

General practitioners' experiences as nursing home medical consultants

Marie Kirsebom RN, PhD (Lecturer), Mariann Hedström RN, PhD (Senior lecturer), Ulrika Pöder RN, PhD (Senior lecturer) and Barbro Wadensten RN (Associate Professor)

Department of Public Health and Caring Sciences, Caring Sciences, Uppsala University, Uppsala, Sweden

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Objective: To describe general practitioners' experiences of being the principal physician responsible for a nursing home.

Method: Fifteen general practitioners assigned to a nursing home participated in semi-structured qualitative interviews. Data were analysed using systematic text condensation.

Result: Medical assessment is the main duty of general practitioners. Advance care planning together with residents and family members facilitates future decisions on medical treatment and end-of-life care. Registered Nurses' continuity and competence are perceived as crucial to the quality of care, but inadequate staffing, lack of medical equipment and less-than-optimal IT systems for

electronic healthcare records are impediments to patient safety.

Conclusion: The study highlights the importance of advance care planning together with residents and family members in facilitating future decisions on medical treatment and end-of-life care. To meet the increasing demands for more complex medical treatment at nursing homes and to provide high-quality palliative care, there would seem to be a need to increase Registered Nurses' staffing and acquire more advanced medical equipment, as well as to create better possibilities for Registered Nurses and general practitioners to access each other's healthcare record systems.

Keywords: advance care planning, experiences, general practitioners, nursing home, family members.

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Introduction

An ageing population (1) and increasing requirements for a robust healthcare and nursing home care system are becoming more evident globally (2). Studies from the Western world have revealed a high rate of hospitalisation and emergency department (ED) use among nursing home residents and have identified the medical reasons for such transfers (3–7), showing that they can be avoided (8–11). For example, reduction in transfers has been observed when certain symptoms were treated in nursing homes to a greater extent (12) and when such treatment was guided by advance care plans (ACPs) (13).

The organisation of medical care in nursing home care differs between countries (14–16), although RNs usually have the highest nursing and medical competence. Physicians, primarily general practitioners (GPs), work as consultants to nursing homes and play an important role in

the medical care provided there. Studies have shown that GPs' consultation rates for nursing home residents and the time they spent looking after each resident were higher compared to other patients aged over 65 (17, 18). On the whole, nursing home residents are associated with a high workload (16, 18, 19). GPs have reported the heavy burden associated with treating seriously ill patients in the community (20), and the optimal time for nursing home visits has been discussed (14). To our knowledge, few previous studies have focused on GPs' views on their work as consultants to nursing homes. Such information is of importance to increasing understanding and cooperation within the healthcare team. Therefore, it is important to hear these views as well as GPs' overall outlook on the care provided at nursing homes. Hence, we decided to study and describe GPs' experiences of being the principal physician responsible for a nursing home.

Materials and methods

A qualitative descriptive design was used. The data were collected using interviews.

Correspondence to:

Marie Kirsebom, Department of Public Health and Caring Sciences, Uppsala University, Box 564, SE-751 22 Uppsala, Sweden.
E-mail: marie.kirsebom@pubcare.uu.se

Setting

The study took place in a metropolitan area in Sweden (population 200 000). At the time of the study, there were 31 nursing homes in the area; they had a range of 16–90 residents per facility.

During the daytime on weekdays, a GP is connected to each nursing home and has principal responsibility for medical care. GPs are employed at healthcare centres where they have outpatients of different ages in addition to their assignment to a nursing home. GPs' responsibilities include scheduled visiting rounds once or twice a week depending on the size of the facility and number of residents; they can also be reached by phone. The time the GPs are allocated is based on a template, and calculated from the number of older persons for whom they are responsible. The stipulated time for GPs includes preparation, transportation to the nursing home, assessments, rounds and documentation. The Registered Nurses (RNs) at the nursing homes work weekdays during daytime hours. During the daytime, the RN is the sole medically responsible person present at the nursing home. Some nursing homes have RNs during the evenings, nights and weekends, but typically on-call RNs are responsible for making emergency visits to nursing homes, each RN being responsible for several facilities. There is also a physician on call during the evenings, nights and weekends.

Study population

The inclusion criterion was that the GPs had an assignment with a nursing home. Purposive sampling (21) – based on sex, age, workplace, years of professional experience, years being responsible for a nursing home – was used to increase the likelihood of variation in the descriptions. There were 8 male and 7 female GPs, between 38 and 70 years old, employed as GPs between 2 years and 30 years, and as a GP for a nursing home included in this study, between 1 month and 14 years.

Data collection and analysis

Semi-structured qualitative interviews were performed from August to October 2014 by the first author and covered the following topics: GPs' experiences of (i) the assignment as a GP responsible for a nursing home; (ii) the advance care plan (ACP) and out-of-hours support; and (iii) the care provided in nursing homes. The topics were chosen on the basis of results from previous studies concerning collaboration between nursing homes and hospital care (22). The interview guide consisted of main questions corresponding to the topics, followed by probing questions when needed. The semi-structured interview guide was used to cover the topics, and the

questions were not always posed in the same order. The interviews were conducted in a quiet room. Each interview lasted between 30 and 90 minutes was digitally recorded and transcribed verbatim.

A method for cross-case thematic analysis of qualitative data inspired by Malterud was used (23). In the present study, the method involved the following: (i) thorough reading of all the material to obtain an overall impression; (ii) sorting the material into themes, identifying meaning units, representing different aspects of participants' experiences of their role as GPs in nursing homes and coding of these units; (iii) condensing the contents of each of the coded groups; and (iv) summarising the contents to form categories, in order to achieve an overall description of the GPs' experiences (Table 1). Quotations representing the central content of the categories were chosen to illustrate the results. Three of the authors read all of the interviews (MK, UP and BW). The complexity of the ways in which the participants experienced their role as GPs in nursing homes was thoroughly discussed. All authors participated in the subsequent elaboration of categories.

Ethical considerations

The primary care director in the county council and the private primary healthcare centres approved the study. According to national directives, formal approval from an ethics committee was not required (24). However, the recommendations for research ethics in Sweden were followed, as all GPs received written and oral information about the study, stating that participation was voluntary and that their responses would be treated confidentially (25). All GPs gave their written informed consent.

Results

The results contain nine categories presented within two main areas.

The content of the work of a GP who is principally responsible for a nursing home

Medical assessment. The GPs reported that most of their work involves medical assessment of the residents and work related to assessment, such as ordering tests (e.g. blood samples), prescribing medicine and documenting in the healthcare record. Assessments are conducted when a new resident is enrolled and when a resident's health status changes. Here, the GPs reported that RNs play an important role, because based on their knowledge about the residents' status RNs select which residents need a medical assessment. The GPs described how they prepare the rounds and assessments of residents by reading the

Table 1 Systematic text condensation. Examples of themes, meaning units, condensed meaning units, codes and categories

Themes	Meaning units	Condensed meaning units	Code	Categories
GPs responsibilities	To the residents, the process of advance care planning is really important. To state preferences so that everybody, the residents, the family and the staff have the same starting position, consensus. To plan for future care, what to do when the person deteriorates... The advance care planning is really important	Advance care plan- consensus for care between the older person, relatives and staff	Advance care plans are important for good care	Advance care planning
Organisation	The RN is the spider in the web. Its incredibly important that the nurse is someone who is comfortable in taking on responsibility and has a sound judgement on what is important. The staffing should be satisfying and there should be continuity, so that the nurse knows the residents. It will not help if someone is incredibly talented and works for a week only. Then, it is impossible to do a good job	The RNs have a great responsibility, their judgements are important, as is RN staffing and continuity	RNs are key persons	Skilled RNs and other staff

electronic healthcare record (EHR) to get an overview of earlier health status, medication and laboratory results.

The GPs reported that assessment of older persons' health takes a great deal of time and can be very complex, because much is occurring in the body as it ages and this must be taken into consideration when prescribing medications. Having the whole picture of the person's health status in mind is especially important with older persons, owing to multimorbidity and the fact that diseases interact. Most GPs with shorter experience in the field expressed that assessment of older persons is a demanding task, especially in case of aphasia or dementia. In contrast, the GPs with long experience did not find it particularly difficult. The GPs described how they try to talk with the resident during assessment, and to ask the RN and the other nursing staff whether the resident has changed in any way, which frequently happens when deteriorations occur.

It's complicated [making assessments] because there are many more parameters one has to consider. Experience and thoroughness are required to avoid making mistakes.

During daytime on weekdays, when the GP is not in the nursing home and the RN detects an acute health problem in a resident, the RN discusses this problem over the phone with the GP, who makes an immediate assessment based on the RN's assessment and description of the resident's symptoms. Health issues such as suspected infections, for example pneumonia, UVI or diabetic issues such as blood sugar levels, are dealt with over the phone by the GP prescribing tests and/or changes in medication. The GPs thought this approach worked satisfactorily.

They found it difficult to fit in unplanned visits for assessments in nursing homes, as these could conflict with patient appointments at the healthcare centre.

Advance care planning. The GPs found having an ACP to be important because it gives structure both to the treatment and to the overall summary of the situation. There is great value in establishing contact rather quickly when a new resident arrives, both with the resident and family members, because it facilitates planning the resident's present and continued care. The optimal outcome of such meetings is to establish objectives and medical treatment levels together with the resident and family members, including a plan for care when the resident's health status deteriorates. The GPs stressed that having reached a consensus on active measures in the event of deteriorating health provides the resident and the family with a sense of security.

Having a care plan is important for older people. Establishing goals so that everyone is starting from the same point, consensus. It results in much better care, definitely.

The GPs reported that if the resident's condition worsens and the resident is unable to participate in the ACP discussion, it is of value that family members and nursing staff in addition to the RN participate in the ACP meeting. Some GPs described using a template with questions about health care at the end of life in the ACP meeting with family members. When this template is followed, all major issues are addressed. The GPs believed it is good for families to have the opportunity to prepare themselves mentally for these questions before the time

comes. It was stressed that ACPs are particularly important because they enable transfer of information between different GPs and RNs. Having up-to-date ACPs was especially important during out-of-hour care, because they establish the structure and level of care, thus helping to determine appropriate treatment when health status changes.

Problems can arise in situations where there is no continuity in nursing staffing in the nursing home and where the GP has not written the ACP or established a relationship with family members. Sometimes, when the workload is too heavy and there are many new residents or changes in residents' health status, it is difficult to prioritise which residents need assessments and discussions to plan further care together with the resident and family, and thereafter make changes in the ACP. For this reason, the ACP is sometimes not up to date.

Medical treatment. The GPs reported that older persons generally have long medication lists when they move to a nursing home. They presumed that older persons often go to different physicians, and if these physicians do not know about or note what other physicians have prescribed, the older person could be taking too much medicine. The GPs stressed the importance of them thoroughly examining and modifying new residents' medication lists. According to the GPs, it is not unusual for new residents' energy levels to increase and their status to improve after modification of their medication lists.

I have an example of a woman who was on the dementia ward. She said: I think I've been placed on the wrong ward. She came in because she'd overdosed on her medicine and was in a confused state. She improved physically. Today she's much better. Now she's not taking all the medicines that made her confused. Now she's on a ward she can get some pleasure from. So she was quite right, she'd been placed on the wrong kind of ward in the nursing home.

The GPs also reported finding it difficult to decide on the level of treatment at the nursing home and on how active they should be in treatment. One GP said that treatment has to reflect a balance between further medical examinations, utility, empathy and concern for the resident. Family members are sometimes very uncertain about whether their relative is receiving the right care and enough care at the nursing home. The GPs described how they carefully discuss what kind of care they can provide for the resident and what family members can expect from the nursing home. They said it is essential to take the time to explain to family members what kind of care the nursing home can provide for their family member on site and to discuss in what cases it might be necessary to refer the resident to the ED. One opinion

expressed was that building consensus with the resident and family about the level of care is fundamental to planning good medical treatment.

Some GPs reported that whether or not the resident should be exposed to the stress associated with hospital care must be taken into consideration; one has to consider what the hospital can be expected to do about this specific health problem. Sometimes a visit to the ED can make a real difference and improve the resident's health. The GPs explained that when the medical resources are not sufficient or when treatment at the nursing home fails, the resident is referred to the ED; patient safety must never be compromised. Some GPs also stressed that staff are often afraid of making mistakes and thus of being reported by families, which results in referrals that benefit no one. It is therefore important to involve the family in the discussion of possible referral to the ED.

If they have a delimited problem, like if someone has fallen, that's limited to getting an x-ray and maybe a cast. That can be beneficial because it reduces pain even if the person has dementia ... they should go to the ED if they've had a heart attack or if there are specific questions that require certain examinations so the right treatment can be started.

Palliative care. Some GPs talked about how nursing homes are well equipped for end-of-life care. They described having a palliative policy, meaning that residents should not experience any pain, anxiety or respiratory difficulties. Hence, medications for these symptoms should be available for each nursing home resident. They reported that RNs can offer pain management using morphine, as well as injections with sedatives and diuretics, at the nursing home. All GPs indicated that nursing homes are places where older persons can end their life with dignity. Some pointed out that the level of palliative care differs between nursing homes. Some also compared the conditions with the care provided in home care, by a mobile palliative care team. The opinion was that the home care organisation had better prerequisites for providing high-level medical care than the nursing homes did. The GPs stressed that deciding when the resident is going into the palliative phase can be problematic. Here it was highlighted that earlier discussions with both the resident and family are of importance, as is having an ACP.

Many people don't want to go to the hospital when they start to deteriorate... What does this person want? Talk with the person if he or she can talk. Having people around them. Not feeling nauseated or feeling pain. Many people think it's important to just be able end life in a good way when it's time. Very few want to die on a gurney in the ED.

Essential conditions for being a GP who is principally responsible for a nursing home

Skilled RNs and other staff. All GPs felt that it is principally the RNs who play the key role in caring for nursing home residents. They stressed that RNs generally are competent, skilled and experienced. RNs ask questions, raise issues and assess who should have a medical evaluation. The GPs discussed the importance of RNs being comfortable with assuming that responsibility and having solid opinions about what is relevant to discuss during rounds. They stressed that they view RNs as discussion partners and are dependent on RNs' medical knowledge about the residents as well as on the observations made by nursing staff, because they as GPs do not see the residents every day. The GPs also described the importance of being able to rely on RNs' skills and that good care is based on having stable RN staffing and continuity of care. It was obvious to the GPs that RN staffing affects their work conditions. When the ordinary RN is not on duty or when a new RN arrives, the GPs' workload increases. It is of no help if RNs come in from a staffing agency for a week; they may well be skilled, but if they do not know the residents, it is difficult for them to do good work. If there is a lack of continuity in RN staffing at the nursing home, the result is less continuity in planning of care, and either no ACPs at all or no updated ACPs. Some GPs had experience of nursing homes that had problems recruiting RNs, too few RNs or high turnover of RNs. According to the GPs, this affects the quality of medical care and residents' safety. Some GPs felt the RN-to-resident ratio was too low. As the nurses are overloaded with work, there needs to be standardisation of RN staffing in relation to nursing home residents, just as there is for GPs.

The RNs are at the center of everything, and it's very, very important that they are comfortable about assuming responsibility. It's important that RN staffing is sufficient and that there's continuity, so she can get to know the residents.

Medical equipment and supplies. One issue at nursing homes that the GPs described was the availability of medicines out of hours. Nursing homes have only a limited supply of medicines. Nursing homes located some distance from a city centre have difficulties with their medical supply due to the distance to the pharmacy. The GPs reported that this is a practical concern for RNs, who often end up borrowing medicines from another resident to solve the problem until more medicines have arrived from the pharmacy. Other problems identified in nursing homes are that it is not possible to take acute blood samples and Coumadin (Warfarin sodium) samples on weekends. Moreover, there are no possibilities to give oxygen therapy. The GPs expressed that the situation would be

better if there were more medical equipment available in nursing homes, such as intravenous therapy, oxygen and other inhalation therapies, and better possibilities to take blood samples. However, the GPs were aware that use of most medical equipment requires RN-level competence, and thus, having and using additional equipment also entails RNs working evening and weekend shifts. The GPs felt that hospitals should be more aware of the resources available at nursing homes and not give prescriptions for treatments that are impossible to carry out there.

We're not supposed to give advanced medical care. But in acute situations I'd like to have the chance to order oxygen treatment and that the RNs had access to suction equipment.

Informatics (IT). The GPs were concerned that RNs are responsible for multi-ill residents but do not have access to updated and accessible healthcare records. RNs have to rely on the GP delivering weekly discharge notes from the hospital and GPs' medical notes from the healthcare record. The RNs have one computer system, the GPs and hospital have another, and some private healthcare centres have a third system. No one has access to the others' systems.

All GPs described problems related to healthcare records. They meant that if the intention is to decrease unnecessary referrals to the ED, the healthcare records must be available for RNs and on-call RNs and GPs. One GP described how they had to print out information from one system, scan, fax and then scan into the next system.

I think these IT systems are scandalous... I probably spend 30% of my work day with them.

Out-of-hours and on-call services. Most GPs found it problematic that on weekends at most nursing homes, there is usually no RN on duty. Some GPs thought the on-call services did the best that could be done under the circumstances, but on-call services are staffed by physicians with different competence. The GPs reported that being an on-call physician or RN is difficult because one does not know the residents. In addition, the written reports in the healthcare records are sometimes a faulty basis for decision-making. It is the on-call GP's responsibility to decide whether the resident should be transferred to the ED.

Problems identified with on-call services concerned failure to follow recommendations for a resident. On-call RNs or GPs sometimes do not read healthcare records to find out what is planned for the resident or cannot find the information in the healthcare record. Consequently, decisions are sometimes made that are contrary to the resident's and family's wishes and the resident could be sent to the ED contrary to the ACP. To prevent this, some nursing homes place GP directives regarding how to manage possible deterioration of health at the front of

the healthcare record so that they are visible. Such directives may state: 'To be cared for at nursing home' or 'Do not resuscitate'.

But I don't think they read the healthcare record, both the on-call physicians and the on-call RNs, what I've planned with the patient ... Excuse me but it's very frustrating!

Organisation of eldercare and desires for improvement. The overall view of all GPs was that care of nursing home residents is characterised by inadequate resources and staffing. They highlighted the importance of having highly skilled and a sufficient number of RNs in the nursing home as well as the importance of the entire nursing staff having adequate skills. Some reported feeling that eldercare in Sweden is neglected and that the focus on quality has been lost.

According to some of the GPs, when they needed to discuss a resident's deteriorating health they could do so with a GP colleague or sometimes phone a colleague at the hospital. But others indicated that they sometimes refer the resident to the ED for an assessment to be 'on the safe side'. The GPs also reported that because people who move to nursing homes are older and have more medical problems than they did in the past, owing to the current shortage of nursing home places, GPs' working conditions have changed. They must keep themselves up to date on an increasing number of medical guidelines. Moreover, the expectation is that more treatments should be dealt with at nursing homes, despite the fact that the resources and prerequisites for this are non-existent. One area of improvement that was being addressed was the collaboration between GPs and hospitals concerning the treatment of older people. The GPs also called for improved collaboration between hospital and municipal care and improved discharge planning so that residents would not have to be readmitted; they stressed that intermediate care wards with the aim to offer post-acute treatment for older people are needed.

One GP suggested that it could mean good continuity of care for the resident if, in the event of transfer, the GP were to follow the resident to the hospital and also be responsible for care there – an organisation that is common in some other countries.

One organisational factor that all GPs found problematic and in need of improvement was the area of information and communication. The GPs stressed that Sweden needs a national standard for EHRs and that the various systems need to be changed so that they can communicate with each other.

Discussion

Medical assessment constitutes the main duty of GPs who are the principal physician responsible for a nursing

home. Advance care planning together with residents and family members facilitates future decisions on medical treatment and end-of-life care. RN continuity and competence are perceived as crucial to the quality of care, but inadequate staffing, lack of medical equipment and less-than-optimal IT systems for EHR are impediments to patient safety.

Providing good care – obstacles and possibilities

While the medical assessments were described as the most time-consuming task at the nursing homes, the GPs stressed that advance care planning is important for overviewing the situation of each resident and for guiding future decisions. Advance care planning is the process of discussing and documenting the type and level of care the person may desire in the future and has been identified as a factor related to fewer referrals to the hospital (26) and fewer hospital deaths (27) among nursing home residents. In our study, the GPs also stressed the value of having discussed the level of care with the resident and the family. It is important that a consensus be reached so the plan is in accordance with the resident's desires in the event of deteriorating health, as such a plan gives the resident and the family a sense of security. This reasoning is in line with the intentions of the concept of person-centred care, which focuses on the individual needs of a person and honours the person's values, choices and preferences (28). A new patient law (29) came into force in Sweden last year. Its purpose is to strengthen and clarify patients' position and to promote their integrity, self-determination and participation. The Social Services Act (30) states that older people have the right to lead a life characterised by dignity and well-being. The intention underlying the text was to consolidate older people's rights under one framework. The GPs were very clear in emphasising residents' participation and empowerment when describing how they perform their work, and were confident that the nursing homes were places where residents could end their life with dignity. Thus, we can conclude that the interviewed GPs' intentions seem to be in line with both the intention of the law and the Social Services Act.

However, the GPs stressed that the organisation of eldercare in Sweden is not optimal. They talked about the frailty of older people who move to nursing homes and their complex health problems. Thus, nursing home residents are in need of good medical and nursing care. The fact that the GPs worked at a healthcare centre, sometimes a long distance from the nursing home, made it difficult to make assessments of residents when their health status worsens. In addition, the nursing homes have limited medical equipment and staffing resources, which severely limits possibilities to offer the level of care that the GPs would like to be able to provide and that they felt was expected of them from the hospital.

The GPs discussed having to rely a great deal on the RNs in the nursing home. They reported that things usually went well and that the RNs are competent, know about residents' health status and know which residents are in need of assessment or an updated ACP. Similar results were found in another study (31). In our study, a high turnover or work overload among nurses affected the GPs' work situation negatively, and was perceived as a general risk for patient safety. Therefore, we wish to suggest that the most recent, up-to-date ACP be placed so as to be highly visible and easy for staff to find out of hours and for replacement nurses to find. To reduce the high turnover, more needs to be done to ensure that RNs working at nursing homes have the right competence level for geriatric nursing. Having skilled nurses, especially if they are available around the clock, has previously been identified as a factor of importance in keeping residents in the facility rather than transferring to hospital (26). The fact that the system for patient records in nursing homes and the system in healthcare centres are incompatible, meaning that RNs and GPs have no access to each others' notes, is perceived as an important area for improvement.

Method discussion

Describing both data collection and the steps in the analysis is a way of establishing credibility, which is in line with Lincoln and Guba's (32) description of establishing the quality and trustworthiness of qualitative data and analysis. To strengthen credibility, participants were selected who varied in age, professional experience, geographical location of the workplace and who had worked both for healthcare centres run by public providers and for private for-profit providers. The first author's experiences from eldercare enabled sensitivity to the subject matter. The other researchers varied in their knowledge and experience of the subject matter, which can be seen as positive in that it may have deepened and improved

the clarity of the study. During the analysis process, we returned to the original text to verify that no content was missing and thereby to improve dependability. Reflective discussions within the research team, a pilot trail of the analysis and translated quotes from the interviews, promoted dependability and confirmability. Furthermore, the context and the research process were described, enabling the reader to determine the trustworthiness and the transferability of the findings to similar settings.

Conclusion

The present study highlights the importance of advance care planning together with residents and family members in facilitating future decisions on medical treatment and end-of-life care. RN continuity and competence are perceived as crucial to the quality of care. To meet the increasing demands for more complex medical treatment at nursing homes and to provide high-quality palliative care, there would seem to be a need to increase RN staffing and acquire more advanced medical equipment as well as to create better possibilities for GPs and RNs to access each other's healthcare record systems.

Author contributions

Study design: MH,UP and BW; datacollection: MK; data analysis: MK, UP and BW. All authors critically reviewed the manuscript.

Ethical approval

None.

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