

Using Yin's framework [40], the study included embedded units of analysis (four acute hospital wards and two community hospital wards) that were studied in depth to gain understanding of care transitions. The wards were selected with expert guidance from a senior nurse, the aim being to include wards that regularly admitted frail older people and that were based in each of the two acute hospitals. The two community hospital wards were selected as they regularly admitted frail older people who were transferred from the four acute wards.

Methods

The data were collected from July to October in 2012, through audio-recorded semi-structured interviews (key staff and patients), and focus groups (ward staff). Researchers used topic guides developed from the literature review.

A purposive sampling approach was used to identify key staff, who were invited for individual interviews via email. A senior nurse identified potential participants according to the following criteria:

- staff with direct, or strategic, involvement with planning and/or managing transitions of frail older people from the acute wards;
- a range of disciplines (medical, nursing and allied health professionals);
- staff from different locations: both acute hospitals, community hospitals and community healthcare teams.

After the first 10 interviews, the sample was reviewed in relation to the above criteria and a further group of staff were identified and invited. The final sample of 17 staff included 9 who were community-based including: a lead general practitioner, an adult community healthcare lead, district nurses, a community physiotherapist, a community occupational therapist and a senior nurse with responsibility for the community hospitals. The other eight participants were acute hospital-based and included: senior nurses, senior operational leads and staff with hospital-wide roles in care transitions. Interviews lasted approximately 30 minutes each. Researchers used open questions, based on the topic guide, to explore participants' views about, and experiences of: the system's strategic commitment to transitions of frail older people, transition processes including involvement of patients/families, and barriers and facilitators to safe and timely transitions. Probing questions were used to elicit more in-depth responses.

The researchers aimed to conduct a focus group on each ward to explore staff experiences. Focus groups are a form of group interview in which the group interaction is explicitly used as part of the method [42]. Table 1

Table 1. Focus groups and participants

Focus group	Participants	Ward
Focus Group 1	2 physiotherapists 1 staff nurse	Community hospital ward (Ward A)
Focus Group 2	6 staff nurses	Acute ward (trauma) (Ward B)
Focus Group 3	1 occupational therapist, 2 staff nurses, 1 ward sister	Community hospital ward (Ward A)
Focus Group 4	1 occupational therapist, 1 physiotherapist, 1 deputy ward sister, 2 nurses	Acute ward (Stroke) (Ward C)
Focus Group 5	1 ward sister, 1 discharge coordinator, 3 social workers, 1 physiotherapy assistant	Acute ward for older people (Ward D)
Focus Group 6	2 occupational therapists, 1 physiotherapist, 1 discharge co-ordinator	Community hospital ward (Ward E)
Focus Group 7	1 ward sister, 1 staff Nurse	Community hospital ward (Ward E)
Focus Group 8	1 ward sister and 2 staff nurses	Acute ward for older people (Ward F)
Focus Group 9	Discharge facilitator, occupational therapist, physiotherapist	Acute ward for older people (Ward F)

summarises the focus groups and participants, who were based on, or linked to, the selected wards (A–F). The original intention was to hold one focus group on each ward with a multidisciplinary staff group. However, staffing issues and time pressures on staff led to organisational difficulties. The researchers were flexible about rearranging dates and times and they ran the groups on Wards A, E and F on two occasions with small numbers so that more staff could participate. In total, 36 staff participated in the 9 focus groups, each of which lasted 30–60 minutes. The topics explored through open questions and probes were: perceptions of the system's strategic commitment to transitions of frail older people, care transition planning processes, facilitators and barriers to transitions, and patient and family involvement in planning transitions.

The project team aimed to interview patients (and their relatives if willing) who met the following criteria: frail, 70 years or above, had experienced a care transition from a selected acute ward to either a community hospital ward or home with community healthcare team support, have the mental capacity to give informed consent, and be able to communicate verbally and in English. However, within the data collection period, only four patients were recruited: two following discharge home and two after transfer to a community hospital ward (see Table 2). No patients who were invited to