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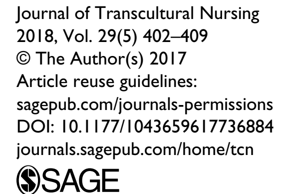

Complexities and Challenges of Singapore Nurses Providing Postacute Home Care in Multicultural Communities: A Grounded Theory Study

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Abstract

Introduction: Studies are needed to inform the preparation of community nurses to address patient behavioral and social factors contributing to unnecessary readmissions to hospital. This study uses nurses' input to understand challenges faced during home care, to derive a framework to address the challenges. **Methods:** Semistructured interviews were conducted to saturation with 16 community nurses in Singapore. Interviews were transcribed verbatim and transcripts independently coded for emergent themes. Themes were interpreted using grounded theory. **Results:** Seven major themes emerged from 16 interviews: Strained social relationships, complex care decision-making processes within families, communication barriers, patient's or caregiver neglect of health issues, building and maintaining trust, trial-and-error nature of work, and dealing with uncertainty. **Discussion:** Community nurses identified uncertainty arising from complexities in social-relational, personal, and organizational factors as a central challenge. Nursing education should focus on navigating and managing uncertainty at the personal, patient, and family levels.

Keywords

community nursing, transitional care, home care, nursing practice, work complexity, challenges, nursing experience, qualitative research.

Introduction

Singapore is one of the fastest-aging countries in the world, with a multiethnic population of 5.5 million, consisting of 76.2% Chinese, 15% Malays, 7.4% Indians, and 1.4% other ethnicities (Singapore Department of Statistics, 2015). The proportion of adults aged 65 years and older is projected to increase from 8.7% to 20% over the next 20 years. Use of acute care is expected to rise with this demographic trend. The proportion of public sector admissions from patients aged 65 years and above has increased from 28.6% in 2006 to 33.4% in 2013 (Ministry of Health Singapore, 2016). As the number of individuals with complex conditions increases, there have been aggressive efforts in shifting training of health professions and development of services to address health and related social service needs in the community and the home (Wong & Landefeld, 2011).

Filling the potential for unmet needs is complicated by fragmentation between multiple disconnected services and providers. Diverse strategies have been implanted to provide service and service coordination and reduce readmissions; this includes the creation of transitional care services for post discharge patients using home-care visits by community nurses (Enderlin et al., 2013; Polak, Ahuja, Milanovich, & Wickline, 2016; Verhaegh & MacNeil-Vroomen, 2014; Voss et al., 2011).

Community nurses in Singapore can play a vital role in supporting patients' transition back to their homes. Singapore's investment into community care resources complements a

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collectivistic Asian culture of ageing within the community and care within the family (Teo, Mehta, Thang, & Chan, 2006). However, facilitating care-transitions of patients involves culturally sensitive care and complex work processes that include monitoring, medical and social assessment, communication, procedural care, training, and administration. The exact processes vary and are dependent on the role and program characteristics developed by the organization employing the nurse. Many work processes occur primarily within the patient's home and involve diverse interactions between nurses, patients, caregivers, family, community services, and other clinical and allied health providers (Enderlin et al., 2013).

With the multiethnic population of Singapore, community nurses encounter cultural complexity. For instance, Asian patients may prefer traditional Chinese medicine over Western medicine; Malay patients engage in fasting during the *Hari Raya* festivities, which influences diabetic treatments. There are limited published studies on nursing processes and skills relevant to work demands experienced by community nurses, and how nurses adapt their practice to the challenges they face. Previous studies of community nurses in North America and Asia have instead described work challenges from an ethical perspective, describing cultural and system barriers that impede optimal patient care (Asahara et al., 2012; Choe, Kim, & Lee, 2015; Oberle & Tenove, 2000). However, these studies do not examine how work burdens and goals change in the face of complex social issues, ethical conflicts, and inadequate or inappropriate resources (Asahara et al., 2012; Choe et al., 2015; Oberle & Tenove, 2000). Understanding how these environmental factors introduce complexity and influence decision making is crucial to facilitate adaptations of nursing processes and skills to overcome challenges experienced by community nurses. The research questions were: What are the complexities and challenges faced by nurses in providing postacute home care and how do they navigate them? The study's purpose was to derive a framework of work demands encountered by nurses supporting patient's transition from hospital to home and to explore the components of nursing expertise in the community setting.

Method

Study Design

A qualitative study design using a grounded-theory framework was used for the study. This inductive methodology enables the researcher to develop explanations about the phenomena under study to inform patient care and future research (Harris, 2015).

Setting and Sample

A purposive sample of community nurses, who were working in a community care program with home visit responsibilities after patients' hospital discharge, was recruited. The inclusion criteria for the study were nurses who (1) were English speaking, (2) were licensed registered nurses (RNs), and (3) were provided skilled nursing services, assessments, care planning, and coordination of care with home visit responsibilities after adult patients' hospital discharge. This community care program was administratively based in a 590-bed regional hospital in Singapore with a combined admission volume of 32,408 per year. Among admitted patients, approximately 1,200 patients per year are referred to the community program.

Data Collection

Semistructured Interview Guide. The Applied Cognitive Task Analysis protocol, which combines a structured diagramming activity and an in-depth semistructured interview, was adapted in this study (Militello & Hutton, 1998). This task analysis method is aimed at understanding mental demands and cognitive skills needed to perform complex tasks efficiently. Participants drew diagrams describing their work flow during the interviews. Diagramming enabled interviewers to visually identify differences in work procedures, identify novel approaches and, if present, explore why they occurred with regards to work challenges. The interview guide was tested in two pilot interviews and then refined and modified (Table 1).

Data Collection Procedure. Researchers sat in on a monthly clinical meeting at the community care department and eligible RNs were invited to participate in the study. Interviews were conducted in English by two trained researchers (AW and KY), in a private office. Field notes were taken by one researcher while the other asked questions. The interviews followed usual qualitative research practice, including using open-ended questions, creating a comfortable atmosphere for responses and encouraging responses using direct and indirect probes (Leech, 2002). Interviews were conducted until data saturation was achieved. Interviews were audio-recorded verbatim and transcribed by contract transcribers. Participants were compensated with an appreciation lunch.

Ethical Considerations

Study approval was obtained from the hospital's institutional review board. The researchers obtained a signed informed consent before the interview began.

Data Analysis

Data analysis occurred concurrently with data collection, consistent with inductive grounded theory research methodology (Harris, 2015). Transcripts were read independently by AW (from a medical perspective) and SO (from a nursing perspective). Data were analyzed by a process of open coding and constant comparative analysis. Initial codes were developed from segments of data. The researchers then met

Table 1. In-depth Interview Guide (Modeled on Applied Cognitive Task Analysis) Used for Community Nurses, Regional Hospital, Singapore, 2015.

Segment	Main Questions	Probes
Phase 1	What work steps do the nurses find difficult?	Say you are given a new patient case. Can you draw out on paper the general steps you take from before your visit to after the visit?
Drawing a process flow diagram	Where in the work process are cognition or intuition used?	1. Can you walk me through what you drew?
Identifying challenges in work process		2. Which steps are difficult for you? (Can you mark these difficult steps on the diagram?)
		3. Which steps require you to communicate with others? (Can you mark these on the diagram?)
		4. Which steps require you to think? By thinking I mean making judgments, decisions, and problem solving. (Can you mark these on the diagram T?)
		5. What are the different ways you follow-up with a patient?
Phase 2	What cognitive or intuitive knowledge do nurses use?	In this interview. I encourage you to tell me a story from your own experience if that would help answer the question.
Focus on the role of knowledge, cognition, and intuition	What are the situations where cognition or intuition used?	1. Before you walk into a patient's home, what are the important things you picture in your mind that you need to do with the patient?
		2. Sometimes information can mislead. For instance, patient records might have mistakes or be out of date, or the stories that patients/caregivers tell you can also be misleading. Can you tell us about a time this happened?
		3. We understand that you need to objectively assess the patient and home. On a home assessment, have you ever noticed something in a patient/caregiver/environment that surprised you? Could you give us an example?
		4. Are there ways of working smart that you have learned that you find useful?
		5. Sometimes you get the bad feeling in your gut that something is wrong. Can you tell us about this feeling and what happened?
		6. Is there a time when you were carrying out a plan where you realized that it was not working like you wanted and that you needed to make a change?
		7. Sometimes before people carry out a plan they made, they play their plan like a movie in their head to see what will happen and if the plan would work. Or, sometimes they can rewind a movie to help them make sense of a situation now. Can you tell us a time when you had this experience?

and organized these codes to generate categories with regard to the research questions.

Rigor

Lincoln and Guba's (1985) four criteria of credibility, transferability, auditability, and confirmability were considered to establish study rigor. Interviews were audio-recorded, transcribed, and reviewed to ensure an accurate reflection of participants' views and promote credibility. Transferability is enhanced as current health care practice, and work processes were described in detail to allow readers to assess the study finding's applicability to other settings. To enhance audibility and confirmability, audio-recordings, transcripts, interview guides, and field notes were kept to establish an audit trail. An audit trail allows others to trace the study processes to determine whether the results are defensible and arrive at the same conclusions about the data (Morse & Field, 1996). In addition, members of the research team were from a diversity of professional backgrounds: medicine, nursing, education, and psychology. Thus, multiple referents with differing perspectives were involved in developing the study and in drawing conclusions about the data. This supports reflexivity and enhances rigor of the study.

Results

Among 18 eligible RNs approached, 16 participated (Table 2). Data saturation was achieved at the 14th interview. Thereafter, two more interviews were conducted to confirm saturation. Each interview took 90 to 120 minutes, with an average of 60 minutes of diagramming and 40 minutes of in-depth interview.

Table 2. Demographic Characteristics of Community Nurse Participants, Regional Hospital, Singapore, 2015.

Characteristic	Participants (*N* = 16)
Gender	
Female	16
Highest level of formal nursing study	
Diploma (Polytechnic)	16
Degree (Baccalaureate)	6
Advanced Diploma (Postgraduate polytechnic)	9
Areas worked prior to transitional care	
Operating theatre	1
Emergency room	1
Intensive care unit/High dependency	3
Obstetric inpatient wards	1
Medical–Surgical inpatient wards	16
Private/Public outpatient clinic	3
Ambulance services	1
Nonprofit community services	1
Years of clinical experience	
2-5	6
5-15	7
15-25	2
>25	1
(Median, years)	(7)
Years of community nursing	
<1	1
1-5	15
(Median, years)	(3)

One nurse, who completed the diagramming, did not complete the in-depth interview due to time constraints.

The two coders created a codebook with 39 codes and reduced it to 21 categories and 7 major themes. Major themes were as follows: strained social relationships; complex care decision-making processes within families, building, and maintaining trust; patient's or caregiver neglect of health issues; trial-and-error nature of work; communication barriers; and dealing with uncertainty.

Strained Social Relationships

Nurses reported that they sought to create a picture of patients' social relationships in order to identify opportunities and risks during patient care. They commented that their success in implementing interventions depended largely on having supportive and involved families. Although many elderly patients visited by nurses live with their families, the families were not always involved with patients' health issues or care. As a result, nurses reported difficulties in obtaining accurate information, pertinent financial information, and in performing certain critical care tasks. Foreign domestic workers (FDWs) employed by families were often responsible for care needs of patient. When patients had care needs, the presence of involved caregivers was essential. One nurse reflected,

> Poor cleaning skills can cause infection and will send patient back to hospital. We try to prevent hospitalization. . . . If they (caregiver) are competent, there's dedication, (hospitalization) can be prevented. (TCN003)

When families or caregivers were perceived by nurses as neglectful or uncooperative, nurses were more stressed with providing care and spent more time monitoring patients. Nurses commented that these circumstances created tension and affected work quality. They also reported frustration that their work evaluation measures, such as readmissions for each patient and number of patients managed, did not take into account increased time and work demands placed on the nurse by family conflict.

Complex Care Decision-Making Process Within Families

Nurses commented that each family has a unique arrangement for decision making and care giving. This introduced a level of complexity that nurses had to navigate. Nurses shared that they could not assume that the family member(s) living with the patient were the main decision maker or advocate, or were directly involved with the care tasks. The arrangement for decision making in a family could frequently change and was often ad hoc. One nurse commented,

> When the care-giver is not the decision-maker, [for instance] the maid (FDW), and the decision-maker, who we are liaising with, doesn't know anything about the patient, [I] can only communicate with the maid. (TC004)

Nurses described having to update multiple decision makers and to face conflicting agendas between decision makers, clinicians, and other family members. Another dimension was the need to actively investigate what a family's decision-making arrangement was, as it was not always apparent. For instance, patients may have preference for one family member's advice over others.

> You know, even though they have three kids, four kids, maybe they have one very loving one, that . . . they will listen to. If that person conveys the message, maybe the patient will listen. (AIP004)

These factors frequently were a source of complexity and often delayed decision making due to revisits needed to establish common understanding or resolve disagreements between patient, caregiver, and nurse.

Communication Barriers

Nurses expressed challenges associated with communication barriers. These were frequently associated with language, patient's cognitive impairment, and phone consultations.

Nurses remarked that at times it was not possible to get adequate language interpretation. This made gathering information and building rapport difficult. Nurses had to "translate" standardized assessment questions into understandable terms, which made them question the accuracy of replies. It was challenging to overcome language barriers through use of sign and body language.

> It is very difficult because I do not know dialect. I only know Mandarin and English. [I use] a mix of body language, and a bit of Malay to make them understand. (TC002)

In patients with active cognitive or memory impairments, interpreting their responses could be challenging and nurses relied more on a caregiver's response. Nurses also remarked that communication barriers were more disruptive in situations where direct contact was limited. For instance, when consulting with patients or caregivers over the phone.

Patients or Caregiver Neglect of Health Issues

Adherence to treatment plan was a challenge that affected plans made by inpatient care teams who were unaware of the home context, as well as those made by community nurses, who were aware. Nurses highlighted patient's lack of insight or self-neglect as a primary contributor to nonadherence. Nurses reported feeling demoralized and unable to help patients who were neglectful of their own health or environment since these patients often did not respond to efforts by the nurse to educate or reinforce plans. Where caregivers were responsible for care tasks, nurses also needed to assess the competency of care provided by them.

> If the patients' attitude towards their health is poor, they are not highly motivated to take care of their health, I will have a tough time. How much can I educate them if they never follow [my recommendations]? (AIP004)

"Trial and Error" Nature of Work

Nurses described care planning as an evolving process that changes frequently according to patients' conditions and preferences. Often, nurses described the need to balance different constraints such as convenience and cost. They reported that patients who were dependent on family for financial support may reject proposed interventions due to financial cost. As a result, nurses had to provide options accounting for affordability and availability of financial aid. In addition, nurses encountered strong preferences of patients or families for complementary and alternative medicines. Nurses mentioned that sometimes it was only after implementing plans that issues such as patient or caregiver stress and inability to cope surfaced.

> We prescribed insulin injection for the morning and evening. However, after a while, we realized that it's not really workable, because the sister (caregiver) also has her own family. She has other care burdens. After the first few days, we realized [that] the [blood] sugars [were] not very good. (AIP002)

Nurses described that they had to assess whether patients could safely complete daily activities. For example, where patients had mobility impairments, nurses devised safe methods of transferring and toileting patients, taking into account the household environment and available resources in the home until patients could be formally assessed or mobility aids were delivered.

Building and Maintaining Trust

Nurses commented that building and maintaining trust and rapport was an essential first step in their work. Nurses reflected that as their rapport with patients and their caregivers grew, patients and families were more willing to share information and accept advice. Accordingly, nurses described the inability to get a thorough assessment from one visit and that more issues, especially social problems, emerged over time.

> So the first visit always takes a longer time because we have to build up our rapport first. . . . I need to get to know the patient, the family, and the primary caregiver. I will talk to them to find out more . . . on the very first visit, it is very, very rare [that] they open up. (AIP004)

Nurses reported that they would make compromises, delay or forgo tasks if they felt that the patient or family did not trust them. Participants described experiences where patients and families seemed mistrustful of nurses when sensitive issues like finances or advanced care directives were explored without rapport.

> So my colleague talked a little bit about financial issues. . . . Wow, the daughter got mad and said, "Why are you asking about my family's finances?" . . . We couldn't go in for a second visit. They were offended. (AIP005)

In such instances, nurses perceived that the damage to the relationship could be irreparable, leading patients or their families to decline the service.

Dealing With Uncertainty

Nurses described being uncertain throughout the patient care process. Their uncertainties were split into two areas: (1) uncertainty about the patient's medical condition or social environmental status and (2) uncertainty about their own knowledge and skills. Nurses were uncertain about patients when they had not had enough time to "get to know them." Uncertainty was commonly reported when nurses took on new patients. They noted that electronic health records were a good source of information, but they were limited in providing socioeconomic and sociocultural information.

> I couldn't totally depend on the discharge summary. On the day I'm visiting the patient, that's where my first assessment and diagnosis starts. So the critical thinking happens when you are seeing the patient. (AIP004)

Nurses also reported assessing behavioral or environmental issues that could potentially put the nurses' own safety at risk. As this nurse described,

> Then it's dark and there are two guys and the patient is in the room. So my first thought was "oh my god, how . . . how can I do." I didn't know what to do. So ah I think safety is sometimes an issue. (TC001)

Nurses described that in the home setting, patients themselves, their families, or caregivers may make misleading statements for social reasons. They commented on the need to be alert to being misled. Reasons for this behavior cited by nurses included the family's shame or embarrassment at revealing private conflicts, mistrust of health professionals, and lack of rapport. In cases where neglect and abuse were identified, nurses reflected that caregivers would obscure information or avoid nurses. Ambiguous, incomplete, or inaccurate statements created confusion. One nurse recalled,

> "Do your children come and visit?" [The patient replies,] "Oh yes, yes, yes, they visit me, every week the so and so visit me." . . . They don't want to let people know that "my children are neglecting me" or "My children don't care about me." . . . They want to show people that my children love me, but you know that nobody is attending to her, somehow or other you know. (AIP011)

Nurses commented on a second area of uncertainty, about their own knowledge and skills. For example, they were unfamiliar with some patient conditions and medications.

> I need to do some research and find out what exactly the condition is and what to look out for. But sometimes I might . . . find sources that are not very accurate, or different sources have different variations. . . . That's one part that I find a bit tough. (AIP009)

Nurses stressed the importance of teamwork by seeking advice of senior colleagues and from team doctors.

> I believe if we share and we discuss among our team members, I think, it would be better because my ideas may not be the same as theirs. . . . When we share, you know what is better for the patient and what we can plan better for the patient. (AIP007)

With regard to having others around to ask for advice, respondents contrasted community practice with inpatient nursing,

> In the hospital, it's okay, we are safe. . . . We have a proper work flow and everything. We know what to do and, you know, that's okay. But in the community and people's house, not everything you can do is according to your plans. I mean, it's not right to make your own decisions. You still have to follow certain rules, or what? I don't know. (AIP004)

Participants expressed distress at being unable to help patients and reflected that this was due to their own inadequacies in knowledge. One nurse commented,

> I fear because you know, I'm worried . . . my patient fell, I want to prevent [that], but how do I help? Fear, means my inadequacy. (AIP005)

Conceptual Framework for Understanding Nursing Challenges

The six themes that emerged were unified by the concept of *uncertainty*, reflecting both its causes and effects (Figure 1). It is proposed that the community nurses' experiences of work processes and perceptions of their roles were founded on how they responded to their uncertainty. Sources of uncertainty arose from the patient–family social context, the accuracy of data collected from assessments, nurses' own expertise and skills, and applying best clinical practice in the community.

Uncertainty about clinical and social information could cause delays in implementing care plans or lead to suboptimal care. Nurses responded by collecting more information over time and/or adapting plans. In general, the more socially sensitive the circumstances, the more resources were needed. To address uncertainty, nurses assumed additional roles, such as that of a detective, counsellor, and negotiator. These roles were perceived as necessary, to build trust, to clarify ambiguities, or to manage expectations of families in carrying out a plan of care.

Nurses experienced uncertainty regarding their own knowledge and judgment with best practices and was attributed to the gap between the clinical complexity of cases and their own prior education. Nurses also encountered uncertainty arising from differences in community support services as factors of availability, reliability, and affordability would need to be addressed by the nurse in care plans. Knowledge uncertainty affected their confidence and judgment about best decisions for their patients and sometimes caused the nurses to feel distressed when they were working alone. When nurses were unable to seek advice, they experienced frustrations and feelings of helplessness. Conversely, when nurses addressed these uncertainties by seeking external support and validation, they reported higher satisfaction and self-confidence.

When uncertainties could be addressed or eliminated, stable and definitive care plans could be put into place to meet care goals. However, new uncertainties could emerge as nurses worked through this process, resulting in unmet goals. Nurses would repeat this process until a patient was stable for successful discharge from the program.

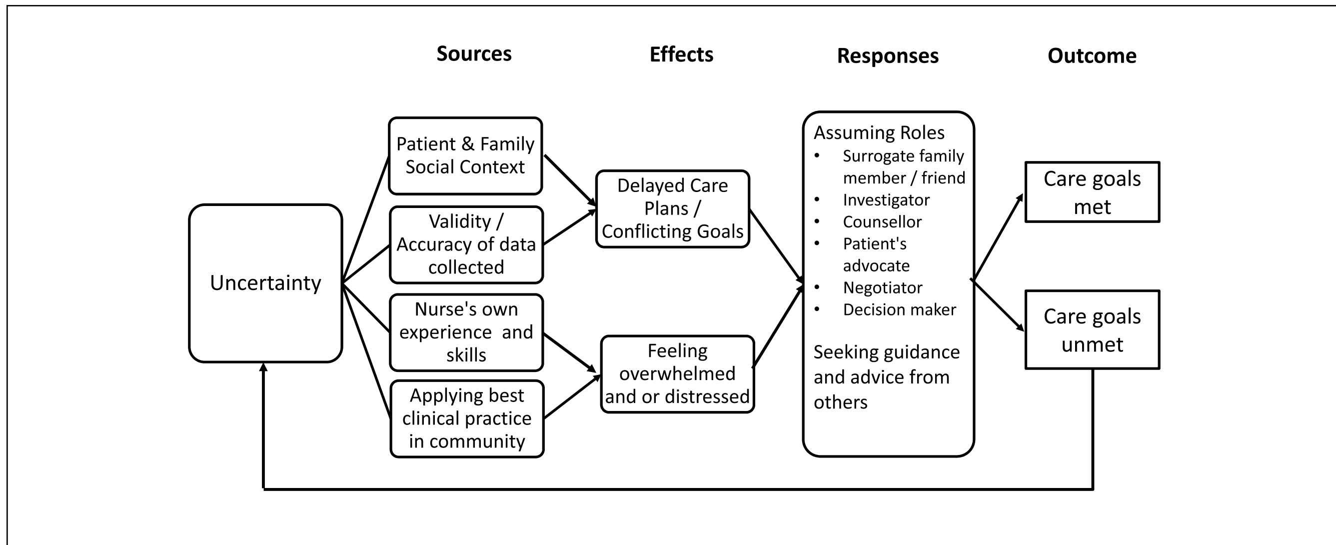

Figure 1. Conceptual Framework - Uncertainty in Community Nursing, Regional Hospital, Singapore, 2015.

Discussion

This qualitative study was conducted with community RNs from an Asian country to explore the challenges and complexities associated with community nursing. Six major themes emerged from the interviews reflecting an overarching theme of *uncertainty* as the encompassing challenge. Their ability to respond and adapt to the challenges depended on their willingness to reflect, assume a variety of roles, interpret complex context-sensitive information, and to seek help and advice from colleagues. The study characterizes community nursing practice as a fluid and uncertain process rather than a purely procedural and predictable one.

A major study finding is that nurses routinely fulfill diverse roles in the care of the patient. In the Singaporean context, decision-making preference is consistent with involvement of the family (Chong, Quah, Yang, Menon, & Krishna, 2012), yet this introduces complexity and potential conflicts between nurses, patients, and families. This observation is supported by a survey of public health nurses in Japan (Asahara et al., 2012), where frequent patient disagreements with their family members regarding decisions on care were reported. Furthermore, this study highlights the roles nurses play in supporting FDWs. FDWs fill as primary caregivers: attending to daily needs such as bathing, feeding, and cleaning. In Singapore, FDWs performed 19% of care tasks (Teo et al., 2006). FDWs may encounter unique challenges as caregivers within the family and may experience significant carer stress and social isolation. Nurses in this study supported FDWs by providing caregiver education and emotional support. Further study is needed to inform nurses on the support needs of FDWs.

In addition, this study illustrates the contextual factors that accompany disagreements, for instance, the presence of neglect, unvoiced care preferences, and contradicting goals of patients versus family members. These social tensions create uncertainty, operational barriers, and emotional–psychological impacts on nurses. End of life care is an area where uncertainty and tensions frequently arise. A study on community nurses' experiences with care planning for dying patients found that nurses perceived their role as helping shift the patient-family perceptions of care away from "curative culture." Nurses encountered uncertainty in identifying which patients would be receptive for this conversation and listened for verbal prompts and cues that signaled a patient's readiness (Seymour, Almack, & Kennedy, 2010).

In this study, nurses did not identify social tensions as ethical ones, per se, although several did recognize the ethical elements that generated the tension in their work. In most cases, nurses found it natural to work with families, assuming different roles as the patient and family situation necessitated. Nurses collected more information to fill in gaps in their understanding of patient needs and often judged information sources. Nurses in this study depended on relationship building. When there was mistrust or suspicion between them and their patients, their job was perceived as more difficult. Accordingly, a Korean study found that frequent changes in nurse–patient assignments had negative effects on relationship building and increased distress among nurses (Choe et al., 2015). Another study of community nurses cited the importance of developing established relationships that enabled information gathering and detection of elder abuse (Sandmoe & Kirkevold, 2010). The study findings expand on previous studies describing significant effort invested by nurses to "tune the relationship" (Oberle & Tenove, 2000) and the importance of communication and language (Giesbrecht, Crooks, & Stajduhar, 2014).

Study Limitations

This was a single-center study, and findings may not be transferable to other settings. Participants had fewer than 5 years of experience in community nursing, and results may not be transferable to more experienced nurses. Perspectives of male nurses are not represented.

Conclusion

Social structures and health systems create complexity and uncertainty. Nurses encounter uncertainty when supporting patients at home in the community. The study findings illuminate context-specific challenges that community nurses in Singapore may encounter and informs the budding development of community care in this region. In addition, the study's developed framework offers an operational lens to which to view community nursing practice. The ability to recognize, communicate, and navigate uncertainty with patients and with family members is a central part of daily practice for community nurses. Future studies exploring learned contextual cues used by experienced community nurses to manage uncertain care situations will provide guidelines for higher education and training.

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