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Nurses' and managers' perceptions of the transition of older adults from long-term care facilities to the emergency department: A mixed-methods study

Gabriela Peguero-Rodriguez[a,b], Viola Polomeno[a], Chantal Backman[a,c,d], Julie Chartrand[a,e], Michelle Lalonde[a,f]

[a] School of Nursing, Faculty of Health Sciences, University of Ottawa, Ontario, Canada
[b] Nursing Department, Université du Québec en Outaouais, Quebec, Canada
[c] Affiliate Investigator, Ottawa Hospital Research Institute, Ottawa, Ontario, Canada
[d] Affiliate Investigator, Bruyère Research Institute, Ottawa, Ontario, Canada
[e] Affiliate Investigator, Children's Hospital of Eastern Ontario Research Institute, Ottawa, Ontario, Canada
[f] Scientist, Institut du Savoir Montfort, Montfort Hospital, Ottawa, Ontario, Canada

Corresponding author: Gabriela Peguero-Rodriguez, 283, boulevard Alexandre-Taché, office F1054
Email : gabriela.peguero-rodriguez@uqo.ca; Telephone: 819 595-3900, ext. 2396

Abstract

Problem: Several challenges are associated with the transition of older adults from a long-term care facility (LTCF) to the emergency department (ED). Nurses play an important role in LTCFs and EDs during this transition.

Objective: To describe the perceptions of nurses and managers in relation to this transition.

Methods: This study used a sequential mixed methods design. An online questionnaire was distributed to LTCF and ED nurses during Phase 1 (quantitative). During Phase 2 (qualitative), semi-structured interviews were conducted with management in these two settings. Descriptive statistics were used as well as t-tests for the quantitative data. Thematic analysis was used for the qualitative data.

Results: After the analysis of the questionnaire's responses (*n* = 38), the nurses from LTCFs and EDs had similar perceptions and considered the transition of older adults from the LTCF to the ED as being ineffective, and the inter-institutional communication was not efficient. Following the interviews conducted with managers (*n* = 7), four themes were identified, reflecting the limitations of LTCFs in caring for the older adults, the obstacles associated with the transfer of information, the consequences of an ED stay for older adults, and the contribution of caregivers.

Conclusion: Four key conclusions can be drawn:

1. this transition is influenced by the LTCF material and human resources;
2. the transfer of information is inefficient;
3. the ED environment is not adapted for the needs of older adults; and
4. the caregivers' integration is important but does present with challenges

Keywords: transition, long-term care facility, emergency department, nurses, older adults.

This article has been translated from French to English and the original French article is also available

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Introduction

In Quebec, 20% of the population is aged 65 and over (Institut de la statistique du Québec, 2023). This demographic statistic presents significant challenges, particularly in terms of emergency service utilization. The Commissaire à la santé et au bien-être du Québec (CSBE, 2017) has established a strong correlation between the growing senior population and the increase in emergency department (ED) visits for this age group in Quebec. This leads to an increase in admissions to long-term care facilities (LTCFs), where the residents of these facilities appear to use the ED more frequently than those in the community (Brucksch et al., 2018; Dwyer et al., 2014).

Despite the well-documented challenges in the literature associated with the transition of older adults from LTCFs to the ED (e.g., inefficient inter-facility communication and the emergence of complications among older adults in the ED, the poor integration of family caregivers (FCGs) (Brucksch et al., 2018; Dwyer et al., 2014; Lemoyne et al., 2019), few studies have examined the perceptions of LTCF and ED nurses regarding this transition. Current literature describes the decision-making role of LTCF nurses in this transition (Gurung et al., 2021; Laging et al., 2014; Laging et al., 2015; Nguyen et al., 2022; O'Neill et al., 2015), whereas the perceptions of emergency nurses have been documented with respect to inter-institutional communication (Griffiths et al., 2014). Few studies have investigated the perceptions of nurses in both settings of the entire transition process, and none have integrated their perceptions in a single study. Moreover, the literature lacks information on the perceptions of managers.

As nurses play a vital role in monitoring and caring for older adults' clinical condition (Choi & Chang, 2022; O'Neill et al., 2015; Steinmiller et al., 2015), it is essential to better understand their perceptions in order to improve this transition. This article's study sheds light on the perceptions of nurses and managers in LTCFs and EDs regarding the entire transition process for older adults. This study was guided by transition theory (Meleis et al., 2000), enhanced by systems theory (Kaakinen, 2018; Shajani & Snell, 2023; Peguero-Rodriguez & Polomeno, 2023).

Objective and research questions

The aim of the study was to describe the perceptions of nurses and managers in public LTCFs and EDs on the transition of older adults and FCGs from LTCFs to EDs (see Figure 1 for research questions).

Methods

Type and research design

A mixed methods research (MMR) approach was used, namely an explanatory sequential mixed methods design (QUAN → qual) (Creswell & Plano Clark, 2018) (see Figure 1). To help guide the writing of this article, the Mixed Methods Article Reporting Standards (MMARS) were applied.

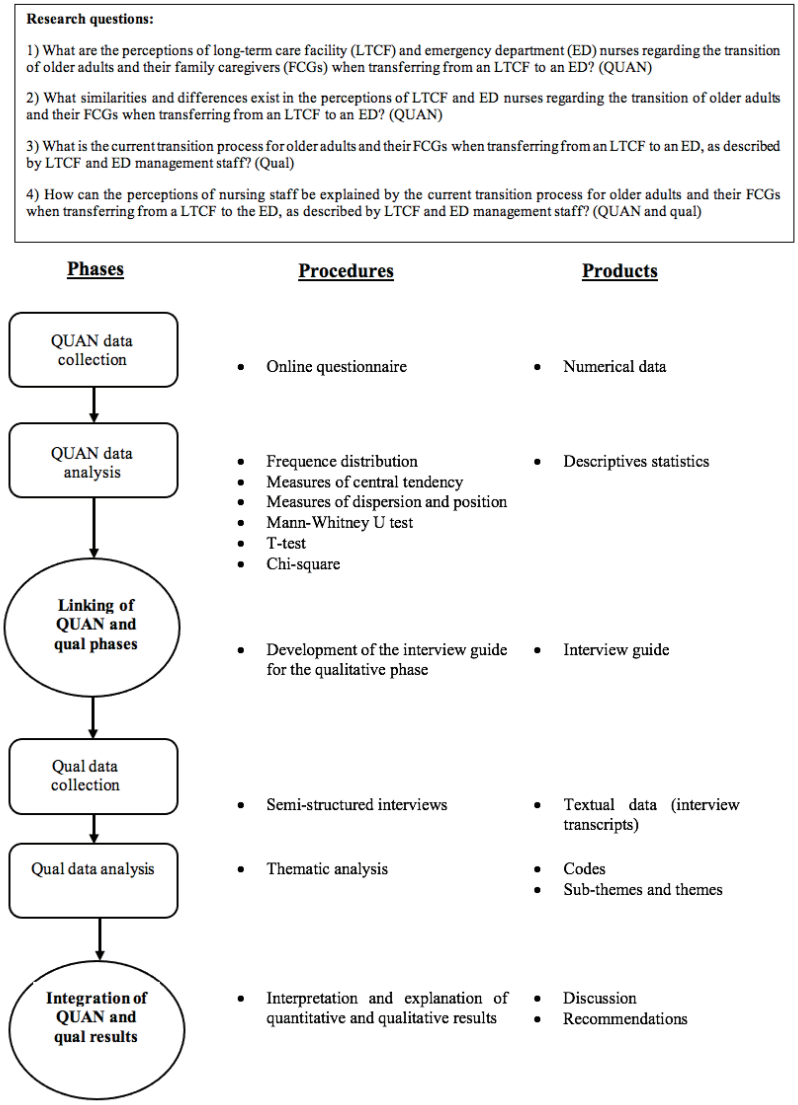
Study population and sample

Phase 1—Quantitative

Phase 1 population consisted of nurses working in public LTCFs and EDs in the Outaouais region (Quebec, Canada). A convenience sampling method (Polit & Beck, 2021) was used, based on the following inclusion criteria: 1) hold the title of registered nurse or licensed practical nurse; 2) hold a position or assignment in an ED, a public LTCFs or in a local community service centre (CLSC) in the Outaouais region; 3) have provided care to at least one senior in the past year who has made the transition from an LTCF to an ED; and 4) read, write and speak French. There were no exclusion criteria.

Figure 1

Research questions and visual model of the explanatory sequential mixed design



Recruitment, carried out from May 2021 to April 2022 during COVID-19, took place in LTCFs and EDs that were significantly affected. Given that the study's principal researcher (first author) did not have physical access to the research environments due to the pandemic context, the research team faced several recruitment hurdles.

Phase 2—Qualitative

The objective of phase 2 was to explain the quantitative results of phase 1. The population was comprised of managers from public network LTCFs and EDs in the Outaouais region. A purposive sampling approach (Polit & Beck, 2021) was used, based on the following inclusion criteria: 1) hold a position or assignment as a liaison nurse, nursing advisor, senior nursing advisor, unit manager or director of nursing care in a public LTCF or ED in the Outaouais region; and 2) read, write and speak French. There were no exclusion criteria. Recruitment took place from March to May 2022. The Malterud et al. (2016) method was used to determine the sample size. The recruited participants held key positions within the organization and contributed rich and valuable information on the topic at hand, thus limiting the number of participants required.

Data collection

Phase 1—Quantitative

Two questionnaires were designed and previously validated (face validity and content validity) by experts and pre-tested by four nurses meeting the inclusion criteria (two from LTCFs and two from the ED) (Peguero-Rodriguez, 2024). They were then distributed through SurveyMonkey©, accessible via a QR link on the recruitment posters or in the email invitation sent by the administrative staff of the Centre intégré de santé et de services sociaux (CISSS).

Two versions of the questionnaire were created: one for LTCF nurses (47 questions) and the other for ED nurses (49 questions) (Peguero-Rodriguez, 2024). The majority of questions were similar, but some varied to reflect aspects specific to each setting. Mean completion time was 18 minutes for LTCF nurses and 14 minutes for ED nurses. The questionnaires were divided into two sections: 1) Sociodemographic profile (10 questions) gathering information such as participants' age, job title and years of work experience, and 2) Perceptions of nursing staff (37 questions for nursing staff from LTCFs and 39 questions for nursing staff from EDs) measuring perceptions about the transition of older adults from LTCFs to EDs.

Phase 2—Qualitative

Individual semi-structured videoconference interviews were conducted by the principal researcher with managers from LTCFs and EDs. Based on a preliminary analysis of quantitative results from Phase 1, the interview guide included 16 questions for LTCFs and 14 questions for EDs (Peguero-Rodriguez, 2024). Both versions had twelve questions in common. The interviews took place on and were recorded via the Zoom© videoconferencing platform, lasting an average of 45 minutes. They were transcribed for analysis. Participants also filled out an online socio-demographic questionnaire on SurveyMonkey©, consisting of eight questions to collect data such as age, level of education and job title.

Data analyses

Phase 1—Quantitative

Descriptive statistical analyses were conducted on quantitative data collected through online questionnaires distributed to nursing staff, using IBM SPSS Statistics software (Version 28). Likert scale responses have been grouped into three categories to summarize the results: agree (1 = strongly agree, 2 = tend to agree), neither agree nor disagree, or disagree (4 = tend to disagree, 5 = strongly disagree). Details of responses are available in the online supplementary data.

Data from both surveys for common questions were compared by setting (LTCF vs. ED). T-tests were then carried out to assess whether there was a statistically significant difference between the perceptions of nurses in the two settings, with a chosen significance level of 0.05. The effect size (Cohen's d) and its confidence range were reported with particular attention to large effect sizes ($d \geq 0.8$) (Cohen, 1988). Nonparametric tests (Mann-Whitney U test) were also performed to validate the t-tests, due to the small sample size and the possible abnormal distribution.

Phase 2—Qualitative

A thematic analysis was performed using the Braun and Clarke (2006, 2022) method via the NVivo version 12 platform. While the aim of the interview guide was to probe quantitative results, an inductive analysis was carried out following the six-step process: 1) familiarization with the data, 2) coding, 3) generating initial themes, 4) developing and revising themes, 5) refining, defining and naming themes, and 6) drafting the final report. The thematic analysis was led by the lead researcher, with revisions made until consensus was reached with the co-researchers.

The collected socio-demographic data were analyzed by means of descriptive statistics using IBM SPSS Statistics software (Version 28).

Mixed model analysis (integration point)

While quantitative and qualitative data analyses were conducted separately, a first point of integration between these two phases took place during the development of the interview guide based on the quantitative results (Creswell & Plano Clark, 2018). This was followed by an effort to synthesize and integrate the two types of results, with the help of joint displays (Creswell & Plano Clark, 2018).

Ethical Considerations

Three ethics approvals were obtained from: 1) University of Ottawa (H-10-20-6151); 2) CISSS de l'Outaouais (Project 2020-319_169); and 3) Université du Québec en Outaouais (Project # 2022-1585). Prior to taking part in the study, each participant completed a consent form, and the confidentiality of all participants was preserved.

Results

Phase 1. Quantitative results

1.1 Sociodemographic profile

In phase 1, 38 nurses from LTCFs (n = 10) and EDs (n = 28) took part in the study (see Table 1).

Table 1

Sociodemographic Characteristics of Nursing Staff in LTCFs and EDs in Phase 1 (Quantitative)

Variable	n(%)[a]		Mean (SD)	
	LTCF	ED	LTCF	ED
Gender				
Feminine	10 (100.0)	23 (82.1)		
Male	0 (0.0)	5 (17.9)		
Age (years)			47.6 (5.7)	32.2 (7.7)
18–< 25	0 (0.0)	3 (10.7)		
25–< 35	0 (0.0)	16 (57.1)		
35–< 45	1 (10.0)	7 (25.0)		
45–< 55	6 (60.0)	2 (7.1)		
55–< 65	1 (10.0)	0 (0.0)		
Not shared	2 (20.0)	0 (0.0)		
Highest level of education attained				
Diploma of Vocational Studies in Health, Assistance, and Nursing	0 (0.0)	3 (10.7)		
Diploma of College Studies in Nursing	2 (20.0)	7 (25.0)		
Bachelor of Science in Nursing	8 (80.0)	19 (67.8)		
Specialized Graduate Diploma in Nursing	0 (0.00)	1 (3.57)		
Employment status				
Part-time	1 (10.0)	6 (21.4)		
Full-time	9 (90.0)	22 (78.6)		
Mainly worked shift				
Day	9 (90.0)	5 (17.9)		
Evening	0 (0.0)	3 (10.7)		
Night	1 (10.0)	8 (28.6)		
Day/Evening	0 (0.0)	9 (32.1)		
Day/Night	0 (0.0)	3 (10.7)		
Number of years of experience as a registered nurse or as a licensed practical nurse			21.1 (12.6)	9.4 (7.3)
< 5	2 (20.0)	8 (28.6)		
5–<15	2 (20.0)	13 (46.4)		
15–< 25	4 (40.0)	6 (21.4)		
≥ 25	2 (20.0)	1 (3.6)		
Number of years of experience in the ED			N/A	6.02 (6.3)
< 5	N/A	8 (28.6)		
5–< 15	N/A	13 (46.4)		
15–< 25	N/A	6 (21.4)		
≥ 25	N/A	1 (3.6)		
Number of years of experience in a LTCF			17.7 (14.6)	N/A
< 5	3 (30.0)	N/A		
5–< 15	2 (20.0)	N/A		
15–< 25	2 (20.0)	N/A		
≥ 25	3 (30.0)	N/A		
Participants' professional experience in the opposing institution (e.g., a LTCF participant who has previously worked in an ED and vice versa).				
Yes	3 (30.0)	1 (3.6)		
No	7 (70.0)	27 (96.4)		

Note. [a] Totals may not add up to 100% due to rounding.

1.2 Perceptions of public LTCF nurses and ED nurses

The transfer of older adults from LTCFs to emergency care. The majority of participants (LTCF *n* = 7, 70%; ED *n* = 18, 64.3%) felt that transfers were not handled efficiently and without gaps. When LTCF seniors had to transfer to the ED, some participants (LTCF *n* = 4, 40%; ER *n* = 4, 14.3%) felt that these transfers were justified, while others (LTCF *n* = 4, 40%; ED *n* = 19, 67.9%) disagreed. All ED participants (*n* = 28, 100%) felt that more proactive strategies could be implemented in LTCF before older adults needed to be transferred. If an older adult's condition deteriorated, 40% (*n* = 4) of LTCF participants said they had the necessary assistance in the transfer process, and 50% (*n* = 5) said they always had access to a physician (on site or on call) to help them make the decision to transfer an older adult to the ED.

Inter-institutional communication during the transfer to the ED. In terms of inter-facility communication, 20% (*n* = 2) of LTCF nurses and 7.4% (*n* = 2)[1] of ED nurses felt it was effective. Ten percent (*n* = 1) of LTCF participants felt it was easy to reach ED nursing staff. ED participants reported that the information most often missing was the older adult's level of autonomy, basic cognitive and physical status, followed by the level of medical intervention, contact information, as well as the detailed reason for transfer and previous interventions. The majority of LTCF (*n* = 8, 80%) and ED (*n* = 25, 89.3%) participants felt that a standardized form listing relevant information when transferring an older adult from an LTCF to the ED was or would be beneficial.

ED stay. All ED participants (*n* = 28, 100%) reported that older adults from LTCFs were a vulnerable clientele, with 85% (*n* = 23) perceiving that they required as much care as other ED patients. Some ED participants (*n* = 13, 48.1%) stated that they did not have enough time to provide quality care, and that basic care (e.g., hygiene, hydration, nutrition) was not adequately provided (*n* = 18, 66.7%). All participants (*n* = 27, 100%) acknowledged the importance of an interdisciplinary approach to the effective management of older adults transferred from LTCF to the ED.

Inter-institutional communication after emergency discharge. Following the older adult's discharge from the ED, some LTCF (*n* = 20, 20%) and ED (*n* = 12, 44.4%) participants mentioned that the way discharges were handled in the ED was appropriate and efficient. All LTCF participants (*n* = 10, 100%) emphasized the importance of ED staff communicating verbally or in writing with LTCF staff following discharge. ED nurses (*n* = 25, 93%) felt it was important to communicate verbally with LTCF staff, and 67% (*n* = 18) felt it was important to communicate in writing. According to LTCF participants, the most important information to obtain following discharge was the care provided in the ED, the examinations completed and the results, as well as any changes in medication.

Integration family caregivers (FCGs) during the transfer to emergency care. Most LTCF (*n* = 7, 80%)[2] and ER (*n* = 25, 92.6%) participants felt that the FGCs were an important source of information about the older adult's health status. Seventy-five percent (*n* = 6) of LTCF participants and all ED participants (*n* = 27, 100%) felt that FCGs could identify their older adult loved one's priority needs. Sixty-three percent (*n* = 5) of LTCF nurses stated that FCG should be consulted before deciding to transfer the older adult to the ED, 50% (*n* = 4) stated that FCGs had the necessary knowledge to participate in the decision-making process, and 88% (*n* = 7) felt comfortable supporting FCGs during this transition.

In the ED, 74% (*n* = 20) of participants felt that FCGs were useful, 93% (*n* = 25) agreed that they should be included in the decision-making process regarding the options for investigations and treatments, 96% (*n* = 26) highlighted the importance of providing regular feedback on investigations and treatments to the older adults and their FCGs, and 22% (*n* = 6) felt that FCGs were adequately informed. Sixty-seven percent (*n* = 18) felt that it was the FCG's responsibility to ask for information on the older adult's condition, and 81% (*n* = 22) said that FCGs could take care of their older adult loved one's basic care.

1.3 Comparison of perceptions between nurses in public network LTCFs and in EDs

Independent t-tests revealed no statistically significant differences ($p \leq 0.05$), except for two statements (Table 2).

A statistically significant difference between the two groups was noted concerning the following statement: "The way in which the return to the LTCF is organized following the discharge of an older adult from the ED is appropriate and effective for continuity of care" ($t(34) = -2{,}456$, $p = 0.019$). ED nurses seemed to agree with this statement ($\bar{x} = 2.96$, $SD = 0.96$), while LTCF nurses tended to disagree ($\bar{x} = 3.90$, $SD = 1.20$). There was also an effect size (Cohen's $d = -0.914$) suggesting a significant standardized difference between the two groups.

The second statistically significant difference concerned the following statement: "It is important to support FCGs during transfers of their elderly loved one from an LTCF to the ED" ($t(33) = 2{,}178$, $p = 0.037$). Both groups agreed with this statement (LTCF: $\bar{x} = 1.38$, $SD = 0.52$; ED: $\bar{x} = 1.96$, $SD = 0.71$). What differed was that LTCF nurses tended to "strongly agree," while ED nurses tended to "somewhat agree."

Phase 2. Qualitative results

2.1 Socio-demographic profile

Seven managers from public network LTCFs (*n* = 5) and EDs (*n* = 2) participated in phase 2 of this study (Table 3).

2.2 Thematic analysis

Four themes have been developed to clarify and complement the quantitative results.

1. The sample size varies between 27 and 28 participants, as some questions were not answered by all participants. Details on the number of respondents per statement can be found in the "additional data" section of the article.

2. The sample size varies between 8 and 10 participants, as some questions were not answered by all participants. Details on the number of respondents per statement can be found in the "additional data" section of the article.

Table 2

Statistical Comparison of Perceptions of LTCF and ED nurses regarding the transition of older adults and their FCGs from a LTCF to the ED (n = 38)

Statements	*n* Mean (SD)		T-test	Degrees of freedom	*p*-value	Cohen's *d* (95% CI)
	LTCF	ED				
1. Transfers of older adults from LTCF to the ED are carried out efficiently and without gaps.	*n* = 10 3.60 (0.97)	*n* = 28 3.46 (1.03)	-0.362	36	0.720	-0.133 (-0.855, 0.590)
2. Communication between LTCF and ED staff is effective.	*n* = 10 4.00 (1.16)	*n* = 27 4.00 (0.88)	0.000	35	1.00	0.000 (-0.710, 0.710)
3. If necessary, the nursing staff at the other facility (LTCF or ED) can easily be contacted.	*n* = 10 3.80 (0.92)	*n* = 28 4.00 (0.98)	0.562	36	0.578	0.207 (-0.518, 0.929)
4. It would be beneficial to send a standardized form containing relevant information when transferring an older adult from a LTCF to the ED.	*n* = 10 1.80 (1.23)	*n* = 28 1.54 (0.92)	-0.712	36	0.481	-0.262 (-0.985, 0.464)
5. It is justified and unavoidable to transfer older adults from LTCFs to EDs.	*n* = 10 2.80 (1.48)	*n* = 28 3.68 (0.91)	1.768	12	0.104	0.816 (0.065, 1.557)
6. The nursing staff at the other facility are competent and capable of providing high-quality care for older adults.	*n* = 10 3.00 (1.16)	*n* = 28 3.18 (0.82)	0.450	12	0.660	0.195 (-0.530, 0.917)
7. Proactive strategies could be implemented in the LTCF prior to proceeding with the transfer.	*n* = 10 1.90 (0.88)	*n* = 28 1.46 (0.51)	-1.487	11.24	0.165	-0.702 (-1.437, 0.042)
8. The organization of the return to the LTCF following an older adult's stay in the ED is appropriate and effective in ensuring continuity of care.	*n* = 10 3.90 (1.20)	*n* = 27 2.96 (0.96)	-2.456	34	0.019*	-0.914 (-1.668, -0.147)
9. I always have access to the information I need to provide appropriate care for older adults, whether from the LTCF or the ED.	*n* = 10 3.70 (1.34)	*n* = 27 3.70 (0.82)	0.008	12	0.994	0.004 (-0.722, 0.729)
10. Caregivers are a valuable source of information about the health of older adults.	*n* = 8 1.63 (1.06)	*n* = 27 1.56 (0.64)	-0.176	9	0.864	-0.093 (-0.881, 0.697)
11. Caregivers can help to identify the most important needs of older adults and promote their preferences.	*n* = 8 2.00 (1.30)	*n* = 27 1.48 (0.51)	-1.096	8	0.306	-0.688 (-1.489, 0.123)
12. Caregivers are well prepared to assist the older adults with transfers.	*n* = 8 3.63 (1.06)	*n* = 27 3.30 (1.17)	-0.711	33	0.482	-0.286 (-1.076, 0.508)
13. Caregivers employ effective coping strategies when transferring their elderly relative from a LTCF to the ED.	*n* = 8 3.63 (1.19)	*n* = 27 2.93 (0.96)	-1.524	10	0.095	-0.692 (-1.493, 0.120)
14. Caregivers have a harmonious relationship with their elderly relatives.	*n* = 8 2.38 (0.74)	*n* = 27 2.26 (0.53)	-0.411	9	0.623	-0.200 (-0.989, 0.592)
15. Caregivers experience stress and a sense of burden during transfers.	*n* = 7 2.43 (1.13)	*n* = 27 2.93 (0.87)	1,080	8	0.216	0.536 (-0.310, 1.373)
16. Supporting caregivers during the transfer of their elderly relative from an LTCF to the ED is important.	*n* = 8 1.38 (0.52)	*n* = 27 1.96 (0.71)	2.178	33	0.037*	0.877 (0.054, 1.687)
17. I have the knowledge and skills to support caregivers whose elderly relative is being transferred from a LTCF to the ED.	*n* = 8 1.75 (0.71)	*n* = 27 2.30 (0.87)	1.621	33	0.115	0.653 (-0.157, 1.452)
18. Caregivers understand my workload.	*n* = 8 3.38 (1.41)	*n* = 27 3.59 (1.19)	0.437	33	0.665	0.176 (-0.615, 0.942)

Note. *p≤ 0.05

Table 3

Sociodemographic Characteristics of Managers in LTCFs (n = 5) and EDs (n = 2) in phase 2 (qualitative)

Variable	*n* (%)		Mean (SD)	
	LTCF	ED	LTCF	ED
Gender				
Feminine	5 (100.0)	1 (50.0)		
Male	0 (0.0)	1 (50.0)		
Age (years)			39.8 (5.5)	37.5 (3.5)
35–< 45	4 (80.0)	2 (100.0)		
45–< 55	1 (20.0)	0 (0.0)		
Highest level of education attained				
Diploma of College Studies in Nursing	1 (20.0)	0 (0.0)		
Bachelor of Science in Nursing	2 (40.0)	2 (100.0)		
Microprogram in Public Administration	1 (20.0)	0 (0.0)		
Master's Degree in Management	1 (20.0)	0 (0.0)		
Employment status				
Full-time employment	5 (100.0)	2 (100.0)		
Professional title				
Nurse	4 (80.0)	2 (100.0)		
Social worker	1 (20.0)	0 (0.0)		
Number of years of experience as a healthcare professional			17.0 (7.1)	11.0 (9.9)
< 5	0 (0.0)	1 (50.0)		
5–< 15	2 (40.0)	0 (0.0)		
15–< 25	2 (40.0)	1 (50.0)		
25–< 35	1 (20.0)	0 (0.0)		
Position held				
Liaison Nurse	0 (0.0)	1 (50.0)		
Site manager	1 (20.0)	0 (0.0)		
Area Manager/Unit Manager	4 (80.0)	1 (50.0)		
Number of years in current position			1.28 (0.99)	3.50 (3.54)
< 5	5 (100.0)	1 (50.0)		
5–< 10	0 (0.0)	1 (50.0)		

2.2.1 Theme 1. The limits of LTCFs intervention: "We can't do everything here either."

This first theme reflects the idea that the decision to transfer an older adult from an LTCF to the ED is primarily driven by the disparity between the material and human resources in the LTCF and the necessary resources to meet the older adult's needs.

The level of medical intervention (LMI) was raised by all participants as an essential component to consider before making the decision to transfer. In LTCFs (CHSLD in Quebec), the physician generally makes the decision to transfer. In intermediate resources, the context differs depending on the time of day, as care aides are usually involved. The decision to transfer will then be made by the nurse on duty, or by the care aide him or herself, *"we have a very vulnerable clientele, but the people who look after our clientele are just care aides. So, they're not even certified orderlies (…)"* (LTCF04).

The decision to transfer the older adult to the ED is often seen as inevitable, once all available LTCF resources have been exhausted: *"(…) when we transfer, it's because we're at that point (...) we can't do everything here either"* (LTCF03). However, the reality of LTCF is not always understood by ED staff, sometimes leading to misunderstandings: *"the doctors (in the ED) don't understand our reality. They think we're like CHSLDs… We can't have them assessed here, there isn't anyone to do that"* (LTCF04). This delay contributes to the idea that transfers seem justified for LTCFs, but not always for EDs.

2.2.2 Theme 2. Information transfer: a "not very smooth" process

This second theme focuses on the gaps in information transfer between LTCFs and EDs. Managers in both settings described the information transfer process as variable and often inefficient. Some LTCFs used checklists or file summaries. In the ED, a checklist was created to guide nursing staff once the patient had

been discharged, particularly with regard to the information to be transmitted. Yet it is sometimes difficult to obtain the information needed to ensure effective management of the older adult in a timely and efficient manner. Therefore, the transfer of information could be summed up as a process that *"is not always very smooth (...)"* (LTCF03). Two subthemes were developed to represent the challenges encountered.

2.2.2.1 Getting information from LTCFs: "Reaching them is very difficult"

When older adults arrive at the ED without adequate information, it's a challenge to get details from the LTCFs:

> *"It's very difficult to reach them (...) you call the residence, you have to dial three hundred numbers to get through to someone whom you have no idea who they are only to find that you've got the wrong person (...) It's hell!"* (EMERG01).

ED managers also complain about the low relevance of the information they receive:

> *They send us residents with their name, and whether they wear glasses, and give us their daughter's number. That's all there is on the sheet. It's ridiculous! (...) I don't even know if he needs mobility assistance, I have no idea regarding his level of intervention nor his medical history.* (EMERG02)

ED managers stated that essential information to have in the ED included the older adult's basic usual condition, level of medical intervention (LMI), reason for consultation, medical history, level of autonomy and mobility, and family and LTCF contact information. Ultimately, the older adult suffers the repercussions of this lack of information.

2.2.2.2 Getting information from the ED: "You have to chase it down"

LTCF managers have difficulty obtaining information when older adults return to the LTCF: *"One resident (...) came back, and then we had no idea she'd been discharged (...). She just suddenly arrived with nothing (...) we had no information and had to chase down what had been said (...)"* (LTCF02).

Besides not receiving information in time, contacting the ED is often time-consuming. This lack of coordination further compounds the problem of continuity of care, as staff have to "chase down" the necessary information, which is perceived as "a waste of time" (LTCF02). Among LTCF managers, the information considered crucial upon the older adult's return includes diagnosis, medication changes, medical prescriptions, examinations carried out, the emergency physician's summary sheet and follow-up recommendations to ensure continuity of care.

2.2.3 Theme 3. The impact of an ED stay on older adults: "It destabilizes them (...) it's a lot for them."

This third theme reflects the possible consequences of a stay in the ED for older adults transferred from LTCFs. Managers in both settings are aware that the ED environment is not tailored to older adults' needs, with negative effects both during and after their stay: *"(...) it destabilizes them, the change, the stretchers, learning. It's a lot for them"* (LTCF01). Two subthemes illustrate these impacts.

2.2.3.1 In the ED: "we're creating delirium"

ED managers were aware that the ED environment was unsuitable for older adults:

> *The noise, the monitors. Stimuli are 24 hours a day in the ED (...) you come in with an Iso-SMAF profile of 10, but you leave here with 14 because you were delirious, because you had a fall and you were confused* (EMERG02).

These complications, often arising from long stays, add a complexity to care: *"The delays in the ED are far too long, and they shouldn't be. We create delirium, we lose control following the delirium that we ourselves have created (...)"* (EMERG01). A number of complications in the elderly were identified following a stay in the ED, including pressure ulcers, deconditioning and delirium.

2.2.3.2 Older adults' return to LTCF: "starting all over again"

LTCF managers suffer the consequences of a stay in the ED, as they must manage older adults who return with new complications, such as pressure ulcers. These problems can further deteriorate the older adult's clinical condition. Many perceive the older adult's return to the LTCF as a restart: *"(...) I used to treat a lot of people who came back from the ED with sores. And that made me angry all the time. Because it's like starting all over again. The resident was doing well, but now he can't even sit"* (LTCF01).

Alongside the physical impact, the relationship of trust between the older adult and staff can also be compromised, making it more difficult to resume care: *"(...) the relationship of trust (is) no longer there. We feel like we're starting all over again"* (LTCF02). As a result of these challenges, some staff members prefer to avoid transfer to the ED, knowing that the older adult would return with new problems.

2.2.4 Theme 4. FCGs: "We need (them), then (they) need us"

This fourth theme explores the relationship between FCGs and LTCF and ED staff, recognizing the contribution of FCGs to older adults' care:

> *A family caregiver is someone who will help with feeding, mobility, hygiene, who will speak up, who knows the person (...) Who (will) sometimes bridge the gap between what the doctor says, and the elderly person who may not be able to understand everything either (...)* (EMERG02).

Several respondents mentioned that FCGs are the older adults' representatives, whether in the LTCF or in the ED: *"(...) when they (caregivers) are there, they are helpful, because they know the patient, they have information (...). We need them"* (EMERG02). However, this collaborative relationship requires ongoing effort: *"(...) it's really about working together (...). We need them and they need us"* (LTCF02).

Managers emphasize the need to keep FCGs informed of their loved one's condition, to promote transparency in exchanges, and to involve them more in the LTCF activities. However, certain trust issues remain, particularly when FCGs install cameras in residents' rooms to monitor care. We sometimes observe a blame culture, where interactions between FCGs and staff are fraught with recriminations.

In the ED, some staff experience being judged by FCGs, which can undermine their effectiveness: *"(...) you feel observed (...) you want to be quick (...) not have someone in your way"* (EMERG01). The physical layout of the ED also makes it challenging to integrate FCGs given that there is little space to accommodate them: *"(...). (If) we allow one or two people to come and help him, I've just reached saturation point. We're not adapted for that"* (EMERG01).

Participant EMERG02 added: *"They (FCGs) are helpful, but they don't have any space. Physically, it's really pitiful. They're on the ends of stretchers, they're in the hallways"* (EMERG02).

2.3 Mixed results: integration of quantitative and qualitative results:

Table 4 provides a matrix linking the quantitative and qualitative results, as well as the mixed meta-inferences, i.e., the conclusions derived from the integration of the two types of results. The qualitative results confirmed and broadened the quantitative findings, reinforcing their scope and providing context. Finally, there were no discrepancies between the two types of results.

Discussion

To our knowledge, this is the first study to combine the perceptions of LTCF and ED nurses, as well as managers, by addressing the entire transfer process. The perceptions of nurses in both settings were similar, highlighting common issues, such as the transfer of information at transition points. In phase 1, nurses' perceptions helped identify the problems associated with these transitions. Phase 2 interviews with managers explained the results obtained in Phase 1. The integration of quantitative and qualitative results provided a better understanding of the problems experienced, and highlighted the context in which LTCF and ED nurses must work together. The four main findings that emerge from this integration will guide our discussion.

The first finding suggests that the transfer of older adults from LTCFs to ED appears to be prompted by a lack of material or human resources in LTCFs. This aligns with the literature, where a number of studies (Dallaire et al., 2018; Gurung et al., 2022; Laging et al., 2014; Lemoyne et al., 2019; Stephens et al., 2020; Trahan et al., 2016; Unroe et al., 2018) highlight that the presence and quality of nursing care in LTCFs, the availability of a physician or nurse practitioner (NP), as well as the accessibility to equipment (e.g., ECG) influence the decision to make this transfer. Some studies (Lemoyne et al., 2019; Stephens et al., 2020) propose that LTCFs should be better equipped with highly skilled professionals (e.g., nurse practitioners) and that nursing staff, in sufficient numbers, receive support in their professional development, thus reducing the number of so-called avoidable transfers. The study presented in this article found that participants in the second phase reported that transfers of older adults from CHSLDs (residential and long-term care centers) to EDs were less frequent and less problematic than those from private seniors' residences and that older adults' wishes, through the level of medical intervention (LMI), were taken into account during transfer decisions. The literature indicates that suboptimal planning of care directives (e.g., advance directives) contributes to avoidable transfers and hospitalizations (Lemoyne et al., 2019; Marincowitz et al., 2022; Stephens et al., 2020; Unroe et al., 2018).

The second finding of this study is that the transfer of information between LTCFs and EDs is ineffective, compromising continuity of care. ED participants reported that information was frequently incomplete or irrelevant when older adults arrived at the ED, a conclusion echoed in the literature (Gettel et al., 2019; Griffiths et al., 2014; Morphet et al., 2014; O'Reilly et al., 2019). Dallaire et al. (2018) note that only 35% of LTCF staff and paramedics transmit detailed information to the ED. Following analysis of 474 charts, Gettel et al. (2019) report that important data are often missing from the documentation that accompanies older adults to the ED, such as reason for transfer (25%), baseline mental status (25%), diagnosis of dementia (23%) and baseline functional status (20%). The use of a standardized document, preferably electronic, highlighting the most relevant information, is recommended by O'Reilly et al. (2019) to guide decisions and interventions in the ED. According to the results obtained from both phases of the study, the content of the transfer document sometimes lacks specificity and is not adapted to the context of the ED and the decisions that need to be made there. Gettel et al. (2019) also observed this in their studies. The time spent in seeking information and clarification prolongs treatment times and length of stay for older adults in the ED (Dwyer et al., 2014; Griffiths et al., 2014; Morphet et al., 2014; O'Neill et al., 2015; Peguero-Rodriguez et al., 2021). Lastly, the LTCF participants in the study identified similar problems when older adults returned from the ED. No study has explored these issues to date, but this one bridges the gap by underscoring the importance of a structured process for relaying information, including when older adults return to the LTCF. Accurate, relevant, succinct, readily accessible, readable documentation is critical to the effective guidance of care (Griffiths et al., 2014; Tate et al., 2023).

The third finding is that EDs are not tailored to the specific needs of the elderly population and their FCGs (e.g., long wait times, continuous noise, lack of routine, etc.). Participants mentioned several adverse effects associated with a stay in the ED, such as delirium, deconditioning and pressure ulcers, all of which are well documented in the literature (Brucksch et al., 2018; Dwyer et al., 2014; Lemoyne et al., 2019; Peguero-Rodriguez et al., 2023). In recent years, a number of initiatives have been introduced to adapt EDs to the needs of the elderly. EDs can now be accredited as "geriatric emergency departments" by the American College of Emergency Physicians after meeting the guidelines (American College of Emergency Physicians et al., 2013). In Quebec, the ministère de la Santé et des Services sociaux (MSSS) has also published a reference framework to help EDs adapt their care and services to the elderly and their FCGs (MSSS, 2022). However, this framework serves merely as a reference, with no formal obligation. In the United States, despite the dissemination of guidelines for geriatric EDs, the presence of these EDs remains heterogeneous, with a low level of compliance (Southerland et al., 2020). Therefore, efforts must continue, at the risk of making the institutions liable.

The final finding of this study accentuates the fact that the presence of FCGs is considered essential in both LTCFs and EDs, but this presents challenges. In Quebec, the role of FCGs has been officially recognized since 2020 with the adoption of the "Loi visant à reconnaître et à soutenir les PPA", resulting in a national policy and a government action plan (MSSS, 2021a; MSSS, 2021b). Study participants emphasized the importance of including FCGs in care planning, recognizing their expertise and respecting their needs, all of which are objectives targeted by the action plan (MSSS, 2021b). However, as participants

Table 4

Joint Display Combining Quantitative, Qualitative, and Mixed Meta-Inferences

Targeted quantitative results (main findings)			Qualitative results	Mixed meta-inferences
Questionnaire statements	**Mean (SD)**		**Themes**	
	LTCF	**ED**		
It is justified and unavoidable to transfer older adults from LTCFs to the ED.	2.80 (1.48)	3.68 (0.91)	**Theme 1.** The limits of LTCFs intervention: "We can't do everything here either."	Expansion Qualitative results provide context and a better understanding of the process leading to older adults transitioning from LTCF to the ED. The results highlight that the decision to transfer is determined by the resources available in the LTCF (both human and material) in relation to the needs and desires of the older adult. Since these resources vary from one setting to another, they contribute to variability in the reasons for transfer. Thus, transfers are perceived as justified for LTCFs since they have reached their limits. However, ED nursing staff witness transfers from several types of LTCFs with different resources and reasons for transfer that sometimes seem incompatible with the emergency department's mission. This may contribute to the perception that transfers from LTCFs are unjustified.
Finding: LTCF nurses are more supportive than ED nurses of the idea that transfers of older adults from LTCFs to EDs are justified and unavoidable.				
Communication between LTC and ED staff is effective.	4.00 (1.16)	4.00 (0.88)	**Theme 2.** Information transfer: a "not very smooth" process	Confirmation and expansion Integrating the quantitative and qualitative results reveals that information transfer is a significant issue when older adults are transferred from LTCFs to the ED. Furthermore, the qualitative results help explain why information transfer is not optimal. Information transfer is not standardized and is poorly supervised, depending on the facility. Difficulty reaching a contact person directly within LTCFs or EDs (e.g., lack of direct numbers).
Finding: According to LTCF and ED nurses, there is a lack of effective communication between LTCF and ED staff.				
If necessary, the nursing staff at the other facility (LTCF or ED) can easily be contacted.	3.80 (0.92)	4.00 (0.98)		
Finding: LTCF and ED nurses believe that it is difficult to contact the nursing staff at the other facility when necessary.				
The organization of the return to the LTCF following an older adult's stay in the ED is appropriate and effective in ensuring continuity of care.	3.90 (1.20)	2.96 (0.96)		• Information provided by LTCFs that is irrelevant to the emergency context. • Information missing when the older adult returns to the LTCF after being discharged from the ED, which hinders continuity of care. Moreover, the quantitative phase revealed that the way older adults returned to LTCFs after being discharged from EDs was inappropriate. The qualitative results suggested that this was mainly due to ineffective information transfer. Although ED managers were aware of persistent shortcomings in this regard, front-line nursing staff may not have had a comprehensive view of the situation.

continued…

Targeted quantitative results (main findings)			Qualitative results	Mixed meta-inferences
Questionnaire statements	**Mean (SD)**		**Themes**	
	LTCF	**ED**		
Finding: ED nurses are more likely than LTCF nurses to agree that the way in which the return to the LTCF is organized following the discharge of an older adult from the ED is appropriate and effective for continuity of care.				
I always have access to the information I need to provide appropriate care for older adults, whether from the LTCF or the ED.	3.70 (1.34)	3.70 (0.82)		
Finding: Nurses in LTCFs and EDs do not always feel they have the information they need to provide appropriate care to older adults (from the LTCF or the ED).				
Transfers of older adults from LTCF to the ED are carried out efficiently and without gaps.	3.60 (0.97)	3.46 (1.03)	**Theme 2.** Information transfer: a "not very smooth" process and **Theme 3.** The impact of an ED stay on older adults: "It destabilizes them (...) it's a lot for them."	Confirmation and expansion The qualitative results provide context and insight into why nursing staff believe the transition of older adults from LTCFs to the ED is ineffective and seamless. The results revealed that the transfer of information hinders the effectiveness of these transitions, as experienced by both parties. Furthermore, the transition from LTCFs to the ED is especially difficult for older adults. As noted in the interviews, older adults may experience complications after a stay in the ED, such as delirium and deconditioning. These complications arise in the ED but continue after the older adult returns to the LTCF.
Finding: Neither LTCF nurses nor ED nurses perceived the transition of older adults from LTCF to the ED as effective or seamless.				
FCGs are a valuable source of information about the health of older adults.	1.63 (1.06)	1.56 (0.64)	**Theme 4.** FCGs: "We need (them), then (they) need us"	Confirmation and expansion The qualitative results reinforced the importance of FCGs in elder care in both LTCFs and EDs. However, an emerging theme added nuance to FCGs involvement. This theme focused on the relationships that FCGs and nursing staff can develop and maintain, as well as the unsuitability of the ED environment for welcoming FCGs.
Finding: According to LTCF and ED nurses, FCGs are a valuable source of information regarding older adults' health.				
FCGs can help to identify the most important needs of older adults and promote their preferences.	2.00 (1.30)	1.48 (0.51)		
Finding: According to LTCF and ED nurses, FCGs can help identify the older adult's priority needs and advocate for their preferences.				

pointed out, there is a discrepancy between these principles and their implementation in clinical settings. For example, the physical layout of the ED may not always allow FCGs to remain at the bedside. Moreover, nursing staff awareness of the importance of proper treatment of FCGs is essential. Certain practices, sometimes shaped by organizational limitations or a lack of resources, can lead to mistreatment of FCGs by nursing staff (Éthier et al., 2020, 2022). This type of mistreatment can manifest itself by forcing FCGs into a role and placing excessive responsibility on them, normalizing their role, denying their needs, casting judgment on the way they do things, and denying their expertise and contribution to the family (Éthier et al., 2020, 2022).

Table 5 provides recommendations for nursing education, clinical practice and research.

Limitations

The limited sample size of the study, despite its methodological rigour, restricted the scope of the statistical analyses. Statistical power could not be achieved, making it necessary to interpret

Table 5

Recommendations on Areas of Training, Clinical Practice, and Nursing Research

Areas	Recommendations
Training	Initial training It is recommended to: • Raise awareness and equip future healthcare professionals: ▪ On approaches tailored to older adults in various contexts, particularly in LTCFs and EDs. ▪ On issues related to caregiving, including the possible impacts of being a FCGs, the roles and responsibilities of FCGs, and the well-treatment of FCGs. • Expose future healthcare professionals to various learning situations related to approaches with older adults and FCGs through different teaching strategies. **Continuing education** *It is recommended that LTCFs and EDs:* • Encourage and offer continuing education to healthcare staff on caring for older adults and their specific needs (in accordance with the needs of each setting), as well as on the concepts of good treatment of older adults. • Offer joint continuing education (between EDs and LTCFs) to enhance shared knowledge and relationships between healthcare staff. • Use the toolkit "Good Treatment of Caregivers: A Shared Responsibility" in the training of healthcare professionals.
Clinical practice	***LTCF*** (with respect to the different missions and scope of practice possible for each type of LTCF): *It is recommended to*: • Ensure that there are enough qualified and trained healthcare personnel in elder care on each shift. • Ensure that a level of medical intervention (LMI) is determined for all residents and updated periodically. • Discuss and raise awareness among PPA about the MIL and its implications. • Facilitate access to a physician or specialized nurse practitioner (SNP). • Use various technological means to maintain contact and communication with PPA. • Adopt and ensure the use of a standardized form to enable optimal transfer of information between LTCFs and the ED when an older adult is transferred to the there. • Use a checklist when preparing to transfer an older adult to the ED. • Initiate or adopt programs (e.g., INTERACT Program) aimed at reducing or improving transfers to the ED. • Use telemedicine. • Use and distribute the toolkit "Good Treatment of Caregivers: A Shared Responsibility" to FCGs. ED: *It is recommended to*: • Adopt geriatric emergency principles, including: ▪ Adapting the physical environment to the needs of older adults to ensure their comfort and that of their FCGs. ▪ Provide basic care for older adults (e.g., hygiene, hydration, nutrition). ▪ Use validated tools to assess various risks in older adults (e.g., falls, delirium) and geriatric syndromes. ▪ Providing care to older adults through a multidisciplinary team (e.g., physician, geriatric nurse, social worker, and physical therapist). ▪ Include FCGs when planning discharges from the ED. ▪ Upon discharge, provide simple and accessible written information to the older adult and their PPA. • Adopt and ensure the use of a standardized form to enable optimal transfer of information to LTCFs once the older adult has been discharged from the ED. • Raise awareness among ED staff about the different types of LTCF and the services they offer.
Research	*It is recommended to*: ▪ Reproduce this study in other regions of Quebec and Canada to establish an overall picture of the situation. ▪ Conduct both cross-sectional and longitudinal studies to identify and evaluate interventions that can reduce or improve the transition of older adults from LTCFs to EDs. ▪ Continue efforts to enrich the scientific literature on elder abuse, particularly that caused by institutions, including awareness, screening, and interventions.

the results with caution. In addition, only the views of nurses and managers from public network LTCFs and EDs in a single administrative region of Quebec were included. However, the results are corroborated by several published studies. In addition, recruitment of participants during COVID-19 was hindered by numerous obstacles, including the impossibility of recruiting in person. Given this context, every possible effort was made, including a modification of the research protocol. Lastly, the COVID-19 context may have influenced perceptions, as some of the events described took place before and during the outbreak.

Conclusion

This study highlights the perceptions of nurses and managers from public network LTCFs and EDs in the context of an older adult's transition from an LTCF to the ED. Perceptions between nurses in these two settings were similar, particularly in terms of the challenges experienced. By integrating both quantitative and qualitative results, we were able to draw a number of conclusions, including the fact that the transfer of older adults from LTCFs to EDs is influenced by the human and material resources available within the LTCFs themselves, that information transfer is inefficient, that the ED environment is not adapted to elderly people's needs, and that the integration of FCGs is perceived as necessary, but no less challenging. To conclude, it's vital to highlight the importance of the nursing role, both in terms of care coordination and continuity, and in terms of the geriatric expertise required. Nurses also play a significant role in the integration of FCGs and their well-being in this type of transfer. Nonetheless, a number of actions need to be taken to improve the transfer of older adults from LTCFs to emergency care, and to implement strategies to improve this type of transition over the long term.

Implications for Emergency Nursing

1. A number of gaps have been identified in the transfer of older adults from LTCFs to the ED. Emergency nurses play a key role on several levels.
2. To improve the quality of care in the LTCFs and EDs, it is crucial to implement reliable systems for exchanging information between these two establishments, whether through the adoption of communication protocols or the creation of standardized transfer forms.
3. Emergency nurses must have comprehensive knowledge of geriatrics in order to provide care tailored to this population. Adherence to the guidelines for geriatric emergency department is strongly encouraged.
4. It is encouraged to involve FCGs in the care provided in the ED, particularly during discharge planning, using a respectful and compassionate approach toward them.

About the Authors

Gabriela Peguero-Rodriguez, RN, PhD, completed her doctorate in nursing at the School of Nursing, Faculty of Health Sciences, University of Ottawa (Ontario, Canada). She is currently Assistant Professor in the Department of Nursing at the Université du Québec en Outaouais (UQO; Quebec, Canada).

Viola Polomeno, RN, PhD, is an Adjunct Professor in the School of Nursing, Faculty of Health Sciences, University of Ottawa, Ontario, Canada. She supervised the doctoral dissertation of the first author.

Chantal Backman, RN, PhD, is Associate Professor at the School of Nursing, Faculty of Health Sciences, University of Ottawa (Ontario, Canada). She is a research affiliate of the Ottawa Hospital Research Institute and the Bruyère Research Institute and was a member of the first author's thesis committee.

Julie Chartrand, RN, PhD, is Associate Professor in the School of Nursing, Faculty of Health Sciences, University of Ottawa (Ontario, Canada). She is a researcher affiliated with the Children's Hospital of Eastern Ontario (CHEO) Research Institute. She was also a member of the first author's thesis committee.

Michelle Lalonde, RN, PhD, is Associate Professor at the School of Nursing, Faculty of Health Sciences, University of Ottawa (Ontario, Canada). She is a senior researcher at the Institut du Savoir Montfort and holds the Research Chair in Francophone Health in Ontario. She was co-director of the first author's doctoral dissertation.

Conflicts of interest

None reported.

Ethics certificate number

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