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General practitioners' experiences as nursing home medical consultants

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Abstract

Objective: To describe general practitioners' experiences and perceptions 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 analyzed 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 is a need to increase registered nurses' staffing and acquire more advanced medical equipment, and to create possibilities for registered nurses and general practitioners to access each other's healthcare record systems.

Keywords: Advance care planning, experiences, general practitioners, nursing home

Introduction

An aging population (1) and increasing requirements for a robust healthcare and nursing home care system are becoming more evident globally (2). Studies have revealed a high rate of hospitalization and emergency department (ED) use among nursing home residents and have identified the medical reasons for such transfers (3-7), and that they can be avoided (8-11). For example reduction in transfers 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 organization of medical care in nursing home care differs between countries (14-16), 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). In general 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. Therefore, it is important to hear these views as well as GPs' overall outlook on the care provided at nursing homes, as their experiences and opinions are crucial. Hence, we decided to study and describe GPs' experiences and perceptions of being the principal physician responsible for a nursing home.

Design and methods

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

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 beds 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 centers where they have out-patients of different ages in addition to 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 38-70 years old, employed as

GPs between 2 years and 30 years, and as a GP for a nursing home 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 and perceptions 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 interviews were conducted in a quiet room. Each interview lasted between 30–90 minutes, was digitally recorded and transcribed verbatim.

The principles of systematic text condensation, a method for cross-case thematic analysis of qualitative data, were used (22). In the present study, the method involved the following: (i) thorough reading of all the material to obtain an overall impression; (ii) identifying meaning units, representing different aspects of participants' experiences and perceptions 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) summarizing the contents to form categories, in order to achieve an overall description of the GPs' experiences and perceptions. 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 and interpretation of findings.

Ethical considerations

The primary care director in the county council and the private primary healthcare centers approved the study. According to national directives, formal approval from an ethics committee was not required (23). 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 (24). All GPs gave their written informed consent.

Results

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

Medical assessment

The GPs described 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 electronic health care record (EHR) to get an overview of earlier health status, medication and lab 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. To have the whole picture of the person's health status in mind is especially important with older persons, because of multimorbidity and interactions of diseases. 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 with 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. Generally they found it difficult to fit in unplanned assessments in nursing homes, as these could conflict with patient appointments at the healthcare center.

Advance care planning

The GPs found 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 can participate in the ACP meeting. Some GPs described using a template with questions about healthcare 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 in determining 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 prioritize 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. A opinion 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 give pain management with morphine, as well as injections with sedatives and diuretics, at the nursing home. All GPs meant that nursing homes are places where older persons can end their life with dignity. Some highlighted that the level of palliative care differs between nursing homes. Some also compared the conditions with the care provided in home care, with a mobile palliative care team. The opinion was that the home care organization 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 largely the RNs who are key persons in the care of 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 of nursing staff, because they as GPs do not see the residents every week. 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 continuation in planning of care, and thereby no ACPs 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 standardization 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 center 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 centers 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 is possible 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

have placed GP directives regarding how to managing a potential deterioration of health visible in front of the healthcare record, e.g. “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!’

Organization of eldercare and desires for improvement

The overall view of all GPs was that care of nursing home residents is characterized 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 good skills. Some reported feeling that eldercare in Sweden is generally neglected and that the quality aspect 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 meant that it happens that they 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 have become older and have more medical problems, owing to the shortage of nursing home places, GPs’ working conditions have changed. They must keep themselves up to date on an increasing number of aspects and 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 nonexistent. 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 organization that is common in some other countries.

One organizational 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 over viewing the situation of each resident and for guiding future decisions. ACP is the process of discussing and documenting the type and level of care the person may want in the future and has been identified as a factor related to fewer referrals to the hospital (25) and fewer hospital deaths (26) among nursing home residents. In our study, the GPs also stressed the value of having discussed the level of care the resident desires in the event of deteriorating health, as it provides the resident and the family with a sense of security. This reasoning is in line with the intentions of the concept of person-centered care, which focuses on the individual needs of a person and honors the person's values, choices and preferences (27). A new patient law (28) 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 (29) states that older people have the right to lead a life characterized by dignity and well-being. The intention underlying the text was to consolidate older people's rights under one framework. The GPs were generally very clear in emphasizing residents' participation and empowerment when describing how they perform their work, and were generally 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 organization 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 center, 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 the GPs would like to be able to provide, and also felt was expected of them from the hospital.

The GPs felt that they must 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 was found in another study (30). 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 latest ACP be placed so as to be highly visible and easy for staff to find out of hours and for replacement nurses to find. 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 (25). The fact that the system for patient records in nursing homes and the system in healthcare centers 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 constitutes a way of establishing credibility, which is in line with Lincoln and Guba's (31), 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 centers 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 trial 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

This study highlights the importance of advance care planning together with residents and family members in order to 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 is a need to increase RN staffing and acquire more advanced medical equipment, and, to create possibilities for GPs and RNs to access each other's healthcare record systems.

References

1. UNFPA aHI. *Ageing in the Twenty-First Century: A celebration and a challenge*. UNFPA, New York. 2012. Available from: <http://www.unfpa.org/public/op/edit/home/publications/pid/11584> (accessed 22 January 2015).
2. WHO - World Health Organization. http://www.who.int/ageing/publications/knowledge_translation/en/ 2012 [150201].
3. Ackermann RJ, Kemle KA, Vogel RL, Griffin RC, Jr. Emergency department use by nursing home residents. *Ann Emerg Med*. 1998;31(6):749-57.
4. Callahan CM, Arling G, Tu W, Rosenman MB, Counsell SR, Stump TE, et al. Transitions in care for older adults with and without dementia. *J Am Geriatr Soc*. 2012;60(5):813-20.
5. Givens JL, Selby K, Goldfeld KS, Mitchell SL. Hospital transfers of nursing home residents with advanced dementia. *J Am Geriatr Soc*. 2012;60(5):905-9.
6. Intrator O, Castle NG, Mor V. Facility characteristics associated with hospitalization of nursing home residents: results of a national study. *Medical care*. 1999;37(3):228-37.
7. Miller SC, Gozalo P, Mor V. Hospice enrollment and hospitalization of dying nursing home patients. *Am J Med*. 2001;111(1):38-44.
8. Naylor MD, Kurtzman ET, Pauly MV. Transitions of elders between long-term care and hospitals. *Policy Polit Nurs Pract*. 2009;10(3):187-94.
9. Ouslander JG, Weinberg AD, Phillips V. Inappropriate hospitalization of nursing facility residents: a symptom of a sick system of care for frail older people: *J Am Geriatr Soc*. 2000 Feb;48(2):230-1.; 2000.
10. Saliba D, Kington R, Buchanan J, Bell R, Wang M, Lee M, et al. Appropriateness of the decision to transfer nursing facility residents to the hospital. *J Am Geriatr Soc*. 2000;48(2):154-63.
11. Ouslander JG, Lamb G, Perloe M, Givens JH, Kluge L, Rutland T, et al. Potentially avoidable hospitalizations of nursing home residents: frequency, causes, and costs: [see editorial comments by Drs. Jean F. Wyman and William R. Hazzard, pp 760-761]. *J Am Geriatr Soc*. 2010;58(4):627-35.
12. Young Y, Barhydt NR, Broderick S, Colello AD, Hannan EL. Factors associated with potentially preventable hospitalization in nursing home residents in New York State: a survey of directors of nursing. *J Am Geriatr Soc*. 2010;58(5):901-7.
13. Caplan GA, Meller A, Squires B, Chan S, Willett W. Advance care planning and hospital in the nursing home. *Age Ageing*. 2006;35(6):581-5.
14. Caprio TV, Karuza J, Katz PR. Profile of physicians in the nursing home: time perception and barriers to optimal medical practice. *J Am Med Dir Assoc*. 2009;10(2):93-7.
15. Hoek JF, Ribbe MW, Hertogh CM, van der Vleuten CP. The role of the specialist physician in nursing homes: the Netherlands' experience. *International journal of geriatric psychiatry*. 2003;18(3):244-9.
16. Levy C, Palat SI, Kramer AM. Physician practice patterns in nursing homes. *J Am Med Dir Assoc*. 2007;8(9):558-67.
17. Andrew RA. Analysis of a general practitioner's work in a private nursing home for the elderly. *The Journal of the Royal College of General Practitioners*. 1988;38(317):546-8.
18. Jacobs S. Addressing the problems associated with general practitioners' workload in nursing and residential homes: findings from a qualitative study. *Br J Gen Pract*. 2003;53(487):113-9.
19. Groom L, Avery AJ, Boot D, O'Neill C, Thornhill K, Brown K, et al. The impact of nursing home patients on general practitioners' workload. *Br J Gen Pract*. 2000;50(455):473-6.

20. Kihlgren AL, Fagerberg I, Skovdahl K, Kihlgren M. Referrals from home care to emergency hospital care: basis for decisions. *J Clin Nurs*. 2003;12(1):28-36.
21. Polit & Beck, editor. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, cop.; 2008.
22. Malterud K. Systematic text condensation: a strategy for qualitative analysis. *Scandinavian journal of public health*. 2012;40(8):795-805.
23. SFS 2003:460. Act concerning the ethical review of research involving humans. <http://www.regeringen.se/>. Accessed May 13, 2011.
24. Codex 2015. Rules and guidelines for research. <http://www.codex.uu.se/>. Accessed Jan 31, 2015.
25. Shanley C, Whitmore E, Conforti D, Masso J, Jayasinghe S, Griffiths R. Decisions about transferring nursing home residents to hospital: highlighting the roles of advance care planning and support from local hospital and community health services. *J Clin Nurs*. 2011;20(19-20):2897-906.
26. Baron K, Hodgson A, Walshe C. Evaluation of an advance care planning education programme for nursing homes: A Longitudinal study. *Nurse Educ Today*. 2015.
27. McCance T, McCormack B, Dewing J. An exploration of person-centredness in practice. *Online journal of issues in nursing*. 2011;16(2):1.
28. SFS 2014:821 Acp. Ministry of Health and Social Affairs Sweden.
29. SFS 2001:453 Social Services Act. Ministry of Health and Social Affairs Sweden.
30. Karlsson I, Nilsson M, Ekman SL. Physicians' expectations regarding registered nurses caring for older people living in sheltered housing, retirement homes and group dwellings. *Journal of interprofessional care*. 2006;20(4):381-90.
31. Lincoln YS GE. *Naturalistic inquiry*. Newbury Park, London, New Deli: Sage Publications Inc;. 1985.