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Transitional 'Hospital to Home' Care of Older Patients: Healthcare Professionals' Perspectives

Running title: Health carer perspectives - transitional care

Abstract

Background: Transitional care is a key area of care provision to older people with chronic and complex health conditions and is associated with the quality of care delivered in the healthcare system.

Aims: This study aimed to explore the perspectives of healthcare providers, including nurses and physicians, regarding transitional care from hospital to home in an urban area of Turkey.

Methods: A qualitative study using a thematic analysis method was carried out. In-depth semi-structured interviews were held with eight clinical nurses and five general physicians involved in the provision of healthcare services to older patients in the transitional care process from hospital to home.

Findings: The thematic analysis of in-depth semi-structured interviews with 13 healthcare professionals led to the development of the following themes: 'uninterrupted chain of care transfer', 'commitment to meet patient's needs', and 'support and removing ambiguities'.

*Conclusions***:** Key factors impacting on the quality and safety of transitional care and continuity of healthcare are communication and collaboration between healthcare staff and settings, and older patients' as well as family caregivers' awareness and their feelings of responsibility toward the continuity of care at home.

Keywords: continuity of care, discharge planning, interdisciplinary collaboration, nursing, transitional care, safe care.

Introduction

Hospital stays have reduced to an average of 4.1 days in Turkish healthcare settings [1], however, no nationwide statistics on readmission rates exist and individual studies have reported rates of 21% and 12% for adults and older people, respectively [2,3]. The international literature indicates that the readmission rates of older people varies from 8% to 13% higher than the rate in other age groups [4,5,6].

The term older people is generally defined according to their chronological age, and people aged 65 years and over are considered 'older people' in Turkey similar to other countries [7]. Older patients discharged from hospital to home in Turkey are referred to outpatient clinics for follow-up care and therapeutic consultations [8]. Specialist physicians, general physicians (GPs) and nurses provide home visits to meet older people's care needs after discharge [9-12].

Transitional care of older people

The worlds populations are aging. It is expected that those aged over 60 years will triple in the next 50 years compared to the beginning of the 21st century and by 2050 this group will form 22% of the world's population. In the past, rapid ageing was a health-related issue for wealthy countries, but many countries will be confronted by this global issue with unmatched healthcare resources and predicted staff shortages [13].

Older people often suffer from multiple chronic health conditions; almost 68% have two or more chronic conditions, and 80% have at least one chronic health condition [14, 15]. This group experience reduced abilities to independently perform daily living activities and often isolate themselves from their social life as their disease progress [15,16].

The Astana Declaration on Primary Health Care states that everybody has the right to have access to promotive, preventive, curative, rehabilitative services and palliative care.

Also, the crucial importance of health promotion and disease prevention is no longer underemphasized, and fragmented, unsafe or poor quality of care can not be tolerated. This statement highlights the need to allocate appropriate and sufficient healthcare resources to maintain and improve the quality of life of older patients in order to reduce the disease burden [17].

Transitional care is defined by the World Health Organization (WHO) as

> *…the various points where a patient moves to, or returns from, a particular physical location or makes contact with a health care professional for the purposes of receiving health care. This includes transitions between home, hospital, residential care settings and consultations with different health care providers in out-patient facilities* [18].

It forms an important part of initiatives to prevent the readmission of patients to healthcare settings and provide integrated and home-based healthcare services [19]. Healthcare providers practicing at primary and hospital settings have the responsibility to adequately prepare and empower patients and their informal caregivers for managing challenges that they may experience in the post-discharge period. The reduction in the length of hospital stay places further empahsis on this important role [20]. Accordingly, healthcare reforms have been expanded to strengthen the role of primary and community healthcare and to link social care with healthcare services to meet the care needs of patients following hospital discharge [21]. Interventions to improve transitional care encompass the reduction of health-related risk factors, patient education and standardisation of the discharge process [22]. Well-established transitional care programmes for older patients need to ensure an appropriate assessment of older person's health conditions, involvement of older patients and their family caregivers in their discharge planning, improvement of

self-care initiatives, and defined roles of healthcare professionals in post discharge care [23, 24].

In the Turkish healthcare system, upon the request of patients or their carers, family physicians along with nurses practicing at family healthcare and home healthcare settings provide home visits to meet the care needs of older patients. If it is necessary, the home healthcare team invites specialist physicians for the provision of appropriate care. Generally, family physicians and the home healthcare team receive information regarding transitional care of older patients from hospital to their own homes from the letter of discharge [9-12].

Transitional care should consider the real environment and available resources at home that facilitates the continuity of care in order to achieve expected outcomes. In this respect, healthcare staff assess the patient's function for self-care, mobility and cognition to develop integrative care plans [25]. As front-line healthcare professionals, nurses are equipped to get a realistic insight about patient's care needs for safer transitional care. It has been proposed that the nurses' core role is integral to successful transitional care and that nurses are central to the management and coordination of roles and tasks of other healthcare providers [25, 26]. Furthermore, nurses assess the biopsychosocial, emotional and environmental needs of patients and their family caregivers through interacting with them at sensitive times of transitional care. They plan for care in community-based settings, including outpatient clinics and home healthcare, and identify barriers to the provision of medical and nursing care [25]. Home healthcare services provided by nurses have been shown to play an essential and critical role in the management of transitional care needs of older adults and prevention of post-discharge adverse drug events that can

lead to hospital readmissions through identifying healthcare issues and immediate interventions [27].

All healthcare providers, especially community nurses, and informal caregivers involved in transitional care should be well-trained and continuously supported. Working without sufficient resources, or a lack of the support by the multidisciplinary team, is recognised as a cause of burnout leading to high turnover in community healthcare settings [28, 29]. Developing competencies to manage the care needs of patients with disabilities, multiple chronic conditions, neurodegenerative diseases, mental ill health, complex and prolonged deaths are of particular relevance. Investments and innovations to build sustainable support systems and communication platforms to rapidly manage patients' and their caregivers' healthcare, medication-related, social, and spiritual care needs is of major importance. The investigations and explorations of transitional care to map gaps and improve this highly relevant area of nursing practice are of high importance to enhance policy, practice, and education.

The perspectives of healthcare professionals involved in transitional care of older patients in Turkey is under-researched. Understandings of these perspectives can be utilised to improve care and reduce readmissions through identifying necessary improvements to transitional care protocols. The definition and identity of transitional care are similar in healthcare settings across the globe given variations in resources and cultural factors influencing transitional care [30], which highlights the importance of studying this phenomenon in different cultural-contexts. Therefore, this study aimed to explore the perspectives of healthcare providers serving older patients after discharge from hospital to home regarding transitional care in an urban area of Turkey.

Methods

Design and data collection

This study used a qualitative approach to enhance our understandings and gain an in-depth knowledge of the perspectives of healthcare professionals involved in transitional care.

In-depth semi-structured interviews [31] were held with eight nurses and five general physicians (GPs) involved in the provision of healthcare services to older patients in the transitional hospital to home care process.

Purposive sampling was used to select the participants from February to April 2019 from both public and private community healthcare sectors in an urban area of Turkey. Inclusion criteria for the selection of healthcare professionals were nurses and GPs working in community healthcare settings, being involved in transitional care of older patients from hospital to home, and paying home visits to older patients in the first two weeks following hospital discharge.

The community healthcare department managers for family and home healthcare centres were contacted to provide the list of healthcare providers visiting older patients at home in the first two weeks following hospital discharge. Nurses and GPs were invited to take part in the study by the departmental managers and those who accepted to attend the study were scheduled regarding the time and place of interviews.

Participant GPs represented public family health centres (n=2), public home healthcare centres (n=2), and a home healthcare centre supported by the public sector (n=1). Participant nurses represented a public home healthcare centre (n=1), a home healthcare centre supported by the private sector (n=1), public family health centre (n=1) and healthcare centres supported by the public sector (n=5). The interviews were conducted

in the Turkish language by the first researcher (ID) in the healthcare professional's office convenient to them.

The guide for semi-structured interviews consisted of the following questions:

How do you conduct discharge planning for older patients?

What challenges do you face for discharge and transitional care from hospital to home?

How do you manage discharge planning challenges?

Probing and branching questions were asked to explore the participants' perspectives and improve the interviews' depth. For instance, they were asked to provide examples for their perspectives, which helped deepen our understandings of the study phenomenon. Given the participants' tolerance and interests to continue with the data collection process, the interview duration varied from 10-30 minutes. Interviews were collected until data saturation was reached with data collection and data analysis conducted simultaneously. The reach of the data saturation was decided when there were no different information and themes derived from data after 13 interviews [31].

Ethical considerations

Non-invasive Investigation Ethics Committee affiliated to the University in which the second author worked provided approval (decree code: 18/285). All participants were fully informed about the study aim, method and process to maintain confidentiality. Each granted consent to audio-record the interview. All transcripts were de-identified through code number allocation.

Data analysis

The thematic analysis method suggested by Braun and Clarke (2006) was utilised for transcript analysis [32]. Audio-recorded data were transcribed *verbatim* and read several

times to become fully familiarised with the content in order to understand underlying ideas and assumptions. Initial codes were generated through open-coding. Themes were developed through comparing and contrasting the codes on the basis of their similarities and differences in an iterative process to refine the themes' names and definitions [33]. The R software package for Qualitative Data Analysis (RQDA) was used for data management. The consolidated criteria for reporting qualitative research (COREQ) guideline [34] was used for reporting this study.

Rigor

The validity of translation of findings from Turkish to English was ensured by the first author (ID) who is proficient in both languages. The whole research team was involved in coding and held discussions for developing themes to achieve a plausible and coherent portrayal and interpretation of the study phenomenon. For member checking, a brief report of findings was given to three participants and were asked to confirm the accuracy of presentation of their perspectives. The first researcher was available to answer their questions and provide descriptions about the findings. For peer checking, two qualitative researchers who were not part of the research team provided external auditing and endorsed the data analysis process [31]. The researchers were aware that the first author's clinical nurse background and being a nurse academic might influence the respondents during the interviews as an interviewer. Therefore, as a matter of reflexivity, she endeavoured to be conscientious of her behaviours and feelings during the interviews through writing reflective notes by which she set aside her own personal feelings and experiences and hindered their impacts on the interpretation of findings [35, 36].

Results

The nurses mean age was 38.1 years (SD= 9.4), with a mean experience of 22.1 years (SD: 10.1) and home/family nursing experience of 7.4 years (SD= 4.2). The mean age of the GPs was 47.2 years (SD: 11.7) with mean years of practice of 21.2 years (SD= 10.8) and in home/family care 8.3 years (SD= 4.6). Demographic details are provided in **Table 1.**

Three main themes were developed from the data: 'uninterrupted chain of care transfer', 'commitment to meet patient's needs', and 'support and removing ambiguities'. **Figure 1** presents a summary of key factors of the healthcare providers' perspectives. Direct quotations are presented in support of each theme.

1. *Uninterrupted chain of care transfer*

This theme represents the importance of information provided by healthcare staff in the hospital before discharge to older patients and their family caregivers. It also highlighted the discharge policy and process at hospital and the type of follow up measures implemented at discharge to safely transfer patients to their own home.

The letter of discharge often did not include detailed information about how the family caregiver or family physician should follow-up the therapeutic regimen after hospital discharge. The lack of a treatment protocol for home care led to confusion regarding caring initiatives after discharge and frequent visits of older patients to hospitals and family healthcare centres.

> *…that is, there is no remark for us on how to follow up patient care in terms of dressing, blood tests, examination and assessment, that are troublesome. Also, patients' and their family caregivers' have not received enough education. I try reading and evaluating the epicrisis, but it contains not enough information and detail.* (GP 5)

Participants indicated the need for a well-established electronic system to facilitate knowledge transfer from hospital to home carers and physicians concerning what measures should be taken for care planning and follow-up.

> … *I should be notified of the reproductive issues of women via the electronic system, through sending a note from the hospital regarding treatment of the patient* (GP5)

It was stated that the orientation of older patients and their family caregivers for transitional care needs was often overlooked leading to a lack knowledge of how to continue care and or how to get consultations for treatment complications or maintaining adherence to the therapeutic regimen.

> …, *after orthopaedic surgeries, subcutaneous thrombolytic drugs are often administered. The patients often cannot administer it at home and do not know about its importance, because they have not been taught about it during hospitalization and discharge. They do not know about wound care and probable complications, and how to get information about them* … (GP5)
>
> Another participants stated: *Most patients do not know when to go for follow up examinations and control…, they often come to ask me when they can start walking and weigh tolerance on their feet.* (GP3)

Provision of information in the written format to older patients and their home carers was prioritized rather than verbal provision of instructions that could be forgotten. Information provided at the discharge should have a holistic perspective and encompass all therapeutic procedures performed at hospital, It should clarify what would be the duty of home/family healthcare centres and communication channels between hospitalization and community

settings for an early response to patients' health-related concerns. Instead of the provision of information on the same day of discharge from hospital, it was requested that hospital staff educate the older patients and their family carers one day in advance giving them enough time to reflect and express their concerns rather than needing to convey all their uncertainties to healthcare staff in home/family healthcare centres.

> *…older people and their family carers forget or do not understand them [provided information], but… a printed instruction such as a checklist…can be really helpful rather than waiting to receive information from home healthcare services,...I think health is holistic and should not be loaded into a single unit. They should be informed about what situations should be paid attention to, and how they can meet their needs, how make an appointment, and what would be the next care process etc.* (Nurse 8)

Variations in hospital discharge education and information hindered the development of a unified transitional care for all older patients.

> *Obviously, it [epicrisis] changes from one doctor to another doctor, or from one hospital to another one. Teaching hospitals often provide a suitable epicrisis, but some other epicrisises are bad, and lack information on what should be done. During patient's visit, I find that insulin has not been administered for a couple of days, because the patient does not know how to do it.* (GP2)
>
> Another participant indicated: *Discharge reports should contain sufficient information for us [nurses], as sometimes discharge reports do not cover what should be exactly done at home.* (Nurse 3)

Private hospitals often provided a better arrangement for home healthcare services and with specialist physicians and private nurses available to visit patients at their own home, if needed.

> *Public hospitals do not deal much with patients after discharge… and the carer should take the patient to the hospital, … but regarding private hospitals, the older patient is regularly visited and his/her health issues are actively monitored and resolved.* (Nurse 3)

2. *Commitment to meet patient's needs*

This theme described healthcare provider's commitment to meeting patient needs and home visits as part of home healthcare. While on-demand family physician visits were not always possible, nurses and physicians in home healthcare services declared their readiness to pay home visits. However, responding to all calls for home visits sometimes led to service misuse, as users often misunderstood the aim of home healthcare and contacted healthcare staff for any trivial change in the patient's health condition.

> *I am the first person [as a family physician] who can be reached by patients and can provide care if she/he cannot access anywhere else. I go there [home visit] and evaluate the general condition of the patient.* (GP5).
>
> Another participant added: *He [family physician] knows everything, …but he refers to home healthcare centres to prescribe medicines to the patient.* (Nurse 5).
>
> In addition, a participant said: *Home visit applications are not refused at all and we respond them all, …we evaluate the patient at home… sometimes this is unnecessary. I mean patients and their carers can manage it at home without help.* (Nurse 2)

The provision of home healthcare to older patients and their family caregivers was guaranteed until older patients were fully treated or could manage their own care safely and independently. In the case of emergencies, public home healthcare centres prioritized the older patient's health condition and arranged appointments at outpatient clinics or admission to hospital. However, a lack of coordination between home healthcare centres and inpatient care settings was observed. This appeared to occur because they were funded and supported by different bodies including municipality, private and public sectors, that had different scopes of service. Another identified problem was the distance between the patients' homes and outpatient clinics in the metropolitan areas that could delay access to the patient.

> *Our support continues until they [patients] are fully recovered. Mostly they need visit every other day for 2 weeks. We assess them routinely once a week and educate them. About 90 percent of them can do their own care by their own for example perform injections.* (GP4).
>
> Another participant said: *If the patient should be hospitalized, we will inform the relevant healthcare department [inpatient setting], … if the patient has difficulty to make an appointment at an outpatient clinic, … , we give a priority to him/her.* (GP2).
>
> It was stated also that … *generally, we are unable to make direct contacts with the public home healthcare centre. We provide direct patient care such as home examinations and tests, but the public home healthcare centres prescribe medicines.* (Nurse 5).

Healthcare professionals for both home healthcare centres or family health centres confessed their lack of up-to-date knowledge of wound dressing or the use of new medical devices at home, due to gaps in continuing education provision.

> *…principles of wound dressing changes continually and there are various dressings to different types of surgeries. This is a challenge for transitional care.* (GP5)
>
> It was added that *Patients need different medical devices, and since we do not work in the hospital, we have no knowledge about them all.* (Nurse 7)

Nurse participants brought forward authorization issues influencing the implementation of nursing care at home. For instance, in the past, nurses performed urethral catheterization but currently insertion was performed only by the physician due to healthcare system legal reforms. Accordingly, the older patients had to wait for catheter changes until a physician was available for a home visit.

> *Now we refer older patients for urethral catheterization to family physicians. We used to insert the urethral catheter [at home] in the past or could insert an intravenous catheter.* (Nurse 6).

Shortcomings in the provision of transition care was attributed to insufficient resources such as transfer ambulances or times of service high demand. .

> *There is only a doctor and a nurse. Sometimes all demands come on the same day and we are a few staff with a few ambulances for patient transfer…* (Nurse 5)

Another participant said: *Transitional care needs special healthcare staff… I think, there should be only healthcare professional people who are responsible to meet older patients' needs after discharge.* (Nurse 1)

3. Support and removing ambiguities

In this theme the role of healthcare providers with adaptation to the transitional care condition was highlighted. The multiple disorders and the complex nature of an older patients' health condition resulted in higher dependence on transitional healthcare providers support and frequent home visits.

… an older patient with PEG [percutaneous endoscopic gastrostomy], has a wound, urinary catheter, or tracheostomy [tube]. As soon as they [home healthcare providers] leave the patients, their situation [patient's health situation] gets deteriorated. (Nurse 3)

Moreover, another participant said: *Many of the patients suffer from lung diseases or have urinary tract infection. The cause of death in 90% of them is this [infections].* (GP3)

Older patients and caregivers need to accept responsibility for those aspects of home care that they can be educated to manage. However, some requested that all caring tasks at home should be done by healthcare providers as they reasoned that they had no knowledge of patient care. Consequently, they did not fully participate in their own care or did not comply with the therapeutic regimen leading to hospital readmission.

Sometime when I visit older patients at home, the carer just says, 'he/she has been hospitalized'. The problem is carers' ignorance, indifference and lack of knowledge of how to provide care. They say

that 'we administer medicines', but they do not know even the name of the medicines. (GP2)

It was added that: *This is a wrong perception that healthcare professionals will do all [healthcare] and do it for free.* (GP5)

Family caregivers were often unwilling to take part in patient care due to the fear of making mistakes. They asserted that caring was the responsibility of healthcare providers and older patients in the hands of family caregivers were not 100% safe.

This is the duty of hospital staff to teach patients and their carers of their duties before discharge and what would be their responsibilities. (GP4)

Next participant said: *They [patients and their carers] often say: 'we cannot do it' at the beginning, because of the fear of doing wrong, …, some of them think that every intervention should be done by healthcare staff…* (Nurse 7)

Older patients and their carers incorrectly perceived that medicines should be prescribed for the treatment of all kind of diseases. This undermined advice given by healthcare professionals such as walking, taking rest and following diet changes, resulted in a lack of adherence to the therapeutic regimen.

Some has a common understanding that only a tablet can solve everything. (GP4)

Another participant confirmed that: … *they [carers] do not mobilize the patient, and older patients lay the whole day on the ground and never encourage patients to walk.* (Nurse 2)

This qualitative study explored the perspectives of healthcare providers who were involved in transitional care from hospital to home in an urban area of Turkey. The healthcare professionals articulated the need for better and more detailed discharge treatment protocols for home care. They expressed their overall willingness to support patients and their caregivers, despite occasionally leading to the misuse of provided services, and stressed the importance of patient's and caregiver's education.

Discussion

In this explorative study, issues in the comprehensiveness of the discharge program and informing older patients and their family caregivers about home healthcare as well as the arrangement of care between healthcare settings were reported as barriers to safe transitional care. Similarly, an Australian study reported that GPs did not always receive enough information about patients' discharge and relied on patients' descriptions of their healthcare needs [37]. While it is believed that the continuous transfer of patient information between healthcare settings is crucial for the continuity of care [38], there is no a standardised format for a hospital discharge letter and it may exhibit uncertainties, especially in terms of medicines management, for the primary care provider [39, 40]. Moreover, patients are often discharged with insufficient instructions regarding simple wound dressing at home [38, 41]. Therefore, a better hospital discharge experience needs better care planning and the building of collaborations with hospital staff for appropriate information transfer [42]. However, the quality and quantity of information needed in the discharge letter for older patients needs further research [41, 43].

Healthcare staff participating in this study indicated their commitment to meet all older patients' and their carers' needs until they reach independence. However, insufficient resources and staffing issues were stated as barriers to perform home care tasks. Staff

shortages for home care follow up and home visits have been shown to hinder transitional care [41, 44] and reduce the ability to meet all older patients' needs [37]. The lack of coordination and communication between healthcare professionals practicing at different healthcare settings, role confusion, conflict and lower qualified staff are associated with patients' poor health outcomes [37, 45]. Authorization problems between nurses and physicians regarding who is responsible and accountable for healthcare provision are a challenge to developing quality transitional care programs [38, 42]. Transitional care interventions for older patients can be cost-effective, but are dependent on management effectiveness of sufficient staff provision and equipment [46, 47]. Considering these multiple stress factors, it is important to provide continuous support to primary and community health nurses to prevent burnout and high staff turnover rates as well as improve patient-related communication mechanisms.

Our study identified that older patients and their family caregivers needed support and education to be able to play their role in home healthcare. Moreover, the safety of home healthcare required the improvement of older patients' and their family caregivers' knowledge and feelings of responsibility to be involved in home healthcare and remove their misperceptions about home healthcare. Patients and carers generally have inadequate level of health literacy [48], leading to more weight being given to the medication process rather than the following up of other health-related and preventive advice [38]. There is also evidence that they do not necessarily realize the complication of long-term therapies that are more common among older patients [44]. Therefore, older patients and their carers should be engaged in the transitional care process from the outset [49, 50], inclusive of discharge planning [51], and need to receive periodic feedback, support and education for improving physical and psychological wellbeing [50]. Older

patients feel more confident and independent when they discuss their care needs with healthcare professionals and learn self-care in relation to their complex healthcare needs [19]. Improved communication with older patients and their carers can be achieved using the task-oriented approach [51]. Further, nurses can be leaders for creating solutions to improve the engagement of carers in transitional care from hospital to home through promoting a communication line between carers and other healthcare professionals [52]. The limitations of this study are based in its location of urban Turkey and the small healthcare professional participant sample size. Additionally, conducting interviews at the workplace of the healthcare providers led to problems affecting the data collection process. In addition to the short duration of interviews, interruptions because of knocking the door and phone calls by patients or other healthcare staff reduced the planned duration of interviews. The strength of the study lies in the participation of both public and private sector healthcare professionals. The study findings on the challenges of transitional care demonstrated similarities with those of other studies supporting confidence in the findings. Therefore they can be used for service planning in order to reduce healthcare costs through decreasing unplanned hospital visits and older patient readmissions.

Conclusion

A large number of older patients are readmitted to hospital within the first 30 days following discharge to own home. According to this study, the reduction of the readmission rate and to improve the safety and continuity of care requires to effective communication between healthcare professionals across healthcare settings. Recommendations to devise and improve safe transitional hospital to home care include increased detail in discharge letters to adequately inform primary healthcare professionals, older patients and their carers; clarification of the role of healthcare staff;

increase in equipment and human resources for the continuity of care; improvement of awareness of patients and carers alongside enhancement of their feelings of responsibility in home care; and provision of continuing education for healthcare staff.

Relevance to clinical practice

Improvements in transitional care and patient safety are dependent on seamless sharing of patients' health-related data and collective care planning that includes informal caregivers. Bundled interventions, involving both home visits and calls, have been demonstrated to be effective in reducing readmissions [53]. The high rate of non-elective hospital visits by older patients indicates the need for improved communication and networking between primary and other healthcare sectors/providers including allied social and community services. Nurses as core coordinators and managers in community care [54] should be acknowledged and supported to better facilitate these processes. In community settings, nurses need access to leadership and management training to maximise their individual strengths for self-efficacy, coping, control, personal and professional practice.

Author contributions

The authors contributed to the design and implementation of the research, to the analysis of the results and to the writing of the manuscript as follows: ID, MIN, MV: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Software; ID, MIN, PAL, PP, MV: Writing - original draft, Writing - review & editing.

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Conflict of interests

The authors declare no conflict of interest.

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Table 1. Characteristics of the study participants

Characteristic	*All*	*Nurses*	*General physicians*
Age, mean (SD)	41.6 (10.9)	38.1 (9.4)	47.2 (11.7)
Gender, n (%)			
Female	7 (53.8)	6 (75.0)	1 (20.0)
Male	6 (46.2)	2 (25.0)	4 (80.0)
Job experience, mean (SD)	22 (10.1)	22.5 (10.3)	21.2 (10.8)
Work experience as the family-home care provider	7.4 (4.2)	6.8 (4.2)	8.3 (4.6)
Work department, n (%)			
Public family health centre	3 (23.1)	1 (12.5)	2 (40.0)
Public home health care	3 (23.1)	1 (12.5)	2 (40.0)
Home health care supported by the public sector	6 (46.2)	5 (62.5)	1 (20.0)
Home health care supported by the private sector	1 (7.7)	1 (12.5)	0 (0.0)

Figure 1. Summary of factors influencing the safety of transitional care of older patients from hospital to home