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Original Article

Physicians' attitudes toward home healthcare services in Turkey: A qualitative study

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KEY MESSAGES:

- Physicians consider home care services to be necessary.
- The legislative background should be well organized for better provision of home care services.
- Cooperation and coordination between primary and secondary healthcare services are crucial for effective execution and improvement of home care services.

ABSTRACT

Background: Because of the growth of the older population and the prevalence of chronic diseases, home care services (HCS) have become an important aspect of healthcare worldwide. However, various difficulties and deficiencies are present in the provision of these recently implemented services in Turkey. Modifications to home healthcare services are in progress.

Objective: Physicians have an active role in home healthcare services. The present study was performed to examine physicians' attitudes toward this service in detail.

Methods: Twenty-six physicians who provide home healthcare services in the city of Ankara were included in the study. We conducted in-depth, semi-structured, face-to-face interviews. The interviews were audio-recorded, transcribed, and qualitatively analysed.

Results: Most physicians thought that home care could be provided to patients who are bedridden, are very old, have a chronic disease, have problems leaving the house, or do not have family support. They also expressed displeasure about the abuse of services and discordance of organization between hospitals and primary care centres. They noted that real circumstances in practice were not compatible with regulations and that cooperation and coordination between departments are necessary and important.

Conclusion: The current study underlines physicians' interest in and support of the home care system, which has various drawbacks and limitations. Legislation needs to be further changed to improve the quality of service and eliminate deficiencies in home healthcare.

Key words: Home care services, physicians, qualitative research

INTRODUCTION

Home care services (HCS) have become an important aspect of healthcare worldwide with the growth in the older population, the increasing prevalence of chronic diseases, and rising hospital costs (1,2).

Many European countries have confronted problems similar to those currently faced by Turkey and have a large older population. These countries have created effective home care models by their needs by integrating HCS with health and social services systems (3,4).

Turkey initiated major healthcare reforms in 2003 by establishing the Healthcare Transformation Program. Some of the important components of the programme include its widespread implementation, easily accessible healthcare services, and strong primary healthcare

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services (5). In the early years of the transformation programme, the Ministry of Health (MoH) released its first regulation on 'delivery of HCS'. According to this 2005 regulation (6), HCS definition is 'the provision of healthcare and follow-up services including rehabilitation, physiotherapy and psychological therapy by the medical team in accordance with the recommendations of physician in the environment where sick people live with their family.' The regulation also states that service providers include community health centres; family health centres and family physicians and staff members who work in community health centres, family health centres, and oral and dental health centres. Primary care physicians held the most responsibility. Hospitals were included in HCS by 2010 under further MoH instructions. People in need of home care can now apply to their family physicians, community health centres, or home-care units in hospitals by phone or by verbal or written petitions (7). The regulation of HCS sparked discussions regarding the protocol for whether the service starts in primary care centres or hospitals, how the HCS will be continued, and how the whole process is to be managed. HCS provided by the MoH units, whether primary care centres or hospitals are reimbursed by the social security system (8). Alternative private services are available for patients able to afford them, especially in large cities (9).

Some drawbacks in the provision of this recently implemented service have been expressed on various platforms. To the best of our knowledge, however, no qualitative studies have examined the experience of HCS delivery in Turkey. Our literature search revealed some quantitative (10–16) and qualitative studies (17–22) dealing with different aspects of HCS. Several quantitative studies from Turkey are also available (23–26).

The aim of the present study was to explore the views and experiences of the HCS physicians in the current system and identify the factors and challenges influencing their practice, motivations for practicing HCS, and weaknesses and strengths of the legislative background. Although a qualitative study may not completely elucidate all of these factors, such an exploration is important because a thorough understanding of the current situation can facilitate the restructuring of the system for better provision of HCS.

METHODS

Study design, setting, and sampling

Physicians who provided HCS in the city of Ankara, Turkey, were included in this study. The interviewees were selected by purposive sampling. HCS providers in hospital settings were identified from official records and a snowball sampling technique was used to identify those in primary care; this increased the likelihood of evaluating different perspectives. Enrolled were only physicians from the city centre. Collecting additional data was stopped when we believed that no additional information could be obtained. This was in line with the estimation of Morse, who estimated that 30 to 35 interviews provide data saturation (27).

Box 1. Interview guideline.

- Would you agree that physicians should hold home healthcare services? (Do you have suggestions for another professional group?)
- How do you organize your home visits? (Frequency, duration?)
- How do you record your visits?
- Do you encounter difficulties in situations that require consultation?
- Are you alone during your visits? With whom do you pay visits?
- Who is need of home healthcare services? (When? In which situations?)
- How do you feel during home visits?
- Are you glad to provide home healthcare services?
- Do you feel satisfied when performing home visit?
- Have you ever received education about home visits? (At the university or course?)
- What are the major challenges you face during visits?
- Is there a legislation related to your home care services? Have you read it?
- How do you find the legislation? Does it cover real life issues? How do you think these could be improved?
- Do you collaborate with other home care units? How is this organized? How should cooperation be with others?

Data collection

Ethical approval (367/2012) was obtained from the Ankara Numune Training and Research Hospital Ethics Committee. Verbal and written informed consent for participation and audio recording of the interviews were received from each participant.

The interviews were performed from 9 May 2012 to 31 October 2012, and the analyses ran through 2013. The research participants were interviewed using semi-structured questions. The interview guideline was prepared based on a similar study in the literature, with modifications relevant to the context; it was piloted with three physicians and restructured (Box 1) (17). There was no time constraint. All interviews were recorded digitally, and the records were transcribed exactly, including all emphases and special expressions. Body language, major gestures, and facial expressions were evaluated during the interview and noted by the interviewer. While transcribing the interview, all special expressions were stated in parentheses, with special notes on emotional content.

Data analysis

Data were analysed using a thematic framework method (28). This method was chosen because it is an excellent tool for supporting thematic (qualitative

Box 2. Reasons for, and against home care services (HCS).

Reasons for HCS	**Reasons against HCS**
More biopsychosocial approach by exploring their living environment	Excessive workload in primary health service
Caring for immobile bedridden patients	Poorly developed legislative background of HCS
Giving more job satisfaction or pleasure	Uncertainty about the job definitions and responsibilities
Reducing costs	Unawareness of people about the extent of HCS and high expectations
Avoiding hospital infections	Displeasure about the abuse or misuse of HCS
Providing more comfort	Unavailability of equipment and staff support
Moral support to both the patients and their caregiver	Inadequate cooperation and coordination of stakeholders (hospital, primary care centre, and nursing facilities)
Desire to be cared at home in end of life	Difficulties of interdisciplinary consultations
Spending more time with patients	Security concerns and violence against health care staff
Inappropriate skill and attitudes, and lack of experience	

content) analysis; it provides a systematic model for managing and mapping the data (29). This enabled themes to be developed from both the guiding questions and transcriptions of the interviewed physicians (30). Although Mayring (31) inspired us, we developed our own analytical approach. The stages of the framework method were followed, but matrices were not constructed (30). Transcriptions of the interviews were read and analysed separately by two researchers. The QSR NVivo 7 software program was used.

We decided to quantify the physicians' responses to express better the extent to which they expressed an opinion. We thought that this could help readers to understand how often different interviewees supported an opinion as well as avoid using numbers throughout the text. The numbers of physicians expressing a theme were grouped by quantifiers as follows: 'a few' = 1–5 persons; 'some' = 6–14 persons; 'many' = 15–20 persons; 'most' = 21–26 persons.

RESULTS

Twenty-six physicians (11 male, 15 female) were included in the study. Seventeen were from family health centres, and nine were from hospitals. Their median age was 45 years (interquartile range, 9 years). The physicians' characteristics are listed in Supplementary Table 1 (available online at http://dx.doi.org/10.3109/13814788.2015.1096339). The median amount of time that the physicians had been active in HCS on the date of the interview was 20.4 months. Each interview lasted approximately 20–30 min.

No remarkable difference was observed in the physicians' opinions with respect to their age, sex, or specialization.

The analysis revealed five main themes: reasons for providing HCS, management of HCS, psychosocial factors that influence HCS, legislation for HCS, and improvement of HCS.

Reasons for home care services

Physicians considered HCS necessary because of societal changes in the family structure, population ageing, and the increasing number of patients with terminal diseases.

> *. . . Turkish society does not look after the bedridden patients as in the past. . . (No. 24).*

Most physicians thought that HCS should be provided to patients who are bedridden with chronic diseases and have problems leaving the house. Some physicians emphasized the advantages of HCS, such as spending more time with the patient at home, exploring their living environment, reducing costs, avoiding hospital infections, and providing more comfort.

However, some physicians were quite sceptical about the quality of services given at home. They suggested that centre-based services were of higher quality because of the ease of intervention, availability of equipment and staff support, existence of examination tools, and ease of consultation.

Another issue was the uncertainty about whether HCS should be provided for all requests (Box 2). One physician who is working in a state hospital said that it was pointless to examine some patients at home when further examination is needed that cannot be performed there.

> *We can run blood tests at home, but there are no ultrasound or X-rays . . . I mean, when a patient has fallen and broken their leg, or you think that it is broken, and they call you . . . there is no sense in going to their home (No. 4).*

Management of home care services

The physicians stated that the patients, their relatives, or the provincial health directorate requested HCS. The physicians followed a specific calendar

to organize a regular visitation programme. Most of them said that the number and duration of visits varied.

Most of the physicians agreed that physicians should hold home healthcare services. Some of the physicians thought that a physician should always be present whereas some of them thought a physician is needed from time to time.

> *Certainly, HCS need to be given by physicians. Because when we go homes, we have a chance to intervene. Doctor and nurse should be together (No. 5).*

The organization was quite different between hospitals and primary care centres. Physicians working at hospital home care units said that they used paper records and were able to perform blood and urine tests at the patient's home. When a consultation was needed, other departments were contacted. Therefore, the process was run within the hospital. Physicians at primary care centres said that they also used paper records, but they informed the provincial health directorate about the patient's follow-up and requested a consultation if necessary. The provincial health directorate decided which hospital unit would be contacted for the consultation process. Both groups faced challenges in this consultation process. While hospital physicians faced resistance from other specialists regarding the performance of HCS because of their poor understanding of the extent of such services and less willingness to cooperate in home visits, the physicians in primary care centres complained about their decreased involvement in the process and lack of feedback.

> *The consultation . . . (takes a deep breath) our hospital is a small one and there is excessive workload; that is why our doctors do not want to visit homes as it takes a lot of time. I mean, they raise difficulties (No. 22).*

The most compelling HCS situations mentioned by physicians were excessive requests, shortages of staff and equipment, legal problems, security problems, transportation difficulties, time constraints, lack of a proper home environment, and abuse. Due to the excessive workload, some family physicians interviewed were found to be exhausted. Interviews were interrupted several times due to the intensity of workload.

> *The number of patients admitted to the family medicine outpatient clinic is over 70 per day. There is no chance to follow a specific calendar for visitation programme. Therefore, we have to work after working hours (No. 7).*

> *The workload is too much. When I leave the policlinic even half an hour, I am having trouble (No. 20).*

Psychosocial factors that influence home care services

Most of the physicians expressed that helping people who are truly in need and meeting patients' expectations made them happy. Additionally, some of the interviewed physicians stated that patients needed care and that home visits provided moral support to both the patients and their caregivers.

> *. . . and really, doctors visiting their home sound like a great event for them. I mean, they feel how nicely they were cared for and valued. This is gratifying for sure' (No. 11).*

Despite this positive feeling about the services, the physicians found some incidents discouraging and demoralizing. The concern about security, which was also described under 'management', caused nervousness and fear, especially among female doctors.

Some of the female physicians told that because of the security problems they would prefer male allied health personnel.

> *. . . What we fear most is the security issues after having heard some incidents. So, at least, we want allied personnel to be men (No. 6).*

> *. . . I am worried of course. I am going to places that I do not know. I can confront with any negative situations. So I prefer male health personnel (No. 24).*

Most of the physicians also expressed displeasure about the abuse of HCS. They said that this situation resulted in lost time and negatively affected their morale.

> *People assume that everything is for them, yet we are to be blamed if something is deficient. . .. Statements or behaviours like ''you have to come, you will come . . .'' This wears out our occupational desire and makes us worried, broken, and sometimes insulted (seemed quite upset) (No. 23).*

> *. . . I am not satisfied. Because I guess, I have never visited a patient who needed HCS (No. 16).*

Legislation for home care services

Most physicians stated that they had read the HCS regulations. However, they noted that real circumstances in practice were not compatible with the regulations and instructions.

Some physicians mentioned several issues faced during actual practice were a result of the poorly developed legislative background for service provisions. The legislation is not clear about job definitions and it does not clarify where primary care is responsible, where the hospital is responsible, how the patients are followed and consulted, or how the medical records are kept.

So, our capabilities and what we can do at home are not clear. For example, does that home care service mean to follow up a patient continuously or just for a certain period, this was not determined (No. 17).

We observed that this situation led to work dissatisfaction for some physicians.

Improvement of home care services

Most of the interviewed physicians stated that cooperation and coordination between departments are necessary for execution and improvement of HCS.

Most physicians said that governmental and administrative support had great importance for improving the quality of HCS and providing integrated care.

> *. . . support from hospital management, especially from the administration, together with the MoH for the patients in need would be good. Special attention should be given to avoid abuse (No. 1).*

A male family medicine specialist who had provided HCS for four years in a private hospital said that government, private institutions, social services, and family physicians should contribute to the service.

> *. . . everyone must labour a small bit. If one of them is missing, the service given is not full service, literally (No. 2).*

Another physician thought that HCS was difficult to perform because of the excessive workload and that there should be financial incentives for the physicians.

Most physicians stated that they were not adequately trained and felt that they had insufficient knowledge and skills in home care. They believed that additional training was necessary. A male physician who had worked at a home care unit in a state hospital for 2.5 months and had practiced medicine for only two years noted that HCS training should be given at the medical faculty.

Most of the physicians thought that the public was misinformed about HCS and that people should be informed correctly to reduce abuse.

> *I think the citizens need to know what the system is, how and when they can get home care, and when they are supposed to come to the office . . . (No. 11).*

The services were thought to have the potential for improvement by better coordination, better communication with the public to improve service use and avoid abuse of the system, and more support for physicians through training and financial incentives.

DISCUSSION

Main findings

This qualitative study showed that most physicians find HCS as a need. Although they thought HCS had an advantage of spending more time with the patient at home and exploring their living environment, they had some concerns about the quality of service, training needs of the doctors, poor legislative background and security issues. Excessive workload and abuse of the system were also mentioned as major challenges. The physicians felt better because they were helping people who are truly in need, but also thought there is a potential for improvement by better coordination and communication to avoid abuse of the system.

Strengths and limitations

This study is the first qualitative evaluation of HCS in Turkey from the physicians' point of view and is expected to fill an important knowledge gap in the field of medical care. This study also has certain limitations. We chose physicians who worked in the urban area of one city. Physicians from rural areas might face different challenges and might have a different view of the system. However, at the time the study was designed, it was not possible for us to include rural physicians due to organizational issues such as time and funding. We also thought that traditionally, even before the legislative changes, the physicians from rural areas already provided HCS, and little was expected change with the new legislation. Still, we accept that this study might be missing some perspectives. One could also argue that the number of physicians we included ($n = 26$) was low. However, we stopped including additional interviewees when we felt that we had reached saturation and when no further information could be obtained from additional interviews. We believe that we still reached out to a large number of doctors representing physicians involved in HCS. Finally, our results cannot be generalized to all physicians because our study was performed in only one city centre; however, the obtained data remain valuable because they provide a good picture of the current services and their practical implications.

Comparison with existing literature

Reasons for HCS. Literature shows that there is a wide range of reasons for individual home care visits (10,11,17,23,25). We did not detail the reasons for individual visits in this study, but explored physician's opinions on overall reasons for HCS itself. Subasi and Oztek (23) complement our findings by quantitatively exploring individual causes of visits in the same city. This study was at earlier stages of the legislative changes and a change in reasons might have occurred over time.

Theile (17) qualitatively evaluated general practitioners' opinions on home visits in Germany. The physicians tended to separate HCS into supportive, routine, and emergency home visits. Unlike the study in Germany, the physicians in the present study felt that it was quite difficult to categorize the causes of visits and the needs of patients. One reason for this might be the short history of HCS and the relative lack of experience with the services among our physicians, which make it difficult to categorize the causes. A more probable reason would be that the HCS medical records are not yet developed enough to provide this information. Moreover, the MoH and related regulations are currently being organized to collect this information, and no published data are yet available.

Management of HCS. The process of organizing HCS varies among different countries depending on their health systems. However, some challenges show similarities among different settings: such as medically challenging home environments, time constraints, difficulties experienced during consultation and planning of requests (12,17).

Psychosocial factors that influence the process of HCS. Theile reported that most physicians had been performing home visits because it was mandatory; a few of them felt uncomfortable because of serving in an environment they did not trust (17) despite positive aspects of home visits, such as feeling professional satisfaction. Some physicians thought that patients were abusing home visits. Although the setting is completely different, how physicians felt about the services were very similar to ours.

In this study, most physicians stated that they were pleased to help fulfil the expectations of patients who were truly in need, which is mentioned by Brown (18) as 'heart work'.

All of the above-mentioned studies, including ours, emphasize the role of moral satisfaction during the provision of services. This may be a major motivation for physicians to continue with HCS despite an occasionally uncomfortable environment.

Legislation for HCS. In the present study, physicians evaluated legislation based on the regulations for 'Delivery of Home Care Services'. They did not comment about the healthcare system in general. Therefore, we cannot compare the opinions on legislation between our physicians and those from studies outside of Turkey. In our study, the majority of the physicians reported that regulations and directives were not compatible with practice and that the biggest problem stemmed from the unclear description of the job.

Improvement of HCS. Training needs and feeling of inadequacy were similar concerns in Brown's study (18) and Brown concluded that such care should be integrated into medical education. On the other hand, Theile (17) raised the need for trained nurses that would help reduce GP's workload. In the present study, the family physicians also mentioned their abundant workload and added that such services should be coordinated by separate home care units dedicated to HCS.

Implications for policy and research

The study has shown physicians' concerns about the legislative background for service provisions, including how to control abuse of the services and organization of care at different levels, including consultancy services.

Future research could focus on understanding and categorizing the causes of admission to HCS so that related training can be provided and organizational issues can be solved. Such studies might also tackle differences between rural and urban areas or among different geographical regions of the country.

Exploration of HCS in other countries has also shown that the challenges faced are not so different despite the substantial differences among healthcare systems and cultures. A collaborative model might be useful between different public authorities at a national and European level to better serve the European population.

Conclusion

This study reveals a promising future for HCS in Turkey and underlines physicians' interest in and support of the system. It also indicates that HCS in Turkey could be further improved. It has shown that the legislation needs to become compatible with current practice. Security issues and abuse of the system are major drawbacks of the HCS.

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REFERENCES

1. Swann H, Benjamin AE. Medicare home health utilization as a function of nursing home market factors. Health Serv Res. 1990;25:479–500.

2. Keenan JM, Bland CJ, Webster L, Myers S. The home care practice and attitude of Minnesota family physicians. J Am Geriatr Soc. 1991;39:1100–4.
3. Ehrenfeld M. Nursing and home care in Europe. Int Nurs Rev. 1998;45:61–4.
4. Tarricone R, Tsouros AD, editors. Home care in Europe. The solid facts. World Health Organization Europe. Universita Commerciale Luigi Bocconi; 2008. pp. 14.
5. Transformation in Health. Ministry of Health of the Republic of Turkey. December 2013. Available at: http://www.saglik.gov.tr/TR/belge/1-2906/saglikta-donusum-programi.html (accessed 16 December 2014).
6. Prime Ministry general directorate of legislative development and publication. regulation on home care services. Ankara, 10 March 2015; official newspaper: No: 25751 (Başbakanlık Mevzuatı Geliştirme ve Yayın Genel Müdürlüğü. Evde Bakım Hizmetleri Sunumu Hakkında Yönetmelik. Ankara, 10 March 2005; Resmi Gazete: Sayı 25751.) Available at: http://www.saglik.gov.tr/TR/belge/1-570/evde-bakim-hizmetleri-sunumuhakkinda-yonetmelik.html (accessed 12 June 2014).
7. Regulation on procedures and principles of home health care services offered by the Ministry of Health. 1 February 2010; authority approval number 3895 (Sağlık Bakanlığınca Sunulan Evde Sağlık Hizmetlerinin Uygulama Usul ve Esasları Hakkında Yönerge. 1 February 2010; 3895 sayılı makam onayı). Available at: http://www.saglik.gov.tr/TR/dosya/1-71581/h/yonerge.docx (accessed 12 June 2014).
8. Özer Ö, Şantaş F. Home care services provided by the public and funding (Kamunun sunduğu evde bakım hizmetleri ve finansmanı). Acıbadem Üniversitesi Sağlık Bil Derg 2012;3:96–103. Turkish.
9. Çoban M, Esatoğlu AE. An overview of home care services (Evde bakım hizmetlerine genel bir bakış). T Klin Tıp Etigi-Hukuku-Tarihi, 2004;12:109–20. Turkish.
10. Keenan JM, Boling PE, Schwartzberg JG, Olson L, Schneiderman M, McCaffrey DJ, et al. A national survey of the home visiting practice and attitudes of family physicians and internists. Arch Intern Med. 1992;152:2025–32.
11. Bergeron R, Leberge A, Vézina L, Aubin M. Which physicians make home visits and why? A survey. CMAJ. 1999;161:369–73.
12. Svab I, Kravos A, Vidmar G. Factors influencing home visits in Slovenia general practice. Fam Pract. 2003;20:58–60.
13. Tendas A, Boschetto C, Baraldi L, Caiazza E, Cupelli L, Lentini R, et al. Homecare-based motor rehabilitation in musculoskeletal chronic graft versus host disease. Indian J Palliat Care 2011;17:159–61.
14. Farber J, Siu A, Bloom P. How much time do physicians spend providing care outside of office visits? Ann Intern Med. 2007;147:693–8.
15. Sumi Y, Ozawa N, Miura H, Miura H, Toba K. Community coordination of dental care needs in a home medical care support ward and at home. Nihon Ronen Igakkai Zasshi 2011;48:391–6.
16. Sears N, Baker GR, Barnsley J, Shortt S. The incidence of adverse events among home care patients. Int J Qual Health Care 2013;25:16–28.
17. Theile G, Kruschinski C, Buck M, Müller CA, Hummers-Pradier E. Home visits-central to primary care, tradition or an obligation? A qualitative study. BMC Fam Pract. 2011;12:24.
18. Brown JB, Sangster M, Swift J. Factors influencing palliative care. Qualitative study of family physicians' practices. Can Fam Physician 1998;44:1028–34.
19. Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. Br Med J. 2004;328:1343.
20. Campbell LM. Experiences of nurses practising home-based palliative care in a rural South African setting. Int J Palliat Nurs. 2011;17:593–8.
21. Davis MM, Devoe M, Kansagara D, Nicolaidis C, Englander H. ''Did I do as best as the system would Let Me?'' Healthcare professional views on hospital to home care transitions. J Gen Intern Med. 2012;27:1649–56.
22. Scheepmans K, De Casterlé BD, Paquay L, Van Gansbeke H, Boonen S, Milisen K. Restraint use in home care: A qualitative study from a nursing perspective. BMC Geriatr. 2014;14:17. doi: 10.1186/1471-2318-14-17.
23. Subaşı N, Öztek Z. An unmet need in Turkey: Home care services (Türkiye'de karşılanamayan bir gereksinim: evde bakım hizmeti). TSK Koruyucu Hekimlik Bülteni 2006;5:19–31. Turkish.
24. Cindoruk M, Yetkin *İ*, Şahin M, Ekici E, Görgül A, *İ*leri F, et al. Home care services (Evde bakım hizmetleri). Akademik Geriatri Dergisi 2010;2:121–7. Turkish.
25. Aktürk AŞ, Atmaca E, Zengin S, Bayramgürler D. The prevalence of pressure ulcers and their clinical features in patients receiving home health care in the city of Kocaeli (Kocaeli ilinde evde bakım hizmeti alan hastalarda bası ülserlerinin prevalansı ve klinik özellikleri). Türkderm 2010;44:128–31. Turkish.
26. Aksüllü N, Doğan S. The relationship between perceived social support factors and depression in the elderly living at nursing home and at home (Huzurevinde ve evde yaşayan yaşlılarda algılanan sosyal destek etkenleri ile depresyon arasındaki ilişki). Anadolu Psikiyatri Dergisi 2004;5:76–84. Turkish.
27. Morse J. Determining sample size. Qual Health Res. 2000;10:3–5.
28. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, editors. Analyzing qualitative research. London: Routledge; 1994. pp. 173–94.
29. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Med Res Methodol. 2013;13:117. doi:10.1186/1471-2288-13-117.
30. Pope C, Ziebland S, Mays N. Qualitative research in health care: Analysing qualitative data. Br Med J. 2000;320:114–6.
31. Mayring P. Qualitative content analysis. Forum Qualitative Sozialforschung/Forum: Qualitative Social Research. 2000;1:Art.20. Available at: http://nbn-resolving.de/urn:nbn:de:0114-fqs0002204 (accessed 2 January 2015).

Supplementary material available online

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