this down in the margin of the transcriptions of the interviews. A strategy used was analytic bracketing, meaning bracketing one aspect when focusing on another. Inspired by Gubrium & Holstein (1997) it meant bracketing the "whats" and the "hows" of the data. The "whats" refers to the substance and the "hows", refers to the form. To answer "what" questions I focused on the people and the settings in relation to the aim of the study. For example, what the next of kin described about what happened prior to, during, and after the admission to the nursing home. To answer "how" questions, I looked at how the next of kin constructed their stories. For instance, many appeared uneasy and hesitant when talking about their impression of and relationship with the staff. When I had transcribed all the next of kin interviews, I read the interviews in one sitting several times to get an overview in relation to the research aim. This, combined with the

approach mentioned above, and repeated readings helped see recurring patterns and linkages between the interviews, and guided the creation of categories and sub-categories.

This way of undertaking the analysis fits well with the hermeneutic circle in that it maintains the circularity and spiral of the analysis. Moreover, I noticed some of my pre-understandings that appeared during the processes I was involved in, which also informed the analysis.

Study II

The analysis of staff actions during the older residents' transition into LTCF was inspired by content analysis (Graneheim and Lundman, 2004; Foreman & Damschroder, 2008). According to Graneheim & Lundeman (2004), the texts relate to the contexts and cultures in which they take place. This is in line with the ethnographic design (O'Reilly, 2012) and the philosophy of Gadamer (2004). Graneheim & Lundman (2004) maintain that the researcher's subjective understanding and personal history will influence on the analysis of the data. This seems to fit with the hermeneutic philosophy although the authors do not explicitly include the concept of pre-understandings in the analysis process. According to Gadamer (2004), the researchers' pre-understanding in all parts of the research process is in dialogue with the understanding of the phenomenon under study.

The data collection and analysis occurred concurrently which mean that analytical reflections started automatically and allowed the pursuits of new perspectives and hunches as the fieldwork and interviews went along (Gubrium & Holstein, 2014; Vike, 2003). During the intermittent POPs, from May 2011 to January 2012, I wrote notes every day after fieldwork. This prepared me for the next day in the field or the next POP, and the interviews.

The analysis continued when the fieldwork was finished in January 2012, and I delved in the material to gain a sense of the whole. I read, listened to and wrote down comments, associations and memos between and across interview transcripts and field notes. While doing this I became curios about some aspect that prompted me to have some more staff and next of kin interviews in spring and early autumn 2012. For instance, the behavior of one staff nurse during the summer holiday challenged the analysis and I asked her for an interview to get her version and not only my POP's version. This meant that the analysis stretched out in time. In the fall of 2012, after finishing the data collection, the analysis continued in a more systematic way (Graneheim & Lundman, 2004; Foreman & Damschroder 2008). The content analysis

focused on manifest as well as latent meanings of the texts, and started after repeated readings of the interview and fieldwork texts and the documents to get a sense of the whole. This overview and preliminary understandings guided the subsequent creation of the meaning units. The meaning units were condensed, without losing the core in the text. Then categories were created that consisted of groups of content that shared commonalities, and lastly themes were developed that encompassed the categories. Due to the aim of the study, the themes and categories are presented in chronological order. As the analysis progressed, the interdependency and complexity between the different staff's actions and interactions emerged. Sometimes, the findings in study II and III intertwined, and I continued to explore some perspectives from study II in the analysis of study III.

Study III

Thematic analysis inspired by Malterud (2011), Hammersley & Atkinson (2007), and O'Reilly (2012), influenced the analysis of staff interactions during the older residents' transition into LTCF. I engaged with the transcribed interviews and fieldwork texts as the study went on, and after the collection of data was over. During the POPs, it was challenging to explore staff actions (II) and interactions (III) at the same time during the older residents' transition into LTCF. This was especially so in the beginning of the fieldwork, and I had a period of trial and error before I made a system that maintained both foci. The "after" work of writing down field notes helped in this endeavor. For instance, I made headings differentiating the two. Further, I linked staff interactions from the field notes and the interviews.
The main approach in this analysis was writing things down. According to O'Reilly (2012) "Writing down (taking notes and collecting information) therefore leads to analysis (sorting and exploring the things written down and collected), which in turn leads to writing things up" (p. 180). Writing things up means to prepare what one has discovered in a way suitable to present to others. During the analysis, I tried to make sense of how occurrences, phrases and phenomena fit together (O'Reilly, 2012; Hammersley & Atkinson, 2007). This approach may connect well with the concepts of the hermeneutic circle and the fusion of horizons (Gadamer, 2004), since the writing down and writing up meant continuous changes and rewriting of the material as the analysis progressed. During this process, some sensitizing concepts, such as "the physician's round" and "chameleon", appeared and suggested further directions to explore (Hammersley & Atkinson, 2007, based on Blumer, 1954). The main role of the

written documentation in this study was how staff related to it. I primarily consulted the written documents to check the understanding of interview and fieldwork data (Fangen, 2010). Thematic analysis inspired by Malterud (2011) was undertaken. The parts of the transcribed interviews and field notes dealing with the same issues were taken out of the contexts in which they occurred to get hold of the different versions of the same phenomenon. For instance, I discovered "spontaneous staff interactions" across the data material. I also made sure that the interpretation of the material taken out of context was in accordance with the contexts where they occurred (Malterud, 2011). The emerging themes were explored to clarify their meanings and relation to other themes. The sub-themes show the variations contained in each theme (Table 3). Simultaneously, I searched for theoretical perspectives central to the aim to help make sense of the emerging patterns, which were sometimes difficult to put into words. I discovered complexity science studies in nursing (Anderson et al. 2003; Anderson et al. 2014) which helped put words on some of the dynamics and paradoxes in the nursing staff interactions during the older residents' transition into LTCF.

Table 2. Aims, participants, data collection, and analyses of studies I-III.

Study title	**Aims**	**Sample and participants**	**Collection of data**	**Data analyses**
Study I: Experiences faced by next of kin during their older family members' transition into long-term care in a Norwegian nursing home	To describe and explore experiences of next of kin during the older persons' transitions into long-term care	10 next of kin to 8 residents	Individual semi structured interviews	Thematic analysis paying attention to content and form, inspired by Gubrium & Holstein (1997)
Study II: Nursing staff's actions during older residents' transition into long-term care placement in a nursing home in rural Norway	To describe and explore different nursing staff's actions during the initial transition period for older people into long-term care facility	The staff assisting 10 new residents on admission day and the residents' first week in the facility 16 staff	Participant observations, informal communication with the staff, and the new resident Semi structured interviews with 16 staff and the leader of the institutional services. Reading of relevant documents – care plans, medical and care records from previous health care setting, daily reports	Content analysis inspired by Graneheim & Lundman (2004), and Foreman & Damschroder (2008)
Study III: Nursing staff interactions ng the older residents' transition into long-term care facility in a nursing home in rural Norway: an ethnographic study	To explore and describe the nursing staff interactions during the older residents' transition into long-term care facility	The staff assisting 10 new residents on admission day and the residents' first week in the facility 16 staff	Participating observations, informal communication with the staff, and the new resident semi-structured interviews with 16 staff + leader of institutional services Reading of relevant documents	Thematic analysis inspired by O'Reilly (2012), Hammersley & Atkinson (2007), and Malterud (2011)

Ethical considerations

The Regional Committees for Medical and Health Research Ethics (REK) in southern Norway (2011/153b) approved the study (Appendix). There are strict regulations how to undertake research in health care settings with vulnerable participants (The Research Ethics Act, 2006; The Health Research Act, 2008). All data were stored in a locked cabinet.

Before the data collection started, the residents, staff and the next of kin were informed orally and later in writing about the project (Appendix). The participants gave their informed consent in a signed document, and informed about their rights in research. They were guaranteed anonymity and confidentiality, and the possibility to withdraw at any time without stating a reason.

On admission day, I asked the new residents if they accepted that I participated in their daily care during their first week in the nursing home. If they accepted, they signed a document. I collaborated with the staff nurses to find a suitable moment to ask permission since admission day is a stressful day for the new resident and their next of kin. Moreover, before I asked the next of kin for an interview, I asked the residents if they accepted that I interviewed their next of kin. For those residents considered unable to consent, I asked the next of kin directly (I).

The staff meeting and the staff interviews maintained to a certain extent the information about the project, and most staff participating in the POPs were familiar with the project. However, it was difficult to inform all the part-time weekend staff beforehand. Not all the staff who participated in the POPs signed a document and individually agreed to my participation. I did not experience that any of the staff disagreed to my participation with them and the new resident during the first week. Had so happened I would have respected this (Beauchamp & Childress, 2009).

Findings

Introduction

The next of kin's transition experiences intertwined with their interpretation of their older family members' transition experiences (I). The older residents in transition into LTCP and LTCF had experienced multiple relocations and transitions due to declining health. This influenced the next of kin in the interviews. Many had a need to retell the older residents' health decline and recalled episodes from different health care arenas, which they compared and contrasted with the current situation and context. The staff in the LTCF mainly focused on their work within the facility. They were in general familiar with the arrival of a new resident, and expected that the new resident would settle in after a while. Many had previous experiences with residents who felt safe and appreciated living there (II). Their focus was the new resident, and they appeared to pay little attention to the next of kin and their potential needs (I, II, III).

The nursing home is a complex organization where each staff was influenced and influenced contexts and circumstances. The findings illuminate the complexity of processes and call the attention to multiple factors that intertwine and influence the older residents and their next of kin during the transition into LTCP. Critical factors include different system levels, such as, the inter organizational-, the organizational-, the professional-, the personal-, and the inter professional. The main findings in the three studies are presented in Table 3.

Table 3. Overview of the main findings of the studies

Study I	***Categories and sub-categories***	***Condensed findings and conclusions***
Title of the paper		
Experiences faced by next of kin during their older family members' transition into long-term care in a Norwegian nursing home	**Striving to handle the new situation** **-**uncertainty and expectations -the moved around resident -the significance of being included **Still feeling responsible** -relationships at stake -support at the right time **Maintaining continuity and dignity** -precious moments -business as usual?	What happened prior to the long-term care placement as well as what happened in the initial period in the nursing home influenced the experiences of the next of kin. They were unprepared for the transition and experienced little support from staff. Information and continuous support from health care providers across as well as within health care setting is vital to secure a healthy transition for the older residents and their next of kin
Study II	***Themes and categories***	***Condensed findings***
Title of paper		
Nursing staff's actions during the older residents' transition into long-term care facility in a nursing home in rural Norway	In the preparation period: **actions of sharing, sorting out and ignoring information** **-**dealing with competing tasks, uncertainty and routines On admission day: **actions of involvement and ignorance** -variations in how the new residents are met -residents' previous residence matter Initial period: **targeted and random actions** associated with contextual features, staff attendance to the residents' self-care abilities, and medical treatment **Actions influenced by embedded knowledge** -there is always somebody in need of a long-term care placement	The study shows variations in all categories staff concerning their actions towards the new resident. The summer holiday and weekends influenced staff's actions negatively in relation to the newly arrived resident in transition. The head nurse's management, individual staff's formal position and traits, resident and staff mix, and local transparency were powerful influential forces on staff's actions.

	-the long-term care facility – a home taken for granted -mentally lucid residents manage on their own **Actions influenced by local transparency** -familiar people and places -good or dubious reputations	
Study III	***Themes and sub-themes***	***Condensed findings***
Title of paper		
Nursing staff interactions during the older residents' transition into long-term care facility in a nursing home in rural Norway: an ethnographic study	**The significance of formal and informal organization** -individual actions and teamwork -information flow **Interpersonal relationships and cultures of care** -alliances and collaboration -the privacy of caring **Professional hierarchy and different scope of practice** -hierarchy and responsibility -monopoly of medical knowledge	The nursing staff interactions varied from spontaneous interactions focusing on the new residents' imminent needs to individual actions ignoring the residents' needs. Organizational factors, staff's formal position and informal staff alliances appeared influential yet, contradictory. The spontaneous staff interactions were key activities that appeared to maintain and enhance the well-being and health of the new resident. Characteristics of theses interactions were the inclusion of all the staff present, staff flexibility, information flow to some extent, and cognitive diversity

Support outside of and within the nursing home

If the next of kin had experienced confusing support or lack of support at the previous health care institution, this appeared to affect their experiences and expectations shortly after the LTCP. At the same time as they now felt relieved, they were apprehensive about the quality of care and their new roles (I).

It frustrated the next of kin that their older family member moved between and within facilities in the nursing home. Most relocations between facilities happened during daytime

shifts, when many next of kin were at work and unable to participate. Only one retired spouse in the next of kin sample participated in the move from the overnight respite care facility to the LTCF. The next of kin who did not participate in the move to the LTCF within the nursing home experienced confusing support from staff at these times. Some experienced that the staff in the LTCF took it for granted that the next of kin knew their way around on their first visit after relocation. Others experienced that they were taken good care of on arrival day, but frequently ignored after that (I).

It was a stressful time for both the new residents and their next of kin in the beginning. For example, during the first night in the facility, one resident made a mess of herself. The staff nurse wanted to put her on medication the morning after. One nurse student, however, reminded the staff nurse that it was the resident's first night in the LTCF and that she needed time to grieve and settle in (II).

Regarding the next of kin, some children expressed that it was hard to balance to look after one parent at home and visit the other parent in the LTCF. Although it was a relief to get a LTCP for the older family member, it was time consuming and exhausting having to visit two places with different and confusing role expectations. Most next of kin did not share such worries with the staff.

To support, maintain and enhance the new resident's self-care abilities and potential depended on the residents' circumstances and illness(es), the commitment of the next of kin, the mix of residents, the mix of staff, and each staff's collaboration with the resident, colleagues, and the next of kin (II, III). The next of kin commitment was decisive. They stayed involved and represented continuity with the past. This supported the residents and the next of kin towards acceptance of the placement and their new situation (I).

At the hospital, the next of kin experienced confusing support from staff, which contributed to putting family relationships at stake during the older residents' transition into the LTCF, illustrated by the following example: the hospital staff supported the wife when she made the decision for LTCP on her husband's behalf. Afterwards, however, she felt alone and unsupported when she informed her husband about the decision. He was furious about the decision taken over his head. This contributed to destabilizing relationship within the family, which continued after the move to the LTCF where the family coped on their own as best they could. It seemed that the adult children took on new roles, such as mediators between their parents in these situations, and unintentionally contributed to a distance between spouses.

Conversely, information and support at the right time directed the next of kin and the resident towards health and well-being. A wife experienced that the hospital staff did not inform her about her husband's serious condition. She was frustrated and sad in the preparation period and shortly after her husband moved into LTCP, and had difficulty accepting that he had to move. The staff sensed her anxiety shortly after arrival, and summoned a meeting. This helped her accept the situation, and perform meaningful activities that contributed to her husband's and her own well-being (I).

The head nurse wished that every staff knew about and would be able to flex between following procedures and routines and act spontaneously if situations required so (II, III). She approached individual staff and made them "aware how much each one of them matters" (III, p. 5). Although experienced permanent staff were able to work like this, the unlicensed weekend and holiday supply staff and those in small positions (III) performed general routine work without paying special attention to the new resident (II). The head nurse was little involved with the unlicensed supply staff since she was seldom present when they worked, and there were few formal staff meetings (III).

The head nurse's participation in the joint morning reports appeared central in directing the staff's actions and interactions towards the new residents on admission day as well as in the initial period (II). She involved herself in the arrival of the new residents and in their initial period by, for instance, instructing her staff to be aware of central aspects of the new resident's needs. The staff nurses paid attention to this and supervised their staff according to the head nurse's concerns.

Moreover, the staff nurses in each unit had great freedom to develop their work the way they thought was best. Sometimes this posed challenges at shifts when the nurse in charge was responsible across all the three units. The nurse may spend a long time looking for the documents following the new residents from the previous health care setting, as they may be stored in different places in the three units (III).

The head nurse was little involved with the next of kin. She trusted the staff nurses in each unit to take care of that. Although she played an active role in the preparation of the arrival of a new resident, she did not participate when the new resident arrived. Few next of kin and residents talked face to face with the head nurse in the initial period. This frustrated some next of kin who wondered who was the leader and had the overview of the facility (I).

The long- term care facility - a home for the resident

Many staff regarded the residents' rooms as their home immediately after arrival and did not want to disturb unnecessarily when the next of kin visited. Many next of kin, however, felt left on their own in the initial period. They expected the staff to approach them while the staff expected the next of kin to initiate contact. Often, when they visited their older family member no staff looked into the resident's room. The next of kin expressed that they would have appreciated a cup of coffee and a little chat (I). One young assistant who had experienced her grandmother's transition into LTCF noticed that the staff kept away from her grandmother's room during visits. She emphasized that she and her parents would have appreciated the interaction with and support from staff. The assistant had not shared this piece of information with the permanent staff colleagues and the head nurse. A formal meeting with the next of kin was routinely arranged within a month after arrival (II). This could mean that few next of kin and the primary contacts talked face to face during the first week, apart from admission day if the primary contacts were at work then. Shift-, part-time work and that most next of kin visited at nights and weekends, also contributed to poor communication between the next of kin and the primary staff.

Information flow between and within health care settings

What happened at the previous health care institution or home care setting influenced the next of kin's expectations and experiences in the nursing home setting (I). It also influenced the nursing staff's actions and interactions with each other and the new residents (II, III).

Health care providers at the hospital or the home health services, seldom informed the next of kin about the nursing home before the admission into LTCP, and the next of kin's information acquisition appeared coincidental. A few had previous experience with the LTCF and based their expectations on this. Others relied on gossip and general notions about nursing homes, which were often negative (I). No next of kin in this sample had consulted the nursing home web site. Even though word of mouth went that the residents in the LTCF "….were placed in a chair and nothing happened" (I, p. 2190), the next of kin regarded the older people's care in this municipality as good compared to elsewhere. Moreover, they knew of the waiting lists for a LTCP, and were grateful for their family members' LTCP.

Within the nursing home on admission day, some next of kin and their family member did not know that the family member had to share a private room with another resident in the overnight respite care facility after the resident had a LTCP. Some next of kin also experienced that the roommates in the overnight respite care facility could be a strain on the family member, and worried about his or her health. In addition, most were unprepared for the relocations within the nursing home. They worried that it was stressful for the family member having to relate to new staff all the time (I). The next of kin blamed this on the system.

Within the LTCF and the specific LTCU, the information flow among the staff was decisive, and influenced the residents during their transition into LTCF in complex ways. The main areas for getting information and knowledge about the new resident were the residents themselves, the next of kin, the short oral reports, the collaborations among the staff directly after the joint oral morning report, the spontaneous and continuous staff interactions in the unit, and the care plans on the computer and in the residents' bathrooms (II, III). In addition, when residents moved between facilities in the nursing home, the staff may exchange information during lunch breaks outside of the LTCF.

Inadequate information and lack of information from the previous health care setting also influenced the staff's work in complex ways (II, III). When the resident arrived from the hospital, it happened that information was lacking or was inadequate. The nurses had to sort this out, which left less time to get to know the new resident, and less time to collaborate with colleagues in the direct care and assessment of the new resident. In addition, if there were seriously ill residents in the LTCU at the time of the arrival of a new resident, the nurses prioritized those residents. To get updated information, the nurses phoned the hospital. Yet, it could be difficult to find someone at the hospital who knew the resident. The nurses were particularly frustrated about lack of or inconsistencies in the medical records, and they worked hard to sort this out before the physician's round the first week (II).

Still, some staff also ignored information from the prior health care setting (II). During the summer holiday with many supply staff at work, none of the staff read all the available information about the new residents before she or he arrived and during the first week. This ignorance directed the resident towards risks initially.

Moreover, the use of assistants could influence negatively on all the staff's assistance of the new residents. Many unlicensed supply staff at work simultaneously, such as the summer holiday, prevented information to flow freely and spontaneously. The permanent staff worked

in a different manner then. Usually their work performances were flexible and dynamic, yet, at these times, they appeared less able to assist the new resident's emerging needs. The permanent staff blamed it on lack of time, and "new" and unfamiliar tasks to perform during the absence of licensed staff colleagues (III).

The assistants wished the permanent staff would inform them better, illustrated by the assistant: "It is easy to forget to inform colleagues when one has been working for a while and knows one's way around" (II, p. 5). Likewise, it appeared self-evident for some assistants that their staff colleagues knew what they knew and they did not pass on vital information about the new resident (III). Sometimes they did not know what to ask about, and they appeared afraid of asking about and passing on information, they believed everybody knew. The consequences for the new residents were that their everyday basic needs and preferences were at risk of being ignored (II).

The dominant oral culture in the LTCF influenced the staff's interactions with each other, and the new residents and their next of kin in intricate ways.

There was a tension between written and oral communication. The predominant attitude was that it was little point reading, which seemed to encourage an attitude of writing less (II). Moreover, during the fieldwork period, there were few formal staff meetings, and often meetings were cancelled (III). Some auxiliaries argued that the meetings helped all those present to get some more information and knowledge about the new residents and the residents in general. In addition, some were frustrated that the informal oral situations favored only the staff present, and left the others to cope as best they could on their own. During the formal meetings, the auxiliaries wanted the nurses to inform and supervise them in medical matters. They claimed that updated information helped them notice and assist the new resident more to the point initially.

Since the nurses had so many fragmented tasks to perform, they often depended on the primary auxiliaries for updated information about the new resident's everyday needs and self-care potential and capabilities. If they did not have this information, their assistance at times appeared random and performed in a routine way not consistent with the assistance developed between the primary auxiliary and the resident. If, however, the resident was mentally lucid, the resident instructed the nurses, and potential other staff. Some mentally lucid residents experienced new staff during nearly every morning care situation the first week. Even though

the residents appreciated being asked, it was exhausting for some to repeat their instructions to new staff many times.

In the initial period, the primary staff continuously assessed the new residents' needs and preferences and did not always write their preliminary observations and actions in the daily reports or the care plans. This made the part-time supply staff depend on the permanent staff to share information face to face with them. However, it was arbitrary if so happened (II, III). Some night shift staff relied too much on the oral communication during the oral shift report with the evening staff, and skipped reading the new resident's care plan on the computer. For instance, it irritated some next of kin that the night shift staff did not know that their older family member depended on assistance to go to the toilet. When the resident called for help, the night shift staff at first did not assist properly and commanded the resident to use the arms. One main reason for the LTCP was the resident's inability to use the arms. This piece of information was written in the care plan on the computer.

The continuous and spontaneous interactions among the staff and between the staff and the residents were key activities in maintaining the health and well-being of the new residents. The most common was that the primary nursing arrangement encouraged the primary contacts to interact spontaneously with each other, and with the residents. Yet, sometimes these interactions also occurred ad hoc among any staff present, whether they were primary contacts or not. These interactions seemed to depend on enthusiastic and devoted permanent staff who believed good collaboration was to "find the best solution together" regardless of professional position (III, p. 7). During these interactions, all the staff present participated in flexible and diverse ways, and shared, discussed and supervised each other concerning the new resident's emerging needs and preferences. These situations created a learning environment where the staff trusted each other, and encouraged curiosity and closer follow up of the resident. It appeared coincidental and depended on persons whether the part-time supply staff participated in these situations (III). They were susceptible of keeping to themselves, and were in danger of not passing on or getting vital information about the new resident. The findings also showed that licensed staff could work on their own and pay no particular attention to the new resident.

The nursing home is in a rural municipality where "everybody knows of everybody" (II). This colored the next of kin as well as the staff attitudes towards each other. For some, familiarity seemed to open up communication between the next of kin and staff. For others, negative stigma appeared to contribute to aloofness and shyness between them. If the next of kin

approached staff, they talked with those they knew (I). Both groups were apprehensive about each other's behaviors.

Furthermore, local transparency influenced how some nursing staff handled and shared information at oral reports (III), and how they behaved towards some residents (II). For instance, knowledge of and personal involvement with the new resident could inhibit the sharing of vital medical information about the resident at the oral shift report on the day of arrival (II). Conversely, local knowledge and familiarity with the residents helped the staff quickly connect with and develop relationships with the new resident. For instance, they shared knowledge and insights about familiar people and places with each other during meals. Moreover, the staff encouraged the resident to connect with potential familiar co-residents. For staff to have the time to do this depended on that most residents in the unit at that time were mentally lucid and not too physically demanding (II), and that some staff were locals (III).

Power as dominance on and power as influence on – hierarchies and networks

Power as dominance on and power as influence on permeated in complex ways what happened between the staff, and between staff and the older residents and their next of kin.

The strong oral culture allowed for the dominance of eloquent and authoritative persons, illustrated by the assistant who felt like a chameleon "trapped between two who have strong opinions about how to care for the new resident" (III, p. 5). This contributed to a variety of approaches towards the new resident initially, which could mean inefficient assessment and assistance. Some permanent staff formed alliances with colleagues from their own professional group, and those with similar attitudes and values. These alliances helped individual staff avoid feeling insecure and inferior to colleagues during their assessment of the new resident (III) and the residents in general. Whether the unlicensed staff formed alliances among themselves is unclear in this project.

The notion of the professional hierarchy influenced the staff's ways of assisting the new residents. The assistants talked about "being at the bottom" (III, p. 7), the auxiliaries about being "not so high up in the hierarchy" (III, p. 7), and the nurses were conscious of being the leaders (III). "Being at the bottom" appeared to pervade the assistants' work situations, illustrated by the following: One assistant was frustrated because the permanent staff had not informed her about what to do concerning a new resident who was prone at choking. She had

to ask for this information, and she was unsure if the assistants would do that" (II). All the staff took it for granted that the unlicensed staff were at the bottom of the top down hierarchy. The use of unlicensed staff was a source of irritation among the permanent licensed staff. For instance, the permanent auxiliaries were frustrated because they had to compensate for the lack of licensed staff at shifts with many unlicensed supply staff (III). Some experienced that this disturbed their assessments of and relationship building with the new resident.

The licensed permanent staff were prone at doing things their ways and ignoring colleagues beneath them in the hierarchy. For example, when a new resident and their next of kin arrived most nurses presented themselves as the sole primary contact and did not mention the primary auxiliary (III). Moreover, it frustrated the auxiliaries that many nurses kept information about medical matters within the nurse's group. Some auxiliaries experienced that this contributed to poorer observations and follow up of the new resident initially, and kept them back from approaching the next of kin during visits. When the next of kin visited, the auxiliary staff who were in the process of getting to know the new resident usually directed them to the nurse (III).

Furthermore, it seemed self-evident for the management and most nurses that the physician and the nurses were the only participants needed during the physician's once a week round, regardless whether the nurse or the physician knew the new resident. The physician was in the LTCF once a week, and although he worked as a GP in the municipality, he may not know the new resident. It irritated some primary auxiliaries that they were not included when the nurse in charge of the unit that day, did not know the new resident. They believed they had something to contribute with since they were in the process of getting to know the new resident, and had the overview of the new residents' situation after admission (III). Likewise, it frustrated the next of kin if the nurse in charge only knew about medical aspects of their older family member initially, and was ignorant of him or her being a unique person with everyday needs and preferences (I).

The continuous and spontaneous staff interactions illustrate the staff networks. These interactions among the staff and between the staff and the residents seemed obvious to most staff and the head nurse, and seldom spoken of. If spoken of, they were referred to as "the little things that matter" (II, p. 9). The primary nursing arrangement and devoted staff facilitated these networks. Yet, among other things, shift- and part-time work, and many supply staff at a shift disturbed the primary nursing arrangement. For instance, at shifts with no primary contact persons at work, the new residents may experience poorer assessment and

follow up. Sometimes those present, avoided involving themselves with the new residents and left this to the primary contacts when they were back at work (III).

Yet, although one pattern was that everybody present participated in the networks and had their say in the process of making sense of the complex and fluctuating needs of the new resident, another pattern was that sometimes the assistants did not participate. This appeared mostly so because the permanent staff did not invite their participation or/and that the assistants did not want to be involved.

The auxiliaries and the nurses had overlapping work domains. The LTCF was well staffed with nurses and the nurses had taken over tasks the auxiliaries had previously performed in the home care services. Many auxiliaries were frustrated about this, and some strongly involved and enthusiastic auxiliary allies compensated by working part-time providing meaningful activities and extras for all the residents in the units in their spare time. For most new residents this appeared to direct them towards well-being, but it did not suit all newcomers who may have more urgent medical and care needs in this initial period (II). The enthusiasts were in danger of ignoring the new resident's complex medical conditions and needs shortly after arrival. The head nurse and the management appreciated these extras, and the head nurse attempted to even things out between the full-time employees who were unable to be so involved in these activities, and the enthusiasts. Still, not all the allied staff worked in the interests of the new residents. Some would rather satisfy their own relationships with colleagues, than involve themselves with the new residents (III).

Due to waiting lists for a LTCP, a new resident would always move into the LTCF when a bed became vacant (II). This influenced some staff who appeared to disregard the new residents' being in transition, and their specific needs. "Daily routines take over; the resident has to adjust to our routines, it is the same procedure as usual" (II, p. 8). Furthermore, many staff believed that mentally lucid residents managed on their own, and seemed to neglect their potential physical disabilities and debilitating circumstances in the initial period (II). The staff took it for granted that the resident would cope by either asking for assistance or doing it on their own. Some ignored that the new resident and their next of kin needed time to get familiar with the new surroundings initially.

Some staff also behaved during their lunch breaks as if the living room area in the LTCU was their home. They had their lunches there, and it was arbitrary if they involved the new residents and the other residents present. The mentally lucid new residents quickly learned to

keep away from the living room area at these times. The cognitively impaired residents or those who depended on help to move, stayed put (II). If some next of kin visited at these times, they were confused and frustrated since they may not know that the staff had their lunch break and appeared to ignore the residents present and those who called for help from their rooms.

Discussion of main findings

The overall purpose of this thesis was to explore the transition process into long-term care placement for older residents from different perspectives in order to maintain and enhance health and well-being, and be able to inform practice and improve care. The specific aims were to describe and explore the experiences of next of kin during the older family members' transition into long-term care (I), and to explore and describe staff actions (II), and interactions (III) and how these may influence their assistance and care of the older residents in transition.

Nursing staff as agents in a complex organization

The transition theory in nursing is mainly concerned with how nurses can assist people towards health and well-being during transitions (Meleis, 2010). In line with complexity science, the findings in this project strongly indicate that the staff are agents as well as those they assist. The interactions among staff, or lack of interactions, with other staff members, the physician, the residents, and the next of kin influenced the next of kin and the older residents' transition processes (III). Moreover, the findings show that the previous health care settings had an impact on the experiences of the next of kin and their older family member (I, II, III), and the staff's actions and interactions.

The findings challenge the professional silo thinking as they show the importance of all the agents in the organization, and their potential influences on each other and the older residents and their next of kin. The current political ambition in Norway is to enhance collaborative competence (white Paper No. 13, 2011-2012). Although a small sample, the findings indicate that in order to support the next of kin and the older residents, health care providers need to be working across professions and health care settings, driven by "collaborative practice development" and not only by "continuing professional development" (Imison & Bohmer, 2013, p. 4). Current policies (white Paper No. 47, 2008-2009; white Paper No. 16, 2010-2011; The Act of Municipal Health Care, 2011) emphasize the need for high quality integrated and coordinated health care services tailored to the individual user.

Bing-Jonsson et al. (2016) identified insufficient competence among nursing staff in community elder care in the areas of nursing measures, advanced procedures and nursing

documentation. They recommend clear role descriptions for all groups of staff, in addition to general competence development in geriatric nursing care. The studies in the current project also found the need for role clarification among the staff, and between the staff and the next of kin. Moreover, it points at the significance of looking beyond individual agents in the nursing home organization, and focus attention on what happens among the staff. Anderson et al. (2003) stress, that strategies needed for improving resident outcomes have to look beyond the traditional emphasis on clinical processes and the skills of individual care providers. In addition, the current project brings up what Xyrichis & Lowton (2008) found in their review study that contexts and circumstances on individual-, inter professional-, professional-, and organizational levels also need contemplation when considering the interactions and team work between the agents in the organization. Furthermore, the findings in the current project show that the inter-organizational level also needs to be paid attention to when considering team working among the agents in the LTCF (I, III).

Information flow, support, and role clarification

The information flow between the different health care institutions and the nursing home, as well as within the nursing home and the LTCF, was inadequate.

Storm et al. (2014) found that a lack of systematic information exchanges between health care professionals and next of kin, between municipality and hospital during older patients' discharge and admissions into hospital, contributed to poor quality care. The findings in the current project also show that the lack of information and support between health care institutions may direct the older resident and their next of kin towards risks during the transition process into LTCP (I, II). In study I in this project, critical stressful points in the next of kin transition experiences were at the hospital when they made the decision for LTCP on behalf of the older family member, and informed the family member about this. These experiences influenced the family relations negatively after the LTCP. Sussman & Dupuis (2012) also found that the next of kin had "horrendous" (p. 406) experiences moving their older family member from hospital to long-term care which shaped their experiences after placement.

Some next of kin in this project were old (I). Bragstad, Kirkevold, Hofoss & Foss (2014) found that the younger generation next of kin received and provided information to hospital

staff to a greater degree than the older, and that they were twice as satisfied with the cooperation with the hospital staff compared with the older generation next of kin. Having this in mind, health care personnel at hospitals and nursing homes should develop knowledge, attitudes, and systems to communicate with and support the next of kin during this period.

Many residents who move into LTCP have complex medical- and care needs. The findings propose developing and integrating professional knowledge and skills with inter relational skills, and knowledge about each other's roles and positions. Between health care organizations, Paulsen, Romøren & Grimsmo (2013) found in their study "A collaborative chain out of phase" that information provided by hospital nurses at discharge was not sufficient with respect to the information needs of nurses in the municipalities. The authors argue that several problems will remain between the hospital and the municipalities because of differences in professional orientation and the contexts of care delivery. They suggest the introduction of asynchronous email like electronic communication where a liaison nurse could answer the requests from the municipal nurses at an appropriate time for both parties. They are, however, unsure if this will compensate for the "richness, flexibility, and immediacy of direct conversations, as information can be corrected and supplemented in real time" (p. 8).

Within the LTCF, the different levels of staff, from nurses to unlicensed assistants, posed challenges. The arrangement of using unlicensed supply staff at weekends and holidays only should be avoided as this appeared to contribute to directing the new residents towards risks initially. Havig et al. (2013) also found that many unlicensed part-time staff at a shift disturbed membership stability in the units, which is important in "real teams" to maintain quality care. According to Begun et al. (2003) the agents of a complex organization, "both alter other agents, and are altered by other agents, in their interactions" (p. 256).

The part time supply staff easily became "outsiders" during the busy weekends and holidays with fewer staff at work, and little opportunity to interact and learn from the permanent staff (III). Corazzini et al. (2015) conducted a study in three nursing homes in the US, where they brought together diverse nursing staff members simultaneously and coached them to clarify what "each role and licensure level contributes to nursing practice in relation to one another" (p. 48). The purpose of their study was to improve detection and management of conditions associated with avoidable hospitalizations. They found that role clarification among diverse nursing staff helped them collaborate in ways that strengthened connections among licensed and unlicensed nursing staff.

The education of professionals within health care in Norway is mostly isolated from each other. According to a report from Collaboration Across Professional Boundaries (CAB) (Bjørke et al., 2009), of a total of 60 health- and social study programs in Norway, only 20 had joint lectures with or themes related to knowledge about other professional groups within the same area of work.

In the LTCF, the nurses had many fragmented tasks to see to, which contributed to delaying their acquaintance with the new resident and inhibited their collaboration with staff colleagues. The nurses prioritized to sort out the medical information from the previous health care setting. Regarding older adults, studies (LaMantia, Scheunemann, Viera, Busby-Whitehead & Hanson, 2010; Coleman, Smith, Raha & Min, 2005) have identified medication errors as a main source of morbidity and mortality in transitional care. The nurses in the LTCF had to make priorities within contextual and circumstantial restraints. Although this could be at the expense of getting to know the new resident and their next of kin and collaborating with staff colleagues, the nurses worked according to their professional qualifications, which is in accordance with the Health Personnel Act (1999). It seemed that the next of kin as well as some staff colleagues were unaware of these aspects of the nurses' work. It is vital that the different staff clarify their roles and circumstances among them, as well as inform the next of kin about their different scope of practices, and potential priorities and contextual restraints that may inhibit the nurses' personal involvement with the new resident initially. It follows, that the primary auxiliaries together with the primary nurse have a more central role in the interactions between the staff and the next of kin as they are central in assessing the older resident initially.

Yet, transition theory stresses that at the same time as it is paramount to maintain continuity with the new residents' medical records, it is also important to get to know the resident. Nursing therapeutics (Meleis & Trangenstein, 1994) is concerned with the residents' lived experiences and daily life events as well as their medical conditions to promote a healthy transition for those involved (II). It frustrated the next of kin that some nurses did not know their older family member personally. Studies (Majerovitz et al., 2009; Haesler et al., 2010) show that in order for the staff to develop a good relationship with the next of kin, the staff have to acknowledge the uniqueness of the older resident and provide information and emotional support. Majerovitz et al. (2009) found that the next of kin wanted clear and timely information about the residents' condition and treatment delivered by someone who knows the resident well.

The findings show that the next of kin and the staff could miss the opportunity for role clarification and the sharing of knowledge and information early in the transition process. Yet, the staff acted ad hoc, and informed and supported the next of kin shortly after the older resident's admission (I, II). This ad hoc ability among the staff is in line with Tregunno & Zimmerman (2008) who emphasize that "accountability needs to incorporate the ability to respond to unanticipated events" (p. 173). This ability is, according to complexity science, generated by the self-organization among the staff within their teams (Colon-Emeric et al., 2006). Transition theory (Chick & Meleis, 1986), also stresses that the staff recognize uncertainties and doubts early to enhance a smooth transition for the persons involved. However, transition theory does not involve the staff members themselves as agents and may miss, as the findings demonstrate, the complex dynamics inherent in the situations. Moreover, the findings suggest that the staff and the next of kin should connect ad hoc several times to focus attention on nonlinear dynamics and unanticipated events during the transition. Kralik et al. (2006) also stress the importance of recognizing nonlinear dynamics during transitions. For example, older residents with chronic illness may experience fluctuating health and well-being (II). It is paramount that the management and staff acknowledge and appreciate the ad hoc ability among the staff. This may encourage staff to keep on paying heed to the emerging needs of the new residents. Likewise, the ability of some permanent staff to stimulate and include every staff member present in the spontaneous staff collaborations to maintain the new residents' health and well-being (II, III) should be appreciated as "pockets of excellence" (Anderson et al., 2014) by the management and the staff.

In addition, the findings strongly imply that structural arrangements such as organizing a meeting within the first week after arrival would ensure that all next of kin would get the same opportunity for role clarification, information, and support. This may make them familiar with central care providers, especially the head nurse (I), and help them get knowledge about what to expect from the different staff members as well as developing appropriate roles in their interactions with the older family member and staff. Further, the next of kin have the possibility to share their own expectations, anxieties, and queries with the staff. This again may assist the staff in assessing what to expect from the next of kin, and how to support them. Lastly, both the formal and informal encounters between the next of kin and the staff may keep the next of kin and staff informed about current circumstances and contexts. Complexity science emphasizes that informal as well as formal communication

between the agents in an organization provide better information flow than only formal (Singhal, 2007).

The long term care facility – a home and a medical institution

The LTCF and its units were a complex mix of home and medical institution (II, III). At times, the notion of home was strong among some staff, which contributed to creating some inconsistencies in the staff's ways of working. Jacobsen (2005) argues that being able to cope with the complex mix of a home and a medical institution depends on some incongruence among the staff in the nursing home culture.

The findings showed opposite expectations between the next of kin and the staff during next of kin visits (I, II). Transitions may take time (Schumacher et al., 1999), and nursing therapeutics may assist the staff to anticipate points at which the person is most likely to reach peak of vulnerability. Regarding the next of kin, the findings show that the initial period in the LTCF is critical. The staff should pay particular attention then, and select appropriate actions to direct the next of kin towards coping and well-being. The next of kin do not demand a lot, which is in line with the study of Austin et al. (2009) who also found that the next of kin appreciated the little things (I). Small talks and a cup of coffee would probably provide opportunities for them to vent their concerns with the staff. The staff should provide information about the resident and participate in small talk. The next of kin approached the staff they knew, regardless of professional background (I). This implies that all categories of staff members approach the next of kin during visits and that each staff category inform the next of kin about their roles and position, and pass on information from these encounters to colleagues.

To promote next of kin involvement and collaboration with the staff, Norheim & Sommerseth (2014) found that a prerequisite was that the staff noticed them during visits. The findings in the current project show that the next of kin were little involved in the LTCF, and that there was a distance between them and the staff. In the perspective of complexity science, each next of kin and staff member influence and is influenced by each other (Begun et al. 2003). The distance between the next of kin and the staff, or the lack of involvement of the next of kin in the facility, may have contributed to stimulating the enthusiasts to work in their spare time to compensate for the lack of social activities among the residents. This again may have made some next of kin feel redundant and not needed as the staff managed well on their own.

Moreover, some staff regarded the LTCF as their home (II), and they seemed to take the role as the new resident's "new family". Holmgren et al. (2013) also found in their study of Swedish nursing homes that the staff expected to become the residents' "new family", and that the next of kin were representatives of their "old family". This is different from what Davies & Nolan (2006) found in their study of the next of kin's self-perceived roles in UK care homes. One main aspect of their role in the nursing home was that they contributed to community by interacting with most residents, other next of kin and staff. They took part in social events and generally provided a link with the outside world.

Many permanent staff were in the process of developing a reciprocal relationship with the new residents at the same time as they encouraged relationships between the residents (II, III). According to transition theory (Meleis & Trangenstein, 1994), persons in transition need to develop new relationships to deal with the new life situation (II). Still, the findings in this project show that shortly after admission the resident and the next of kin were in the process of letting go of their past life simultaneously as they tried to adjust to the new life. For some next of kin, it was hard to accept the older family member's current situation and health deterioration, and their own changed roles (I). According to Bridges (2004), the ending phase, characterized by disenchantment, is the first phase a person in transition goes through. Bridges (2004) emphasizes this phase as central in the persons' letting go" and experiencing loss in some form. Brownie, Horstmanshof & Garbutt (2014) argue that failure to come to terms with the changes, "may trap the person in emotional limbo and create a situation where grieving is misinterpreted" (p.1664). It is paramount that the nursing staff allow the new residents and their next of kin the time to grieve and react in the initial period.

The fluid character of power

Juritzen & Heggen (2009) found in their ethnographic study of power practices between staff and residents in nursing homes, that power is dynamic, instable, and not localized (II). They underscore the importance of not having a too rigid understanding of the power relation between care provider and patients. The complex power dynamics between the staff in this current project seem to echo aspects of this fluid understanding of power. The findings show that power as dominance on as well as influence on others were at play.

The professional hierarchy influenced the staff interactions with each other, the older resident and their next of kin. Members from all staff categories were aware of their positions in the

hierarchical order, and they talked about it as something definite and fixed. Capra (1997) argues that many people have come to see their position in the hierarchy as part of their identity. Study III shows that the professional hierarchical order contributed to preventing staff at different competence levels to exchange information about how to assist the recently arrived resident in the morning care situations. Moreover, it contributed to the auxiliaries' not approaching the next of kin during visits.

The physician's weekly round influenced negatively on the staff collaboration. That the nurses and the physician were the only participants contributed to signaling, among other things, that medical knowledge about the new resident was exclusive and had hegemonic status in the LTCF.

There are no national standards for how many hours a physician should work in nursing homes in Norway (Statistics Norway, 2014), and there are huge differences between the municipalities how many hours a physician spends weekly per resident. In 2014, the average was 0,49 hours per resident per week. This often means that the nurses have to compensate for the relative absence of the physician. The nurses, in the current project, spent considerable time preparing for the physician's round. The primary auxiliary who was in the process of getting familiar with the new resident could play a more central role in the physician's round. This contributes to cognitive diversity and the building of relationships between colleagues at different competence levels. According to Anderson et al. (2003), diverse perspectives in decision making have the potential of leading to better resident outcomes.

There were some paradoxes inherent in the professional hierarchy, which contributed to a variety of approaches towards the new residents. The enthusiasts worked part time to be able to provide extra activities in their spare time for the residents (II). These extra activities can be considered process indicators facilitating a healthy transition (Meleis et al., 2000). However, this unpaid work suggests that the enthusiasts solved the organizational demands and potential shortcomings by making them their private responsibility (Vike et al., 2002). The staff members had freedom to develop their care, yet they had no influence on the workload and resources. Other studies (Schirm et al., 2000; Clarke, 2011) also found that staff focused on good teamwork, their extra, unpaid help, and the respect they got from patients and members of the public in general. According to Clarke (2011), staff in rural areas in the US provide more extra-required services than staff in urban areas.

Yet, the findings also show networking among the staff members. The spontaneous interactions when everybody present participated, illustrates power as influence on each other were at play. Still, few staff members talked about these "pockets of excellence" (II) which may put these in danger of being ignored by staff members, managers, educators, researchers, and politicians in their efforts to improve quality care in nursing homes. Juritzen & Heggen (2009) also found that little of the nurses' work was written down, and "that a lot may not even be verbalized" (II, p. 9).

Shortly after arrival, the staff sometimes ignored the older residents' needs and preferences, and they followed-up structural arrangements instead (II). Costigan (2013) worries that regulatory systems may eliminate the unstructured ordinariness of daily life. Tregunno (2013), however, underscores, from a complexity science perspective to understanding safe transitions in care, that there is a need for the coexistence of structures and flexibility. She argues that standard operating procedures are important to establish general goals, while also the ability to explore, act on experience, and interact and respond are keys to the delivery of safe and effective care. The findings in the current project indicate that during the initial transition period in the LTCF it could be wise to carefully attempt to balance staff flexibility with structural demands prioritizing the older residents' and their next of kin's particular needs.

The head nurse's involvement with the staff also influenced the staff's interactions and ways of working. Yet, not every staff member had the opportunity to interact with the head nurse. It appears crucial that all the staff members, particularly the part time unlicensed staff, are involved with the head nurse. Anderson & McDaniel (2008) observed that when nursing managers "pitched in" and supported each staff member, this created connections among the staff, facilitated teamwork and broke down status barriers. In addition, regular formal meetings with the supply- and part time staff would secure that everybody is informed and involved.

The oral culture dominated and influenced the information flow and relationships in intricate ways. Oral culture is multifaceted and paradoxical. At the same time as oral communication allows for the dominance of eloquent and authoritative persons regardless of formal position (Lindhart, 1989) it also encourages ad hoc and spontaneous interactions in networks. In this project, the connection between the oral and written language was unsettled and a source of frustration for the staff. Further, the findings indicate that sometimes staff did not write down vital information in the computer program. The written document represents memory and is a

judicial document (The Health Personnel Act, 1999). However, the static character of the written language on the non-portable computers seemed inadequate to get hold of, and maintain the dynamics between the new residents' ever-changing situations and staff's flexible ways of handling this. According to Colon-Emeric et al. (2006), information emerges and flows spontaneously when agents interact. Anderson (2013) argues that management focus on using information technology to improve communication and information flow among team members may not adequately address the development of the relationships needed to support coordination and interdependencies in the work. She claims that using information technologies in isolation might make outcomes worse by "interrupting existing interaction patterns among the agent in the organization" (Anderson, 2013, p. 29). Kontos, Miller & Michell (2009) found that the written care plans reduced "inter-professional collaboration and communication" (p. 360) among personal support workers in two Canadian nursing homes. The findings in this current project suggest that presently the oral communication dominates maybe unknowingly, to "protect" the interaction patterns that do exist between the staff, and between the staff and the residents. Still, one drawback of the oral culture is that not everybody is usually included and involved.

Similar to the findings in this project, other studies have also found a distance between the next of kin and staff (Bowers, 1988; Hertzberg et al., 2001; Majerovitz et al., 2009; Utley-Smith et al., 2009). Hertzberg et al. (2001) found that the next of kin felt it depended on them if and what kind of communication took place between staff and them. This resonates to some extent with the findings in this project where both groups expected a person from the other group to initiate contact. The rural community appeared to have a profound effect on both the next of kin's and the staff's expectations, experiences and actions towards each other, as well as the staff's actions and interactions with the new residents (II). Ryan & McKenna (2013) found that familiarity permeated all aspects of the next of kin's experiences during the nursing home placement, and that those next of kin who reported a high degree of familiarity seemed to experience a more positive transition than those who were not so familiar in the rural setting. The findings in this project show variations. At the same time as familiarity influenced positively on the next of kin and the staff interactions, the transparent rural community at times inhibited both the next of kin and the staff to initiate contact with each other.

Both groups need to get to know each other beyond the rumor level. Majerovitz et al. (2009) propose that the staff need to recognize next of kin and the next of kin need to recognize staff. Familiarity with each other's expectations, cultures, and values may contribute to improving communication between these two groups. Studies stress that staff should initiate the contact with the next of kin and encourage their involvement with the older family member after placement (Logue, 2003; Bramble et al., 2009; Wilson & Davies, 2009; Bauer et al., 2014; O' Shea et al., 2014).

Methodological considerations

The next of kin in study I were recruited by the help of the head nurses in the overnight respite care facility and the LTCF. This in itself may be questionable since the head nurses may have chosen those most agreeable to them. It was difficult to recruit the next of kin. Firstly, few residents move into LTCP each year in this rural municipality, and the head nurses suggested every next of kin they knew had recently experienced an older family member's transition into LTCP. Secondly, criterion for participation was that the next of kin presently or recently had experienced that one older family member had moved into LTCP. All the next of kin in this project were involved with their older resident. Not all next of kin are involved with their older family member, but they were not part of this sample.

It may seem strange that the residents themselves were not the focus of attention. Reasons for this are that it may have been difficult to recruit mentally lucid residents within the timeframe of this study. More than 80% of nursing home residents in Norway are categorized mentally impaired (Selbaek, Kirkevold, & Engedal, 2007; Roen, Selbæk, Kirkevold, Bergh, & Engeldal, 2013). In addition, it was unpredictable how many residents would move into LTCF in this project period since the nursing home is in a rural municipality with potentially few admissions every year.

It turned out that most residents in this project were mentally lucid, and they influenced the fieldwork, interviews, and analyses. During the POPs, I developed relationships with some new residents, and they gave me valuable insights into their situation and circumstances. For some I became a companion, which periodically disturbed my attention on the current resident I was following. As I had POPs following ten new resident during their first week in the LTCF, it happened that I met a previous participating resident. We appreciated seeing each other again and it was intriguing for me to have the possibility to get some insights into the residents' transition process over a longer period than just the first week after admission. This however, was not the purpose of the current project. The daily reflections after the fieldwork helped me balance my course and refocus my attention on the aims of the study.

There were many participants in studies II and III, which gave rich data. The interviews with the staff without the POPs would have left out important data, such as the discovery of the spontaneous staff interactions. No staff talked directly about these interactions in the

interviews without me bringing them into the conversation first, after I had noticed them during fieldwork periods.

In study III, I concluded that the staff's interactions sometimes appeared contradictory. A more accurate word to use here is paradoxical. The understanding of contradiction is two opposites that cannot co-exist. The understanding of paradoxical is when apparent opposites do co-exist (Tregunno & Zimmerman, 2008), which is the case in this project.

According to Malterud (2011), quality characteristics of qualitative research are relevance, validity, and reflexivity. The findings and analyses in this project are relevant as they demonstrate the importance of including all staff categories when investigating staff actions and interactions during the older residents' transition into LTCF. The findings also propose to include the next of kin more, and that staff develop closer collaboration with them. This project may stimulate knowledge development within practice settings, research and policy development areas. Due to demographic challenges in many countries, recruiting licensed competent staff is difficult (Roksvaag & Texmon, 2012). The municipalities depend on using unlicensed staff. This poses challenges in the municipal health services where the health care providers have to assist older, frail people with complex needs. Hence, exploring the interactions between licensed and unlicensed staff us timely.

All the participants were aware that they were participating in a research project, and the staff, the next of kin, and the new residents may have adapted their behaviors due to this. Many staff participants in the interviews and the POPs underscored that my presence contributed to increased focus on the older residents' transitions. Moreover, the next of kin appreciated having someone to talk with during this stressful time.

Regarding validity, according to Kvale & Brinkman (2009), qualitative studies should be considered by their "intellectual craftsmanship" which refers to the combination of practical experience and theoretical knowledge to secure good quality work. Throughout the presentation of this project, I have attempted to describe the research process and the analyses as detailed as possible. For instance, I have shown both advantages and disadvantages with me having both theoretical knowledge and practical experience with LTCFs. I have, however, little experience with ethnographic work, and the competent reader may find weaknesses. Moreover, according to Kvale & Brinchman (2009), communicative and pragmatic forms of validity may inform the assessment of the quality of this project. The three included papers are published in peer-reviewed international journals.

In ethnographic studies, the researcher is part of the social world she studies (Hammersley & Atkinson, 2007), and being reflexive throughout the research process is vital.

It is a long time since I worked as a nurse in a LTCF and a lot has changed since then. I have however, stayed in touch with practice for about fifteen years as a teacher in high school supervising auxiliary students in their work experience placement periods in different nursing homes. Moreover, my Master's project in cultural studies (Eika, 2004) investigated the language usage among health care providers in an urban LTCF, by interviewing licensed and unlicensed nursing staff. More recently, during supervision of nurse students, I discovered that many were rather ignorant of other care provider groups such as auxiliaries and assistants. All these inputs influenced and still influence my understandings of LTCFs and nursing homes. One preunderstanding I brought with me from the Master's project was that I expected the unlicensed staff would "disturb" the licensed nursing staff's work in subtle ways. This has to some extent, been confirmed in this thesis, yet quite different from the findings in my Master's project. I have spent a lot of time clarifying my own preunderstandings.

In the beginning of the fieldwork, it was important to develop rapport with the different nursing staff and the new residents. This was, however, an act of balance since the staff themselves was the focus of attention. The mere presence of me as a researcher in this setting signaled an unequal distribution of power, underscored further by the purpose of the project. I sometimes felt that some staff perceived me as a "spy". This, paired with a general feeling among many staff of the negative stigma of nursing home work (Stone & Harahan, 2010), seemed to contribute to efforts among a few to please me, and do what they believed I regarded as good quality care. Others attempted to keep me at arm's length, while some let me in and we gradually trusted each other. The combination of POPs and interviews seemed to help establish rapport with some staff. Many appreciated the interview situation where they talked about and reflected on their work with me as a genuinely interested co-constructor. At times, especially the auxiliaries tested if I was competent in direct care work. It was difficult for me to combine observations and perform assistance at the same time, and I often acted clumsily as my attention was elsewhere. Eventually I realized that I had to be open about this and remind the nursing staff about the purpose of the project and that I needed to focus on what went on around the new resident, and that it was difficult for me to do both. Moreover, when I asked about self-evident matters some auxiliaries and nurses put me off and more or less explicitly told me that I ought to know this. As I am a middle-aged researcher and many believed I had long experience as a nurse, their reactions were understandable. Still, I treated

most episodes as unfamiliar. Although I struggled to get my courage back to continue asking about the obvious, these episodes directed the ongoing fieldwork and interviews as well as the analyses in fruitful ways. For example, it appeared quite common to put colleagues off when they asked about self-evident matters, regardless of age.

During the fieldwork, interviews, and concurrent analysis I discovered that some staff had an established way of thinking and speaking about the hierarchy and "chain of command" (Sennett, 1993). Yet, the fieldwork suggested that other mechanisms were at work, too, such as power as influence on (Capra, 1997).

During the summer holiday, one auxiliary asked me to check the new resident's blood pressure. At first, this confused me, but it triggered my curiosity why the auxiliary needed a nurse to take the blood pressure and not automatically do it herself. This episode gave direction in the exploration of staff interactions. In this nursing home, the auxiliaries experienced that the nurses had taken over tasks that they had previously performed in the home care services. This made some auxiliaries reluctant to perform these tasks when occasionally there were no nurses at work, and they had to compensate for this.

I enjoyed being in the LTCF. The atmosphere was pleasant and gave respite from the lonely work as a researcher. Sometimes, if I was not on the guard and actively pursuing the purposes of the studies (II, III), I became "one of them". According to Hammersley & Atkinson (2007), the researcher should base which role to adopt during data collection on the setting and the purpose of the research. It varied if I wore a nurse's uniform. If the new resident needed two nursing staff to assist in the morning care situations, I wore a nurse's uniform and participated in assisting the resident. If, however, the new resident managed with the assistance of one staff, I sometimes chose to wear my private clothes. This helped me focus on staff actions and interactions and take notes as they occurred. Moreover, it sometimes seemed easier for the staff, the residents, the next of kin, and myself not to confuse me as a nurse when I wore my private clothes. Still, it created a distance to staff, and hindered gaining data, so I mostly wore

Strengths and limitations

The ethnographic approach is useful to generate rich data of a previously unexplored topic of research (Gubrium & Holstein, 2009; Hilden & Middelthon, 2002), involving both contexts, circumstances, and persons. It is particularly useful to explore a culture or group of

individuals to “understand more about the social or human problem this group experiences” (Goodson & Vasser, 2011, p. 1).

This ethnographic study used transition theory in nursing as a perspective only and not as a framework. Hence, it had the potential of adding new knowledge otherwise not discoverable within a framework of transition. Lastly, ethnographies can be a starting point and stimulate further research with larger samples, and other designs to generate data in larger populations.

Other studies have found similar findings to some of the findings in this project. This adds credibility to the project.

Sample size and one nursing home setting imply limited transferability and generalizations of this project. The findings may not be transferable to other populations and settings. Yet, according to O’Reilly (2012) “maybe what we discover can have *inferences* for another group, or maybe we can transfer what we have learnt to another group” (p. 225). This project makes suggestions for developing the transition theory further by connecting with complexity science, which may have relevance beyond the specific setting of this project. Although Kralik et al. (2006) highlight the nonlinearity in the transition experience, this, as far as I understand, has not been the focus of transition studies in nursing so far. Some concepts in complexity science, for instance nonlinearity, relationships, interdependencies, sensemaking and cognitive diversity help see nuances in the transition processes that previously may have gone unnoticed. Transitions occur in contexts, and complexity science assists in the understanding of the dialectics between individuals, contexts and circumstances. In addition, complexity science draws the attention of the significance of every agent in the organization, and not only those who experience transition.

Subjectivity was a limitation. The project was subject to the processes, and interpretations developed by the researcher and the research team (Goodson & Vasser, 2011). As I have already elaborated above, it was paramount with continuous reflections.

Most nursing staff participants were females of European origin apart from two males of European origin, and two females with Asian and Middle East origin. During the POPs at weekends, more supply staff were of Asian origin. I have not focused on these aspects in the studies. Currently there are dramatic demographic and cultural changes in Norway as well as in other European countries with many migrants from the Middle East and Asia moving into rural as well as urban municipalities. This may influence the demographic and cultural

characteristics of nursing staff, next of kin, and residents in nursing homes in near future. Further studies need to explore this.

Ethical issues

The staff in the LTCF were vulnerable as they were the focus of attention and at the mercy of my interpretations. Malterud (2011) stresses the importance of the researcher doing her best to perform "a responsible research ethics regarding those who trust us with their knowledge and their everyday work" (p. 207). During the fieldwork periods, I consulted my supervisor about difficult matters. I have tried to balance the favorable as well as the less favorable practices in the three papers, and attempted to maintain anonymity and show respect through the language usage. Yet, in order to improve health services it is important to bring to the forefront adverse practices also (Malterud, 2011).

The design of the project was also demanding since I had to act quickly to get the new residents' consent to follow them on admission day and the first week. Older residents eligible for LTCP are vulnerable and frail. I considered arrival day stressful for the resident and their next of kin, and collaborated closely with the staff nurse to choose the most appropriate moment of approaching them in this matter. In addition, to inform the residents orally about the project, I made sure to hand out the written information and go through it with them at an appropriate time either on arrival day or later, or both.

One resident consented initially, but became apprehensive about the participation after a few days. The staff nurse noticed this and informed me about it. The staff nurse joined me when I repeated the information about the project and underscored that the resident could withdraw without stating a reason. The resident chose to continue to participate.

Regarding the fieldwork periods, I informed the staff present at a staff meeting about the project. Yet, I was unable to inform every staff participant and get their approval to follow them in their care and assistance of the new resident. This was especially difficult at weekends and the summer holiday with many new and unfamiliar part-time unlicensed staff. Moreover, I experienced that often it was little time to inform the staff, and that it might unduly disrupt both the staff's work and my work.

Some staff participants seemed to have difficulty understanding that they were the focus of attention and not the new resident. It was easier for those who participated in a formal interview to understand the purpose of the project.

It was challenging to alternate between closeness and distance. During the summer holiday, the staff ignored the new resident's complex needs. I attempted to compensate by spending time with the resident, yet, the resident and I knew my role, and my limitations. At first, I thought of sharing my concerns about the resident's needs at the oral shift reports. However, this would disturb the main purpose of my investigation so I chose to inform the staff members at the last day of my POP regarding this resident. In hindsight, I realized that spending so much time with this resident might have made some staff believe I had the responsibility for this resident. Yet, some permanent staff familiar with the purpose of my project worked at that time, too, and their negligence of the new resident puzzled me. Later, I head hunted central staff for an interview.

Conclusions and implications

From the findings of this project, the older residents' transition into LTCP and LTCF posed challenges for the next of kin and staff. The findings demonstrate the importance of not viewing the transition into LTCP and LTCF in isolation from the previous health care setting. The implications of the challenges affect the next of kin, the staff, health care institutions, educational institutions, and authorities at municipal and national levels.

Ensuring information flow, support, and role clarifications among the staff, and between the staff and the next of kin, between health care organizations as well as within the LTCF, are essential in directing the older resident and their next of kin towards a smooth transition. Within the LTCF, due to nonlinearity in the organization and in the next of kin experiences, there is a need to repeat information, support and role clarifications. Formal meeting points as well as informal communication would contribute to ensuring this.

The findings demonstrate that every agent (staff, resident, next of kin, and physician) in the LTCF matters and may influence the older residents' transition processes in unpredictable ways. It is vital that the staff and the management acknowledge this. Some mechanisms played out among the staff, whether the staff had formal training in health care or not, influenced their assistance of the new residents initially. Both the licensed and unlicensed staff were susceptible of performing poor assistance of the new residents. Powerful influential forces on the staff's actions and interactions were the management of the facility, the professional staff hierarchy, individual staff's formal position, traits and enthusiasm, resident- and staff mix, the physician's round, the dominant oral culture, local transparency, and the taken for granted. Aspects of power pervaded the situations in the facility. Situations where power as influence on were played out among the staff, illustrated by the spontaneous and continuous staff interactions, were "pockets of excellence" that maintained the older residents' needs in their initial transition period. Conversely, power as dominance played out among the staff influenced, mostly negatively, the older residents' and their next of kin's transitions.

Awareness of these forces and mechanisms and their potential consequences may give new directions to the organization of the staff work, including the physician. For instance, based on the findings, it would be wise to include and involve the primary auxiliaries in the physician's round. This would provide cognitive diversity and potential new perspectives to

base their decisions on regarding the new residents. Moreover, the management should avoid using many supply staff at one shift and at weekends only. These arrangements contributed to directing the new residents towards risks as they disturbed the permanent staff's spontaneous and flexible ways of assisting the residents and inhibited the development of relationships between the staff and the new residents, and between the unlicensed and licensed staff.

In addition, there is a need for further development of collaborations across health care settings. National as well as municipal authorities have already addressed this. This project shows the ripple effects lack of collaboration across health care settings may have on the older residents' and their next of kin's transition processes. The findings indicate that collaborative care should be developed in the curricula of nursing and other health allied professions, including the health care workers in high schools and physicians in medical studies. Relating to transitional care, students from different health disciplines together could follow the residents from one health care institution, for example the hospital, to the nursing home to get some insights into the challenges that the older residents, their next of kin, and the health care providers face across health care organizations.

The findings also show that the nurses compensated for the relative absence of the physician. I recommend, in line with others, that national health authorities develop national staffing norms for physicians in nursing homes. Due to the complexity of the older residents' illnesses and circumstances, the national staffing norms have to secure that the physicians spend more time in the nursing homes than what most currently do. This could lessen some of the nurses' responsibilities concerning medical matters initially, and give them more time to develop a relationship with the older residents, and assess the new residents' medical and everyday needs and preferences in close collaboration with the residents and staff colleagues. In addition, due to the challenges of recruiting licensed staff in nursing homes, the nurses and auxiliaries may have to spend more time developing relationship with and supervising unlicensed staff colleagues.

Within the LTCF, I suggest that the management and the staff should appreciate already existing "pockets of excellence" to maintain and develop structures that enhance collaboration among all the staff. Management and staff need to focus on and develop relationships among the staff, and among the staff and the next of kin, to secure a healthy transition for the older residents and their next of kin.

The transition experiences of the next of kin intertwined with their interpretations of their older family members' transitions. There was a distance between the next of kin and the staff within the LTCF. From the perspectives of the next of kin, negative experiences at the previous health care setting, local transparency, and limited interactions with the staff in the initial period in the LTCF contributed to the distance to staff. In the staff perspectives, the professional hierarchy, the local transparency, the taken for granted, and the notion that the residents' room was their home immediately after arrival contributed to their distance to the next of kin. Based on the findings from this project paired with findings from other studies, it is essential that staff notice and approach the next of kin during visits the first week and develop a relationship with them.

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Paper I

JCN Journal of Clinical Nursing

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ORIGINAL ARTICLE

Experiences faced by next of kin during their older family members' transition into long-term care in a Norwegian nursing home

Marianne Eika, Geir Arild Espnes, Olle Söderhamn and Sigrun Hvalvik

Aims and objectives. To describe and explore experiences of next of kin during the older persons' transition into long-term care.

Background. Moving into long-term care is a challenge for both resident and next of kin. Next of kin experience transitions at the same time as they play significant parts in their family members' transition into long-term care placement.

Design. Constructivist hermeneutical design.

Methods. Ten next of kin to newly admitted eight residents were recruited by purposeful sampling and interviewed. Periodic participant observation periods following new residents on arrival day and the first week after admission and some written documentation were the backdrops to the interviews.

Results. What happened prior to the long-term care placement as well as what happened in the initial period of transition influenced the experiences of next of kin. Characteristics of their experiences were: 'striving to handle the new situation', 'still feeling responsible', and 'maintaining dignity and continuity'.

Conclusions. Next of kin were unprepared for the transition and had little support from staff. Staff lacked awareness about next of kin's transition experiences. Their involvement with next of kin was unpredictable, and this added to the burdens of next of kin in this period.

Relevance to clinical practice. Knowledge about experiences of next of kin needs to be acknowledged among healthcare professionals. Health professionals need to pay attention to what happens across institutional borders within families as well as between staff and family members. Individual family members need support in this period of change.

What does this paper contribute to the wider global clinical community?

- Next of kin are susceptible to what has happened before a placement in long-time care.
- Next of kin may be unprepared for the transition into long-time care.

Key words: care home, family caregivers, family members, long-term care, relative, transition

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Introduction

Moving into a long-term care facility (LTCF) in a nursing home is often considered a fundamental and a most stressful and challenging change for those concerned (Ryan & Scullion 2000, Sandberg *et al.* 2002, Davies & Nolan 2003). Prior to moving into long time care (LTC), older people have often been exposed to multiple and simultaneous transitions, and these transitions may have contributed to stressful periods for both resident and next of kin. Older home-dwelling people with complex medical and care needs (Husebø & Husebø 2005) may have, in addition to support from next of kin, received help from community nurses in their homes or community care houses. Furthermore, some of them may have experienced multiple crisis situations and been hospitalised and had intermittent overnight respite care (ORC) stays in a nursing home (Coleman 2003, Aksøy 2012). Transition into LTC is therefore most commonly a part of chains of events regarding the older person and next of kin.

Background

Moving to a LTCF may be studied in the perspective of life transitions. Transition (Chick & Meleis 1986) is understood as a passage from one life phase, condition or status to another. Transition refers to both process and outcome of complex person–environment interactions. It may involve more than one person and is embedded in the context and the situation. Properties of transition (Meleis *et al.* 2000) experiences include awareness, engagement, change and difference, time span and critical points and events. Transitions are often initiated by changes or marker event that triggers a period of disequilibrium and upheaval. In this period, needs are not met in familiar ways, and this may lead to changes in self-perception and self-esteem. Transitions are not linear processes, but are intricate processes with forward and backward movements (Kralik *et al.* 2006). The time spans of transitions vary greatly from a short period of time to many months/years. During the ongoing transitions, close family may experience a sense of loss and alienation.

Our study is concerned with the initial period of transition into LTC placement. Transition experience may be conceptualised as a dynamic process (Nolan *et al.* 1996, Lundh *et al.* 2000). Nolan *et al.* (1996) argued that 'the processes preceding admission to care and the perceptions that these processes engender will influence and partly determine the quality of that admission and subsequent adjustment' (p. 271). Studies (Reed & Morgan 1999, Ryan & Scullion 2000, Sandberg *et al.* 2002)) show that the decision about placing an older person in LTC placement was a challenge for next of kin, and some complained that they had inadequate support from staff in this decision. Also, studies (Nolan *et al.* 1996, Kellet 1999, Davies & Nolan 2004) suggest that family caregivers, who assisted an older person to move into a nursing home, were still involved and commonly struggled to adjust to changes in their relationship with the older person and establish new roles.

Internationally, a substantial body of literature has been produced focusing on different aspects of next of kin's transition experiences during an older family members' transition into LTC placement (Gaugler 2005, Reuss *et al.* 2005, Wilkes *et al.* 2008). Most studies have demonstrated that next of kin are involved in their older family members' transition, and the literature has identified a wide variety of roles played by families (Rowles & High 2003, Haesler *et al.* 2010). Studies are often conducted from different perspectives, and findings are therefore diverse. Our study's primary focus is on next of kin's transition experiences per se and not on their interpretations of their older family member's transition experiences.

No studies have so far been undertaken in a Norwegian context concerning next of kin's experiences of an older person's transition into LTC placement. Understanding next of kin's experiences during the initial transition processes is essential for LTCF, community nursing facilities and hospitals to know about in order to provide adequate support and contribute to a smooth transition period for families and residents.

Aim

The aim of this study was to describe and explore next of kin's experiences during the older person's transition into long-term care.

Methods

The ontological position taken was constructivist hermeneutical. This constructivist approach is an analytic middle ground between reality and representation (Gubrium & Holstein 1997). In the tradition of Gadamer (2004), horizon is a central concept, which is created by traditions and our life history. Prejudices are part of our horizons and are prerequisite for interpretations (Debesay *et al.* 2008). In this study, the authors have a background as registered nurses and researchers with particular interest in the care of older people.

Sample

This study was conducted in a municipality in rural southern Norway. Criterion for participation was that next of kin recently (i.e. within four weeks after admission) had experienced that an older person had moved into LTC placement in a nursing home. The sample was purposeful. Staff nurses at the two facilities in the nursing home gave names of possible participants for interviews.

Between June 2011–September 2012, ten next of kin were interviewed in connection with the transition of eight residents. Eight next of kin were interviewed individually, and two children were interviewed together. Included in this sample were three sons, four daughters, two spouses and one niece. Next of kin covered age categories from 30s–80s. Five were retired and five were employed. Both spouses were retired. One spouse had been involved in caregiving on a daily basis, while the others were not caregivers, but helped out on a regular basis.

The older residents covered age categories from 70s–90s. Five of the eight residents stayed in the overnight respite care unit (ORCU) before they were given a LTC placement. In the ORCU, three private rooms had been converted into shared rooms, and four of the residents stayed in a shared room before they moved into a private room in the LTCF (Table 1).

Data collection

The main source of data in this study was interviews. Periodic participant observations (PPOs) and reading of relevant documents functioned as backdrops. The PPOs followed the resident and his/her next of kin on admission day and the first week after admission. Daily field notes were written in these periods. Documents were daily written reports, and the resident's preliminary care plans on the computer and written plans in each resident's bathroom.

The interviews were semi-structured with an interview guide with questions about the preparation period, the admission day and the initial period after placement.

Next of kin decided where the interviews were to take place; three interviews were in participants' homes, one was in participant's workplace and five interviews were conducted in a small room in the nursing home facility prior to participants visiting the older family member. Each interview lasted for approximately one hour. As a consequence of the ontological position, the interviews were con-

Table 1 Some characteristics of the older persons in transition and their next of kin

Respondents' relationship to resident	Other relatives in this family	Main reasons for LTC placement	In a shared room in overnight respite care unit with a LTC placement	Number of transfers between rooms after nursing home admission
Son	Two sons	Rehabilitation and confusion	X	3
Two daughters	Two brothers Husband	Confusion and exhausted spouse	X	2
Wife	One daughter and three sons	Serious heart condition, need for constant medical supervision	X for many months	2
Son Wife		Serious renal disease and periodic confusion Exhausted spouse		1
Niece	One brother and two sisters	Old age and leukaemia, exhausted siblings	X	3
Daughter	One daughter	Old age and confusion, inability to cope on his own	X for many months	2
Daughter	One son	Cancer and inability to manage at home, long distance for nurses to travel		1
Son	Husband One son	Dementia and inability to manage on her own.		5

sidered jointly social constructions by participants and interviewer and focusing on both content and form.

The interviews were transcribed from oral to written form as soon as possible after the interview had taken place. In line with Gubrium and Holstein (2009), the transcriptions were accurate and noticed overlaps, pauses, laughter, sighs, in addition to verbal content. In addition, attention was on collaboration, linkages and performances. Notes about participants' nonverbal language were written down from memory and notes about content and associations to previous interviews and fieldwork periods. It was attempted to balance the interview guide and observation from fieldwork with what appeared on the spot in the interview situation, on which relevant follow-up questions were asked.

Data analysis

Each interview was read in connection with all the other interviews. At this stage, some episodic narratives in the interviews were seen in connection with field notes. When written documentation was consulted, focus was on what they wrote and how they wrote it (Gubrium & Holstein 1997, Järvinen & Mik-Meyer 2005).

In the first phase of the analysis, experience-near concepts (Geertz 1973) understood in the context of the participants were searched for in the transcribed and processed data material. Concepts and word phrases were, for example, 'change of room', 'loneliness' and 'safety 24 hours a day'.

In the next phase, repeating patterns and linkages between the interviews both relating to content and form were identified. The participants constructed multiple episodic narratives, and a striking feature across all interviews was the use of comparisons. Present situations were often compared and contrasted with previous situations and circumstances. This contributed to multiple perspectives and meanings. Theory was mainly consulted after data collection and at the last stage of analysis.

Ethical considerations

Ethical approval was obtained from Regional Committees for Medical and Health Research Ethics in Norway (2011/153b). Formal access to the field was made through the healthcare authorities in the municipality. The participants were assured confidentiality. Their participation was voluntary, and they were informed that they had the right to withdraw at any time without stating a reason. Before data collection, written informed consent was obtained. Residents were asked whether they accepted that their next of kin would be interviewed about their transition into LTC. If they consented, next of kin were contacted through phone and informed about the project.

Findings

Next of kin's experiences were intertwined with their interpretation of their older family members' experiences. Both what happened prior to the admission into the nursing home and what happened in the initial period in the nursing home affected their transition experiences and influenced the relationships among family members and staff. The following categories were obtained: striving to handle the new situation, still feeling responsible, and maintaining dignity and continuity.

Striving to handle the new situation

Next of kin's attempts to cope with the new situations were often seen in the light of previous experiences and characterised by uncertainty and expectations. Families had little formal information about the nursing home before admission, and many were frustrated with their older family member having to move about within the nursing home. All needed to feel welcome in the nursing home environment.

Uncertainty and expectations. While the older family member was at home or in community housing with the support of family members and community nurses, many family members expressed profound feelings of insecurity in periods when older family member's health declined. They feared that they would handle a possible crisis situation incorrectly, and they were constantly on the alert. Many felt left on their own with little support from community nurses at these times and were uncertain who was responsible – the nurses or themselves. When the older person finally moved to the nursing home, often after a hospital stay, next of kin's feelings were mixed; at the same time as they were relieved and felt safe, some were apprehensive about the quality of care.

When a son visited one night during the evening meal, his father sat alone in his room with a bucket between his legs vomiting. The son was worried and it took a while before a registered nurse arrived to take a blood sample. The son stayed with his father for a long time and did not leave him before his condition stabilised. No staff looked into their room during this visit.

Next of kin who perceived they had little support from community nurse staff or hospital staff were unsure about what to expect from staff at the nursing home. Rumours

added to this. The nursing home is situated in a rural municipality where everybody knows of everybody. Nearly all next of kin knew of somebody who had previously lived in the LTC unit, and there were some anxiety associated with it:

…because I had heard that when you move to the LTC-unit you were placed in a chair and nothing happened.

Some children were shy and kept some of staff at a distance because they believed staff knew about them and their circumstances in the community. They talked with staff they trusted, regardless of formal education. As one child put it:

I talk with x I know, and who knows me also.

The moved-around resident. Many next of kin had experienced multiple healthcare settings prior to the LTC placement. Furthermore, five of the eight residents were admitted into the ORCU prior to the LTCF, and they continued being relocated within the nursing home:

Yes, I would think this was related to, to the system here and it is also easier for them to keep her here…. As long as she gets the care she needs so damn be it……. The fact that she has moved so many times, that is the worst……because she has had to cope with new staff and that is crap.

Four residents stayed in a private room used as a shared room in the ORCU for a while. Some families were not prepared for this and were taken by surprise on arrival day, and they did not know how long this would last. One LTC resident stayed for about six months in such a room, and next of kin believed it was strenuous for him sharing a small room with somebody. Also they had little privacy during visits. He became great friends with his first roommate, but it was exhausting periodically to adapt to new roommates. In particular, when a co-resident was confused, he was tired. He resisted that next of kin should push for a private room, but somebody told them that 'he is going to stay put if you don't do anything'. The children argued for their father's well-being, and he was given a private room in the LTCF within a week. When he finally moved into this room, he was happy to bring his computer, some personal belongings and have some peace and quiet when it suited him.

However, next of kin knew of the waiting lists for a nursing home placement, and they were grateful that their older family members were chosen. They regarded the older people's care in this municipality as good contrary to largely negative public perceptions of poor care of older people and family members' experiences elsewhere.

The significance of being included. Most next of kin expressed a wish for a cup of coffee while visiting, but experienced that staff handled it by chance; some were offered a cup of coffee, others had to ask for, still others had no coffee and some brought their own coffee and home-made food because they wanted to keep up previous routines from home.

One daughter was impressed by how she was taken care of by staff when she visited her mother on the night of her mother's admission. Later, however, she experienced that she was frequently ignored by staff when she visited. They did not notice her when she arrived, and they did not look into her mother's room while she was there. Neither she nor her mother was offered coffee during the afternoon coffee.

Most next of kin had little communication with staff, and sometimes, in particular at night, some felt they disturbed staff routines. Two children experienced that a nurse opened the door without knocking one night while visiting their mother. This nurse did not introduce herself, and the children assumed that staff wanted to put their mother to bed at that time. They felt like intruders, and this episode added to their shyness with staff. However, a niece handled it differently. She was irritated that staff had not informed her that her aunt had fallen out of bed one night. This had happened because her aunt did not want to bother staff. The niece promptly contacted staff and it opened up communication between them from then on.

Still feeling responsible

Next of kin kept on feeling responsible for the older person after they had moved into LTC placement. This seemed sometimes to challenge relationships within families. Staff outside of the nursing home also added to this by leaving next of kin on their own to inform the older person about the decision for LTC placement.

Relationships at stake. Complex patterns of family relationships were played out and destabilised in the initial period of transition. The children took a lot of responsibility for improving matters regardless of whether they had one or two parents alive. They tried to mediate between their parents in matters at stake between them, and they attempted to balance their attention between both. They presented themselves to be equally responsible for the home-dwelling parent as the parent in LTC placement. However, they appeared to favour one of them and to adhere to previous family patterns. Some substituted for their parents' damaged relationship and by that unknowingly contributed to a possible prevailing distance between parents.

Support at the right time. One marker event that influenced the transition experience was the decision of LTC placement on behalf of older family member. Staff and spouse or children applied for LTC placement without prospective residents' and sometimes other family members' participation. When LTC placement was due, the spouse or children informed the prospective resident about the decision.

A husband was mad at his wife when she at the hospital was the one who told him about the decision for his LTC placement. He did not participate in the application because of his, at that time, critical condition. But his condition improved. In family affairs, he usually was in charge and had control. After the admission into LTCF, he kept on blaming his wife, and she felt their relationship as a couple was damaged. It took about four months before the LTCF summoned a next of kin meeting with her. The doctor informed her about her husband's serious condition, but she experienced little support herself.

Another spouse was sad and grieved when she heard that her husband had to move into LTC. She accepted the circumstances when staff at the ORCU shortly after her husband's arrival summoned a meeting and informed her about her husband's serious condition:

> It was worse for me than for him, because he knew he needed to be there.

After this meeting, she visited once or twice a day and experienced that she contributed to her husband's improved condition.

Maintaining continuity and dignity

Next of kin were vulnerable at this stage of the transition process. At the same time, as they wanted status quo, they had to face the older person's critical conditions. This triggered reflections and memories from their previous life together. Regular visits contributed to keeping up family connections and continuity. It also gave them the possibility of keeping an eye on things and support residents in circumstances that threatened their dignity.

Precious moments. Next of kin hoped to preserve the most precious in their relationship with their older family member. One son who had been very close to his mother, and had 'shared everything with her', recalled a good conversation with his confused mother in the nursing home. Afterwards, when he left, he was so happy for their invaluable time together:

> ….I drove straight from here and to our cabin and I almost flew towards the cabin. It was great, top experience really – eh and then I don't know what to expect today.

A wife was flexible and kept up a valuable activity with her husband. They appreciated being outdoors, and when the husband moved into LTCF, his wife took him out in a wheelchair for regular walks. He was reluctant at first, but with the help of staff, he agreed to go out with her. She believed this helped stabilise his condition.

Business as usual? Next of kin continued doing some of the same activities as they did when the older person still lived at home. One daughter continued doing her mother's hair in spite of her mother's regular visits to the nursing home hairdresser. Others brought the daily newspaper and took their older ones home for visits. Also, they brought electricity bills and bank notes to those residents who were able to carry on controlling parts of their economy. This helped keep the connection between the resident and their former household, and it gave a meaningful interaction between next of kin and resident.

Before admission, many next of kin and prospective residents chose not to pack too many clothes or belongings to bring to the nursing home, because then the move was not regarded so absolute. This was also so because five of the residents stayed in the ORCU first, and neither they nor their next of kin knew if and when they were going to get a LTC placement.

In these cases, it was unwise to bring too many belongings. However, after sometime in LTC placement, the belongings represented the continuity and then next of kin were frustrated if their older family member continued staying in a shared room in the ORCU with little space for that. Some residents did not want next of kin to bring some private belongings to their room.

Next of kin were directly involved in keeping up previous standards of their older family member. One son recalled his older father's shame when he once at the hospital was confronted with his dirty underwear. This was the worst that could ever happen to his father. At the nursing home, he was very preoccupied with being clean and well dressed, and it was hard for him to accept that his son one evening confronted him with his dirty trousers. His eyesight was so poor that he did not see that himself.

However, sometimes next of kin knew that business was not as usual. Many residents in this sample were cognitive able and good at expressing themselves verbally and therefore regarded as resource persons by staff. Next of kin

experienced that staff sometimes seemed to believe that these residents were able to maintain their self-care better than they actually did. One son worried about some of staff's attitude that his father was constantly able to maintain his self-care. Due to his illnesses, at times, he needed more help than some of staff was aware of. When he occasionally asked for help, some of the staff refused to help him and argued that he was able to do it himself.

Discussion

Two closely related critical points stood out in next of kin's transition experiences. These were when the decision for LTC placement on behalf of the older person was made and the situation when next of kin told the older person about this decision. Critical points are often associated with increasing awareness of change or difference and heightened vulnerability and uncertainty. Each critical point requires the nurse's attention, knowledge and experience in different ways (Meleis *et al.* 2010). Next of kin were supported by staff in the decision-making process for a LTC placement, but felt abandoned by them once the decision was made. Next of kin, particularly the spouses, were not supported and prepared for the emotional turmoil in these transition periods. This is consistent with Lundh *et al.* (2000) and Sandberg *et al.* (2002) who found that staff did not support spouses who needed to be 'prepared for the separation'. One may wonder why staff withdrew at this critical period of change. This is contrary to ethical and professional standards in nursing. This lack of involvement from staff seemed to contribute to distrust and disrupted relationships within some families, and after nursing home placement, to a distance to some of the staff.

Furthermore, staff at the nursing home knew little about the initial internal difficulties within families, and family members tried to handle it as best they could. However, staff at the nursing home was attentive to one spouse at the right time, while another spouse experienced little support. This suggests that staff needs knowledge to identify possible critical points in next of kin's transition processes. In addition, structures within each facility need to be developed to attend to all next of kin and not only some. The supported spouse accepted the new situation, and the outcome of her transition experience seemed to be healthy, although Meleis *et al.* (2010) underscore that in evaluating transition experiences, it is important to consider the flux and variability over time.

It was vital for next of kin, in particular the spouses but also some of the children, to maintain continuity in their own lives and with the older family member. This finding is consistent with literature (Kellett 1998, Sandberg *et al.* 2001) and was a coping strategy which helped them maintain some sense of purpose and self-worth. According to Schumacker *et al.* (1999), healthy transitions are characterised by whatever continuity it is possible to maintain. This fosters a person's ability to integrate the transition experience in his/her life. However, some changes are inevitable in transition, and our findings hint that in some cases, next of kin wanted continuity, while their older family member seemed to modify their expectations more readily. Modifying expectations is part of a healthy transition process (Schumacker *et al.* 1999).

Distance between next of kin and staff was a recurring feature in the analysed material. This distance may be regarded as a process indicator that moves next of kin towards vulnerability, with the risk of an unhealthy transition process (Meleis *et al.* 2000). Our findings suggest that the potential difficulties that arose at the identified critical periods, in addition to little formal information about the nursing home facility in advance paired with rumours in the local community, may have spiralled to this. After the nursing home admission, next of kin as well as staff were sensitive to each other's behaviour. Hertzberg *et al.* (2001) also found that staff kept a distance to relatives in their study of relatives' interactions and relationships with staff in three Swedish nursing homes.

To let two residents stay in a shared room is a structural arrangement that is going to continue even though there are political ambitions for private rooms only (Ministry of Health & Care Services 2005-2006). This arrangement also seemed to create a distance between next of kin and staff. Next of kin were defensive and powerless in this system, and it discouraged them to invest something in staff that did not last for long. It is interesting to note that the niece stood out in our sample and involved herself on behalf of her aunt regardless of where her aunt was placed. Spouses and children were emotionally involved and had perhaps too much to handle regarding their own transition experiences in this period.

Still, the arrangement with ORCUs also seemed to alleviate the families' first encounter with the nursing home institution. While there, next of kin and older resident did not regard it as so permanent, and it contributed to a gradual transition into LTC placement. This finding is consistent with some literature (Zarit *et al.* 1999).

Next of kin hardly expressed any expectations on their own behalf. However, during visits they expected a cup of coffee. This may at first sight seem little and insignificant, but a study by Austin *et al.* (2009) found that it was the little things that counted for families with family members in continuing care facilities. This metaphorical expression

might in the context of the nursing home be associated with warm situations in the home where visitors are welcomed and included. It symbolises that next of kin were appreciated and seen by staffand accepted as still part of the older person's family life and the unit's. Furthermore, when next of kin brought their own coffee and sometimes something to eat, they wanted to make sure that this everyday ritual was maintained within the family (Gullestad 1989, Album 1996). Sandberg *et al.* (2001) also found that spouses tried to keep their relationship with resident special by ensuring that cherished routines were maintained, and thereby reaffirm their special relationship.

Conclusion

Older persons and their next of kin may experience multiple relocations at the end of the older persons' life. In this study, most next of kin experienced little and confusing support from staff at these times. This inconsistent and arbitrary staff support seemed to add an extra burden to their transition experiences. Nurses and staff in general need knowledge about transition theory as well as transitional care to facilitate healthy transition processes. It also suggests the acknowledgement of the power of local cultures and small rural societies.

Even though enhancing coordination between primary and secondary health care has been central in Norwegian healthcare policy in the last decade, this study shows that there are potential for improvements on both individual staff level and organisational levels.

Relevance to clinical practice

This study raises important issues for staff to consider. Nurses must be aware of situations outside of and prior to the nursing home admission which may influence next of kin's transition experiences. Structures need to be developed to assist nurses and other staff to communicate within settings as well as across settings. Within the nursing home, there are local relocations and these need to be treated as new places for next of kin to adjust to.

Also, next of kin need to feel welcome and supported by staff, and findings suggest that little things may make a big difference. The shyness signalled by some next of kin should stimulate staff to make an effort to get in touch with them.

Trustworthiness and limitations

Trustworthiness was established using multiple methods in data collection. Although data from participant observation periods and documents functioned mostly as backdrop in this interview study, they nevertheless influenced the interaction between participants in the interviews and gave direction and rich descriptions.

Findings in this sample are not altogether transferable to other similar settings. However, some findings were consistent with previous research in other countries which add validity to the study.

Only first author had field work periods in the different units in the nursing home, and this may be considered a limitation in this project. Next of kin were informed about first author's periodic participation periods in the nursing home, and this may have created some mistrust about first author's different roles and the research project's agenda. Next of kin withdrew when asked about matters relating to staff. They were afraid of criticising staff because of possible negative sanctions towards their older family member.

Disclosure

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1author.html), as follows: (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content and (3) final approval of the version to be published.

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Conflict of interest

The authors declare that they have no conflict of interest.

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Paper II

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EMPIRICAL STUDY

Nursing staff's actions during older residents' transition into long-term care facility in a nursing home in rural Norway

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Abstract
Working in long-term care units poses particular staff challenges as these facilities are expected to provide services for seriously ill residents and give help in a homelike atmosphere. Licensed and unlicensed personnel work together in these surroundings, and their contributions may ease or inhibit a smooth transition for recently admitted residents. The aim of the study was to describe and explore different nursing staff's actions during the initial transition period for older people into a long-term care facility. Participant observation periods were undertaken following staff during 10 new residents' admissions and their first week in the facility. In addition 16 interviews of different staff categories and reading of written documents were carried out. The findings show great variations of the staff's actions during the older residents' initial transition period. Characteristics of their actions were (1) in the preparation period: "actions of sharing, sorting out, and ignoring information"; (2) on admission day: "actions of involvement and ignorance"; and (3) in the initial period: "targeted and random actions," "actions influenced by embedded knowledge," and "actions influenced by local transparency."

Key words: *Residential long-term care, nursing staff, admission, rural community, context*

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The transition into a long-term care facility (LTCF) can be traumatic for residents and their family members, and demanding for staff (Davies, 2005). Many older residents may have experienced multiple and simultaneous transitions (Young, 1990, Aksøy, 2012, Eika, Espnes, Söderhamn, & Hvalvik, 2014) before they finally move into an LTCF. Staff in LTCFs provide services for residents with complex chronic and acute medical problems and give daily care in a homelike atmosphere (Hauge, 2004, Ryvicker, 2011). Most Norwegian nursing homes are run by the municipality, and are close to the home communities of the residents (Jacobsen & Mekki, 2011). There are no formal staffing standards (Harrington et al., 2012), and Jacobsen and Mekki (2011) claim the staff coverage in Norway is more than double that of most European countries and that staff are relatively formally qualified.

Transition theory in nursing has been defined differently during the development of the theory, and has varied with the context in which the term has been used (Kralik, Visentin, & van Loon, 2006). According to Chick and Meleis (1986), transition is understood as a passage from one life phase, condition, or status to another. It refers to both process and outcome of complex person–environment interactions, and may bring about fundamental changes in the person's view of self and the world (Meleis & Trangenstein, 1994). Transitions are initiated by a change or marker event that brings about disequilibrium and upheaval that requires new patterns of response. Transitions are processes that may take

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time (Schumacher, Jones, & Meleis, 1999), and it is important that older people who may experience multiple transitions in late life, are given the time to "experiment with different strategies and patterns of responses and to incorporate them into one's own repertoire" (p. 130). Strategies may involve the development of new roles, new relationships, and new skills. Transition theory in nursing highlights the importance of professional support in these periods of change. Facilitating healthy transition processes and outcomes focus on nursing therapeutics and process indicators which allow early assessment and interventions (Meleis, Sawyer, Im, Hilfinger Messias, & Schumacher 2000).

Our study is concerned with staff's actions in the initial transition period into LTCF which is a critical time in the older residents' transition experience (Young, 1990, Reed, & Morgan, 1999). Research examining staffs' perspectives during older residents' transition into LTCF is scarce (Wiersma, 2010, Ryan & McKenna, 2013), and we have been unable to find research describing different staff's actions targeted at this group. However, various aspects of staff involvement are presented through the lenses of family members (Hertzberg, Ekman, & Axelson, 2001, Davies, 2005, Flynn Reuss, Dupuis, & Whitefield, 2005) and through the residents' perspectives (Kahn, 1999, Heliker, & Scholler-Jaquish 2006, Coughlan & Ward, 2007). Yet it is also important to focus directly on staff's actions to identify potential factors that may ease or inhibit a smooth transition for recently admitted residents.

Aim

The aim of the study was to describe and explore nursing staff's actions during older people's transition into LTCF in a Norwegian rural context.

Methodology

The epistemological position was constructivist hermeneutical. The constructivist position is an analytic middle ground between reality and representation (Gubrium & Holstein, 1997). Horizon is a central concept in the tradition of Gadamer (2007), and a metaphor for how we perceive and interpret reality. Prejudices as part of our horizons are prerequisite for interpretations (Debesay, Nåden, & Slettebø, 2008), and identification of the researchers' pre-understandings is part of exceeding one's horizon (Gadamer, 2007). An important part of the researchers' pre-understandings is connected to their background as registered nurses and researchers with particular interest in the care of older people.

Setting and participants

The municipal nursing home is situated in rural southern Norway. The LTCF is split into three units (LTCU) each with 10 private rooms. The facility is organized according to a modified primary nursing model (Lakso & Routasalo, 2001) where each nurse is primary contact for five residents, and the auxiliaries are secondary contacts for three residents each. Staffing ratios varied with the shifts. During daytime weekdays the staffing levels in each unit were three staff to 10 residents. At the evening shifts there were usually two staff, auxiliaries, or assistants in each unit and one nurse in charge of the 30 residents in the facility. The assistants do not have the responsibility for any particular residents, and are used where needed across the units. In Norway the nurses have 3 years nursing education from university college, the auxiliaries have 1 or 2 years nursing education from high school (Høst, 2010), and the assistants have no health care education apart from short introductory courses at the workplace.

In our study the nurses and auxiliaries interviewed were between the ages of 30 and 60. Nine were female and two were male. The assistants were females between the ages of 20 and 30. The nurses and auxiliaries had long work experience with older people, whereas the assistants had less than 5 years.

Data collection

Three approaches – periodic participant observations, semistructured interviews, and reading of relevant documents were used to collect data. All the data were recorded in field notes and verbatim transcript. The transcribed texts from interviews and the texts from field notes were regarded as texts equally important (Atkinson & Coffey, 2002), and contributed to rich descriptions.

Participant observations were undertaken periodically following 10 new residents on admission day and their first week in the LTC unit. Observations were carried out in the residents' private rooms, the corridors, the living room, the dining room, the kitchen, and the staff's room. First author spent on average 4 h a day and was in the facility at different times, and during weekends and summer holiday. A total of 200 h of observations were undertaken periodically in the 8-month period, from June 2011 to January 2012. The design of the study with participant observations involved not only the nursing staff, but also the residents, and therefore gave insights into their experiences too.

Field notes recorded staff activities with the newly admitted resident and each other on admission day and the initial period after the admission. Also the

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field notes included researcher's feelings and reactions which assisted in realizing the researcher's prejudices brought to the study.

In addition, interviews were conducted with four nurses, one head nurse, six auxiliaries, and five assistants. Recruitment was by voluntary participation and snowball effect. Before the project started staff members were informed both orally and in writing by first author and later by head nurse about the project. Written information was put on the wall in the head nurse's office where staff could write their names if they wanted to participate.

The interviews took place in a small room in the nursing home outside of the LTCF, and lasted about 1 h. The interviews were semistructured with an interview guide focusing on the preparation period before a new resident arrived, the admission day, and the initial period after placements, with particular focus on residents' self-care capabilities. Follow-up on what the respondents themselves elaborated upon was attempted.

The text should be: Documents read were residents' charts and medical histories at the time of arrival as were the daily care plans on the computer and in the residents' bathrooms. These were mainly consulted to fill in on the data from observations and interviews (Fangen, 2010).

Data analysis

The data collection and analysis occurred concurrently. This meant that analytical reflections started automatically and opened up for the pursuit of new perspectives and hunches as the field work and interviews went along (Sandelowski, 2000, Vike, 2003). The analysis continued in a more systematic way when the researcher immersed herself in the material to gain a sense of the whole, and used the analysis methods outlined by Foreman and Damschroder (2008) and Graneheim and Lundman (2004) as the major guidelines for the systematic analysis of the data. This was done in different ways. Transcripts, field notes, and written documentation were read several times. Additional listening to the audio files, and writing down comments, associations, and memos between and across interview transcripts and field notes were carried out. Memos served to initiate the data analysis by identifying and sharpening categories and themes that began to emerge. In the reduction phase, a systematic approach to the data was developed aimed at focusing on relevant data to answer the research question. Meaning units and codes representing topics, concepts, or categories of events did this. These codes were then grouped together to create subcategories and categories which were then arranged into themes (Table I).

Rigor

Rigor was secured by the 8-month time frame of the study and the different approaches investigating the same phenomenon (O'Reilly, 2012). The time frame and the periodic participant observation periods paired with interviews allowed the researcher to ask new questions and follow new direction as the fieldwork went along (Vike, 2003). Data collection from different sources gave rich material, allowing complexity and in-depth observations to occur. Also the use of an experienced qualitative researcher at several points in the analysis was schemed to reduce bias.

Table I. Themes and categories regarding staff's actions during older people's transition into long-term care facility (LTCF).

Time—chronological order	Themes	Categories
Preparation period	Actions of sharing, sorting out and ignoring information	• Dealing with -Competing tasks -Uncertainty -Routines
Admission day	Actions of involvement and ignorance	• Variations in how new residents are met • Residents' previous residence matter
Initial period	Targeted and random actions	• Contextual features • Self-care activities • Medical Treatment
	Actions influenced by embedded knowledge	• There is always someone in need of an LTCF placement • The LTCF—a home taken-for-granted • Mentally lucid residents manage on-their-own
	Actions influenced by local transparency	• Familiar people and places • Good or dubious reputation

Ethical considerations

The research was executed in accordance with the Declaration of Helsinki. Approval was obtained from the Regional Committees for Medical and Health Research Ethics in Norway (2011/153b). Formal access to the field was made through the municipal health care authorities. The staff participants were assured confidentiality. Their participation was voluntary, and they were informed they had the right to withdraw at any time without stating a reason. Before data collection, written informed consent was obtained from all staff participating in the interviews.

Residents were asked on arrival day if they accepted that first author participated in their daily care the first week after arrival. Eight residents accepted. For two residents their families consented on their behalf. All 10 residents were orally informed about the project.

Findings

In what follows the themes identified are presented in chronologic order starting with the preparation period, the admission day, and the initial period. The theme identified in the preparation period was "actions of sharing, sorting out, and ignoring information." The theme identified on admission day was "actions of involvement and ignorance." The initial phase themes identified were "targeted and random actions," "actions influenced by embedded knowledge," and "actions influenced by local transparency."

The themes are not mutually exclusive, and intertwine in complex ways. In addition to quotes, abstract narratives are used to illustrate the influence staff's action had on the resident.

Preparation period

The preparation period was characterized by staff actions that varied from sharing, sorting out, and ignoring information.

Actions of sharing, sorting out, and ignoring information

In this period the staff had to deal with competing tasks, uncertainty, and routines.

Dealing with competing tasks. Most staff started preparing themselves for the arrival of a new resident on admission day. This, paired with the other daily tasks, gave them little time to prepare. The time span between the death of a resident and the arrival of a new resident varied between 2 and 6 days. The admission team decided who would get a LTC-placement, and they provided the head nurse with some written information about the prospective resident which she shared with all staff present at the joint morning shift report on admission day.

The prospective resident could arrive from hospital, community dwellings, home, or from other facilities within the nursing home. The exact time of arrival was often not known, however, if the residents arrived from hospital, staff knew they would probably arrive in the afternoon at the time of the shift report.

Moreover, written information about the resident-to-be was sometimes ignored by staff. During the summer holiday which was considered a strenuous time to work because of all the supply staff, none of the staff appeared to read the information about the expected resident "Ann" before arrival. When she arrived with her family member in the morning, she was met by the nurse. On the threshold to her room the nurse said "look, your name is on the door so we are expecting you, and look at the beautiful flowers on the photo." "Ann" replied in a hardly audible voice that she could not see it.

The nurse appeared unaware of the resident's impaired vision. During the first week her low vision seemed to be disregarded by most staff in this unit. The primary auxiliary told on the last day of "Ann's" first week that she had not yet read the information about her.

Dealing with uncertainty. Some nurses were concerned about maintaining continuity across health care settings particularly regarding resident's medical condition and medication. Yet information from hospital could be lacking on arrival day. Then using the phone was the most appropriate means to get information. Still, using the phone could be frustrating because sometimes nobody answered or the person did not know the resident in question.

Furthermore the head nurse experienced that sometimes the resident was welcomed ad hoc:

> I write in the program book the expected resident's name and the room. I realize that sometimes I can be more specific about who is to welcome the new resident. If there is a nurse in the unit it is self-evident she will do it, but if there is none then sometimes it is random that the one who accidentally meets the new resident welcomes. This is not optimal, I have thought about it and we need to do something about it. Even though I have been in the game for many years, it is weird that such simple things—it takes such a long time before they are written. But it has something to do with balancing how much am I to interfere and how much are they to think themselves (interview head nurse).

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The head nurse had a balanced ideology on behalf of her staff that all staff knew and would flex between following procedures and their skills there and then in interaction with the new resident. Not all staff appeared to be familiar with this, however, and information in the preparation period could be ignored or lacking. The assistants were expected to take responsibility for the prospective resident's room on equal footing as the auxiliaries. Still this expectation was not always carried out: "Sometimes the information is poor so you have to take some initiative yourself, and I am unsure if the assistants do that" (interview assistant).

Dealing with routines. The different staff had different procedures to follow in this period. The primary nurse in the unit had the responsibility to check the information available and have a preliminary overview of the resident's condition and needs, whereas the auxiliaries and the assistants mainly had the responsibility to prepare a tidy, clean, and welcoming room, in addition to taking care of the residents. The head nurse made sure that the resident's name was on the door before arrival.

However, routines were not always carried out by the staff, such as preparing the resident's room properly, which puzzled the staff nurse:

> I expect such matters to be automatic, but I have experienced that they are not, so maybe it is in its place to have more routines, that I have to give more specific information in the program book. At the same time I find that a little unnecessary—when we are organized according to primary nursing and each claim they want to be responsible. But it is sort of divided here—so I have, I check the room the day the new resident will arrive (interview head nurse).

Admission day

Admission day was characterized by actions that differed from involvement to ignorance.

Actions of involvement and ignorance

In these periods the new residents' previous residence appeared to matter, and it varied as to how staff met the new residents.

All staff perceived admission day as important and the head nurse prepared the grounds for this: "It is vital for the new residents to feel expected and that their arrival is prepared because this is going to be their new home for the rest of their lives" (interview head nurse). Most staff had a nuanced understanding of the older resident in transition into LTCU. Some underscored the residents' experiences of losses, such as losses of belongings, losses of mastery of activities of daily living, and the grief and sadness of losing their previous lifestyle. However, they also experienced that residents were pleased with this arrangement and felt safe, less lonely, and were relieved they were no longer a burden to their family members. Furthermore, for some their health improved.

The resident's previous residence matter. These understandings of the new resident paired with circumstances such as the resident's previous residence appeared to influence staff's actions. If a resident was transferred between facilities in the nursing home, the staff found a convenient transfer time for the staff in both facilities. They assumed, as one of the nurses claimed, that the resident was already familiar with the routines, the joint living room area, and living together with other people. If a resident arrived from hospital, however, the time of arrival in the afternoon was inconvenient, and particularly the nurses were frustrated because they had less time to welcome the resident and his family member(s) properly. Sometimes a day shift nurse worked overtime to welcome the resident whereas at other times the resident was welcomed by the nurse after the afternoon shift report was over, or by an auxiliary.

Moreover if a resident arrived directly from home, concrete arrangement of arrival time could be made, illustrated by the following: The nurse had phoned the prospective resident at home 2 days ahead of the admission and arranged for her to arrive in the morning so that she had time to welcome her properly. On arrival day "Helga" arrived alone in her electric wheelchair and was met by the primary nurse who showed her the room. There the nurse carried out the expected procedures at the same time as she listened attentively to the new resident's wishes and worries. The nurse signaled she had time for the resident, and the pace and rhythm in their interaction and dialogues appeared to give the new resident time to respond and take the initiative. Furthermore the nurse prepared the resident for lunch and the other residents at the table where she was going to sit. Also she encouraged "Helga" to contact staff at any time.

This admission was well planned and appeared to be a good start for the resident's further stay in the unit. However, "Helga" had to arrive on her own without her child who was unable to rearrange the work schedule due to the short notice.

Variations in how new residents are met. As a rule the nurse in the unit welcomed the new resident. Apart from following the checklists and procedures

the nurses appeared to welcome in slightly different ways. If the nurse was absent on arrival day it varied to a greater extent how the resident was met. The auxiliaries had little practice in welcoming new residents which influenced their approaches; some were confident and appeared to follow the procedures in roughly the same way as a nurse, whereas others seemed uncomfortable with this role. Also some appeared unaware of what they were expected to do. In the middle of what they were doing one could hear "oh, yes, is a resident coming? I had forgotten — which room" (interview nurse). Both staff categories were influenced by the daily routines and the needs of the residents already there. Some claimed it was difficult to focus on the new resident while thinking about all the other tasks that needed to be done.

Initial period

The initial period comprised mainly the first week after the resident's arrival. Three main themes were identified; "targeted and random actions," "actions influenced by embedded knowledge," and "actions influenced by local transparency."

Targeted and random actions

In the current study targeted and random actions could be associated with contextual features, and staff's attendance to the residents' self-care and medical treatment.

Contextual features. The predominant oral culture influenced staff actions. Many believed the demand for continuous updated written information was meaningless: "... who do we write for; nobody reads" (interview nurse). Especially full-time auxiliaries claimed they had the overview in the small units and knew what they needed to know about the new residents without reading about them. However, the nurses working shifts across all units during afternoon and weekend shift sought written information and guidance with colleagues. The major occasion for seeking written information for all staff was when they had been off work some days. Staff worked shifts and many had part-time positions, and depended on ways of getting and giving information about the new resident. At the time of the study no formal staff meetings were arranged to maintain this need. Although the nurses arranged for the other staff to read information from the previous health care setting, not everybody appeared to do so. Furthermore the oral shift reports lasted about five minutes for each unit. However, after the joint morning report, staff in each unit was expected to plan the day's work together. The most important way of information sharing among staff was continuous on-the-spur-of-the-moment staff interactions: "I believe we cooperate well I sort of get something all the time" (interview auxiliary).

The head nurse's participation in the morning shift reports seemed to be central in directing the staff's actions toward new residents: On the fourth morning after "Olav's" arrival the head nurse supplemented the night nurse's report underscoring that "... he is very social, and he does not express how he really feels." In the unit afterwards, the nurse supervised the two assistants in detail how to interact with the resident in this matter.

Self-care activities. Residents' self-care capabilities were treated differently. A general attitude was that it would take some time before they would know the new resident: "Eh you have to sort of try and fail a little initially; you have to get to know the resident" (interview auxiliary).

Primary contacts were aware of the distress some new residents experienced initially when needing assistance, and discussed with colleagues how to approach them in the best possible way. The routine writing of care plans within 3 days after admission, however, appeared to work against the staff's approach of gradually getting to know the residents. These plans were put on the wall in the resident's bathroom and provided detailed descriptions of the residents' need for help and what they managed on their own. They were updated once a year before the summer holiday: "Then everything needs to be spick-and-span before the supply staff comes" (interview nurse). Most permanent staff, however, appeared to regard these plans as guidelines only and did what they thought was best as the situations occurred. Although some focused on aspects of the resident's physical self-care maintenance others seemed to automatically take over:

> ... I was about to wash the resident in the morning and pull off his t-shirt eh and helped him sit on the toilet. While he was sitting there I was tapping water into the sink because I had not done that, and while doing this I saw in the mirror that he pulled off his t-shirt himself, and I, gosh, I had a revelation ... yes, he could manage on his own and I acted as if he could not ... just a little more time to get started, so that was a little embarrassing (interview auxiliary).

Likewise others admitted they were too quick to help out:

> I experienced today, a classical example, and I did not even reflect on it; but I'm in a resident's

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> room together with the auxiliary, and I know that the resident is able to brush her hair. When the other auxiliary is about to give her the brush my hand automatically grabs it and I quickly brush her hair—it may be valuable for the resident herself to be allowed to do that, and then I in my eagerness ... (interview nurse).

One nurse found it meaningless to spend a lot of time encouraging frail elder's self-care during the morning care because it was both time consuming for the nurse and exhausting for the resident. He would rather prioritize the resident's participation in some other activity during the day. Yet others experienced that new residents wanted help with everything after admission, and that they had to supervise both resident and family members in this matter.

Especially some assistants seemed to believe that all that self-care meant was that residents washed their face and hands themselves. However, they underscored other aspects of self-care such as respecting the new resident's boundaries initially, and avoiding exposing their intimate body parts during morning care.

Often staff experienced that the information from the previous health care setting was not transferable in the current LTC- setting, and they did it their way. One auxiliary engaged a resident who did not want to do anything herself, and at times her behavior was threatening. Information from the previous health care setting advised that there be two staff during the morning care, and to use plastic utensils at meals because the resident could throw dishes around. Initially there were two staff during the morning care, but after a few days the primary auxiliary changed her strategy:

> I went in alone and put the wash bowl in front of her and asked her to try herself. I arrived back after 15 minutes and the resident had done nothing. I said "are you not going to wash yourself?" "Ye-e-e-s" "Yes, but then you have to sit up." No, she was not able to do that. Then I say "but may I help you up to sit on the bedside?" This is how we started. After a while she washed her upper body herself, and we stopped using plastic utensils (interview auxiliary).

Also some skilled staff expressed a concern for acting quickly after the resident's arrival in order to maintain some of the resident's previous lifestyle like going out before they became too institutionalized.

Holidays and weekends disturbed the weekday rhythm, and many supply staff appeared unaware of the complexities regarding the new residents' self-care capabilities. The mix of staff was decisive; if only supply staff worked at a shift, the residents were helped too much during meals, for instance.

How new residents were treated during meals varied among staff as well as between the units. Across all the units some interacted in nuanced ways with the new residents, encouraging their mastery of physical as well as psychosocial needs in their current setting. For example, the recently admitted "Olav" was placed next to a childhood friend's husband. This made "Olav" at ease, and provided continuity with his past life.

Sometimes projects and procedures were prioritized at the expense of the new resident. The following episode illustrates this: On her first morning after arrival, at the breakfast table in the dining room, "Ann" wanted her usual oatmeal and milk for breakfast. However she was persuaded by the staff to eat a slice of bread with cheese and honey. They argued it was important that her nutrition be more varied. During the meal she enjoyed her coffee. When she got her walking frame the auxiliary put her arm around her shoulder and complimented her she had done well eating the bread. The resident replied she was not fond of bread.

Even though the resident probably needed to vary her foods, the staff did not appear to pay attention to the resident's first morning in the unit. Furthermore they seemed unaware of the resident's serious condition. At other times, however, staff could ignore following routines. For instance, all new residents' nutritional status was to be checked 3 days in a row shortly after arrival, but these observations were not always followed up with appropriate actions.

Moreover, in spite of "Helga's" good start, after admission day she seemed not to be prioritized. Even though she had expressed that "the food tastes so much better in the company of others" and needed to improve her nutritional status, she was often helped a little too late for a joint breakfast with coresidents and had to eat dry bread in her own company.

Medical treatment. After arrival knowledge about the resident's medical conditions and medication depended on staff's formal position in the facility. The first days after admission, the nurses focused primarily on the resident's medical condition and prepared for the physician's round which was once a week. Because information from other health care settings could be unclear or lacking, the nurses were busy sorting these matters out in addition to other daily tasks they had to perform.

The auxiliaries did not take part in the physician's round, and their medical information acquisition

seemed coincidental. This perceived lack of medical knowledge made some unsure if their care and observations were good enough.

Most nurses worried that the new resident would be put on medication too soon after arrival and not be allowed to react "normally" in this turbulent period, but the time aspect seemed to be forgotten by some: "Kari" had arrived the day before and the night nurse reported to the daytime staff that she was in a mess during the night, and "afraid and anxious." The nurse in charge of that unit immediately said she would discuss this with the physician and look at the resident's medication. One nightshift nurse student reminded them that this was the resident's first night in an unfamiliar setting, and that she probably needed some time to settle in.

Actions influenced by embedded knowledge

There were some taken-for-granted assumptions that were rarely if ever expressed by staff. These include: there is always someone in need of an LTCF placement; the LTC unit—a home taken-for-granted; and mentally lucid residents manage on-their-own.

There is always someone in need of an LTCF placement. There were waiting lists to get a LTC-placement in the LTCF, and a new resident would move into one of the units when there was a vacant bed. This somehow appeared to influence staff's taken-for-granted attitude of the older person being there after admission day, and not considering him or her being in transition: "Daily routines take over; the resident has to adjust to our routines, it is the same procedure as usual" (interview nurse).

The LTC unit—a home taken-for-granted. Even though some openly talked about the "unit as home" for the residents, the notion of home seemed to apply to some staff, too.

Some preferred to have their lunches in the unit's living room instead of the staff's canteen. Most staff seemed absorbed in their own matters then and did not pay much attention to the residents present. The mentally lucid new residents quickly learned to keep away from the living room at these times, but not all the new residents were aware of this, and some were stuck: One wheelchair-bound resident unable to speak was ignored during these times. Moreover the new resident "Rut" suffering from mild dementia seemed to enjoy listening to the staff talking. At times she persisted in her attempts to be included in the staff's interaction; sometimes she was included other times she was ignored.

Mentally lucid residents manage on-their-own. Cognitively able residents were in danger of being ignored because staff took it for granted they coped either by asking for help or doing it themselves. The following observation illustrates this: "Helga" depended on help to move around. During the first week at mid-afternoon coffee for residents and staff, she was never invited. She wondered if staff knew she was incapable of managing herself and needing help to move from her chair into her wheelchair. She expressed modesty in this matter and would have appreciated staff seeing her and inviting her to join them.

Actions influenced by local transparency

Local transparency could be associated with familiar people and places, and good or dubious reputation.

Familiar people and places. The rural community and local staff appeared to influence the cultures in the units. Many female local staff had lived most of their lives in this area, although some had moved to this area from other places in Norway or abroad. The interviews revealed that the management wanted the nursing home to have a good reputation in the community, and appreciated devoted staff. Jobs for auxiliaries and assistants were scarce, and the management could select those most suitable.

Six of the 10 new residents moved into the same unit where most residents were cognitively able with not too demanding physical needs for staff to assist with. Local staff and many residents knew of each other in these surroundings and this created familiarity and connections. At meals staff and residents shared joint knowledge about people and places, and the new residents were quickly included and involved. One new resident, homebound the last 20 years, enjoyed these meals, and was impressed by what her coresidents knew. Another resident transferred from a dementia-specific unit was waited upon by some of the other residents and became more social.

Good or dubious reputation. Familiarity with residents contributed sometimes to blur the exchange of information: During the afternoon shift report, the assistant reported that the new resident "Ann" who arrived that morning suffered from cancer with metastases to several organs. One of the auxiliaries immediately said: "I know her. She is the one who worked for years in x institution; she is a very nice lady" (end of report for this resident).

If a resident had a dubious reputation, he or she at times was in danger of being ignored by some staff: At a quiet time before the evening meal, the new resident "Berth" approached one of her previous neighbors, auxiliary X who was sitting in a couch

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chatting with a colleague. "Berth" asked about X's children. She answered, but did not ask any questions back and redirected her attention to her colleague. This auxiliary however, acted professionally toward this resident in the morning care situations but appeared not wanting to get too personally involved with her.

Word of mouth went within the staff group that a new resident was fond of the ladies. When he asked for help to put on his sweater the auxiliary argued he could do it himself. However, he suffered from a serious illness which periodically made him depend on more help than usual.

Discussion

Lack of cooperation between and within institutional settings influenced the different staff's actions in multiple ways. Moreover the findings disclose an array of actions in a complex organization where individual staff were influenced by and influenced back on the environment.

From the nurses' perspective, lack of information about the new resident seemed to pose challenges, particularly concerning medication. Bollig, Ester, and Landro (2010) found that every fifth resident, at the time of their arrival in the nursing home, had misleading information about medication. Because written information could be lacking or be incomplete, the nurses compensated by relying on oral sources of information. Getting information through phone may be problematic. Oral language in this setting placed the sole responsibility for the interpretation on the receiver who would pass this on to colleagues. Spoken words are gone immediately after they are articulated and thereby less reliable than written words (Ong, 1982, 2002). What is written can be read by many and functions as memory and proof for what is to be done and what has been done. Yet communication by phone also made it possible to ask questions about matters that were not so clear in the written information. Furthermore, these activities could be time consuming initially and maybe steal time from direct interaction with the new resident and colleagues. Our findings suggest there is a connection between the auxiliaries' and assistants' perceived lack of medical knowledge, and how they assisted and cared for the new residents. The auxiliaries handled their frustration differently.

Although some asked the nurses directly for guidance, others expected the nurse to take the initiative, and some appeared to compensate with strong involvement in care. Others still seemed to rely on gossip. The young assistants kept in the background at most times.

Consistent with other research (Krogstad, Hofoss, Veenstra, & Hjortdal, 2006), the head nurse had a decisive role in this facility, and her balanced ideology seemed to allow for a wide specter of performances; from high quality care to accidental and incongruent care. Some staff appeared competent to balance routines and procedures with on the spur-of-the-moment actions when caring for the new residents. This is different from other studies (Wiersma, 2010, Harnett, 2010) where routines are regarded as both rigid and adhered to as goals within themselves. According to Berger and Luckmann (1966, 2006), habits and routines may be understood as patterns of actions alternating between individual performance and social control. Routines contribute to predictability and habits in one's work. This may liberate staff to be flexible and creative in interactions. Some appreciated developing their work in close interaction with the new resident, and quickly adapted to specific situations. In a transition perspective, Schumacher et al. (1999) underscore that the goal of nursing is the creation of an environment that is dynamic and flexible enough to change in synchrony with the older residents' evolving needs. The findings show that some exploited situations and circumstances to facilitate the new residents' feeling connected, being situated, and developing confidence and mastery which are in line with Meleis et al.'s (2000) process indicators moving a resident toward a healthy transition. Yet these actions were seldom appreciated and shared in formal settings, and were frequently referred to as the "little things that matter." This demonstrates the taken-for-granted in this particular practice situation. But as MacLeod (1994) states, these nursing practices are often purposeful, complex, multifaceted, and patient centered. Research on these kind of practices related to transition would allow more insight into process indicators that facilitate healthy transitions, and are therefore of great significance. Juritzen and Heggen (2009) concluded in their study that little of the nurses' work is written down and that a lot may not even be verbalized.

Furthermore, our study found that most of what was shared during oral shift reports initially concerned medical matters. Meleis et al. (2000) argue that actions facilitating a healthy transition transcend biomedical driven strategies and focus on residents' "lived experiences, the daily life events, and lifestyles" (p. 70). These aspects were mainly shared in informal staff interactions. One drawback with these settings is that they do not include everybody, and may thereby have contributed to coincidental actions or lack of actions. Although this applied to all staff, particularly part-time unlicensed staff could miss vital information about how to assist the new

residents. Our study shows that all residents, regardless of cognitive function, at times could be ignored. This is different from Slettebø et al. (2010) who found that particularly the cognitively impaired were prone to experiencing unjust health-services due to contextual restraints.

The findings show multiple staff perspectives concerning the new residents' self-care capabilities. Most residents had experienced multiple transitions before they finally moved into a private room in the LTCF (Eika et al., 2014). Hence their self-care capabilities had been challenged for some time. After admission, although some primary auxiliaries and nurses focused on the residents' maintenance of their self-care, others ignored it blaming it on their own personal qualities, embedded beliefs, and work circumstances. Staff, regardless of professional background, did not seem preoccupied with soliciting knowledge about the residents' past self-care practices from their home environment. Jensen and Cohen Mansfield (2006) found in their study that this applied to hands-on nursing assistants who were almost totally lacking in the knowledge of residents' previous self-care routines. Most residents in our study came from other health care settings and not their homes, and staff focused mainly on information from these settings which they often did not find helpful.

Local affinity influenced the staff's actions. Staff involvement in rural contexts has been observed in other studies (Congdon & Magilvy, 1995/2007, Ryan & McKenna, 2013). Ryan and McKenna (2013) found that when the older residents and staff knew each other and friends and neighbors visited, this facilitated a more positive transition for older people and their families. Many studies show that relationships with peer residents (Bradshaw, Playford, & Riaz, 2012) and staff (Glover, 2001, Coughlan & Ward, 2007, Nakrem, Vinsnes, Harkless, Paulsen, & Seim, 2011) contribute greatly to the residents' experiences of good quality life in nursing homes. Furthermore, familiarity with people and places helped the residents still feel part of their community after admission. Ytrehus (2004) found in her study of younger older people's reflections about moving that familiar places played a more significant role than did their house in their experiences of continuity and connection. Still our findings show that the influence of local community could lead to stigmatization of some residents and sometimes overshadow their complex needs. Staff in some instances appeared to mix professional roles and local roles, whereas at other times they tried to maintain the boundary between their professional role and the role as local persons. Masvie and Ytrehus (2013) also found in their study of mental health workers' experiences in small municipalities that their professional roles could affect their private life and the role and relations they had in the community as a citizen.

Strengths and limitations of the study. The study is limited to one LTCF in a nursing home in rural Norway. The strength of this study is the focus on different staff's action in this period of change for older people, and a multiple methods approach in data collection. The findings are not altogether transferable to other similar settings due mainly to the lack of similar research to compare with.

Conclusion

Nursing staff's actions varied from moving the new residents in the direction of health to moving them toward vulnerability and risk. Some powerful influential forces on staff's actions during these times were the head nurse's leadership style; individual staff's formal position, traits, and enthusiasm; resident and staff mix; and local transparency. This study gives a picture of different staff's actions at a key point in the residents' ongoing transition process, which shows that both unlicensed and licensed staff were susceptible to performing congruent as well as incongruent care. Our study contributes with new knowledge describing circumstances and mechanisms played out among staff within the LTCF setting which goes beyond the fact that they were trained in health care or not. Currently recruitment of licensed personnel in the care of the elderly is a challenge in many countries. The Norwegian Research Council, in line with Report to the Storting No. 13, underscores the need for research exploring different professional groups' cooperation and interaction skills on both individual and organizational levels. Additional studies need to explore this issue further.

Authors' contributions

Marianne Eika collected, processed, and analyzed the data; and wrote the paper. Sigrun Hvalvik, together with the first author, analyzed and evaluated the material and the content. Geir Arild Espnes commented on the finished paper.

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Note

1. Characteristics of eight of the 10 new residents are found in a previously published article (Eika et al., 2014).

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Paper III

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RESEARCH ARTICLE Open Access

Nursing staff interactions during the older residents' transition into long-term care facility in a nursing home in rural Norway: an ethnographic study

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Abstract

Background: Future challenges in many countries are the recruitment of competent staff in long-term care facilities, and the use of unlicensed staff. Our study describes and explores staff interactions in a long-term care facility, which may facilitate or impede healthy transition processes for older residents in transition.

Methods: An ethnographic study based on fieldwork following ten older residents admission day and their initial week in the long-term care facility, seventeen individual semi-structured interviews with different nursing staff categories and the leader of the institution, and reading of relevant documents.

Results: The interaction among all staff categories influenced the new residents' transition processes in various ways. We identified three main themes: The significance of formal and informal organization; interpersonal relationships and cultures of care; and professional hierarchy and different scopes of practice.

Conclusions: The continuous and spontaneous staff collaborations were key activities in supporting quality care in the transition period. These interactions maintained the inclusion of all staff present, staff flexibility, information flow to some extent, and cognitive diversity, and the new resident's emerging needs appeared met. Organizational structures, staff's formal position, and informal staff alliances were complex and sometimes appeared contradictory. Not all the staff were necessarily included, and the new residents' needs not always noticed and dealt with. Paying attention to the playing out of power in staff interactions appears vital to secure a healthy transition process for the older residents.

Keywords: Long-term care facility, Staff interactions, Transition, Complexity science, Resident, Ethnography

Background

In developed nations, there is an expected increase in the number of older people above the age of 67 [1]. In Norway the number of people above the age of 80 is estimated to double over the next 35 years. Due to the increasing number of older frail people and a decrease in the number of people to take care of them, there is a growing concern for the future recruitment of competent nursing staff to nursing homes [2,3]. Older people in long-term care facilities (LTCFs) have complex medical and care conditions [4,5] and require competent care. Internationally, in contemporary health care environments for the elderly, the employment of unlicensed staff in direct patient care is on the increase [6,7]. Researchers [6] have noted that there has been a paradigmatic shift in staffing outcome literature from "an individual to team mindset" (p 10), emphasizing teamwork and inter-professional collaboration. Harris and McGillis [6], conclude that administrators and researchers need to pay attention not only to skill mix and numbers of staff, but also to processes of interaction between patients, providers and organizations.

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Staff interaction plays a role in the quality of care to older people in nursing homes [8-10], and the challenges are to use the available personnel in the best possible ways to promote good quality care. There are no national guidelines for formal staffing levels in nursing homes in Norway [11]. Yet, the licensed staffing levels are relatively high, compared to other European countries [12]. According to a study of 12 nursing homes in 4 of the largest municipalities in Norway [13], registered nurses constituted 24,1% of the workforce, auxiliaries 46,3%, and unlicensed assistants 29,6% on weekdays. During weekends the unlicensed assistants constituted 47,6% of the workforce. Varieties of primary nursing systems are used in many Norwegian nursing homes. The primary nursing care delivery model [14], support a patient-centered nurse-patient relationship that promotes continuity of care. Each patient is assigned one primary nurse who assumes responsibility and authority to "assess, plan, organize, implement, coordinate, and evaluate care in collaboration with the patients and their families" (p 295).

Moving into LTCF is a stressful change [15-17] for older residents and their family members, and can be associated with the concept transition defined as a passage between two relatively stable periods of time where the person moves from one life phase, condition or status to another [17]. It refers to processes and outcomes of complex person-environment interactions [18]. A transition may be triggered by a change or marker event, which may bring a period of upheaval and disequilibrium for the person (s) involved. Nursing research show [17] that transitions may connect with uncertainty, emotional distress, interpersonal distress and worry. Needs may not be met in familiar ways and changes in the person's self-perception and self-esteem are common. Transition theory in nursing is useful in the development of nursing therapeutics to facilitate the transition that people undergo. According to Meleis et al. [18], nursing therapeutics involves nursing strategies during transition enabling the nurses to anticipate points at which the person is most likely to reach peak of vulnerability, and select "the most fruitful kinds of action and optimal intervention points for achieving the desired health maintenance or health promotion goals" (p 29). Possible interventions include continuous assessment, reminiscence, role supplementation, creation of a healthy environment, and mobilization of resources [17]. Geary & Schumacher [19] suggest integrating concepts of complex adaptive systems from complexity science to connect the transitions to the context in which they are occurring. Transition is a process, not a change that occurs in a moment of time [18,19], and complexity science [19], "illuminates the nature of the transition process and changes that occur while a transition is unfolding" (p 241). During interactions, new processes or patterns of interaction, as well as new outcomes, emerge. Concepts suggested [19] are multiple individual agents interacting locally in a dynamic non-linear fashion, relationships, self-organization, emergence, and culture and environment of all agents. Self-organization refers to new behaviors or new patterns that emerge from individual agents' reaction to changes within the complex organization. Although self-organization "appears to be planned within the system, it is actually the reaction of an agent or a group of agents to change made by another. With the new information, agents, acting on established rules, change their behavior, leading to a new structure" ([19], p 239). Emergence refers to changes that are not predictable for two reasons, the absence of a complete context, and that interactions between persons are nonlinear.

This paper is part of a larger study exploring and describing the transition of older people into LTCF in a nursing home in southern rural Norway from the perspective of next-of kin and staff. In our first study [16], we explored the experiences of next-of kin during their older family members' transition into LTC-placement. In the second study [20], we explored and described different nursing staff's actions during the older residents' initial transition period in the LTCF. This present study focuses on staff interaction based on the same ethnographic data as in the second study. Literature exploring staff interaction within residential long- term care for the elderly has different perspectives and foci. One study explores the challenges between licensed and unlicensed staff working together [21], others explore and support the empowerment of direct care workers [8,22], and yet others explore and describe interaction patterns among all nursing staff [10]. We have been unable to find studies dealing with licensed and unlicensed staff interactions during older residents' transition into LTCF.

The aims of this study were to explore and describe the nursing staff interactions during the older residents' transition into LTCF, and how staff interactions may influence their assistance and care for the older residents in transition.

Methods

An ethnographic design helped gain in-depth understanding of staff interaction in contexts [23,24]. Humans are social beings whose actions, opinions and self-understanding are influenced by context, and influence back on context [25]. The ontological position taken was constructivist [26] with an analytical middle ground between reality and representation. In the hermeneutical tradition of Gadamer [27], the concepts horizon and prejudices closely link with the identification of the researchers' pre-understandings as part of exceeding one's horizon. It posed challenges that the authors have a background as registered nurses with

an interest in the care of older people. While our preconceptions and knowledge could give an easier understanding of what was going on, we could also become too familiar and understand too quickly. Daily critical reflection during the participant observation periods and interviews helped to use our preconceptions in critical and constructive ways [27,28].

Rigor was established by the time frame of the study, and by using multiple methods in data collection. The analysis was undertaken in collaboration with an experienced researcher in qualitative methods.

Data collection, context and participants

Three sources of data were used; periodic participant observations, interviews and reading of documents. Periodic participant observation periods following ten new residents on admission day and the initial week were performed, commencing early June 2011 and ending January 2012. The head nurse contacted the researcher about the expected arrival of a new resident. The researcher was present in the LTCF during the preparation period before the resident arrived, on admission day and the first week. The selection of staff participants were mainly those who were appointed primary contacts for the new resident, and those they interacted with. The participant observations were carried out to get insights into staff's interactions in different settings such as meal situations, new residents' morning care and oral shift reports, to name a few. The researcher was in the facility during daytime and afternoon shifts weekdays, weekends and summer holiday. Writing memos was carried out as soon as possible after something had taken place. When the researcher did not directly participate, for instance during a meal or a shift report, notes were taken as the event evolved. This strategy was used when the staff had become familiar with the researcher's presence. Further, the researcher's reactions and reflections were written down daily to identify prejudices and role confusions brought to the study. These intermittent periods posed challenges both for the researcher's own role understanding, and in ensuring that all the staff involved in the study at any given time were informed about the researcher's role, and the purpose of the research project. The sporadic participant observation periods opened up to perform some of the semi-structured interviews in-between. This combination helped clarify issues that were unclear, and directed the subsequent observation periods and semi-structured interviews. The written material such as the individual plan on the computer, the care plans in the residents' bathrooms, and daily written reports were consulted [29], mainly to confirm and augment data from other sources. Individual semi-structured interviews with seventeen staff members comprising four nurses, six auxiliaries, five assistants, the head nurse, and the leader of the institution were carried out in a small room in the nursing home outside of the LTCF. The recruitment of the respondents to the formal interviews were by voluntary participation, and some were headhunted by the researcher as the study went on. Each interview lasted an hour on average. The interview guide had questions about how staff interacted with colleagues during the preparation period, admission day and initial week after arrival. The first author attempted to follow what the respondents themselves associated and found relevant to talk about relating to this topic. The interviews were audio recorded and transcribed as soon as possible after they had taken place. The weekly periodic participant observations opened up for the researcher to have informal conversations with the new residents, and this influenced further fieldwork and the analysis.

The nursing home is situated in rural southern Norway. The LTCF consists of thirty private rooms split into three units each with ten private rooms. The nursing staff comprises licensed registered nurses (nurses), auxiliaries (auxiliaries), and unlicensed care assistants (assistants). The nurses have three years' nursing education from university/university-college and the auxiliaries have two years' training in high school [30]. The unlicensed assistants were not educated in health care apart from short courses at the workplace. The participants were females with two exceptions. The age ranged from early 20s to early 60s, and the length of employment varied from a few weeks to more than 30 years. Staffing ratios and mix varied with the shifts, weekdays or weekends, and holidays. During daytime on weekdays, the staffing was three staff to ten residents, and usually there was one nurse to ten residents or sometimes one nurse to five residents. The auxiliaries or assistants ratio was one staff to three or four residents. In the evenings, there were usually two staff (auxiliaries or assistants, or both) in each unit and one nurse in charge of the facility. In addition to permanent licensed and unlicensed staff, there were part-time supply assistants who worked weekends only. All staff categories performed direct resident care. The care was organized according to a primary nursing model [14], meaning that in this LTCF the nurses were responsible for five residents each, and the auxiliaries normally shared responsibility with the nurse in each unit for three residents each.

Data analysis

The first author immersed herself in the transcribed interviews and field notes as the study went on and after the collection of data was over. Writing is a key part of the entire research process, and closely related to analysis [23].Writing things down during the fieldwork and interview periods, and then writing things up [24] helped in this endeavor. The interview texts and the

fieldwork texts were treated as texts equally important [31]. Sensitizing concepts suggested further directions in which to look, and gave us "a general sense of reference and guidelines in approaching empirical instances ([23], p 164, based on Blumer [32]). Some concepts were "the physician's round", "primary nursing", "open door" and "chameleon." The written documents were consulted mainly to check our understanding of the data from the interviews and the fieldwork [29]. The data were read repeatedly and in different ways to get different versions [23,33]. The parts of the transcribed interviews and field notes dealing with the same issues were taken out of the contexts in which they occurred, to help get hold of the different versions of the same phenomenon [33]. For instance, "spontaneous staff interactions" was connected across the data material. The researchers also searched for theoretical perspectives that helped make sense of the emerging patterns [23,24] central to the aims. We then checked if what we had interpreted from the material taken out of context was in accordance with the contexts where they occurred [33]. If not, we started all over again. The emerging themes were further explored to clarify their meaning and explore their relation to other themes. The sub-themes show the variations contained in each theme.

Ethical considerations

The Regional Committees for Medical and Health Research Ethics in southern Norway approved the project (REK 2011/153b). Formal access to the field was granted through the health care authorities in the municipality. Participants were assured confidentiality, informed that their participation was voluntary, and that they had the right to withdraw at any time without stating a reason. Written informed consent was obtained from all staff participating in the interviews, and all agreed to the interviews being recorded. A staff information meeting was arranged prior to the fieldwork. Residents were asked orally and in writing if they accepted that the first author participated in their daily care in the first week after arrival. Eight residents consented while two residents were considered cognitively impaired, and next-of kin consented on their behalf.

Results

The analysis consists of three overall themes with several sub-themes, which illuminate how staff interacted during the older residents' transition into LTCF, and possible influence on patient assistance. The following identified overall themes: The significance of formal and informal organization; interpersonal relationships and cultures of care; professional hierarchy and different scope of practice. The themes overlap and intertwine in complex ways.

The significance of formal and informal organization

The staff interactions appeared modulated by the primary nursing model, the head nurse management style, and staff mix at different shifts. Their interactions were influenced by, and influenced back on, individual actions and team work, and information flow.

Individual actions and team work

Often the staff in the small units appeared to interact continuously while assisting and assessing the new residents. They acted in coordinated ways with their colleagues regardless of professional level while attempting to adapt to the new resident's evolving needs. Yet the staff interactions were to a certain extent characterized by the understanding of their work as individual actions. Due to the primary nursing model, most licensed permanent staff were responsible for three to five residents each. They attempted to cater for most aspects of the new resident's needs, and this ambition put pressure on each staff member. For instance, one primary nurse was at work on her day off to talk to family members after a newly arrived resident had died. In addition, a part-time primary nurse wanted to get an overview of all the residents in the facility, and thus worked extra. The nurses claimed that the primary nursing model in each unit meant that no nurse had an overview of all the residents in the facility. Furthermore, those who chose to work part-time, on average in eighty percent positions, did so to have the strength to do a proper job. If they considered their job well done, it gave them energy to accomplish the little extra for the new residents and the residents in general.

Connected with the notion of total responsibility for the new resident, the staff viewed their own work and that of each other differently. Many auxiliaries felt that they knew more about the new residents' overall needs initially than the nurses, because the nurses had so many other tasks to perform in this period. It appeared in the interviews and the participant observation periods that most nurses regarded it as self-evident that they knew most about the new residents' psychosocial as well as medical needs. They argued that even though they had many different tasks to perform initially, they still spent a lot of time with the resident in the small units. In addition to many fragmented tasks to perform concerning the new residents, the nurses had to prioritize those residents in most need. Sometimes this was at the expense of interacting and collaborating with staff colleagues during the shifts, and could restrict their face-to-face interaction with the new residents.

The primary contacts, the nurses and auxiliaries, had authority among the staff, and few colleagues wanted to interfere. In their absence, some were reluctant to perform

independently towards the new resident, illustrated by the following:

> When the primary nurse was on sick leave, another nurse was responsible for that unit. She did not establish documentation areas in the computer care plan, and argued that she would not interfere with the ways her absent nurse colleague worked. This made it difficult for the other staff to document in the computer program the first days after the resident's arrival (fieldwork observations).

During evenings, week-ends and holidays, the mix of staff could disturb the primary nursing arrangement, illustrated by the following:

> If only supply staff worked in one unit during a shift, the primary auxiliary could be transferred from her unit to compensate for the shortage of licensed personnel in the other unit. This was frustrating because she did not have the chance to follow up the newly arrived resident as well as she would have liked (summary of parts of interview with auxiliary).

These circumstances disturbed the permanent staff's work rhythm with their primary residents. Some found supply staff a nuisance to work with mainly because of this.

In these periods with many part-time supply staff at work, the care appeared crudely performed. It seemed that the regular staff helped the new residents to settle in, while some of the new residents withdrew with many supply staff at a shift:

> Even though many residents preferred to spend time in their rooms between meals, it was exceptionally quiet in the units at shifts with many supply staff at work. It seemed the cognitively able new residents quickly learned to take after the other residents' strategies at these times; after the meals, they went into their rooms and shut the door behind them (fieldwork observations).

The head nurse (HN) attempted to support each staff's self-confidence and self-reliance in their interaction with the residents, "to make them aware how much each one of them matters" (interview HN), and she kept her door open when she was in her office. It varied among the staff how they related to this. Some consulted her frequently, while others said that the HN was often away at meetings. Still others, like the week-end supply staff, never had the opportunity to interact with the HN in this way. This management style encouraged individual staff to develop a relationship with the new resident at their own speed. Furthermore, it seemed to legitimize that the staff nurses managed their units differently. This could cause problems particularly for the nurse in charge of a night or weekend shift, who had responsibility across all three units. For instance, written information on paper about the new resident was stored in different places in the three units, and the nurse in charge spent a long time before she found the papers.

Information flow

There was a dominant oral culture in the LTCF and its units, and face-to-face communication was the most common. Often the unit staff interacted spontaneously by sharing information and brainstorming together to help the new resident. Some staff could dominate in the oral culture irrespective of formal position, which frustrated some assistants:

> As unlicensed staff it is very difficult – eh it often happens that you are trapped between two who have strong opinions about how to care for the new resident, right? Eh, sometimes one feels like a chameleon - that one goes into the roles of those one works with at any given time (interview assistant).

This assistant frequently consulted the HN when she was available, and these interactions contributed to strengthening her self- esteem and belief in her own skills.

Particularly the auxiliaries and assistants perceived that they had neither the time nor the calmness to read about the new resident in the computer program "while colleagues were toiling in the units" (interview auxiliary). Some were apprehensive that their colleagues could interpret sitting at the computer as avoiding work.

The assistants felt that they sometimes lacked information about the new resident, and how to perform their work. They had some initial training in the facility before they started, but had to tackle many things ad hoc. They generally wished the permanent staff to inform them better. "It is easy to forget to inform colleagues when one has been working for a while, and knows one's way around" (interview assistant). Some assistants admitted that they should ask when in need, but were afraid of asking about something they believed everybody knew, and sometimes they did not know what to ask about. The potential consequences for the new residents were that everyday basic needs and observations were unnoticed, or if noticed, would not be passed on to colleagues. The assistants' lack of knowledge about the new resident's needs could be uncomfortable, for the new resident and the assistants, illustrated by the following:

> It was during one of the first shifts I worked after some time off and I assisted a new resident whom I did not know. I just poured milk into his glass and gave it to him. He coughed a lot and I was afraid he would choke. I learned afterwards that he should have had "Thick and Easy", instant food thickener, added to his milk to make it easier for him to swallow. Nobody told me and it was not written anywhere – so such things are easily forgotten and taken for granted that everybody knows ……..so poor resident, he coughed and hawked during the entire breakfast (interview assistant).

This assistant read about the new resident when she arrived back at work after some days off, and discovered that this important piece of information was unwritten. It appeared to be an attitude among many staff that it was little point in reading, which again seemed to encourage an attitude of writing less. Furthermore, the permanent licensed staff, particularly the night shift staff, could lack information about the new resident. At the oral shift reports staff did not have the time to report all aspects of the new resident's condition and needs to the staff at the next shift, and the next shift staff did not always read the new resident's individual protocol:

> The night shift staff was unaware that the new resident was incontinent for feces, and did not look into his room during the night rounds. This information was not passed on at the oral shift report, but was written in the computer care plan. Since the new resident did not want to disturb the night staff, he tried to manage on his own. He made a mess and felt very bad about it. He had poor vision and it was difficult for him to tidy up after himself, and he needed help. Regarding this resident, the oral interactions among staff in the initial period did not focus on his physical shortcomings (fieldwork observations).

The taken-for-granted attitude among permanent staff combined with little or no writing or reading, made it even harder for the staff in need of information about the new resident. There were serious consequences for the new resident. Even though the staff could adjust to the new resident's evolving needs, the care could also be based on general principles of care instead of tuning in to the new resident's particular needs and preferences. For some new residents the unpredictability of the assistance was disheartening.

Interpersonal relationships and cultures of caring

The staff interactions were influenced by, and influenced, intra- and inter -professional collaboration, personal traits and attitudes, and professional authority.

Alliances and collaboration

Staff collaboration appeared strong in intra- professional alliances. The general pattern was that individual staff appreciated working with people similar to themselves, and some met each other in their spare time. Typical for most alliances was a need of sparring with partners with the same values and outlooks of good patient care. Having a partner (s) helped the individual staff stick to their ideals and norms. Some felt they could accomplish more, and exploited the shifts they worked together to do it their way and accomplish little extras such as bringing strawberries for the afternoon coffee. The nurse alliances helped to strengthen their belief in their own professional judgments, and influenced their authority. Those who were not so strongly involved in alliances said that they felt insecure and inferior to some authoritative nurse colleagues.

The alliances seemed to influence the assistance of the new residents in different and unpredictable ways. Some allies focused on the new resident's emerging needs and attempted to assist in their best interest, while others would rather "satisfy your relationships with colleagues than assist the residents (interview nurse).

The staff also collaborated inter-professionally, and the primary nursing arrangement in the small units encouraged such interactions. Yet it seemed to some extent to depend on individual staff and those working together at any given time. For instance, the collaboration between the assistants and the other staff appeared to depend on person. Some assistants seemed to have more authority than others, and be more part of the unit team. Mostly, the assistants kept in the background in staff interactions, and permanent staff appeared to make few efforts to include them in discussions about the new resident.

Regardless of alliances, most permanent staff missed regular formal meetings. The meetings were cancelled mainly because key persons such as the nurses were absent, or too busy. Some auxiliaries claimed these meetings would provide them with the same medical information from the nurses about the new residents, and make them more confident in their observations and assistance of the new residents. In addition, the auxiliaries appreciated being in a setting of dialogue and discussions, where everybody had the chance to participate.

The privacy of caring

Some auxiliary allies were strongly involved with the residents and provided extras such as making cookie dough at home for the residents to bake, bringing local poetry to read, and arranging parties. Full-time employees and nurses with their professional focus had neither the time nor the energy to be so involved in these activities. The head nurse attempted to even things out, so that everybody felt their work appreciated. Most new residents

appeared at ease participating in familiar everyday activities. One new resident was provoked, however, when asked to participate in the baking of Christmas cookies the day after he had arrived. He claimed the activity was a fake. He had other needs at this time, such as getting help with his diahorrea, and come to terms with being in the LTSF (field observations).

Professional hierarchy – different scopes of practice

The staff interactions were influenced by, and influenced back on, the professional hierarchy and the different staff's perceived responsibility and work domains.

Hierarchy and responsibility

The staff awareness of the professional hierarchy varied. The assistants talked about "being at the bottom" while the auxiliaries expressed that "we are not so high up in the hierarchy". The nurses did not explicitly talk about it, but appeared self-conscious about being the leaders.

Some assistants seemed comfortable with not having the same responsibility as the others. The danger was that they took for granted that the licensed staff knew what they knew, and would see to it. Some did not report obvious everyday observations about the new residents, which may be considered negligence on their part. One assistant said that she sometimes kept quiet when she knew something about the new resident that the permanent staff did not know, because she was "only an assistant" Illustrated by the following:

> When two staff had to assist the new resident in the morning care, the assistant knows in detail how the new resident prefers his assistance because she has helped him in previous morning care situations. The licensed nurse/auxiliary, however, may assist the resident for the first time, and she is paying little attention to the resident's preferences and abilities and the assistant's knowledge and experience (summary part of interview assistant).

Moreover, the assistants believed that if the permanent staff regarded them as incompetent they might lose their job. The fact that many permanent staff appeared not to expect the assistants' participation in discussions about the new resident could reinforce the mechanism of assistants being exempt from responsibility. One assistant felt personal responsible and would have appreciated information from the permanent licensed staff. For instance, she had to ask to get supervised in the Heimlich maneuver, which is a technique for preventing suffocation when a person's airways become blocked. She had expected the permanent staff to inform her about that.

Monopoly of medical knowledge

It appeared as self-evident for the management and most nurses that the nurses and the physician had the monopoly of the body of medical knowledge. The physician expected the nurses to prepare his once-a-week round properly, so that he could perform his work efficiently. This could keep the nurses away from interaction with colleagues and the new resident in the initial transition period. The primary auxiliaries perceived this round as a "secret meeting" between the physician and the nurses:

> We are not nurses and we are not physicians, and we know that, and I believe we do not trespass into their professional territories. I believe we are very conscious about that. Yet we are knowledgeable, but we are never asked. The physician never asks us about anything. If the staff nurse is absent, a nurse from another unit who does not know the residents joins the physician on his round. I think we could have done that, too. We auxiliaries are, however, not high up in the hierarchy. I like my job and I do my best and don't care if I am not so high up there. I have collaborated with the occupational therapist and she listens to us and acts on our observations. We cooperate well and find the best solutions together" (interview auxiliary).

This quote illustrates an attitude among many auxiliaries that good collaboration was to "find the best solutions together" regardless of professional position. Moreover, many connected staff collaboration with knowing one's limitations: "Residents trust us when they know that staff cooperate well and know their limitations" (interview auxiliary).

Many auxiliaries, assistants and supply staff would have appreciated that the nurses supervised them orally after the physician's round. Sometimes this happened, but was not a pattern. The nurses seemed to have different opinions about the auxiliaries' involvement in medical matters. Some stressed that "If one wants to help the patients in the best possible ways one has to involve everybody who is together with the patient" (interview nurse), and argued that it was unrealistic for the nurses to manage all the follow-up on their own. Not all the nurses or the management seemed to share this view.

When a new resident arrived, the nurse presented herself to the resident and his/her family as the sole primary nurse, and omitted mentioning the primary auxiliaries. If the next-of-kin asked for information about their older resident, the primary auxiliaries were frustrated when they had to direct them to a nurse who might not know the resident at all but knew the resident's medical situation. The consequences for the new residents could be that critical observations and knowledge about their

everyday needs, preferences and medical condition were ignored initially.

Discussion

The aims of this study were to explore staff interactions, and how the interactions may influence the care of the older residents in transition into LTCF. The findings reveal complex staff interactions, and suggest that this influenced how they assisted and cared for the new resident.

The HN's relationship-orientation seemed to encourage individual staff in their interaction with her, and the new residents. She appeared to create a climate that inspired possibilities and safety among the permanent staff. We wonder, however, if sometimes her involvement with individual staff could impede the team interactions. When the HN was available it seemed easier for individual staff to discuss their imminent concerns about the new residents with her. These interactions appeared to give individual staff authority among the other staff since they had consulted the head of the facility. According to studies [10,34,35], management support of good relationships among staff such as building connections and developing existing strengths, contribute to the delivery of better resident care and foster staff interdependence. The HN attempted to balance structures and routines with building individual staff's self-confidence in spontaneous interactions with the new resident. This management ideology may connect with complex adaptive system's theory. According to Penprase & Norris [36], this theory frees nurse leaders from a management that prescribe behaviors that stress prediction and control, to behaviors that aim to build strong relationships with the freedom to produce creative outcome. "Allowing teams to form on their own encourages a culture of care and connection in which staff are highly responsive to the needs of their units"(p 128). Transition theory in nursing [18], also underscores that the agents react to the emergent changes in flexible and dynamic ways. Still, the HN's balanced approach appeared contradictory, at the same time as the HN provided feedback and praise to mainly the permanent staff, this individual staff focus could contribute to less focus on staff interactions that promoted good quality care. Research suggest [10] that "managers should scan their facility for existing pockets of excellence, to discover, support and expand staff interactions and relationships that already promote better performance" (p 13).

The arrangement with the primary nursing model influenced staff interactions in complex and at times contradictory ways. This way of organizing the work supported the dynamic, inter-professional staff collaborations among the primary contacts, where staff discussed their observations and uncertainties concerning the new resident. Still, each primary contact was assigned their role in the primary nursing teams. This organization appeared to legitimize that some did not fully involve themselves with each other and the new residents at shifts where the primary nurse and auxiliaries were absent. Needs considered unnecessary to deal with immediately, were left to the primaries to take care of when they were back at work. Research regarding the relationship between the primary nursing model and the quality of care is inconclusive [14]. Furthermore, the findings suggest that the primary nursing arrangement contributed to gluing the primaries to their individual responsibility beyond their paid work responsibilities.

The staff in the units also formed their own teams. Often, in these situations, everybody contributed regardless of professional competence, and noticed and assisted the new residents' emergent needs. This can be associated to research pointing at physical infrastructure [37] as one necessary component for successful staff collaboration. Each unit was small and encouraged the staff to continuously interact and complement each other. While the nurses focused predominantly on the new residents' medical condition, the enthusiasts provided good care in a homelike atmosphere. According to a study [38], quality care comprises attention to psychological and social needs along with medical considerations.

Moreover, Geary and Schumacher [19] argue that open boundaries between the agents "provide the potential for interactions that enable self-organizations, sense-making, and emergence of agent-specific processes and outcomes" (p 244). Our findings suggest that at some times, in some situations and depending on persons involved, boundaries were more open than at other times. It appeared that the spontaneous interactions per se contributed to creating open boundaries among the staff. Leykum et al. [39], found in their analysis of eight observational and interventional studies that how individuals self-organized was not necessarily done according to hierarchy or organizational structure but "based on how the work is actually accomplished" (p 2). In our study, the staff self- organization appeared based on structural features as well as how the work was carried out.

The arrival of a new resident in the LTCF and particular unit changed the work environment. Literature [40] has identified key practices that allow organizations to adapt successfully to such changes. One is to let information flow spontaneously among all agents. Our study focused on staff as agents, and although information at times flowed spontaneously among them, the findings also demonstrate otherwise. The lack of medical knowledge among the auxiliaries and assistants and sometimes the nurses' lack of personal involvement and knowledge about the new residents' everyday needs could contribute to fragmented understandings and resident assistance during this period.

Aspects of authority and power within the LTCF influenced staff interactions, and the findings disclose intricate power mechanisms at play. The oral culture allowed some to dominate, between staff groups as well as within staff groups. Eloquent persons got their opinions through, sometimes at the expense of sound professional knowledge and colleagues' well-being. Being a member of an alliance gave some power and authority, sometimes at the expense of others, and staff collaboration on a more general level was disrupted. The unlicensed staff were often not fully involved in the staff collaborations and discussions about the new residents. Not being involved may have negative consequences in several ways. This is in accordance with studies [40,41] which show that well- informed and supervised nursing assistants perform better towards patients.

Some permanent staff considered the unlicensed staff a nuisance to work with, and did not expect their participation. Jacobsen [42] also found that the assistants were a "fellowship of those who have no say" (p 86). For instance, during meals [20] with many cognitively able residents the local staff's involvement with the new residents could shut the weekend supply staff off from participation. The enthusiastic allies were good at what they were doing and the supply staff could feel redundant. That the assistants kept a distance in staff interactions, may also suggest that this legitimized their at times poor involvement with the new resident. The licensed staff may have to compensate for the assistants' limited contributions towards the new residents, or as the findings suggest, some needs were ignored. Many auxiliaries handled the distance and difference from the nurses and themselves by the appreciation of the homelike, everyday activities, where the nurses also participated; here everybody was of equal worth. According to Gullestad [43], sameness and being of equal worth relate closely in Norwegian culture. In order to be of equal worth, one has to be the same as. Moreover, shortly after a resident had moved in, the primary auxiliaries had authority in oral interactions. The oral culture in this LTCF allowed the auxiliaries to some extent to control the information flow of the new residents' everyday needs. If the nurses were preoccupied with other tasks, they depended on the auxiliaries' preliminary knowledge and insights. This is to some extent in line with Alcorn [44], who in a review of the relationship between registered nurses and healthcare assistants found that "power plays materializes through this relationship as healthcare assistants are placed in powerful positions through controlling the flow of communication between registered nurses and patients" (p 11).

The nurses in our study functioned as gatekeepers as to whether they would share medical information and knowledge about the new resident with the other nursing staff. The staff nurses also had the power to decide how they wanted to involve and supervise their staff. The findings in our study suggest that the auxiliaries at times did not work to the full of their scope. This appears to be in accordance with Spilsbury & Meyer [45], who in their UK study found that the nurses had the power to control whether the health care assistant used their skills and experience to the full. Still, the dynamic interactions between all the staff suggest the strong interdependence among them. In our previous study [20], the task of writing the handwritten care plans was delegated to the primary auxiliaries to be performed shortly after the new resident had arrived. This indicate that the nurses supported the auxiliaries' independent contributions. Alcorn and Topping [46] found that registered nurses supported the health care assistants' development, and that patient care was enhanced through their development.

However, some auxiliaries felt excluded since they were not involved in the residents' medical situation, and their intra-professional alliances seemed particularly important to them. One way of understanding this mechanism is that the auxiliaries found a niche for themselves within the organization, which protected them from the inherent organizational contradiction of not being involved in every aspect of the new resident, at the same time as being involved in everything [47]. Historically, the development of professions aimed at securing and protecting exclusive areas of knowledge [48], and the nurses and physician in our study acted according to this tradition. In line with some studies [9,37,49], we found that the professional cultures challenged spontaneous inter-professional collaboration, which again influenced how the new residents were treated initially. Current political trends [9,37,50] aim at developing cooperative competence among all staff categories, also the unlicensed staff. This requires close collaboration between different levels of educational institutions, and between practice institutions and educational institutions. Clark [51] found, by examining the interface between interprofessional practice and education in a Norwegian context, that there is a need to link developments in health care practice settings with those in education, "particularly in such areas as continuing professional development, may be critical to the success of inter-professional practice and inter-professional education" (p 31).

Few professional groups work in most Norwegian LTCFs and in this LTCF only nursing staff worked on an everyday basis. That the physician only interacted with the nurses also hampered cognitive diversity. In their study of two Norwegian nursing homes, Jakobsen & Granebo [52], found that there is a need for wider multidisciplinary teams to develop variations in the approaches to the older residents. The everyday extra activities provided by some enthusiasts, seemed to move the new

residents towards a healthy transition. Yet, the findings show that they may overshadow the new residents' complex needs, and well-meant activities from the staff's point of view may have the adverse effect on some residents. Moving into LTCF is a dramatic change in a person's life [15-17], and the person needs time to adjust to the new situation and circumstances. However, unlike in most countries, the nurses performed hands-on care. This provided diverse and complementary contributions in the spontaneous staff interactions. Moreover, the number of nurses helped maintain a clear nurse identity, and seemed to support their self-confidence in their interaction with the auxiliaries and assistants. Yet, the findings suggest that the freedom the staff nurses had to manage their units in different ways, could at times delay the work of the facility nurse.

The reading and writing of the daily reports and care plans was inefficiently performed by many. The notion that the computer program and its standards [53] from a social point of view serve as a "means for collaboration, shared meaning and far-reaching coordination among different health care professionals" (p 207) did not seem to be the view of many staff. Spontaneous oral interaction was the most useful. According to the WHO [37], inconsistent use and understanding of language may be a barrier to inter-professional collaborative practice. Ellingsen [53] argues that standardization efforts must target a level that is acceptable for those involved. Our findings suggest that the computer program did not consider the different levels of staff, and the computer care plans did not generally seem to guide the daily care of the new residents, particularly not the licensed staff who regarded the written care plans as rough guidelines only. This is in accordance with Lanham et al. [54], who argue that complex adaptive systems contain unpredictability, and that care be conceptualized as provisional plans for actions and not detailed plans to be strictly followed.

All these complex aspects of staff interactions appeared to create stress among some, regardless of formal position, although our findings suggest that the assistants, particularly the weekend supply staff, were those who most clearly appeared aloof from the rest of the staff. The focus of attention during negative stress shifts from interactions to withdrawal [49], to preserve the individual's dignity and self-esteem. Withdrawals may contribute to less nuanced care because they mean fewer opportunities to verbalize questions and actions, and thereby less awareness of one's own and other's work [55].

Conclusions

The continuous and spontaneous staff collaborations were key activities in supporting quality care in the transition period. These interactions maintained the inclusion of all staff present, staff flexibility, information flow to some extent, and cognitive diversity, and the new resident's emerging needs appeared met. Organizational structures, staff's formal position, and informal staff alliances were complex and sometimes appeared contradictory. Not all the staff were necessarily included, and the new residents' needs not always noticed and dealt with. Paying attention to the playing out of power in staff interactions appears vital to secure a healthy transition process for the older residents.

Strengths and limitations

The rich data from this small sample size study fulfil the intention of ethnographic studies to get in-depth insight into a phenomenon. This approach is valuable since no studies so far have investigated this phenomenon, and may help extract ideas and directions in future studies with larger samples and other designs. A future survey study of a representative sample of different staff employed in LTCFs could elucidate knowledge about this topic on a greater scale. Also, future studies need to link the development in health care practice settings during older residents' transitions into LTCF with different levels of educational institutions, to explore and encourage inter-professional collaboration.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

ME designed, collected, processed and analyzed the data, was responsible for the oversight of the study, and wrote the paper. SH together with ME designed, analyzed and read and revised drafts to the manuscript. BD commented on the manuscript. GAE together with the others read and approved the final manuscript.

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Appendices

Til pasienten 1

Forespørsel om deltagelse i forskningsstudie

«Overgang/flytting til langtidsavdeling i sykehjem. En studie av overgangsfasen hos eldre fra annet bosted til langtidsavdeling i sykehjem»

Bakgrunn og hensikt

Dette er et spørsmål til deg i å samtykke at din pårørende deltar i en intervjuundersøkelse som angår flyttingen og overgangsfasen for deg som pasient til langtidsavdelingen. Du kan synes det er rart at ikke du selv skal bli intervjuet, men du som pasient er ikke hovedfokus i denne undersøkelsen. Selv om intervjuene ikke fokuserer på din helsetilstand kan det likevel komme fram helseopplysninger om deg underveis i samtalen og det er grunnen til at vi ber om at du samtykker i at din pårørende deltar i denne undersøkelsen.

Målet med studien er å få innsikt i hvordan overgangsfaser til langtidsavdelinger for syke eldre oppfattes og ivaretas av pleierne, samt hvordan pårørende oppfatter at den gamle blir ivaretatt. Hensikten er å synliggjøre og utvikle kunnskap som kan bidra til god omsorg for pasientene og pårørende i slike overgangsfaser.

Forespørsel om deltagelse blir formidlet via avdelingsleder og navnet ditt vil ikke bli gjort kjent for forsker før du eventuelt gir ditt samtykke.

Hva innebærer studien?

Studien består av 3 delstudier. Din pårørende blir spurt om å delta i en av disse som er en intervjuundersøkelse. Pårørende vil bli intervjuet en gang i løpet av de første 2-4 ukene etter din innleggelse. Pårørende vil blant annet bli intervjuet om hvordan han/hun og du som pasient har opplevd flyttingen/overgangen til langtidsavdelinga, med fokus på hva som skjer på forhånd, under og etter flyttinga.

Intervjuet blir tatt opp på bånd og skrevet ut etterpå. Lydbånd og utskrift vil bli oppbevart i låsbart skap, der kun forsker har tilgang. Lydbånd og informasjon som kan knyttes til deg og pårørende vil bli slettet senest innen utgangen av 2016. Forsker som gjennomfører studien er Marianne Eika. Jeg er spesialsykepleier i eldreomsorg, og er doktorgradsstipendiat ved høgskolen i Telemark og NTNU i Trondheim.

Hva skjer med informasjonen om deg?

Forsker har taushetsplikt i forhold til alle opplysninger om deg, og all informasjon som innhentes vil bli behandlet konfidensielt. Informasjonen som innhentes om deg og pårørende skal kun brukes slik det er beskrevet i hensikten med studien. Alle opplysninger vil bli behandlet uten nevn eller andre gjenkjennende opplysninger. En kode knytter pårørende (og deg) til pårørendes opplysninger gjennom en navneliste. Det er kun forsker som har adgang til kode og navneliste. Kode- og navneliste slettes innen utgangen av 2016.

Frivillig deltagelse

Det er frivillig for pårørende å delta i undersøkelsen. Dersom din pårørende sier seg villig til å delta, spør vi deg om du samtykker i det. Pårørende kan når som helst og uten å oppgi grunn

trekke seg fra studien. Dette vil ikke få konsekvenser for ditt forhold til avdelingen i sykehjemmet. Dersom du samtykker i at din pårørende kan delta i undersøkelsen, undertegner du samtykkeerklæringen på siste side. Dersom du senere ønsker å trekke samtykkeerklæringen, kan du kontakte Marianne Eika, tlf. mobil: 97143576 eller 35575431. Kontaktadresse: Kjølnes Ring 56, 3901 Porsgrunn.

Studien er godkjent av regional etisk komite for medisinsk og helsefaglig forskning (REK).

Ytterligere informasjon om studien finnes i kapittel A – *utdypende forklaring av hva studien innebærer.*

Ytterligere informasjon om personvern og forsikring finnes i kapittel B – *personvern, økonomi og forsikring*

Kapittel A – utdypende forklaring av hva studien innebærer

Kriterier for deltagelse

De som blir forespurt om å delta i denne forskningsundersøkelsen er pårørende til eldre personer som nylig er innlagt i langtidsavdeling.

Bakgrunnsinformasjon om studien

Høgskolen i Telemark, avdeling for helse- og sosialfag har Omsorg 2015 som ett av sine satsningsområder. Satsningsområdet skal bidra til kunnskapsproduksjon og kompetanseheving innen blant annet eldreomsorg. Dette doktorgradsprosjektet knyttes til dette satsningsområdet. Prosjektet består av fire delstudier.

Eldre mennesker opplever mange overgangsfaser og de som kommer til langtidsavdeling kan ha opplevd flere overganger, fra blant annet sykehus og korttidsavdeling før de kommer til langtidsavdelingen. Slike flyttinger tar på og pasienten kan i starten av oppholdet i avdelingen være sliten og lei seg, og ikke orke så mye. Det er likevel spesielt viktig at pasienten opplever mestring, ved blant annet å ivareta noe av sin egenomsorg, for ellers er hun/han utsatt for å miste denne evnen. Å få kunnskap om den aktuelle overgangsfasen kan bidra til at pasienten og pårørende får best mulig hjelp i en slik periode.

Den første studien er deltagende observasjoner der forsker vil være i avdelingen alle dager den første uken etter at en pasient er kommet til avdelingen. Som pasient vil du nok legge merke til det. Den andre studien er intervjuer av pårørende, og den tredje studien er intervjuer av pleiere som arbeider i avdelingen.

Tidsskjema – hva skjer og når skjer det?

Siden det er uvisst når pasienten legges inn i langtidsavdelingen er det umulig å tidfeste helt når intervjuene fil finne sted. Imidlertid ønskes det intervjuer av pårørende innen 2-4 uker etter at du er kommet til avdelingen. Du får ganske raskt etter innleggelse forespørsel om samtykke.

Mulige fordeler og ulemper

Studien innebærer at pårørende formidler erfaringer og betraktninger knyttet til overgangen til langtidsavdelingen. Dette kan medføre tristhet og glede. Forsker skal utøve varsomhet for de grensene deltakerne ønsker å sette i intervjusituasjonen.

Kapittel B – personvern, økonomi og forsikring

Personvern

Opplysninger som registreres om deg er av-identifiserbare data. Det vil si, som forklart tidligere, at navn erstattes med en kode. Intervjuene blir overført til skriftlig form og analysert. I artiklene som skrives skal det ikke være mulig å kjenne igjen individuelle data. Lydbånd, navneliste og kodenøkkel vil bli slettet innen utgangen av 2016. Det er kun forsker som har tilgang til det innsamlede materialet. Datamaterialet i sin helhet vil bli slettet innen 2018.

Rett til innsyn og sletting

Dersom du samtykker i at din pårørende deltar i undersøkelsen, har du rett til å korrigere eventuelle feil i de opplysninger om deg som er registrert. Om pårørende trekker seg fra studien, kan hun/han kreve å få slettet innsamlede opplysninger, med mindre opplysninger som allerede er inngått i analyser brukt i vitenskapelige publikasjoner.

Økonomi og høgskolen i Telemark sin rolle

Høgskolen i Telemark har ansatt en stipendiat til å utføre disse studiene. Professor Olle Söderhamn ved universitetet i Agder er hovedveileder, og førsteamanuensis Sigrun Hvalvik ved høgskolen i Telemark er biveileder.

Informasjon om utfallet av studien

Deltagerne har rett til å få informasjon om resultatet av studien. Artiklene som blir publisert vil videreformidles til studiedeltagerne og virksomhetsledere.

Samtykke til at din pårørende deltar i studien:

«Overgang/flytting til langtidsavdeling i sykehjem. En studie av overgangsfasen hos eldre fra annet bosted til langtidsavdeling i sykehjem»

Jeg har lest informasjonsskrivet og jeg gir mitt samtykke til at min pårørende deltar i studien

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(signert av pasient, dato)

Jeg bekrefter å ha gitt informasjon om studien

(signert av forsker, dato)

Til pasienten 2

Forespørsel om deltagelse i forskningsstudie

«Overgang/flytting til langtidsavdeling i sykehjem. En studie av overgangsfasen hos eldre fra annet bosted til langtidsavdeling i sykehjem»

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie. Du blir forespurt om å delta fordi du nettopp har flyttet inn i avdelingen. Du blir berørt i den forstand at jeg som forsker vil være i avdelinga den første uka etter at du er innlagt, og skal delta i det som skjer i forhold til deg.

Målet med studien er å få innsikt i hvordan overgangsfaser til langtidsavdelinger for syke eldre oppfattes og ivaretas av pleierne, og hvilke utfordringer som oppstår underveis i oppholdet for pasienten, pårørende og pleierne. Hensikten er å synliggjøre og utvikle kunnskap som kan bidra til god omsorg for pasienten og pårørende i slike overganger.

Forespørsel om deltagelse blir formidlet via avdelingsleder og navnet ditt vil ikke bli gjort kjent for forsker før du eventuelt samtykker til det.

Hva innebærer studien?

Studien består av 3 delstudier. Du forespørres til å samtykke i å delta i en av dem. Imidlertid skal du ikke gjøre noe i forhold til meg, annet enn at du samtykker i at jeg deltar sammen med andre pleiere i pleie og samhandling med deg.

Forsker som gjennomfører studien er Marianne Eika. Jeg er spesialsykepleier i eldreomsorg, og er doktorgradsstipendiat ved høgskolen i Telemark og NTNU i Trondheim.

Hva skjer med informasjonen om deg?

Forsker har taushetsplikt i forhold til alle opplysninger om deg, og all informasjon som innhentes vil bli behandlet konfidensielt. Informasjonen som innhentes om deg skal kun brukes slik det er beskrevet i hensikten med studien. Alle opplysninger vil bli behandlet uten nevn eller andre gjenkjennende opplysninger.

Informasjonen som innhentes via deltagelse og intervjuer, vil danne grunnlag for artikler som skal publiseres. Det vil ikke være mulig å identifisere deg i resultatene av studiene når disse publiseres.

Frivillig deltagelse

Det er frivillig for deg å delta i undersøkelsen. Dersom du samtykker i å delta, kan du når som helst og uten å oppgi grunn, trekke deg fra studien. Dette vil ikke få konsekvenser for ditt forhold til avdelingen i sykehjemmet. Dersom du samtykker, undertegner du samtykkeerklæringen på siste siden. Dersom du senere ønsker å trekke samtykkeerklæringen, kan du kontakte Marianne Eika, tlf. mobil: 97143576 eller 35575431. Kontaktadresse: Kjølnes Ring 56, 3901 Porsgrunn.

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Ytterligere informasjon om personvern og forsikring finnes i kapittel B – *personvern, økonomi og forsikring*

Kapittel A – utdypende forklaring av hva studien innebærer

Bakgrunnsinformasjon om studien

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Den første studien er deltagende observasjoner der forsker vil være i avdelingen alle dager den første uken etter at en pasient er kommet til avdelingen. Som pasient vil du nok legge merke til det. Den andre studien er intervjuer av pårørende, og den tredje studien er intervjuer av pleiere som arbeider i avdelingen

Kapittel B – personvern, økonomi og forsikring

Personvern

Opplysninger som registreres om deg er av-identifiserbare data. Det vil si, som forklart tidligere, at navn erstattes med en kode. Intervjuene blir overført til skriftlig form og analysert. I artiklene som skrives skal det ikke være mulig å kjenne igjen individuelle data. Lydbånd, navneliste og kodenøkkel vil bli slettet innen utgangen av 2016. Det er kun forsker som har tilgang til det innsamlede materialet. Datamaterialet i sin helhet vil bli slettet innen 2018.

Rett til innsyn og sletting

Dersom du samtykker i å delta i undersøkelsen, har du rett til å korrigere eventuelle feil i de opplysninger om deg som er registrert. Om du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysninger som allerede er inngått i analyser brukt i vitenskapelige publikasjoner.

Økonomi og høgskolen i Telemark sin rolle

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Deltagerne har rett til å få informasjon om resultatet av studien. Artiklene som blir publisert vil videreformidles til studiedeltagerne og virksomhetsledere.

Samtykke til at du som pasient deltar i studien:

«Overgang/flytting til langtidsavdeling i sykehjem. En studie av overgangsfasen hos eldre fra annet bosted til langtidsavdeling i sykehjem»

Jeg har lest informasjonsskrivet og jeg gir mitt samtykke til å delta i studien

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(signert av pasient, dato)

Jeg bekrefter å ha gitt informasjon om studien

(signert av forsker, dato)

Til pleierne

Forespørsel om deltagelse i forskningsstudie

«Overgang/flytting til langtidsavdeling i sykehjem. En studie av overgangsfasen hos eldre fra annet bosted til langtidsavdeling i sykehjem»

Bakgrunn og hensikt

Mitt navn er Marianne Eika. Jeg er sjukepleier og doktorgradsstipendiat ved institutt for helsefag ved høgskolen i Telemark. Som en del av mitt doktorgradsprosjekt undersøker jeg hvordan flyttefasen og overgangen til langtidsavdeling i sykehjem for eldre syke mennesker oppfattes, erfares og ivaretas av pleiere og pårørende.

Grunnen til at denne undersøkelsen er igangsatt er at det finnes lite kunnskap om overgangsperiodene for syke, gamle mennesker som flytter til langtidsavdeling i sykehjem. Hensikten er å få tak i og å utvikle kunnskap som kan bidra til god omsorg for pasienter i overflyttingsfasen i slike avdelinger.

Dette er et spørsmål til deg om å delta i dette forskningsprosjektet. Studien består av 3 delprosjektet. Det første prosjektet er deltagende observasjoner, det andre prosjektet er intervjuer av pårørende og det tredje er intervjuer av pleiere som arbeider i avdelinga.

Hva innebærer studien?

I den første del-studien, vil jeg være i avdelinga alle ukedager den første uka etter at en ny pasient har flyttet inn. Det er tenkt å følge 10 nyinnlagte pasienter på denne måten. Jeg kommer til å være i avdelinga sammen med både dere og pasientene, og delta i de aktivitetene som foregår, men jeg har fokus på hva som skjer i forhold til den nyinnlagte pasienten. Jeg vil være i avdelinga 5-7 timer hver dag. Siden det er uvisst når det kommer nye pasienter til avdelinga, kan jeg ikke angi mer konkret når jeg vil være der. Imidlertid ønsker jeg å starte feltarbeidet fra mai/juni 2011.

Jeg kommer til å skrive notater i en kladdebok om observasjoner og samtaler som jeg mener kan belyse tematikken i forskningsprosjektet. Dette hjelper meg å huske.

Underveis vil noen av dere få forespørsel om å delta i et intervju. Forespørsel blir formidlet via avdelingsleder og navnet ditt vil ikke bli gjort kjent for meg før du evt. samtykker i å delta i studien. For pleierne sin del er dette intervjuet tenkt å foregå i arbeidstida i et rom utenfor avdelinga slik at vi får sitte i ro.

Mulige fordeler og ulemper

Fordelen med studien er at den kan bidra med kunnskap om hvordan flytting og overgang til langtidsavdelinger i sykehjem planlegges og ivaretas av pleiere. Denne kunnskapen er viktig for å gi best mulig omsorg i en slik overgangsfase. Det kan oppleves positivt å få mulighet til å vise sin kompetanse i slike situasjoner. På den andre siden kan feltarbeidet oppleves ubehagelig av noen av pleierne ved at forsker involverer seg i det daglige arbeidet i avdelinga. Siden denne studien er en av tre studier, vil dette eventuelle ubehaget kunne rettes opp ved at dere som pleiere har mulighet til å komme til orde i en intervjusituasjon senere.

Hva skjer med informasjonen om deg?

Forsker har taushetsplikt i forhold til alle opplysninger om deg, og all informasjon som innhentes vil bli behandlet konfidensielt. Intervjuene og observasjonene som blir gjort vil danne grunnlag for artikler som skal publiseres. Artiklene vil foreligge i anonymisert form. Det vil si at det ikke vil være mulig å kjenne igjen enkeltpersoner eller avdeling i studien.

Informasjonen som innhentes om deg skal kun brukes slik det er beskrevet i hensikten med studien. Alle opplysninger vil bli behandlet uten nevn eller andre gjenkjennende opplysninger. En kode knytter pårørende (og deg) til pårørendes opplysninger gjennom en navneliste. Det er kun forsker som har adgang til kode og navneliste. Kode- og navneliste slettes innen utgangen av 2016. Datamaterialet i sin helhet vil bli slettet innen 2018.

Frivillig deltagelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke fra å delta i prosjektet. Dersom du senere ønsker å trekke samtykkeerklæringen, kan du kontakte Marianne Eika, tlf. mobil: 97143576 eller 35575431. Kontaktadresse: Kjølnes Ring 56, 3901 Porsgrunn.

Studien er godkjent av regional etisk komite for medisinsk og helsefaglig forskning (REK).

Ytterligere informasjon om studien finnes i kapittel A – *utdypende forklaring av hva studien innebærer.*

Ytterligere informasjon om personvern og forsikring finnes i kapittel B – *personvern, økonomi og forsikring*

Kapittel A – utdypende forklaring av hva studien innebærer

Kriterier for deltagelse

Dere som blir forespurt om å delta i denne forskningsstudien er pleiere som arbeider i langtidsavdelingen.

Bakgrunnsinformasjon om studien

Høgskolen i Telemark, avdeling for helse- og sosialfag har Omsorg 2015 som ett av sine satsningsområder. Satsningsområdet skal bidra til kunnskapsproduksjon og kompetanseheving innen blant annet eldreomsorg. Dette doktorgradsprosjektet knyttes til dette satsningsområdet. Prosjektet består av fire delstudier.

Eldre mennesker opplever mange overgangsfaser og de som kommer til langtidsavdeling kan ha opplevd flere overganger, fra blant annet sykehus og korttidsavdeling før de kommer til langtidsavdelingen. Slike flyttinger tar på og pasienten kan i starten av oppholdet i avdelingen være sliten og lei seg, og ikke orke så mye. Det er likevel spesielt viktig at pasienten opplever mestring, ved blant annet å ivareta noe av sin egenomsorg, for ellers er hun/han utsatt for å miste denne evnen. Å få kunnskap om den aktuelle overgangsfasen kan bidra til at pasienten og pårørende får best mulig hjelp i en slik periode.

Den første studien er deltagende observasjoner der forsker vil være i avdelingen alle dager den første uka etter at en pasient er kommet til avdelingen. Som pleier vil du nok legge merke

til det. Den andre studien er intervjuer av pårørende, og den tredje studien er intervjuer av pleiere som arbeider i avdelingen.

Tidsskjema – hva skjer og når skjer det?

Siden det er uvisst når pasienter legges inn i langtidsavdelingen er det umulig å vite når intervjuene av pleierne vil finne sted. De skal imidlertid utføres etter at noe av den deltagende observasjonsstudien er unnagjort og noen av intervjuene med pårørende. Pårørende til nyinnlagte pasienter skal intervjues 2-4 uker etter innleggelse.

Intervjuene vil finne sted i sykehjemmet i løpet av arbeidsdagen, i et eget rom utenfor avdelingen. Intervjuene vil bli avtalt i god tid mellom forsker og pleier.

Mulige fordeler og ulemper

Studien innebærer at deltagerne formidler erfaringer og betraktninger knyttet til overgangsfasen til langtidsavdeling. For pleierne kan det være godt å få vist sin kompetanse, og også forklare eventuelle uklarheter som kan ha oppstått i forskers observasjonsperiode.

Kapittel B – personvern, økonomi og forsikring

Personvern

Opplysninger som registreres om deg er av-identifiserbare data. Det vil si, som forklart tidligere, at navn erstattes med en kode. Intervjuene blir overført til skriftlig form og analysert. I artiklene som skrives skal det ikke være mulig å kjenne igjen individuelle data. Lydbånd, navneliste og kodenøkkel vil bli slettet innen utgangen av 2016. Det er kun forsker som har tilgang til det innsamlede materialet.

Rett til innsyn og sletting

Dersom du samtykker i å delta i undersøkelsen, har du rett til å korrigere eventuelle feil i de opplysninger om deg som er registrert. Om du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysninger som allerede er inngått i analyser brukt i vitenskapelige publikasjoner.

Økonomi og høgskolen i Telemark sin rolle

Høgskolen i Telemark har ansatt en stipendiat til å utføre disse studiene. Professor Olle Söderhamn ved universitetet i Agder er hovedveileder, og førsteamanuensis Sigrun Hvalvik ved høgskolen i Telemark er biveileder.

Informasjon om utfallet av studien

Deltagerne har rett til å få informasjon om resultatet av studien. Artiklene som blir publisert vil videreformidles til studiedeltagerne og virksomhetsledere.

Samtykke til deltagelse i studien:

«Overgang/flytting til langtidsavdeling i sykehjem. En studie av overgangsfasen hos eldre fra annet bosted til langtidsavdeling i sykehjem»

Jeg har lest informasjonsskrivet og jeg er villig til å delta i studien

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(signert av studiedeltager, dato)

Jeg bekrefter å ha gitt informasjon om studien

(signert av forsker, dato)

Til pårørende

Forespørsel om deltagelse i forskningsstudie

«Overgang/flytting til langtidsavdeling i sykehjem. En studie av overgangsfasen hos eldre fra annet bosted til langtidsavdeling i sykehjem»

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie. Du blir forespurt om å delta i denne studien fordi du er pårørende til en nylig innlagt pasient i langtidsavdelingen. Dette er en ny situasjon for deg og pasienten. Målet med studien er å få bedre innsikt i hvordan overgangsfasen til langtidsavdelinger for syke eldre oppfattes av pleierne, og hvilke utfordringer som oppstår underveis i oppholdet både for pasienten og pårørende. Hensikten er å synliggjøre og utvikle kunnskap som kan bidra til god omsorg for pasientene og pårørende i slike overganger.

Forespørsel om deltagelse blir formidlet via avdelingsleder og navnet ditt vil ikke bli gjort kjent for forsker før du eventuelt samtykker til dette.

Hva innebærer studien?

Studien består av 3 delstudier. Du forespørres om å delta i en av disse som er en intervjuundersøkelse. Du vil bli intervjuet en gang i løpet av de første 2-4 ukene etter din innleggelse. Du vil blant annet bli intervjuet om hvordan du har opplevd flyttinga til langtidsavdelingen for pasienten og deg selv. Det er fokus på det som skjer på forhånd, under og etter flyttinga. Det kan synes merkelig at ikke pasienten selv skal intervjues. Men eldre som legges inn i langtidsavdelinger kan ha problemer med å gjennomføre denne type intervjuer. De vil imidlertid bli informert skriftlig og muntlig om studien og gi sitt samtykke til at du som pårørende deltar, dersom det er mulig.

Når og hvor intervjuet skal finne sted kan avtales med forsker etter at du har sagt deg villig til å delta. Intervjuet vil vare ca. 1-1,5 time. Intervjuet blir tatt opp på bånd og skrevet ut etterpå. Lydbånd og utskrift vil bli oppbevart i låsbart skap, der kun forsker har tilgang. Lydbånd og informasjon som kan knyttes til deg og pårørende vil bli slettet senest innen utgangen av 2016. Forsker som gjennomfører studien er Marianne Eika. Jeg er spesialsykepleier i eldreomsorg, og er doktorgradsstipendiat ved høgskolen i Telemark og NTNU i Trondheim.

Mulige fordeler og ulemper

Fordelen med studien er at den kan bidra med fokus på og kunnskap om overgangsfasen som kan ha betydning for pasientens opphold i slike langtidsavdelinger. Studien vil ikke gi den enkelte deltager noen direkte fordeler. Det kan imidlertid oppleves positivt for deg som pårørende å få snakket om denne overgangen.

Hva skjer med informasjonen om deg?

Forsker har taushetsplikt i forhold til alle opplysninger om deg, og all informasjon som innhentes vil bli behandlet konfidensielt. Siden det i intervjusituasjonen med deg kan komme fram informasjon om pasientens helsetilstand, må den pasienten som er samtykkekompetent samtykke i at du som pårørende deltar i denne undersøkelsen.

Intervjuene som blir gjennomført vil sammen med andre studier, danne grunnlaget for artikler som skal publiseres. Artiklene vil foreligge i anonymisert form. Det vil si at det ikke vil være mulig å kjenne igjen enkeltpersoner i studien.

Informasjonen som innhentes om deg og pårørende skal kun brukes slik det er beskrevet i hensikten med studien. Alle opplysninger vil bli behandlet uten nevn eller andre gjenkjennende opplysninger. En kode knytter pårørende (og deg) til pårørendes opplysninger gjennom en navneliste. Det er kun forsker som har adgang til kode og navneliste. Kode- og navneliste slettes innen utgangen av 2016.

Frivillig deltagelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi grunn trekke deg fra studien. Dette vil ikke få konsekvenser for ditt forhold til avdelingen i sykehjemmet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Dersom du senere ønsker å trekke samtykkeerklæringen, kan du kontakte Marianne Eika, tlf. mobil: 97143576 eller 35575431. Kontaktadresse: Kjølnes Ring 56, 3901 Porsgrunn.

Studien er godkjent av regional etisk komite for medisinsk og helsefaglig forskning (REK).

Ytterligere informasjon om studien finnes i kapittel A – *utdypende forklaring av hva studien innebærer.*

Ytterligere informasjon om personvern og forsikring finnes i kapittel B – *personvern, økonomi og forsikring*

Kapittel A – utdypende forklaring av hva studien innebærer

Kriterier for deltagelse

Dere som blir forespurt om å delta i denne forskningsundersøkelsen er pårørende til eldre personer som nylig er innlagt i langtidsavdeling.

Bakgrunnsinformasjon om studien

Høgskolen i Telemark, avdeling for helse- og sosialfag har Omsorg 2015 som ett av sine satsningsområder. Satsningsområdet skal bidra til kunnskapsproduksjon og kompetanseheving innen blant annet eldreomsorg. Dette doktorgradsprosjektet knyttes til dette satsningsområdet. Prosjektet består av fire delstudier.

Eldre mennesker opplever mange overgangsfaser og de som kommer til langtidsavdeling kan ha opplevd flere overganger, fra blant annet sykehus og korttidsavdeling før de kommer til langtidsavdelingen. Slike flyttinger tar på og pasienten kan i starten av oppholdet i avdelingen være sliten og lei seg, og ikke orke så mye. Det er likevel spesielt viktig at pasienten opplever mestring, ved blant annet å ivareta noe av sin egenomsorg, for ellers er hun/han utsatt for å miste denne evnen. Å få kunnskap om den aktuelle overgangsfasen kan bidra til at pasienten og pårørende får best mulig hjelp i en slik periode.

Den første studien er deltagende observasjoner der forsker vil være i avdelingen alle dager den første uka etter at en pasient er kommet til avdelingen. Som pasient vil du nok legge

merke til det. Den andre studien er intervjuer av pårørende, og den tredje studien er intervjuer av pleiere som arbeider i avdelingen.

Tidsskjema – hva skjer og når skjer det?

Siden det er uvisst når pasienten legges inn i langtidsavdelingen er det umulig å tidfeste helt når intervjuene fil finne sted. Imidlertid ønskes det intervjuer av pårørende innen 2-4 uker etter at pasienten er kommet til avdelingen. Du får ganske raskt etter innleggelse forespørsel om å delta.

Mulige fordeler og ulemper

Studien innebærer at pårørende formidler erfaringer og betraktninger knyttet til overgangen til langtidsavdelingen. Dette kan medføre tristhet og glede. Forsker skal utøve varsomhet for de grensene deltakerne ønsker å sette i intervjusituasjonen.

Kapittel B – personvern, økonomi og forsikring

Personvern

Opplysninger som registreres om deg er av-identifiserbare data. Det vil si, som forklart tidligere, at navn erstattes med en kode. Intervjuene blir overført til skriftlig form og analysert. I artiklene som skrives skal det ikke være mulig å kjenne igjen individuelle data. Lydbånd, navneliste og kodenøkkel vil bli slettet innen utgangen av 2016. Det er kun forsker som har tilgang til det innsamlede materialet. Datamaterialet i sin helhet vil bli slettet innen 2018.

Rett til innsyn og sletting

Dersom du samtykker i å delta i undersøkelsen, har du rett til å korrigere eventuelle feil i de opplysninger om deg som er registrert. Om pårørende trekker seg fra studien, kan hun/han kreve å få slettet innsamlede opplysninger, med mindre opplysninger som allerede er inngått i analyser brukt i vitenskapelige publikasjoner.

Økonomi og høgskolen i Telemark sin rolle

Høgskolen i Telemark har ansatt en stipendiat til å utføre disse studiene. Professor Olle Söderhamn ved universitetet i Agder er hovedveileder, og førsteamanuensis Sigrun Hvalvik ved høgskolen i Telemark er biveileder.

Informasjon om utfallet av studien

Deltagerne har rett til å få informasjon om resultatet av studien. Artiklene som blir publisert vil videreformidles til studiedeltagerne og virksomhetsledere.

Samtykke til at du som pårørende deltar i studien:

«Overgang/flytting til langtidsavdeling i sykehjem. En studie av overgangsfasen hos eldre fra annet bosted til langtidsavdeling i sykehjem»

Jeg har lest informasjonsskrivet og jeg gir mitt samtykke til å delta i studien

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(signert av pårørende, dato)

Jeg bekrefter å ha gitt informasjon om studien

(signert av forsker, dato)

UNIVERSITETET I OSLO
DET MEDISINSKE FAKULTET

Cand. Philol. Marianne Eika
Høgskolen i Telemark
Institutt for Helsefag
Postboks 203
3901 Porsgrunn

Regional komité for medisinsk og helsefaglig forskningsetikk sør-øst B (REK sør-øst B)
Postboks 1130 Blindern
NO-0318 Oslo

Telefon: 22 84 46 24

E-post: post@helseforskning.etikkom.no
Nettadresse: http://helseforskning.etikkom.no

Dato: 10.03.11
Deres ref.:
Vår ref.: 2011/153-1

2011/153b Innleggelse av eldre pasienter i langtidsavdeling i sykehjem med fokus på overgangen. Studier i hvordan nylig innlagte pasienter blir oppfattet, erfart og hjulpet av pleiere og pårørende

Prosjektleder: Marianne Eika
Forskningsansvarlig: Høgskolen i Telemark ved øverste ledelse

Saksfremstilling
Formålet med studien er å undersøke hvordan eldre pasienter som legges inn på langtidssykehjem behandles av pleierne i overgangsperioden etter innleggelse, og spesielt i hvilken grad deres evne til egenomsorg kan ivaretas i forbindelse med denne overgangen.

Studien har i utgangspunktet fokus på pleiere og pårørende til nylig innlagte pasienter i en langtidsavdeling i sykehjem. Pårørende er primært valgt fordi ca 70 % av pasientene som legges inn i langtidsavdelinger har kognitiv svikt. Prosjektet det søkes om består av tre delstudier (et fjerde delstudium skal det søkes om separat om): 1. En observasjonsstudie av behandlingen som ca 10 pasienter mottar av pleiere den første uke etter innleggelse; 2. Intervjuer med pleiere om hvordan de behandler pasientene i overgangsperioden; 3. Intervjuer med pårørende om hvordan de oppfatter overgangsperioden.

Forskningsetisk vurdering
Prosjektets formål virker samfunnsnyttig. Skriftlig samtykke skal gis av både pleiere og pårørende som intervjues. I tillegg skal de pasientene som har samtykkekompetanse gi samtykke til at pårørende intervjues, da pårørende i intervjuet kan gi informasjon om pasientens helsetilstand. Søker skriver at en del av pasientene kan ha kognitiv svikt og dermed manglende samtykkekompetanse, og i de tilfellene, bes det om samtykke fra pårørende på deres vegne. Det legges ikke opp til at pasientene skal samtykke til delstudium 1, der forskeren skal observere pleiers samspill med pasientene. Komiteen mener at også delstudium 1 bør være samtykkebasert og setter derfor det som vilkår for gjennomføring av studien.

Informasjonsskriv og samtykkeerklæring
Informasjonsskriv og samtykkeerklæring virker god utformet. Komiteen vil likevel bemerke at ved bruk av stedfortredende samtykke, pga redusert samtykkekompetanse hos forskningsdeltaker, skal man ta hensyn til forskningsdeltakernes personlige integritet. Personer med redusert samtykkekompetanse har nektelseskomptanse som skal respekteres.

Vedtak
Komiteen godkjenner at prosjektet gjennomføres i samsvar med det som framgår av søknaden og på det vilkår at samtlige deler av studien er samtykkebasert.

Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden, og de bestemmelser som følger av helseforskningsloven med forskrifter.

Dersom det skal gjøres endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden, må prosjektleder sende endringsmelding til REK.

Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder for «Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren». Personidentifiserbare data slettes straks det ikke lenger er behov for dem og senest ved prosjektets avslutning.

Godkjenningen gjelder til 01.08.2016. Prosjektet skal sende sluttmelding på eget skjema, senest et halvt år etter prosjektslutt, jfr helseforskningsloven § 12.

Vi ber om at alle henvendelser sendes inn via vår saksportal:
http://helseforskning.etikkom.no eller på e-post til post@helseforskning.etikkom.no.

Vennligst oppgi vårt referansenummer i korrespondansen.

Med vennlig hilsen,

Stein Opjordsmoen Ilner (sign.)
Professor dr. med
Komiteleder

Katrine Ore
Katrine Ore
Komitésekretær/Rådgiver

Kopi:
- Dekan Kathrine Cappelen, Avdeling for helse og sosialfag, Høgskolen i Telemark, kathrine.cappelen@hit.no