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ORIGINAL RESEARCH

Communication and coordination during transition of older persons between nursing homes and hospital still in need of improvement

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Abstract

Aim. To investigate registered hospital and nursing home nurses' experiences of coordination and communication within and between care settings when older persons are transferred from nursing homes to hospital and *vice versa*.

Background. It has previously been reported that transfers to hospital from nursing homes and discharge of patients from hospital are surrounded by communication difficulties. However, studies focusing on both hospital and nursing home registered nurses' experiences of communication and coordination within and between nursing homes and hospitals are uncommon.

Design. A descriptive study design with a qualitative approach was used.

Methods. In 2008, three focus group discussions were conducted with registered nurses from hospitals and nursing homes ($n = 20$). Data were analysed using content analysis.

Results. Nursing home registered nurses found it difficult to decide whether the older person should be referred to hospital from the nursing home. Hospital registered nurses reported often trying to stop premature discharges or having to carry out the discharge although it had not been fully prepared. Both hospital and nursing home registered nurses suggested increased collaboration to understand each other's work situation better.

Conclusion. Communication and coordination among hospital and nursing home registered nurses need to be furthered improved. Registered nurses' coordination and planning in the nursing home are extremely important to future elder care. We recommend that the medical care plan be regularly updated and meticulously followed, the aim being to reduce the risk of inappropriate medical treatment and nursing care and unnecessary transfer and admission to hospital.

Keywords: admission to hospital, communication, coordination, discharge from hospital, focus groups, nursing homes, older person

Introduction

Worldwide, life expectancy is increasing (WHO 2012). Over the last century, chronic health problems related to age have become the dominant healthcare burden. Old age has been identified as a risk factor for multi morbidity, which, in turn, is associated with increased healthcare utilization (Marengoni *et al.* 2011). Patients are often moved between different care settings, e.g. between hospital wards or between the hospital and community-based care, such as nursing homes. The transfer of older people between community care and hospital and *vice versa* may entail risks for patient safety, because it has implications for continuity of care and makes it more difficult to ensure that patients will receive correct medical treatment and nursing care (Payne *et al.* 2000). Information transfer between different categories of care staff and individual care planning are of crucial importance to patient safety. Therefore, patient transfer requires collaboration between hospital staff and staff working in community settings (Wicke *et al.* 2004, Shanley *et al.* 2008). Accordingly, communication between hospital and nursing home registered nurses (RNs) is of great importance. This applies to communication in both directions (Rydeman & Tornkvist 2006). However, communication and information transfer between providers in the healthcare delivery system are sometimes inefficient and often inadequate (Payne *et al.* 2002).

Background

Admission

In Sweden, health care is a public responsibility, financed primarily through taxation. The communities are responsible for long-term elder care, such as home-based care and nursing homes, and the county councils are responsible for primary and hospital care (SALAR 2010). Older people often require hospital care when they are stricken by acute sickness. In Sweden, the annual rate of unplanned transfers to hospital is about 520 of 1000 inhabitants 80 years and older (SALAR 2008). Studies have shown that some hospital admissions could be prevented if residents received better care in the nursing home (Murray & Laditka 2010, Ouslander *et al.* 2010, Young *et al.* 2010). For example, Lamb *et al.* (2011) found that detecting early signs of deterioration helps prevent admissions to hospital. Dobalian reported that nursing home residents with medical directives from a physician not to be admitted to hospital are less likely to be transferred (Dobalian 2004). Buchanan *et al.* (2006) emphasized the need for adequate information from physicians and nurses in end-of-life care. During the past decade, the trend has been towards shorter hospital stays (SALAR 2010). An unplanned readmission soon after discharge is regarded as a premature discharge or a shortcoming in hospital care (Marcantonio *et al.* 1999).

Discharge

Communication between staff has been recognized as a key element of effective discharge planning from hospitals (Tierney 1993, Bull & Roberts 2001, Bolch *et al.* 2005). Hospital RNs have reported finding the discharge process difficult to organize (Bull & Roberts 2001, Atwal 2002) and that they do not have sufficient time for discharge planning. The documentation associated with discharge is experienced as an extra burden (Watts *et al.* 2005). The fact that the time available for discharge planning has decreased along with increasingly short periods of in-hospital care could affect the content of communication (Bull & Roberts 2001, Atwal 2002). Furthermore, deficiencies in communication have been found (Bull & Roberts 2001, Atwal 2002, Cortes *et al.* 2004). Staff in home-based care considered that the following factors were most important to successful discharge: receiving information about the discharge in sufficient time and obtaining a written nursing plan and information about medical diagnosis and treatment (Grönroos & Perälä 2005). Differences in the care culture context in hospitals and in community care have also been discussed, as they may constitute a communication barrier (Payne *et al.* 2002). However, communication and information transfer problems between hospital care and other kinds of care are not only nursing problems; Kripalani *et al.* (2007) reported similar findings for physicians.

Communication processes are very complex and no universal theory exists. About 40 different views on communication were identified by Littlejohn (1992). It is relevant to reflect on what kind of information a given act of communication should include. Discharge planning plays an important role in continuing care of patients, and it is the mutual responsibility of the hospital and the nursing home that the patient's transition proceeds smoothly and without unnecessary delays or problems. It has been suggested that a nursing discharge note should include information on four aspects: care delivered during the hospital stay, changes in the patient's status during the hospital stay, the patient's status at discharge, and recommendations for continued care (Ehnfors & Thorell-Ekstrand 2000).

The use of computers in nursing has increased and enabled implementation of electronic information systems accessible from different care settings (Smith *et al.* 2005). This could ensure rapid information transfer (Schleyer *et al.* 2011).

To our knowledge, few previous studies have focused on both hospital and nursing home RNs' experiences of communication and coordination within and between nursing homes and hospital. There is a need to gather information on this process and to hear RNs' points of view.

The study

Aim

The aim of this study was to investigate hospital and nursing home RNs' experiences of coordination and communication within and between care settings when older people are transferred from nursing homes to hospital and *vice versa*.

Design

A descriptive study design with a qualitative approach was used.

Settings

Community RNs are on duty in nursing homes from 7 a.m. –4 p.m. on weekdays. During the daytime, the RN is the sole medically responsible person present at the nursing home. During the evenings, nights, and weekends, on-call RNs are responsible for all emergency calls and visits, and the nursing homes are staffed by assistant nurses and nurse's aides who can call the RN on call if needed. Thus, Swedish night RNs caring for older people have a telephone consultation function, unlike night RNs in, for instance, the UK and the USA (Gustafsson *et al.* 2009). In Sweden, there are no recommendations for minimum nurse staffing as there are in the USA (Harrington *et al.* 2000). During the daytime on weekdays, a primary care physician connected to each nursing home and responsible for medical care can usually be reached by phone. There is also a physician on call during the evenings, nights, and weekends.

When an older person is transferred to hospital, information about this person is usually exchanged between the nursing home and hospital through a written note and medications list that are sent with the patient in the ambulance. If the patient is admitted to the hospital, communication between hospital and nursing home RNs primarily occurs via an electronic data system, where most of the patient information transfer takes place. This system is specific to the community region. Entries are made regarding the patient's progress in the hospital and information on care and discharge plans. The patient's hospital medical records are kept in another electronic system, which the primary care physician but not the nursing home RNs have access to.

Participants

Sixteen department directors at a university hospital and eight department directors at community nursing homes in the same city were informed about the study and asked to help recruit one RN for participation in a focus group discussion. The inclusion criteria were engagement in issues of patient transfer between the hospital and community care settings and a willingness to participate in a focus group discussion. One nursing home director did not wish to participate, due to a personnel shortage at the time. The other department directors recruited one RN each. Two hospital RNs and one community RN did not come to the focus group sessions. Thus, a sample of 14 hospital and six nursing home RNs, all female but one, participated.

Data collection

Three focus group discussions were conducted during spring 2008. In the first discussion, seven hospital RNs from geriatric and acute care wards participated. In the second discussion, seven hospital RNs from oncology, neurology, thoracic, surgical, and orthopaedic wards participated. In the third discussion, six RNs from community nursing homes participated. Focus group methodology means that a small group of people (preferably six to twelve), representing a target group, meet and discuss a certain topic during a limited time. The idea is that the interactive process will provide information allowing the researcher to map out conscious and unconscious opinions concerning a specific topic. An effort should be made to achieve as homogeneous groups as possible to give participants a sense of security and allow them to speak more freely (Morgan 1998). For this reason, nursing home RNs and hospital RNs were not included in the same focus group sessions. Each focus group continued the discussion until no new information on the subject emerged.

Each discussion lasted between 60–90 minutes and was tape recorded and transcribed verbatim. The last author acted as the moderator, which involved guiding and encouraging the discussion. Initially, the moderator clarified the aim of the session and reviewed the process with the participants (e.g. all opinions are welcome even if you disagree with each other). A discussion guide was used in which the following topics were covered:

- Experiences of coordination and communication when older persons are transferred from nursing homes to hospital.
- Experiences of coordination and communication when older persons are discharged from hospital to nursing homes.
- Perceptions of their role and of how their workplace functions when older persons are admitted to and discharged from hospital.
- Thoughts about how nurses from the other care settings might perceive the functioning of their own workplace when older persons are admitted to and discharged from hospital.

Ethical considerations

According to national directives, formal approval from an ethics committee was not required (Swedish Code of Statutes, SFS 2003:460). However, the recommendations for research ethics in Sweden were followed, as all nurses received written and oral information about the study, stating that participation was voluntary and that their responses would be treated confidentially (Codex 2011).

Data analysis

The data were analysed using content analysis, which can be employed to draw conclusions based on a written text through systematic identification of characteristics in the text (Weber 1990). Answers to open-ended questions are suitable for this technique. The analysis was performed in the following steps: (1) the transcribed text was read several times to get an overview, provide a sense of the whole, and generate ideas about how to analyse the text in more detail (Sandelowski 1995); (2) passages and sentences relevant to the study aim were identified; (3) these passages and sentences were grouped into themes, in which agreement and differing opinions, either in a group or between groups, were reflected in the context of the conversation; (4) finally, the themes were refined, clarified, condensed, and organized (Barbour 2005).

Rigour

To achieve trustworthiness, several aspects were considered. To capture as diverse experiences as possible, RNs representing 14 different units were recruited. To ensure dependability, the same discussion guide was used with each group and the discussions were audio-taped and transcribed verbatim (Nyamathi & Shuler 1990, Krueger & Casey 2000, Polit & Beck 2008). Credibility was strengthened by the fact that the participants had no difficulty understanding and answering the questions during the discussion. At the end of each session, the discussions were summarized and participants were asked to verify that the summaries accurately reflected the discussion (Polit & Beck 2008). The themes were identified and formulated in the course of discussions among the authors, which strengthens the confirmability of the data analysis (Polit & Beck 2008).

Results

The following major themes were identified in the focus group: (1) transfer and admission; (2) discharge and return to nursing home; and (3) improving collaboration and quality.

Transfer and admission

Nursing home RNs

The nursing home RNs often found it difficult to decide whether a patient should be transferred to hospital when the patient's health deteriorated. Factors perceived to facilitate decisions were general recommendations from the National Board of Health and Welfare (regarding, e.g. suspicions of fractures, in which case patients are to be transferred to hospital) and being able to consult a dedicated and accessible physician. Physician accessibility varies across nursing homes; however, most RNs said they could reach and consult a physician over the phone most of the time.

Some RNs reported feeling supported in their decisions not to transfer older persons to hospital if the nursing home has a palliative approach, or if documented medical care plans exist. These nurses stressed the importance of keeping medical care plans up-to-date and of ensuring that on-call nurses read and follow these plans:

> I've seen cases when there is a medical care plan at the nursing home and when entries are made in care records, but then an evening or night nurse comes along and does something completely different.

The RNs stressed the importance of family members being involved in the process and being aware of what kinds of medical care can be offered at the nursing home. Family members should feel that the older person is in good hands and will receive professional care of good quality:

We are able to offer injections, oxygen and we have suction. We can do lots of the things the hospital does, just the same, so family members can feel secure long before anything happens.

Occasionally, family members wish to send their older relative to hospital because they believe the hospital can provide better care and has better resources. Some RNs had experienced difficulties in convincing family members that the older person would receive satisfactory medical care at the nursing home. Referring to such situations, the RNs expressed their fear of being reported by family members, which could have legal consequences:

Today, relatives have a lot of power… 'My mother is going to the hospital because they have better resources there. If you don't send her I'll report you at once.' They make threats, it's so unpleasant.

Some RNs told of situations when the workload had been high or when they had failed to contact a physician. In these situations, they sometimes felt it was safer to send the older person with declining health to the hospital. The fact that no RN would be on duty in the evenings, nights, and weekends was also mentioned as influencing the decision to send patients to the hospital:

Often when it's 2 or 3 in the afternoon and you haven't been able to deal with what's happened it feels safer just to send the patient in.

When the older person has been transferred and admitted to the hospital, the nursing home RNs reported desiring contact with the hospital RNs, as they often possess valuable information about the patient. Because the nursing home RNs have a long-term engagement with and responsibility for the older person, they stressed wanting to play some role in decision-making that will influence future care of the patient:

A couple weeks ago a man suffered from further setbacks of his stroke so we sent him in for assessment. Then I heard through the backdoor that the doctors were planning to consult his family members about putting in a percutaneous endoscopic gastrostomy tube. It was lucky I heard. I called the hospital and said that the man hasn't wanted to live for the past several months, doesn't eat well, it goes back and forth, but we are taking care of him. So we want to be in on the decisions…

Hospital RNs

Communication with the nursing home RNs takes place via the electronic information system, to which all care facilities in the hospital and nursing homes have access. The hospital RNs requested clearer guidelines from the local community regarding what information they are expected to provide in this system, as well as more training in using the system. They did not feel fully secure about information transfer unless they spoke with the nursing home RNs as well. To acquire more detailed information about the patient, some RNs in the geriatric department appreciated a phone call with the nursing home RNs; they emphasized the importance of a good dialogue. The hospital RNs said that some chronically ill patients – e.g. those with chronic obstructive pulmonary disease or some neurological diagnoses and who frequently visited the hospital – were not actually in need of the specialist care provided there. They thought patients such as these could benefit from living, for a longer or shorter period, in an accommodation that could deliver medical care specific to their needs. The hospital would benefit because this would ease the pressure on emergency care:

What we're lacking is an intermediate level for patients who maybe need the care of a nurse who can give inhalation treatment sometimes but who don't need specialist care. This is a major problem.

Discharge and return to the nursing home

Hospital RNs

When a patient's health is chronically impaired, many RNs reported finding it difficult to determine when the patient has been fully medically treated. The RNs had experienced how different outlooks can lead to disputes between the hospital and nursing homes regarding whether the patient has been fully medically treated:

Well it's hard to judge. The doctors think the patient's medical treatment is complete and that she can go home, regardless of how she feels otherwise, as long as she's been fully treated for what she came in with, then we can send her home. And I'm sure the community care people have complaints about patients who've got worse after coming in, but still we can't do any more…

RNs from the emergency ward reported that bed shortages and long waiting lists led to difficult situations when planning patient discharge. The RNs stressed that even though the physicians have formal responsibility for deciding when patients have been fully medically treated and should be discharged, the nurses are left with a great responsibility in practice. They felt they often had to try to stop early discharges, or to arrange a return to the nursing home even though the discharge had not been fully prepared:

So then the doctor comes along as says 'that's it, we need that bed for another patient, so discharge the patient.' Or maybe it takes too long and you don't have the discharge note from the doctor, you don't have the final report and then the nursing home can't take the patient because it's too late in the day and there's no RN there who can receive the patient and check the medications and then there we stand and have to juggle things and find a solution.

Hospital RNs on geriatric wards had different experiences. They reported creating a care plan for almost every patient and not having time shortages like those described by nurses from other wards. On the geriatric wards, the RNs work in teams with physiotherapists and physicians, which facilitates the care planning process:

It seems like we have time for our patients. We plan care for almost all our patients, so we're like pros at it. We also work in teams, so everyone gets to put in their two cents, regardless of whether you're the physiotherapist, nurse or doctor.

Nursing home RNs

The nursing home RNs reported that many older persons return to the nursing home without satisfactory forward planning from the hospital, which may entail the patient arriving late in the afternoon when there is no RN present, or not well enough to be cared for at the nursing home:

As soon as something has been treated they're to be sent back to the nursing home, patients don't have time to recover, the hospital staff don't check to see if the patients are stable and can sit upright.

The nursing home RNs reported that when patients return to the nursing home, there are frequently problems with the medicines that are sent with the patient from the hospital. Medicines are often missing or inaccurate. The nursing home RNs stressed that if a new medicine is introduced at the hospital, the prescription should be prepared the day before discharge to avoid problems, because nursing homes have a limited amount of medicine at their disposal. The RNs sometimes lacked valuable information about the care given at the hospital. They usually received a nursing care plan from the hospital RNs, but no discharge note from the physician. Laboratory records were seldom included. The RNs stressed that information about care at the hospital is extremely important for them, because they are responsible for the patient:

The care summary from the hospital RNs doesn't contain half the information I need, because it's the doctor's final summary that contains what I want to know about medications… I want a history of what they've done…

Improving quality and collaboration

Hospital RNs

Hospital RNs wished that the nursing home RNs would dare to keep older people at the nursing home to a greater extent. They said that older patients were sometimes sent to the hospital unnecessarily because the nurse was not able to contact a physician for consultation, especially if patients fell ill in the evening or at night. Some hospital RNs also believed older patients were sometimes transferred to hospital because of nursing home RNs' fear of being reported. The hospital RNs were concerned about these older patients, because a transfer between care settings means being in a new environment with people they do not recognize:

We don't think it's ethical, all this moving around of very ill, old people.

The hospital RNs had suggestions for quality improvement at nursing homes. These included increased staffing of RNs at nursing homes, especially during evenings, at night, and weekends. This would improve conditions for continuity of care and make it easier to offer less complicated medical tasks, such as providing drip-feed. Another suggestion concerned training of assistant nurses/nurse's aide, for example, to react faster to nutritional problems. The hospital RNs also suggested that they could help in training nursing home staff on specific medical illnesses and associated nursing practice:

… and then comes the fear, what is this anyway, we can't deal with this and then you could say, I'll come over and show you what you can do. And they hadn't even considered asking.

Nursing home RNs

The nursing home RNs were concerned about how older people were treated at the hospital. They said that older patients were not always treated as readily as younger patients and that basic nursing practices were sometimes neglected. They reported that it was not uncommon for older persons to return to the nursing home with newly developed bed sores. Nursing home RNs wished that hospital RNs would take greater responsibility in the discharge process and prevent premature discharge of older people:

Sometimes it seems as though the nurses have given up. It's the doctors who decide when the patient's treatment is complete, 'now you make sure he gets home'… They are responsible for nursing care and they're not just the doctor's assistants… Sometimes you need to put your foot down.

The nursing home RNs would like the hospital RNs to be better informed about two important conditions at the nursing home: there are no medication supplies and no RN is on duty after 4 p.m. or at weekends. Therefore, it is vital for patient safety that older persons return to the nursing home during the day, so that the RN can check up on medications, nutritional status, mobilization schedule, and inform the staff:

> It's hard to get them to realize that there is no RN on duty around the clock, if a patient comes home on a Friday at 5 p.m. and there are no medications…. I don't know how many times this has happened to me.

Shared views

Hospital and nursing home RNs alike said that communication and collaboration between RNs from both settings should increase and that this would also increase their understanding of each other's work situation. An extended collaboration effort between the hospital and nursing homes, together with job rotation, could be one way to improve teamwork. Some RNs suggested that meetings and discussion platforms for hospital and nursing home RNs would be a valuable contribution and a way to develop collaboration. Both groups of RNs stressed that a mutual patient journal system for the hospital and the nursing homes would promote patient safety:

> To me it seems like the patients come second, we just sit around and try to avoid taking responsibility… It would be better if we could work together for the patients' well-being and not work so that it's the county council against the local community, that is just so, so wrong.

Discussion

Transfer and admission

The question of how RNs coordinate and communicate between nursing home and hospital settings when transferring patients to hospital and *vice versa* has received little attention in the literature. Importantly, our results reveal the lack of communication between nursing home and hospital, that communicative content is not always sufficient, and that the electronic data system for transferring patient information does not seem to be used to its full potential. Coordination and communication in the nursing home are very important, because they constitute the key to safe and professional elder care. In cases where the nursing home had a palliative approach and used medical care plans, RNs felt supported in their decision not to refer older patients to hospital. The family members should be part of the process and hence aware of what kind of medical care can be offered at the nursing home (Buchanan *et al.* 2006). Williams showed that the role of community matrons may have a positive impact on elder care. A community matron provides patient-centred care and improves their access to other healthcare services (Williams *et al.* 2011). A study by Kane *et al.* (2003) indicates that active primary care provided by nurse practitioners may decrease the incidence of hospitalizations among residents at nursing homes and increase cost-efficiency. This may be valuable when discussing and coordinating future care in the local communities in Sweden.

None of the nursing home RNs in the present study mentioned having been in contact with the hospital regarding the older person's need for hospital care prior to the transfer of a patient. In one study, most nurses and hospital providers agreed that verbal communication should occur when patients are moved between care settings, as this positively affects patient transitions (Gillespie *et al.* 2010). This is in line with our result showing that hospital RNs appreciated speaking with nursing home RNs to obtain additional patient information. The hospital RNs stressed that nursing home RNs should try to keep older patients in the nursing home to a greater extent. They said that many older persons were sent to hospital due to a lack of communication between nursing home nurses and primary physicians. Improved planning and increased medical and nursing support for nursing home residents may prevent emergency admission and deaths in hospital (Evans 2011). Carter emphasized that prevention of unnecessary admissions among dementia patients is particularly important, as these patients are less able to communicate their healthcare needs (Carter & Porell 2005).

Discharge and return

The hospital RNs found it difficult to know when patients had been fully medically treated. In their experience, bed shortages and long waiting lists led to difficult situations in the form of unplanned discharges and attempts on their part to stop early discharges. These findings are in accordance with previous studies (Bull & Roberts 2001, Atwal 2002). Nursing home RNs often received patients late in the day, with an insufficient care plan and missing or inaccurate medications sent from the hospital. This is in accordance with previous findings showing that communication and information transfer between care settings are sometimes inefficient and inadequate (Payne *et al.* 2002). It has been shown that discharge planning is a problematic area and that where communication is poor, quality discharge

What is already known about this topic

- Older persons are vulnerable during transitions between care settings, and poor communication may jeopardize the continuity of care.
- In general, communication problems associated with hospital admission and discharge are well known.

What this paper adds

- Communication and coordination between nursing home and hospital registered nurses require further improvement.
- According to nurses, medical care plans in nursing homes are important to reduce the risk of unnecessary transfers to hospital.
- According to nurses, older persons are unnecessarily transferred to and prematurely discharged from hospital due to organizational factors.

Implications for practice and/or policy

- Nursing home and hospital registered nurses should be aware that effective communication and coordination are vital to patient safety for older persons.
- It is vital to elder care that medical care plans be updated at the nursing home and that family members have been involved in the decision-making.
- It is important to develop communication systems between hospitals and nursing homes.

planning is also difficult (Waters 1987, Armitage & Kavanagh 1995, Bull & Robert 1996, Morgan *et al.* 1997). Poor communication and discontinuity of information have an impact on quality of care (Armitage & Kavanagh 1995). The insight gained in this study about communication and coordination is important; the RNs believed that patients were sometimes discharged when they were not well enough to return to the nursing home.

Improving quality

During the focus group discussion, the RNs made spontaneous suggestions about how to improve communication and coordination between hospital and nursing home RNs. Hospital RNs requested clearer guidelines to help them feel more secure about using the electronic data system. They said that the existing electronic data system, which is used for reporting between settings, should be supplemented with access to the patient electronic medical records used in the hospital. A joint electronic patient medical record system could enhance patient safety and speed up the information transfer process.

If transitional care is to improve, healthcare providers need to motivate staff to reach the common goal of smooth and professional transition between care settings for older patients. Regular meetings between hospital and nursing home RNs could be one way to improve their understanding of each other's work situation. Both groups believed that nurses from the other care setting would benefit from learning about the setting they themselves worked in. Continuity of care between hospital and nursing home is vital to patient safety and would facilitate cost effective utilization of resources (Armitage & Kavanagh 1998).

Limitations of the study

The limitation of this study is that the study group was small, and it is possible that more information would have been obtained if more focus group discussion had been conducted until saturation was reached. Although the groups were few, the study still generated a great deal of information about the RNs' experiences of coordination and communication between nursing home and hospital RNs. Another limitation is the lack of demographic data. We do know the participating nurses were of different ages and varied in experience, but information on their exact age and years of and nature of experience was not collected.

Conclusion

Communication and coordination need to be furthered improved among hospital and nursing home RNs. Nursing coordination and planning in the nursing home are extremely important for the future care of older people. Nursing home and hospital RNs should all benefit from having a better understanding of each other's work situation on a daily basis and from improving their collaboration. Regular meetings between hospital and nursing home staff and visiting each other's workplace could be ways to improve understanding of each other's work situation. It is also important to improve reports and electronic data systems, because there is a safety risk associated with this lack of coordination of work.

The common goal should be that older patients remain in the nursing home as long as possible and only be transferred to hospital when the medical need is severe. We suggest, therefore, that attention be focused on providing nursing home residents with a medical care plan at least once a year, in cooperation with family members and that the care plan be updated when there is a change in their

condition. We further recommend that nursing staff working evenings, nights, and weekends follow the medical care plan that exists for each individual. This could reduce the risk of incorrect medical treatment and nursing care and unnecessary admission to hospital.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

All authors meet at least one of the following criteria (recommended by the ICMJE: http://www.icmje.org/ethical_1author.html) and have agreed on the final version:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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