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Original Article

Caring in the Nursing Practice of Mid-Career Generalist Nurses at an Acute Regional Support Hospital

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ABSTRACT

Aim and Objectives: This study aimed to elucidate the current state of caring in nursing practice in Japan by mid-career generalist nurses following the implementation of a community-based integrated care system at an acute regional support hospital.
Background: With the promotion of functional specialization of medical care throughout Japan, the mean length of hospital stay at acute regional support hospitals is decreasing. Understanding the current state of caring (consideration and concern) for patients by mid-career generalist nurses who promote nursing practice to discharge or transfer patients in short-term hospitalizations is important as it will help determine the impact on caring in Japan.
Design: Qualitative descriptive study
Methods: We conducted semi-structured interviews with six mid-career generalist nurses working at acute care hospitals in Japan. Narratives about caring (consideration and concern) for patients were recorded verbatim and were qualitatively analyzed using a qualitative inductive approach.
Results: We determined five categories of caring (consideration and concern) by mid-career generalist nurses in Japanese acute care hospitals: respect for individual patients and protection of their safety, accurate observation of symptoms, working on the strengths of the patient, working on the strengths of the family, and having a good understanding of the role of an acute care hospital nurse.
Conclusions: Assuming that respect for patients and the protection of their safety are the basis for mid-career generalist nurses at acute care hospitals, we found that with a good understanding of the role of acute care hospitals, mid-career generalist nurses have been entrusted with intervention for families and nursing care after discharge. We also found that concern for each terminal phase patient arises during the course of care, which is difficult to share. Caring (consideration and concern), which is the core of nursing care, arises through situations and relationships. In the event of hospital transfers or transitions to home care from short-term hospital stays, sharing information with the local individual in charge is an issue, and the continuity of caring in nursing practice should be examined from the perspective of the patients' and nurses' satisfaction.

<Key-words>
Mid-career generalist nurse, caring, acute regional support hospital,
community-based integrated care system

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I. Introduction

Caring in nursing was first investigated by Nightingale[1)], followed by Leininger[2)] in the 1970s, and then by Watson[3)], Benner[4)], and Roach[5)] in the 1980s and thereafter. However, while the concept is still considered as the basis of nursing care, it is said to be diverse and complicated[6)]. In Japan, a concept analysis of care/caring was conducted by Misao et al. in 1996[7)]. In 2004, Gregg et al. established 12 categories as values of clinical nursing practices[8)]. More recent research on caring includes research on caring specific to nursing care in specialized fields[9)], and theoretical research[10)]. However, very limited research has been conducted on the nursing practice of caring by mid-career generalist nurses at acute care hospitals.

In Japan, the population of individuals aged ≥65 years is expected to increase to 35.3% by 2040[11)]. A community-based integrated care system was implemented in 2014[12)] with the aim of being established by 2025. Simultaneously, functional specialization of medical care provided by hospitals has been promoted, and patients who have completed acute-phase treatment are being discharged early. As a result, the length of hospital stay in general sickbeds is decreasing, and the mean length of hospital stay is now 16 days[13)]. In particular, at acute regional support hospitals, the mean length of hospital stay has been reduced to 10 days, similar to that in other advanced countries. Nurses at acute care hospitals have shifted from caring for a single patient over a relatively long period from the acute phase through the convalescent phase to providing precise acute-phase medical care for patients who are admitted to and discharged from hospitals on a daily basis. They also deal with transfers and discharges earlier. These changes in the medical system associated with such social changes also affect nursing care at acute care hospitals, and we believe that aspects of caring provided by the nurses, such as consideration and concern, are also changing. In this study, caring refers to how nurses show consideration and concern to patients in their nursing practice. Generalist nurses are the most likely to show such caring due to their high level of patient contact. According to Benner[4)], mid-career nurses are best able to reflect on and report on their own nursing practices.

Research on the practices of mid-career generalist nurses at acute care hospitals has led to the elucidation of independent judgment[14)], factors related to situations involving nursing practices that consider at-home care by general ward nurses at regional medical care support hospitals[15,16)], and life support services provided by mid-career generalist nurses at acute care hospitals[17)]. These studies have elucidated the ability of mid-career generalist nurses to implement discharge support and the actual state of life support. However, there are few comprehensive descriptions of caring by mid-career generalist nurses at acute care hospitals.

Therefore, in this study, we examined the current state of caring (consideration and concern) by mid-career generalist nurses at acute care hospitals. Verbalizing and visualizing caring in nursing practice by mid-career generalist nurses at acute care

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regional support hospitals is also important in terms of conveying caring in nursing practice to young nurses and in basic nursing education.

II. Objectives

This study aimed to elucidate the current state of community-based integrated care systems of caring (consideration and care) by mid-career generalist nurses at acute care hospitals in Japan.

III. Methods

1. Study Design

Qualitative descriptive study (survey via a semi-structured interview)

2. Study Period

From August to September 2016

3. Participants

Among mid-career generalist nurses working at Japanese acute care hospitals, we included six nurses who were referred by the nursing department and who were able to talk about their consideration and concerns toward patients. The inclusion criteria were as follows at the time of obtaining consent: ① mid-career nurses with at least 5 years of clinical experience, ② nurses working for at least 6 months in the acute internal medicine ward, ③ nurses who directly care for patients, ④ nurses who can talk about their consideration and concern for patients in nursing practice, and nurses who were able to provide written consent in person of their own free will upon fully understanding the study after receiving a thorough explanation about participation.

The specific procedure was to contact the head of the nursing department of the acute care community hospital, explain the research plan, obtain approval from the hospital's ethics committee, and then, in cooperation with the head of the education department, post the recruitment posters for research participants at the staff service entrance and in the wards. Following this, we conducted a briefing session for nurses who had been introduced to the study by the nursing department, explained the research cooperation to them, and asked those who were willing to participate to return the consent form by mail.

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4. Data collection methods

1) Interview method

Semi-structured interviews were conducted twice for each participant. The interview content was recorded with the approval of the participants. The study collaborators were requested to not talk about caring. This was conveyed to the participants by using expressions such as "consideration" and "concern" so that the nurses could respond without confusion because there is presently no set definition of "caring." For these interviews, we used the interview guide shown in Table 1.

<Table 1> Interview guide

1. Please talk about your practices regarding consideration and concern for the patient.
2. How does such consideration and concern begin?

2) Information of the participants

We recorded basic information about the nurses, including age, sex, last specialized school, number of years of clinical experience, number of years of experience in the acute internal medicine ward, information about preceptorship experience, and student guidance experience.

5. Analytical methods

The interviews were recorded, and verbatim records were created, which were then qualitatively analyzed by an inductive approach. 1) Regarding consideration and concern for patients that the nurses talked about, codes were created by open coding each unity of meaning[18], such that the meanings could be understood from the context alone. 2) We established common codes by focused coding[18] and extracted final codes, subcategories, and categories. 3) When naming the subcategories and categories, we conducted the analysis after repeatedly investigating names while returning to the codes and data. 4) The analysis of the verbatim records of all study participants was performed in the order of 1) - 3).

6. Ethical considerations

The study was conducted with the approval of the ethical review board of Tokyo Women's Medical University (approval number: 3962). Participation in this study was voluntarily, and adequate written and verbal explanations were given to ensure that there would be no disadvantage if the participants did not cooperate in the study and that their anonymity would be ensured. The study was conducted after obtaining written consent from the study collaborators of their own free will.

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IV. Results

1. Basic attributes (Table 2)

All the participants were women. Their mean age was 35.8 ± 5.9 years (26–46 years). The mean number of years of nursing experience was 12.5 ± 4.8 years (6–19 years). The mean number of years of experience working in the current ward was 3 ± 0.4 years (2.4–4 years). The last specialized school attended was a junior college of nursing for one participant, a 3-year course at a nursing school for three participants, and a 2-year course at a nursing school for two participants. In the ward, one individual was in charge of new nurse education and conducted student guidance as a team leader. The duration of the first interview was 57–62 min (Avg, 59.5 ± 1.8 min) and of the second interview was 55–62 min (Avg, 55.8 ± 5.4 min). The characteristics and interview durations of the participants are presented in Table 2.

<Table 2> Basic attributes

No.	Age	No. of years of experience	No. of years of experience in the present ward	Last specialized school	Interview duration 1st (min)	Interview duration 2nd (min)
A	38	17	3	2-year course at nursing school	62	62
B	46	19	3	3-year nursing school	59	56
C	26	6	4	3-year nursing school	62	45
D	36	7	3	3-year nursing school	58	57
E	36	15	3	2-year nursing school	59	60
F	33	11	2.4	Junior college of nursing	57	55
Avg.	35.8 ± 5.9	12.5 ± 4.8	3.0 ± 0.4		59.5 ± 1.8	55.8 ± 5.4

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<Table 3> Caring by mid-career nurses at an acute regional support hospital

Category	Subcategory	Final code
Respect for individual patients and protection of their safety	Creation of a sense of security and a relationship of trust	Place a sense of relief and trust into greetings Have interest in and be thoughtful toward the patient
	Protection of the patient's privacy, safety, and freedom	Protect the patient's privacy Protect the patient's safety and freedom as a person
	Care taking into account the patient's thoughts and feelings	Share feelings and give peace of mind Care taking into account the patient's intentions and preferences
Accurate observation of symptoms	Careful observation and understanding of the patient's symptoms and complaints	Observe the patient's condition regularly Look at patient's reactions well and respond Make judgments after carefully listening to the symptoms and complaints Create conditions wherein it is easy for the patient to speak
	Repeated observation and comparative examination	Repeat observations until satisfied with results and compare them with the normal state Know the patient's situation without relying only on nursing records
	Observe the patient's strengths through care	Observe the need for care at the bedside, and make preparations Have patients move during care to observe their physical and mental state
Working on the strengths of the patient	Provide the nursing care required for the level of the patient's health	Provide the nursing care required for each individual patient with different health levels Provide intervention at the timing suited to the patient
	Aim to look toward recovery	Convey prospects of illness and treatment and support the will to want to get better Create an environment with the patient's lifestyle in mind
	Create an atmosphere in which time can be spent in a pleasant manner	Improve symptoms that cause distress Make an inpatient environment where one can spend time in a pleasant manner Have time to enable patient satisfaction and reassurance
	Create a plan that enables patients to display their abilities	Create a schedule so that patients can display their abilities Create plans so that patients can display their abilities
	Foster the ability of self-care	Listen to their thoughts about their lifestyle Talk with patients to help them adopt treatment into their lifestyle Teach patients about self-care suited to their symptoms and lifestyle Help patients visualize self-care following discharge
	Intervention for individual needs via team collaboration	Negotiate with doctors to improve the patient's level of satisfaction Revise care and continue nursing care through sharing information within the team Expand the patient's possibilities through team cooperation Plan emotional control through nursing team collaboration
Working on the strengths of the family	Draw on the family's ability to care	Listen to the family's intentions, sense family fatigue, obtain family cooperation, and help the family imagine the patient's lifestyle
	Convey care methods to the family	Inform the family of care that only they can provide and perform intervention so that the family can provide care
Understanding the role of acute care hospital nurses well	Provide care required by acute care hospital nurses	Entrust family intervention to post-discharge nursing care Concern for each individual terminal phase patient arises during the course of care and is difficult to share

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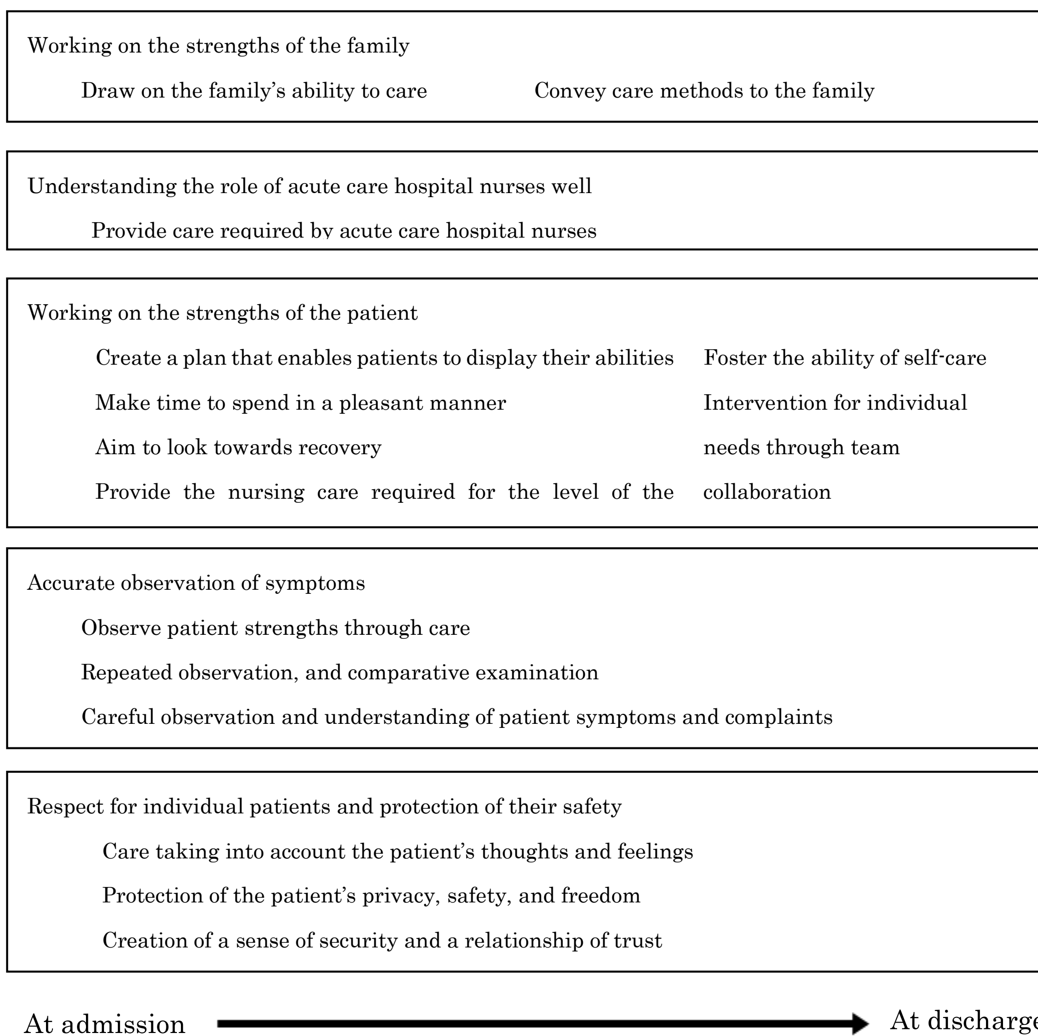
2. Caring (consideration and concern) by mid-career generalist nurses in acute regional medical care support hospitals

The details of caring (consideration and concern) by mid-career generalist nurses are presented in Table 3 and Figure 1. There were five categories, 15 subcategories, 40 final codes, and 143 codes. In the description of the results given below, categories are presented in bold, subcategories in bold italics, and final codes in italics. The statements of the participants are presented with the individual indicated as A–F at the end of the sentence. The researchers verified that there was no discrepancy between the English translation and Japanese interview to confirm the validity. The codes were given a number and then returned to the original data to confirm that there was no discrepancy in meaning. The categories included **respect for individual patients and protection of their safety**, **accurate observation of symptoms**, **working on the strengths of the patient**, **working on the strengths of the family**, and **understanding the role of acute care hospital nurses well.**



<Figure 1> The state of caring by acute care hospital nurses throughout hospitalization

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1) Respect for individual patients and protection of their safety

Respect for individual patients and protection of their safety involves working to provide peace of mind through inpatient treatment by approaching the patient as an ordinary citizen and not merely a sick person to create a relationship of trust. We created three subcategories, including ***creation of a sense of security and a relationship of trust; protection of the patient's privacy, safety, and freedom; and care taking into account the patient's thoughts and feelings***. ***Creation of a sense of security and a relationship of trust*** consists of placing a sense of relief and trust into greetings and having an interest in and being thoughtful toward the patient. ***Protection of the patient's privacy, safety, and freedom*** consists of protecting the patient's privacy and protecting the patient's safety and freedom as a person. ***Care taking into account the patient's thoughts and feelings*** consists of sharing feelings, providing peace of mind, and providing care taking into account the patient's intentions and preferences.

Consideration and concern described by a participant:

Nurses greet who they see and tell patients who they will look after on that day as well as individuals who they know, even if they are not patients who are under their charge for the day, that the meal has started. I think that individuals who they see are happy and that they feel a sense of peace of mind, and so make a point of being spoken to by nurses. (F)

Other participants said:

I consider greetings important, and it implies that I will pass the day as part of the team, in that I believe in you too, so that the day will pass safely and smoothly. (B)

To have people understand that I am reliable even with one word, I talk using polite language rather than informal language. (F)

I perform bed-baths while talking and ask the patient whether I should change their undergarments. (C)

For restrictions to physiological needs, such as diet restrictions, I consider whether the restrictions can be alleviated, even if slightly. (F)

If I can understand how a certain person feels, then I can approach them with such knowledge about their mood during their hospital stay. (F)

2) Accurate observation of symptoms

Accurate observation of symptoms involves performing repeated observation using the five senses to observe well and accurately determining the patient's physical and mental condition to the extent of being satisfactory for the individual nurse with an interest in the patient, which is performed through various comparative examinations and during care by having the patient move. We created three subcategories, including ***careful observation and understanding of the patient's symptoms and complaints; repeated observation; and observe the patient's strengths through care***.

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Careful observation and understanding of the patient's symptoms and complaints consists of observing the patient's condition regularly, looking at their reactions and responding, making judgments after carefully listening to their symptoms and complaints, and creating conditions wherein it is easy for the patient to speak. ***Repeated observation*** consists of repeating observations until understanding them and comparing them with the normal state and determining the patient's situation without relying only on nursing records. ***Observe the patient's strengths through care*** consists of observing the need for care at the bedside, making preparations, and having patients move during care to observe their physical and mental state.

Consideration and concern described by a participant:

After ensuring the patient's environment in terms of whether their vital signs have not deviated from the normal range, whether there is no leakage from the drip infusion, and whether the infusion rate is right, and that there is no dangerous behavior by the patient concerned, I judge that I can move onto the next patient. (B)

Other participants said:

No matter who I ask, they come and observe, to talk about the condition of the acute-phase patient who is being observed. (B)

Because the paralysis is progressing, I repeat the observations to confirm the judgment of the preceding individual on duty. (B)

When they feel that something is odd, their condition is somehow different. Such sensations are important, and in some instances, the measured temperature and blood sampling data and even their talking manner, meal volume, and suffering suddenly change. (F)

The way that the patient reacts to the first word spoken by the nurse is very important, and it helps us to understand various things, such as the patient's level of consciousness, visual acuity, and auditory acuity. (B)

I make a conversation based on the cosmetics and stuffed toys at the patient's bedside to try and learn about the person who I am speaking to. I glance at the television program that they are watching together with them, and by making small talk, I can learn about their occupational information and background and change the way that I speak to them and react. (C)

The patient's personality and the way that they are received by the nurse can differ, and so I talk to try understanding the patient and take their records alone with a pinch of salt. (E)

I encourage patients to perform bed-baths by themselves and understand the consciousness and symptoms of the patients on the basis of whether they respond that they cannot do it or whether they end up only wiping their hands. (B)

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3) Working on the strengths of the patient

Working on the strengths of the patient involves addressing the needs of each individual as a team, such as looking toward recovery, making time to feel at ease, increasing the will for recovery, and creating a schedule for patients to display their abilities so that the patient can display their own self-healing and self-care abilities.

We created six subcategories, including ***providing nursing care required for the level of the patient's health, aiming to look toward recovery, making time to be able to spend in a pleasant manner, creating a plan that enables patients to display their abilities, fostering the ability of self-care, and providing intervention for individual needs through team collaboration.***

Providing nursing care required for the level of the patient's health consists of providing the nursing care required for each patient with different health levels and providing intervention at the time suited to the patient. ***Aiming to look towards recovery*** consists of conveying prospects of illness and treatment as well as supporting the will to want to get better and creating an environment with the patient's lifestyle in mind. ***Making time to be able to spend in a pleasant manner*** consists of improving symptoms that cause distress, making an inpatient environment where one can spend time in a pleasant manner, and having time to enable patient satisfaction and reassurance. ***Creating a plan that enables patients to display their abilities*** consists of creating a schedule and devising a plan so that patients can display their abilities. ***Fostering the ability of self-care*** consists of listening to the patient's thoughts about lifestyle, talking with patients to help them adopt treatment into their lifestyle, teaching patients about self-care suited to their symptoms and lifestyle, and helping patients maintain self-care following discharge. ***Providing intervention for individual needs through team collaboration*** consists of collaborating with doctors to improve the patient's level of satisfaction, revising care, and continuing nursing care through sharing information within the team, expanding the patient's possibilities through team cooperation, and planning emotional control through nursing team collaboration.

Considerations and concerns described by a participant:

I think that they wouldn't be able to remember if I say everything at once, so I try to explain by talking about lifestyle situations and scenarios as well as meals if it is meal time. (F)

Other participants said:

While taking into account the patient's personality, I inform them of the pathology and symptoms that might arise from drug-taking and instruct them to call for a nurse. (D)

With symptoms of any illness, the patient worries about whether it only affects them, and when told that it is not the case, they express relief on their face. (E)

It is important for the patient to go back to their life, so I anticipate increasing the level of personal hygiene care and bed rest, even if a little, which I confirm with the doctor, and try preventing the patient from being bedridden. (D)

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Considering restoring the ability to perform activities of daily life (ADL) only, I carry out the role of negotiating rehabilitation requests with the doctor and conveying the family's intention to improve ADL. (A)

4) **Working on the strengths of the family**

Working on the strengths of the family involves the nurse proactively speaking to the patient's family at the hospital admission and when coming for meetings as well as ascertaining the state of the family members while being informed that the nurse is watching the patients and of the patient's condition. In doing so, nurses obtain the cooperation of the family for after discharge and work to help them so that they are able to provide the necessary care for the patient after discharge.

We created two subcategories, including ***drawing on the family's ability to care and conveying care methods to the family***. ***Drawing on the family's ability to care*** consists of listening to the family's intentions, sensing family fatigue, obtaining family cooperation, and helping the family visualize the patient's lifestyle. ***Conveying care methods to the family*** consists of informing the family of care that only they can provide and performing intervention so that the family can provide care.

Consideration and concern described by a participant:

The nursing team has a system of cooperation to accommodate time to speak to family members, even if it is tough. (F)

Other participants said:

I think that one should talk with the family at the right time, which is cultivated through experience, so I advise nurses and talk with the family even if I am not personally in charge. (F)

I acquire hints about how I should approach a patient based on the appearance of the family members who I meet. (B)

When I inform the family about the patient's changes, I also sympathize with the family; I tell them that the nurse is watching the patient, and we rejoice together that the patient can now move their body, which deepens the relationship of trust. (B)

I think that conversing with the family and conversing with the patient are equallyimportant, and when I meet them, I try to tell the family how the day went and what the patient has been able to do that they couldn't do before during visits. (B)

There is an increasing number of elderly individuals aged in their 90s, and I ask whether they have someone around to help, to inform about the progression of patient's health in future, what to do when the patient becomes unable to eat, and things that will be necessary. (E)

Nurses can provide toileting assistance during hospitalization, but if it turns out that the patient will go back to their own home after discharge, then I will see if the family can assist, and I will have them look at the present situation during hospitalization. (A)

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5) Understanding the role of acute care hospital nurses well

In **understanding the role of acute care hospital nurses well,** it was mentioned that, due to the short hospitalization period, interventions for family members to care for the patient at home and words of encouragement that can be conveyed to the patient because of the patient's efforts and persistence over the course of treatment after repeated hospitalization and discharge were left to the nursing staff involved in the patient's transfer to another hospital or after discharge.

We created one subcategory, which was ***providing care required of acute care hospital nurses. Providing care required of acute care hospital nurses*** consists of leaving family intervention up to nursing care after discharge, and concern for each individual arising during the course of care, which is difficult to share.

Consideration and concern described by an individual study participant:

Normally, when a patient recovers or convalesces, they should return home, but there is the dilemma presented by discharging the patient to admit the next patient in the acute phase, when the family is not ready to do so. (F)

Other individuals said:

(Regarding terminal phase patients who were repeatedly admitted and discharged from the hospital), we listened to the family background and feelings, and if the patient has to go to a different hospital for their last moments, for such individuals, in some instances I cannot put on the summary that I want them to take care here, and when a request is made (to the hospital where the patient is transferred) as is, I think about the mission of the acute care hospital in that they will not know how the patient's last moments will be. (E)

V. Discussion

This study visualized the current state of caring (consideration and concern) in nursing practice among mid-career generalist nurses at acute care hospitals in Japan where a community-based integrated care system has been introduced. In terms of caring by mid-career generalist nurses at acute care hospitals, it was thought that, after the community-based integrated care system was introduced in 2014, the mean length of hospital stay would decrease, which in turn affected caring in nursing practice. At acute care hospitals here, the mean length of hospital stay is decreasing, so comprehensively understanding caring through the nursing practices of mid-career generalist nurses who promote nursing care is essential as it clarifies points that serve as an example for new and junior nurses. In the discussion, we will compare the characteristics of caring through the nursing practice of mid-career generalist nurses at acute care hospitals against existing literature. Thereafter, we will examine the effect on caring in nursing practice associated with changes in the role of acute care hospitals under a community-based integrated care

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system.

Caring by mid-career generalist nurses at acute care hospitals involves placing importance on greetings and using polite language to provide a sense of security, and confidence, when providing effective nursing care during short hospital stays, through respecting the individual patient and protecting their safety, and providing ethical nursing care that protects the *patient's safety*, *and freedom as a person*. This has long been considered the basic nursing approach[6,8,13], and it is thought that greater emphasis is placed on establishing a relationship of trust early, and to start working toward discharge from the time of admission.

Furthermore, it can be said that nurses characteristically perform **accurate observation of symptoms** as part of consideration and concern in caring. Observation and monitoring in nursing care are always required from the start of nursing practice until completion, and the observation results are an important technique from the perspective of influencing assessments and evaluations[7].

Therefore, we were able to confirm that caring in nursing practice enriched with basic interpersonal skills, as well as observational skills, is considered more important than ever for shortening hospital stays and for early discharge, and is thus put into practice. Caring in nursing practice is an indispensable skill for improving observational skills and health assessments and in carrying out the community-based role of acute care hospitals. In a study specific to nursing care for discharge support,[16] emphasis was placed on planning and cooperation, while basic interpersonal support skills tended to be overlooked. Caring in nursing practice involving consideration and concern by mid-career generalist nurses at acute care hospitals to **respect individual patients and protect their safety**, and **accurately observing symptoms** also served as a fundamental nursing skill during basic education. Such skills are specifically conveyed as practice methods, and it is imperative for students and new nurses to understand these practical skills and related know-how to be able to use them from the early stage. For example, they should visualize the patient's condition regularly, repeat observations until they comprehend them, compare against the normal state, and have patients move during care to observe their physical and mental condition.

Furthermore, the nurses said that **working on the strengths of the patient**, and **working on the strengths of the family** were performed in anticipation of the future so that they could visualize the path to recovery and life after discharge. These practices were possible because mid-career generalist nurses could use past experiences. In being shown the way by nurses, patients obtain suggestions as to how to face their illness, which helps to motivate the patient to recover. Arita et al.[16] conducted a fact-finding survey of the actual situation regarding "ward nursing from the perspective of at-home care" in acute regional medical care support hospitals. In their conclusions, they noted "the importance of educational support that enables nurses to have opportunities to be able to visualize the patient's life at home from a time when they have little experience," and that the main

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factors included "drafting a plan for the transition to home," "experience in home-visits after discharge," and "experience in conference participation prior to discharge." Caring in the nursing practice of mid-career generalist nurses at the acute regional medical care support hospital that was elucidated in the present study includes the ability to visualize the life of the patient and their family members after discharge. Therefore, it can be said that it is imperative that nurses perceive patients and their family as ordinary citizens, who are not only in the hospital, and pay attention to the lifestyle and life of the individual concerned. This should be done to be engaged in support for health as part of their life, and to provide support to help the individual lead their life in their own manner. In this way, perceiving the patient as an ordinary citizen, and devising ways for the patient to show their strengths to ensure ordinariness for the patient's physical and mental stability, and providing multidisciplinary support in anticipation of life after discharge is consistent with the survey results of Tokuhara et al.[17)] focusing on life assistance.

While the functions of hospitals in regional areas change, to **understand the role of acute care hospital nurses well**, nurses felt a dilemma in being in a situation where they have patients discharged at the stage when the feelings of the patient and their family member do not follow the recovery process. Furthermore, while repeating hospital admissions and discharges, they knew how the patient faced their illness and lived, and so they had words that they wanted to say to terminal phase patients and their family members, but they could not fully express them on the summaries of patients who are transferred for the terminal phase. Although they felt frustration in being unable to practice caring for such individuals, they carried out their clear-cut duties in their role as an acute care hospital nurse. Nurses are flesh-and-blood human beings, and it was thought that situations that cause conflict in caring practice are related to the motivation of the nurse. In the future, information about patients who provide consent, such as information on regional patient information systems, will be shared between organizations, which we believe will allow progress to be checked, and ensure continuity of caring in nursing practice.

A limitation of the present study was that the results are limited in terms of the fact that the subject sample consisted of mid-career generalist nurses at a single acute care hospital, and in particular, that the subjects were ward nurses of the department of internal medicine. To generalize our results, further accumulation of data from several acute care hospitals is needed. The survey was conducted during the second year of operation of the community-based care system, and we believe that caring by nurses in nursing practice was affected by the shortening of the mean length of hospital stays, and the state of development of the regional patient information sharing system. By comprehensively presenting caring in nursing practice of mid-career generalist nurses, we were able to clarify basic relationships of mutual trust, as well as improve observation and monitoring, which have been overlooked in the study of discharge support[15)], and which is significant in that it supplements existing research.

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VI. Conclusion

As characteristics of mid-career generalist nurses at an acute regional medical care support hospital, we obtained five categories, including **respect for individual patients and protection of their safety**, **accurate observation of symptoms**, **working on the strengths of the patient**, **working on the strengths of the family**, and **understanding the role of acute care hospital nurses well**. Under the community-based integrated care system, mid-career generalist nurses at an acute regional medical care support hospital work to help patients and their family members display their strengths from the time of admission in the aim of early discharge, and on the basis of this, while performing accurate observations, they engage with the patient with respect, thereby creating a sense of security, and building a relationship of trust wherein emphasis is placed on basic interpersonal support and observation skills. Furthermore, in situations involving ongoing nursing care for early discharge, while the role of acute care hospital nurses was understood, nurses experienced a dilemma in having patients discharged before the family feels ready, and that individual caring in nursing practice aimed at caregiving could not be conveyed in the written summary. In regional caring in nursing practice, sharing of patient information is an issue, and we believe that the motivation of mid-career generalist nurses is also involved.

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