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ORIGINAL ARTICLE

Nurses' experiences of continuity of care for patients with heart failure: A thematic analysis

Malin Östman PhD, RN, Research Leader[1,2,3] | Siv Bäck-Pettersson PhD, RN, Research Leader[3] | Annelie J. Sundler PhD, RN, Professor[1] | Ann-Helén Sandvik PhD, RN, Senior Lecturer[1]

[1]Faculty of Caring Science, Work Life and Social Welfare, University of Borås, Borås, Sweden

[2]Region Västra Götaland, Närhälsan Källstorp Health Centre, Trollhättan, Sweden

[3]Region Västra Götaland, Research and Development Primary Health Care, R, D&E Centre Fyrbodal, Västra Götaland, Sweden

Correspondence
Malin Östman, Faculty of Caring Science, Work Life and Social Welfare, University of Borås, Allégatan 1, SE-50190 Borås, Sweden.
Email: malin.ostman@hb.se or malin.ostman@vgregion.se

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Abstract

Aims and Objectives: This study aimed to describe nurses' experiences of continuity of care for patients with heart failure.

Background: Heart failure is a life-influencing condition that causes varying care needs over time with risks of fragmentation. Nurses play an important role in caring for patients with heart failure. However, nurses' experiences of continuity of care seem to be less explored in this context.

Design: A qualitative study with a descriptive design.

Methods: Four focus groups were chosen to collect the data, and the analysis was made by using a method for thematic analysis. A purposeful sampling of nurses (n = 14) with experiences from hospital-connected heart failure clinics, primary healthcare centres and municipal home healthcare settings was recruited. The COREQ checklist was used in this study.

Results: The nurses' experiences of continuity of care for patients with heart failure were described in four themes: access and flexibility, responsibility and transparency, trustful and caring relationships and communication and collaboration.

Conclusions: The results indicate that nurses have an excellent position to act as the "hub" in caring for patients with heart failure, but they need to have the possibility of networking and establishing trusting relationships with their colleagues. From the nurses' point of view, mutual trust between the nurse, the patient and the patient's next of kin is crucial for promoting and maintaining continuity of care in patients with heart failure.

Relevance to clinical practice: To promote continuity of care for patients with heart failure, nurses expressed the necessity of establishing trusting relationships in a continuity-promoting organisation with seamless coordination. Nurses can be the "hub" supporting a person-centred care approach based on the patients' needs. There seems to be a need for better collaboration with common guidelines across and within primary healthcare centres, hospital-connected heart failure clinics and municipal home healthcare settings.

KEYWORDS
caring, continuity of care, focus group, heart failure, nurses, qualitative research, thematic analysis

1 | INTRODUCTION

Patients with heart failure (HF) depend on long-term contacts with different healthcare providers because of the nature of the disease (Ponikowski et al., 2016). Care for patients with HF is provided by various healthcare professionals in the continuum of care ranging from prevention to primary, secondary and tertiary care and, in some cases, end-of-life and palliative care (Jaarsma et al., 2014; Ponikowski et al., 2016). It is not uncommon for patients with a long-term illness to feel that they "fall between the cracks" when the care duties are divided among several healthcare providers. Patients may experience a lack of information transfer and coordination between healthcare organisations and healthcare professionals (Säfström et al., 2018; Tarrant et al., 2015). In the event of deterioration, hospitalisation or the need for care in different healthcare settings, there is a risk of a lack of continuity of care (McDonagh et al., 2011; Ryan & Farrelly, 2009). Several studies have shown that a combination of increased age, multiple illnesses and fragmented care increases the need for continuity of care in patients with HF (Säfström et al., 2018; Stewart et al., 2016). Continuity of care can be defined as the degree to which a series of discrete healthcare events is experienced as coherent, connected and consistent with the patient's medical needs and personal context (Haggerty et al., 2003).

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

- To ensure continuity of care for patients with HF, nurses can act as the "hub" in the collaboration between healthcare professionals within HFCs, PHCs and HHCs.
- Continuity of care can support patients' health and well-being when the care is accessible, sufficiently flexible to meet their needs, regardless of which healthcare organisation delivers the care.
- When nurses in HFCs, PHCs and HHCs collaborate in the care of patients with HF, continuity of care is promoted for patients, their next of kin and nurses.

2 | BACKGROUND

Most HF patients are cared for at primary healthcare centres (PHCs). In some situations, these patients also require specialist care in hospital-connected HF clinics (HFCs) (Mårtensson et al., 2009; McDonagh et al., 2011). In Europe, patients with HF are cared for in various healthcare organisations (Ponikowski et al., 2016). In Sweden, these patients are commonly cared for in HFCs, in PHCs and in municipal home healthcare settings (HHCs) by various healthcare professionals, including nurses (Säfström et al., 2018).

In care for patients with HF, the goal is to relieve the patients' symptoms, avoid hospital admissions and extend their lifespan (Ponikowski et al., 2016). The term, care, is widely used and described as the responsibility for or attention to health, well-being and safety (Jaarsma et al., 2014). The development of medical treatment and medical devices, and clinics led by nurses specialising in care for patients with HF, have proven to be important factors in providing effective care and medical treatment for these patients (Ponikowski et al., 2016; Takeda et al., 2012). Moreover, structured and planned follow-up visits after hospitalisation at a nurse-led heart failure clinic has been found to reduce mortality, the number of hospital readmissions and the length of hospitalisation (Lambrinou et al., 2012; Takeda et al., 2012), and to contribute to improved quality of life for the patient (Rice et al., 2018). Today, there are nurse-led heart failure clinics in most hospitals in Sweden; however, despite good results, the Swedish PHC has not used the expertise of nursing professionals to ensure the quality of care for patients with HF (Liljeroos & Strömberg, 2019; Mårtensson et al., 2009).

Caring is considered to be the core of the nursing profession; its primary tasks are to promote health, prevent illness, restore health and alleviate suffering (Arman et al., 2015). In caring for patients with HF, the nurse's role is to help patients and next of kin understand and manage the illness and its impact on the life situation (Ponikowski et al., 2016). From a caring perspective, this also includes HF patients' physical and existential problems (Arman et al., 2015). Nurses are considered to care for patients with HF via a clinic, at home or by telephone contact. The care delivered by nurses should contain targeted information on care and medical treatment to offer psychosocial support based on the needs of the patient and the patient's next of kin (Ågren et al., 2012; Glogowska et al., 2015; Jaarsma et al., 2014; McDonagh et al., 2011). Caring for patients with HF is a complex task because patients have different care needs in various situations, and the patients and their next of kin have expectations about the nurse's ability to help them (Sedlar et al., 2020). Nurses also facilitate collaboration between healthcare professionals in different organisations (Nordfonn et al., 2019; Olano-Lizarraga et al., 2016). Patients being cared for in different healthcare organisations face the risk that the care may become fragmented. Nurses stress that care for patients with HF needs to be organised and coordinated to promote continuity of care (Close et al., 2013; Kirsebom et al., 2013).

Continuity of care has mainly been studied from the perspective of the patient–physician relationship, where the number of contacts with the same physician over time is considered a measure of continuity (Hussey et al., 2014; Van Walraven et al., 2010).

Previous studies that have focused on nurse–patient relationships in municipal home health care or neurological healthcare settings have reported that nurses can contribute to continuity of care for both patients and their next of kin (Aspinal et al., 2012; Close et al., 2013; Nilsen et al., 2019). In an ongoing project, patients and their next of kin describe nursing care as important in promoting continuity of life for patients with HF (Östman et al., 2015a, 2015b, 2019). As previously described, nurses play an important role in caring for patients with HF, whether the care takes place in HFCs, in PHCs or in HHCs. However, nurses' experiences of continuity of care seem to be less explored in this context. Therefore, this study aimed to describe nurses' experiences of continuity of care for patients with HF.

3 | METHOD

3.1 | Design

In this study, a qualitative descriptive approach for thematic analysis was used, grounded in descriptive phenomenology (Sundler et al., 2019). This method makes it possible to understand the meaning of continuity of care for patients with HF based on nurses' lived experiences from a lifeworld perspective (Dahlberg et al., 2008). Focus groups were chosen for collecting the data (Krueger & Casey, 2015; Morgan & Hoffman, 2018). The focus group interviews allowed participants to discuss and compare their experiences of continuity of care during the session, making it possible to get as rich descriptions as possible of the phenomenon in focus (Morgan & Hoffman, 2018). The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used for reporting this study (Tong et al., 2007) (Appendix S1).

3.2 | Participant and recruitment procedure

A purposeful sampling of nurses (n = 14) with varying levels of experience in caring for patients with HF was recruited from two HFCs (n = 3), four PHCs (n = 5) and three HHCs (n = 6) in southwestern Sweden. Eleven women and three men, with an average of 22 years of experience in the nursing profession, participated in the study. The characteristics of the participants are presented in Table 1.

Information regarding the study and the recruitment of nurses was sent to the respective heads of administration in HFC, PHC and HHC (n = 9) via email. After receiving approval for conducting the study, the respective managers at HFC, PHC and HHC (n = 24) were contacted by letter to enable getting in touch with nurses from each organisation. In some of the HHCs (n = 2), the nurse with medical responsibility was informed about the study to first provide contact information to the managers in the HHCs and then to the nurses. Two weeks later, and then twice thereafter, reminders were sent via email to those who did not respond to the initial request. Written information about the aim of the study and contact information to the first author (MÖ) were sent to potential participants (n = 22). After one week, the nurses were contacted via email or telephone for further information about the study and the opportunity to ask questions. Five declined participation. For those who wanted to participate (n = 17), the time and place for a focus group interview (FGI) were booked. However, two participants cancelled the interview on the day it was scheduled due to their heavy workload, and one participant was unable to participate due to lack of time. Thus, 14 nurses participated in the study.

TABLE 1 Participants' characteristics (n = 14)

Gender	Female	n = 11
	Male	n = 3
Age	Range	30–65
	Mean	49
Healthcare organisation	HFC	n = 3
	PHC	n = 5
	HHC	n = 6
Years in the nursing profession	Range	2.5 to 40
	Mean	22
Healthcare contacts with patients with HF	Daily	n = 6
	Weekly	n = 7
	Monthly	n = 1
Healthcare contacts with next of kin	Daily	n = 3
	Weekly	n = 3
	Monthly	n = 8

3.3 | Data collection

Data were collected through four FGIs with two to five nurses in each group (FGI 1 n = 3; FGI 2 n = 5; FGI 3 n = 4; FGI 4 n = 2). FGIs were used to investigate participants' experiences. During the interviews, the interactions between the participants were used to stimulate and obtain as rich descriptions as possible to elucidate the phenomenon (Morgan & Hoffman, 2018). Using FGI can allow participants to engage in sharing and comparing experiences among themselves (Krueger & Casey, 2015; Morgan & Hoffman, 2018).

The FGIs took place at different healthcare settings from October 2019–December 2019. The FGIs lasted 80–100 min. All the FGIs were conducted by the first author (MÖ) as a moderator with the second author (SBP) as an observer, except for FGI 4, which was conducted with only the moderator (MÖ) since that FGI only had two participants because two others had cancelled on the day the session was scheduled. FGI 4 was conducted even though there were only two participants to obtain their experiences (Krueger & Casey, 2015). In connection with the FGIs, demographic data were collected. A semi-structured interview guide with open-ended questions was used to capture the nurses' experiences of continuity of care (Krueger & Casey, 2015; Morgan &

Hoffman, 2018). After FGI 1, the authors discussed the interview guide and no changes were made to the questions. All interviews began with the initial question: How do you experience continuity of care in the care for patients with HF? Follow-up questions were asked based on the participants' answers. These questions were used to stimulate reflection and to obtain as detailed and nuanced descriptions as possible about the phenomenon. These questions could include: Can you describe? Can you tell us more? and Can you give an example?

3.4 | Data analysis

The interviews were digitally recorded and transcribed verbatim. The text was analysed according to the method of qualitative thematic analysis described by Sundler et al. (2019). The analysis consisted of four steps. Step one consisted of repeatedly open-minded reading of the text to become familiar with the material. In step two, the text was re-read to find details that enabled new insights and meaning units in the data that represented experiences of continuity of care. These meaning units were marked in the text and described with a few words in the margin. The meaning units were then compared based on similarities and differences and systematically grouped to develop patterns. In step three, the meaning units were condensed in a descriptive text. These descriptions were then described and labelled into themes. This process included writing and rewriting the text to explore and organise meanings. In the final step, the meanings were organised into a wholeness with themes describing the nurses' experiences of continuity of care for patients with HF. To illustrate that themes were grounded in data, the results were illustrated with quotes.

The first author (MÖ) conducted the analysis in collaboration with the second author (SBP). Thereafter, all the authors discussed the analysis and its results until consensus was reached. The result was also discussed in the research community with other experienced researchers. This led to further clarifications of the result.

3.5 | Ethical considerations

The study was conducted in accordance with the Helsinki Declaration (WMA, 2013). Ethical permission for the study was obtained from the Regional Ethical Review Board in Gothenburg, Sweden (Ref. No. 918–71). The interviews, analysis and reporting of the results were conducted by researchers with expertise in the field. The participants received oral and written information about the study, its purpose, procedures and confidentiality, as well as the opportunity to withdraw their participation at any time, without suffering any consequences. Written informed consent was obtained from each participant before the interview started, and it was clarified that confidentiality between the participants could not be guaranteed in the FGIs. All personal data was decoded, and each participant was assigned a number. The code list was stored in a secure file cabinet, only available to the research team.

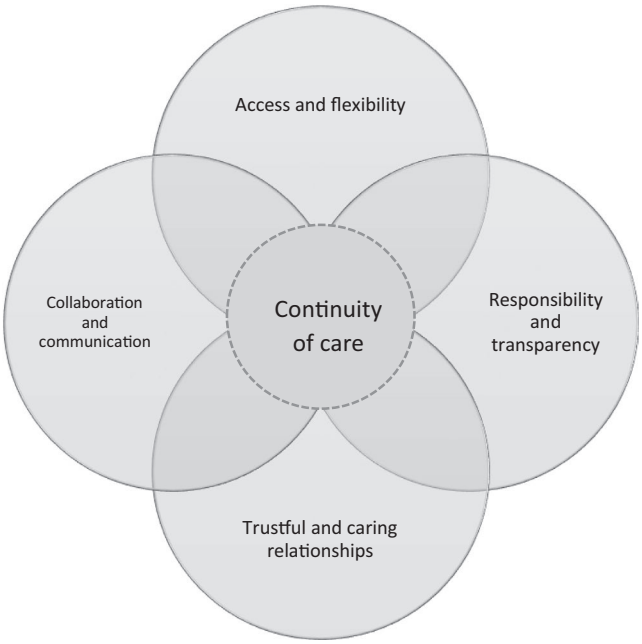

FIGURE 1 Nurses' experiences of continuity of care for patients with HF

4 | RESULTS

The analysis resulted in four themes describing experiences of continuity of care for patients with HF, as reported by nurses that represented HFCs, PHCs and HHCs. These themes are: access and flexibility, responsibility and transparency, trustful and caring relationships and communication and collaboration. The themes need to be understood in a healthcare organisation context. The theme of access and flexibility can be regarded as a basic prerequisite for continuity of care for patients with HF. The next theme illustrates nurses experiencing responsibility and transparency, as an aspect of continuity of care being necessary for a more holistic approach when caring for patients with HF. They expressed the importance of healthcare providers taking responsibility for the patient's care and that they as nurses could constitute the "hub" in this context. The nurses' viewed trustful and caring relationships as important for the continuity of care. It was about the nurses emphasising the value of getting to know the patient as a person and creating a mutual and long-lasting relationship with both the patients and their next of kin. To develop these relationships, both access and flexibility as well as responsibility and transparency were experienced as required. The theme communication and collaboration were described by the nurses to involve functioning communication and collaboration between the patient, the patient's next of kin, healthcare professionals and healthcare providers. The nurses felt that they needed to use their communication skills to collaborate and create networks

with different healthcare professionals across healthcare providers/organisations, all to ensure continuity of care for patients with HF Figure 1.

4.1 | Access and flexibility

In this theme, the nurses viewed continuity of care as being related to patients having access to care and the care being flexible, based on the patients' needs. The nurses described continuity of care as care where the patients are able to get in touch with healthcare professionals by telephone or in person. It was also about patients encountering a competent nurse to get advice, support and help according to their needs. Thus, a prerequisite for continuity of care was flexibility in the organisation and structural possibilities for nurses to plan and create space for the patient's visits, according to each patient's individual needs.

> That you have a work situation that allows you to be available, that you can meet the patient on their initiative // It should be easy for the patient to contact his/her HF nurse, that we are easily accessible, that they can call, that it is easy to reach them.

The nurses' described that access to care was about the patients' need for care, which should be a priority of the healthcare organisation; the type of care provided should not be solely based on costs. Short-term financial solutions for saving money were viewed as hindering the nurses' ability to deliver good, sustainable care on equal terms. It was also about patients being cared for by healthcare professionals that are specialists in the area of HF; thus, it was important that patients have access to multi-professional teams with physicians, nurses, dieticians, occupational therapists, physiotherapists and psychologists, even if not all of them were caring for the patient at the same time. When these teams were mobile, it could enable specialist nurses and physicians to make home visits. Mobile visits were considered as simultaneously promoting access and continuity of care, for example by preventing unnecessary hospitalisation.

> The mobile team, for example, if we have a patient who is ill, who has difficulties in breathing, then I can call them, and they will come out. They can prescribe to inject Furix intravenously or change the patient's drug prescription a little. // Then the patient can stay at home; that is the goal.

4.2 | Responsibility and transparency

This theme describes the nurses' view of continuity of care as related to the responsibility and transparency in providing care for patients with HF. This was characterised by the fact that nurses and other healthcare professionals could take responsibility for the patient's care. The nurses emphasised the importance of common procedures for follow-up, either at HFCs and PHCs or in HHCs, whether through telephone contact, outpatient visits or at home. For patients, responsibility and transparency entails having insight into what was going to happen to them and that they could feel safe regarding who to turn to when needing health care between planned visits or when the condition worsened. According to the nurses, this was experienced as promoting continuity of care.

> I usually give them the time for the next appointment directly in their hand. So, when they leave, they know when to come back // So, there is a plan, that the patient is present all the time and that I explain what I am going to do, what the plan is and what we should do next.

The nurses stated that the health care was mainly organised in a fragmented way, in which the care was delivered based on different specialities, without considering the patients' needs. However, the nurses described that continuity of care was about having someone who was responsible for all the care of patients with HF. In such care, the nurses could serve as the "hub" to support less fragmented care.

> That we see the patient as our responsibility, that you feel you are responsible, so that the patient doesn't have to be bounced around // It is important that you can take the main responsibility when you encounter such a patient.

While nurses view continuity of care as the responsibility for the care that is organised based on the patients' needs, there is a need for consensus on the long-term care goals among all the healthcare professionals that are involved. The nurses emphasised that the care plan was an important tool for planning and follow-up of the care delivered. They felt the need for a care plan drawn up across healthcare organisations that contains clear instructions on what to do and that identifies who is responsible for performing various care measures. This would reduce the risk of an unnecessary gap in the care for patients with HF.

> Everyone involved with the patient is included. Of course, there may be next of kin and several healthcare professionals, and some nurse with the overall responsibility for the patient's care planning. With agreements regarding what to do to make it as good as possible for the patient. What to do when the HF deteriorates, and so on.

According to the view of the nurses, continuity of care was also related to the medical treatment the patient received. This required responsibility and transparency in monitoring that the prescribed drugs were adequate, that the drug lists were updated at each healthcare visit and that the patient received a current medication list and learned to recognise the names of their prescribed drugs. In contrast, nurses

saw a risk with the use of generic drugs, as different and complicated names could result in the patient not taking the right medication or not following the prescribed dosage.

Consensus about the patient's prescriptions was required to promote medical treatment continuity. To promote continuous medical treatment, consensus about the patient's prescriptions was required. The advice regarding medication was usually given in connection with a physician's or nurse's visits, but it also referred to pharmacists at pharmacies. The nurses expressed the importance of a healthcare professional's responsibility to provide consistent information and advice about the patient's drug treatment to preserve continuity in medical treatment. At the same time, they noted that pharmacists' counselling of medical treatment sometimes caused the patients to stop taking their prescribed drugs.

> Sometimes the pharmacists start to question it and say that this pill does not go together with this, and then the patient ends up not taking any medication. Then the patient comes to a return visit and they have stopped with the pill we prescribed, so it will be a completely unnecessary visit // Then, we must start from the beginning.

4.3 | Trustful and caring relationships

The nurses' view of continuity of care in HF was related to trustful and caring relationships. The nurses described that continuity of care in the meaning of trustful and caring relationships was a prerequisite for getting to know the patient with HF, his or her medical history and life situation. The nurses experienced that trustful relationships provided security for both the nurses and the patients with HF so that they could relate to previous visits, agreements and measures. However, it did not necessarily have to be a personal relationship; as long as the patient had someone, they could turn to that made them feel confident and who could coordinate their care.

> Above all, it is the security that patients feel when they talk to us on the phone, that they know, that we know who they are. It is not just heart failure; it is also social context and how the patient functions at home, what they need and so on. You do not need to go into depth every time, and it is easier to make decisions when you know the patient.

Nurses also described that there could be disadvantages with continuity of care in relation to trustful relationships if the patient became dependent on the same nurse. For example, this might occur if the patient delayed seeking care even if his/her condition was deteriorating while waiting for an appointment with a specific nurse.

> When they have problems with their HF, they turn to their HF nurse, then no one else will do. It becomes almost a problem in that way; they wait a while. So, when they come, they have worsened so much that they need to go to the hospital by ambulance. Then, you have almost succeeded too well with the continuity [ironically].

Continuity of care was experienced as an opportunity to establish long-lasting relationships with the patients with HF and their next of kin. The nurses pointed out that it took time for them and a patient getting to know one another in depth. Developing trust in the relationship required the nurses to be able to communicate with the patient and their next of kin on a 'you and I level'. Consequently, the nurses expressed the importance of mutual trust in the relationship, especially in municipal home healthcare settings. In this way, the nurse, together with the patient and the patient's next of kin, formed a team and created security, which facilitated the nurse's ability to assess and make decisions about the care for the patient with HF. Thus, the nurses experienced that continuity of care, through long-lasting relationships, contributed to increased knowledge about the patient and his or her situation, which helped the nurses make decisions regarding the patient's care.

> The fact that I know and can follow a patient over time gives me a sense of security; it gives me peace of mind // I feel confident in deciding not to send the patient to the hospital. I give the care I can here and now, and it is "good enough."

4.4 | Communication and collaboration

In this theme, nurses described continuity of care as communication and collaboration in care. This was characterised by functioning communication and collaboration paths between the patient, different healthcare professionals, the healthcare team and the patient's next of kin. The nurses noted that the healthcare professionals' attitude affected the communication and information exchange with patients. They needed to be available, to talk, listen, understand and be interested in the patient's experiences to support the patient's health and well-being. This also included listening to the patient's next of kin. To collaborate with the patient, the nurses needed to be able to identify the patient's information needs and tailor the communication according to those needs.

> It is very important that you get to know the patient and can meet the patient where the patient is right now. How to inform, what to inform and how much. There is a lot that comes into play for making it right. Then, there are patients who do not want to hear or know so much, and that you must also respect. Knowing what is right, can be very hard.

To communicate and collaborate, nurses described well-functioning digital solutions as being important for supporting continuity

of care. By using digital solutions, it was possible to obtain comprehensive written information about the patient's care and medical treatment of HF, and to conduct digital care encounters with the patient and/or other healthcare professionals. In contrast, the nurses articulated some concern that digital encounters would be prioritised over physical encounters in the future. They emphasised that distance care could make it difficult to transmit information that is otherwise obtained in an in-person encounter. The nurses expressed that they need to use their senses when communicating with the patient, and that this cannot be captured digitally.

> You need to use all the senses // You need to see them; you should hear them and listen to what is said and what is not said. You should be able to feel and smell // You can't get to know the patient only through digital encounters.

Communication and collaboration between healthcare professionals in different healthcare organisations was viewed as important for continuity of care when patients with HF were transferred. The nurses highlighted several current issues about not having access to the same information and medical record regarding the patient. This impeded information-sharing and collaboration, and sometimes, the patient had to take responsibility for the transfer of information between healthcare providers.

> We can take care of patients, and suddenly there is a prescription we have no idea about. If you are lucky, then the patient has control over the situation' but if you are unlucky, things are totally forgotten. If we don't get any written information to the municipal home healthcare, we know nothing. Because we don't have the same medical record system.

Communication and collaboration with colleagues and the ability to build collaborative relationships with colleagues could support continuity of care. This is about nurses in a catchment area, who, by knowing each other's skills, exchanging experiences and collaborating, are able to better rely on each other's competence and thereby support continuity of care for patients with HF across care providers' boundaries.

> I have worked with one and the same heart failure nurse // We have had several contacts the last six months, so it feels like we have worked together; it gets easier and easier. Then, I feel, this is good. We know each other // Thanks to our collaboration, the patient doesn't need to go to hospital as often as before; now, maybe it is once a year.

5 | DISCUSSION

This study, presents that nurses experience access and flexibility in the care contacts as a basic prerequisite for continuity of care in patients with HF. Other studies in this area have highlighted access to care as an aspect of quality of health care that needs to be improved (Ängerud et al., 2017, 2018; Browne et al., 2014). In this study, the nurses stated that access to multidisciplinary teams and built-in flexibility in planning visits were both essential to continuity of care for patients with HF. If they had the opportunity to plan and reallocate time for visits according to the patients' changing needs, both access to and continuity of care could be supported.

Continuity of care was also described as being related to responsibility and transparency in the patient's care process. The nurses pointed out that a common and transparent care plan could be the working instrument that allows nurses to provide coherent and quality-safe care for patients with HF. Haggerty et al. (2003) described this as information continuity, and they believe that the information should be well documented and easily accessible to everybody involved in caring for a patient. In the present study, continuity of care was experienced being as related to responsibility and transparency in the patient's care process. The importance of an integrated care plan is also presented in studies by Gusdal et al. (2016) and Jones and Johnstone (2019). In the present study, the nurses considered that the openness and accessibility of the patient's care process was adversely affected by the prevailing medical specialisation and fragmentation within the healthcare organisation. They noted that information transfer was not working as smoothly as desired because the medical records of the respective healthcare providers were incompatible. This meant that documentation for the patient's care and treatment was not available to the concerned healthcare professionals. This lack of information jeopardises patient safety and makes it difficult to ensure continuity of care for patients with HF. The nurses in this study stressed the need to, once and for all, establish conditions for a secure and easily accessible information transfer between professionals from the care providers concerned with each case.

The nurses described that the responsibility and coordination of care for patients with HF was not acknowledged at the regional or local level in the healthcare organisation, despite government directives. The nurses considered this to be one of the main causes for the lack of continuity in patient care and poor quality of care for patients with HF. Close et al. (2013) highlighted that unclear care responsibilities lead to delayed diagnosis and poor care and medical treatment among elderly patients with HF. The present study found similar results. When the nurses are prepared to assume this responsibility by acting as the "hub" and coordinators, continuity of care for patients with HF is supported. The participants' considered that nurse-led HF clinics in a PHC were the most urgent for implementing care for patients with HF. This is in line with European guidelines that recommend nurse-led HF clinics to ensure adequate care and medical treatment for patients with HF (Ponikowski et al., 2016). These clinics have been proven to prevent unnecessary hospitalisations, result in shorter hospital stays and improve medical care based on current guidelines (Agvall et al., 2013; Lambrinou et al., 2012; Liljeroos & Strömberg, 2019). Moreover, patients with HF have been found to be more satisfied with the care provided, due to the fact that they had contact with

a specific nurse over time (Liljeroos & Strömberg, 2019). The present study's results, together with the findings reported in previous research, show that care for patients with HF must be organised and implemented so that it can effectively meet the continuity of care needs of patients, their next of kin and professional nurses.

Trustful and caring relationships with patients and their next of kin were considered necessary to ensure continuity of care in HF according to the nurses in this present study. Haggerty et al. (2003) highlighted relational continuity as one of three important components of a multidimensional care continuity model. Here, the relationship between patients and physicians is presented as essential for promoting continuity of contact. According to Waibel et al. (2012), the importance of allowing patients to see a physician over time is considered to be the most studied area of continuity of care. However, few studies have investigated nurses' views of the importance of a trusting and caring relationship to support continuity of care. Aspinal et al (2019) highlighted the importance of the nurse's knowledge of the patient as a person in the case of deterioration as a continuity aspect for adequate care in a neurological care context. Other studies have shown that patients with a long-term illness, including patients with HF, feel more secure and receive better information when they have a trusting relationship with healthcare professionals (Brand & Pollock, 2018; Östman et al., 2015b; Tarrant et al., 2015). In the present study, it was found that a trusting and caring relationship was important in supporting continuity of care and thereby increasing the safety with which the care for patients with HF is conducted. The nurses considered that this close relationship made it easier to quickly assess the patient's care needs and situation, and it facilitated the nurses' decision-making about care measures both in the short- and long-term. Thus, a trusting and caring relationship was considered to support continuity of care for patients with HF. Planning, implementing and evaluating care in accordance with the patient and his/her next of kin are possible if the quality of the communication and information exchange is high enough to ensure collaboration. Trusting and caring relationships across organisational and care providers' boundaries are essential to support the continuity of care of patients with HF according to the nurses in this study. Similar results can be found in other studies (Glogowska et al., 2015; Larsson et al., 2017).

The nurses in this study stressed the need for collaboration between healthcare professionals and nurses within the same catchment area. They emphasised that there must be effective collaboration between HFCs, PHCs and HHCs to support continuity of care for patients with HF. Patients should experience the care as coherent and seamless (Bodenheimer, 2008; Jones & Johnstone, 2019; McDonagh et al., 2011). Haggerty et al. (2003) described the importance of collaboration between healthcare professionals across care providers' boundaries as management continuity. Aspinal et al. (2012) described this as cross-border continuity. In the present study, the nurses stressed the need to establish a professional collaboration forum in care for patients with HF to deliver coordinated and seamless care for those patients. At this forum, nurses at HFCs, PHCs and HHCs could get together for continuing education and exchange of experiences. Here, joint routines and guidelines could be developed that support the cross-border continuity of care for patients with HF.

5.1 | Strengths and limitations

The rigour of this study is discussed in relation to reflexivity, credibility and transferability (Sundler et al., 2019). Throughout the research process the authors strived for a reflective attitude questioning one's pre-understanding. FGIs were chosen to elucidate the participants' experiences of the phenomenon, in line with recommendations (Krueger & Casey, 2015). First author's (MÖ) pre-understanding included experiences from working as a nurse in PHC. All participants were informed about MÖ's professional background, and some of the participants knew about MÖ through their work. To minimise the interviewers' pre-understanding to influence the FGIs, a semi-structured interview guide with predetermined questions was used. One limitation may be that FGI 4 only had two participants. Commonly, FGI may consist of five to 10 people, depending on which phenomenon is being studied. Still, a group may advantageously be smaller in situations where participants have a high degree of involvement with and experiences in relation to the study's aim (Krueger & Casey, 2015; Morgan & Hoffman, 2018), which was the case in the present study.

The data gathered included varied descriptions of the phenomenon and illustrated the participants' extensive and rich experience in caring for patients with HF. During the analysis, the authors continually discussed their understanding of data and the derived themes, to assure that they stated what was described in the text. The process included an ongoing reflection of the researchers understanding as meanings and themes emerged. In addition, the results were presented to and discussed with experienced researchers (Sundler et al., 2019). Multiple authors and researchers can strengthen the rigour of the analysis and results as they can add supplementary views (Malterud, 2001). Finally, the research process was carefully described step-by-step, so the readers can more easily determine how this result has emerged. To further strengthen the credibility and trustworthiness of the results quotes from the participants were used to illustrate the relationship between the empirical data and the themes derived (Sundler et al., 2019).

The study was limited to a Swedish care context, which may affect the transferability of the results. Still, the results may be useful and relevant in other contexts (Sundler et al., 2019), yet results should be transferred with caution. However, continuity of care is an international phenomenon, and the concept of continuity of care can probably be applied in other healthcare contexts. To make it easier for the reader to judge whether these results can be transferred to other contexts or not, the analysis process has been presented as comprehensively as possible.

6 | CONCLUSION

The present study indicates that nurses are in an excellent position to promote and maintain continuity of care by acting as the "hub" in the care of patients with HF. This study highlights nurses' experiences of continuity of care, a less explored area in care research for patients with HF. The nurses emphasise that continuity of care is important for patients with HF and have suggestions about how continuity can be supported in the care of patients with HF. To maintain and support continuity of care, nurses need to have the possibility of networking and establishing trusting relationships with their colleagues, the patient and the patient's next of kin. Mutual trust between the nurse, the patient and the patient's next of kin is crucial for promoting and maintaining continuity of care. However, the nurses expressed a need for healthcare professionals to pay attention to the necessity of continuity of care for patients with HF and other long-term illnesses.

7 | RELEVANCE TO CLINICAL PRACTICE

To promote continuity of care for patients with HF, it is necessary that healthcare leaders develop a continuity-promoting organisation with seamless collaboration between healthcare professionals. In this study, continuity of care was characterised by access and flexibility, responsibility and transparency, trustful and caring relationships, communication and collaboration. Nurses can promote continuity of care by being the "hub," and the person who coordinates care with other healthcare professionals, given that there are prerequisites for performing the assignment. Similarly, common guidelines for care need to be developed and used, and nurses need to have opportunities to network and collaborate with other healthcare professionals and establish reliable relationships with their nursing colleagues. Mutual trust between the nurse, the patient and the patient's next of kin is crucial for promoting and maintaining continuity of care for patients with HF.

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CONFLICT OF INTERESTS

The authors declare that they have no conflicts of interest.

AUTHOR CONTRIBUTIONS

Study design: MÖ, SBP, AS and A-HS. Data collection: MÖ and SBP. Data analysis and manuscript preparation: MÖ, SBP, AS and A-HS.

ORCID

Malin Östman https://orcid.org/0000-0002-7633-482X
Siv Bäck-Pettersson https://orcid.org/0000-0001-8938-4415
Annelie J. Sundler https://orcid.org/0000-0002-9194-3244
Ann-Helén Sandvik https://orcid.org/0000-0001-5005-9535

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SUPPORTING INFORMATION

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