

One patient, two worlds – coordination between nursing home and hospital doctors

BACKGROUND Increasingly poor health in the nursing home population and transfer of responsibilities to the municipal health services place great demands on collaboration between primary and secondary health services. The article presents the opinions of nursing home and hospital doctors with regard to treatment of nursing home patients and their descriptions of the coordination between doctors at the two levels.

MATERIAL AND METHOD This qualitative study was conducted in a Norwegian county in 2011–12. The results are based on manifest content analysis of ten focus group interviews with a total of 46 nursing home doctors, and eight focus group interviews with 41 hospital doctors from the medical departments in the public county hospital.

RESULTS From their respective standpoints, both groups of doctors were concerned about unnecessary admissions and overtreatment in hospitals. They had widely differing approaches to patient treatment and communicated that little coordination took place in the treatment of nursing home patients. Both groups described strikingly little communication between the doctors in the context of transfer between the levels.

INTERPRETATION Preconceived notions, negative experiences and lack of communication may reduce trust and prevent proper dialogue about patients. This may cause both over- and undertreatment, as well as give rise to erroneous expectations. The municipal health services and the hospitals share the responsibility for appropriate coordination and treatment of individual patients from nursing homes.

Doctors who work with elderly, ill patients need to take account of numerous concerns, and collaboration with other agencies is often required. Patients are entitled to clinically adequate and empathic health care, which must be both beneficial and cost-effective (1, 2). As a main rule, treatment presupposes informed consent, and some patients will decline treatment (3). The manual *Beslutningsprosesser ved begrensning av livsforlengende behandling [Decision-making processes related to restriction of life-prolonging treatment]* from the Directorate of Health underscores the importance of a good dialogue to elicit the patient's wishes and values (4).

In Norway, nearly half of all deaths occur in nursing homes (5). Hospital admissions occur frequently – two Norwegian studies have shown an incidence of about 600 per 1 000 nursing home beds per year (6, 7). The Health and Care Services Act obligates municipalities and health trusts to enter into partnership agreements, which must include guidelines for collaboration on admission to and discharge from hospitals (8). The manual from the Ministry of Health and Care Services states: «Mutual knowledge transfer, dialogue and exchange of information are key coordination elements and crucial to ensuring high-quality services and patient pathways» (9).

In 2009–10, the nursing homes in a Norwegian county received training in intrave-

nous therapy, with the aim of strengthening local medical competence. The project was initiated in the context of the Coordination Reform and was a collaboration between the medical department at the hospital, the Development Centre for Nursing Homes and Home Care Services and the nursing homes in the county.

As part of this project we interviewed doctors in the nursing homes as well as in the hospital about ethical aspects of the treatment of nursing home patients. This article presents the attitudes of the nursing home and the hospital doctors regarding the treatment of nursing home patients. This includes their descriptions and explanations of the nature of the coordination between the doctors at these two levels upon admission of these patients to hospital, during their stay and upon their discharge to the nursing home.

Material and method

The study is based on ten focus group interviews with 46 nursing home doctors from a total of 26 nursing homes in the period from June to December 2011 and eight focus group interviews with a total of 41 hospital doctors in the period from June to December 2012.

The use of focus groups is a qualitative research method which is suited for eliciting rich descriptions of the participants' experiences and in-depth knowledge about complex phenomena (10).

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MAIN MESSAGE

From their respective standpoints, nursing home and hospital doctors shared a concern about unnecessary admissions and overtreatment of nursing home patients in hospitals.

Both groups of doctors regarded the limited degree of coordination and insufficient exchange of information upon admission to and discharge from hospitals as problematic.

Lack of coordination complicates decisions concerning appropriate treatment intensity that complies with the wishes of individual patients, and makes positive cooperation with their next of kin difficult.

The nursing home doctors

All the 57 nursing home doctors in 30 nursing homes in the country were personally invited to participate by email and telephone. In addition to those who were interviewed there were another five who wanted to participate but were not included, since we felt that we had achieved saturation after ten interviews. Six nursing home doctors declined to participate. Each group consisted of three to six participants.

We interviewed 30 men and 16 women whose experience as doctors ranged from one to 38 years. They worked in nursing homes that had from 12 to 169 beds, and one to eight departments with different types of specialisations: rehabilitation, short-term and long-term stay, palliative care and dementia care. Eight of the 46 doctors were employed in full-time positions and two in half-time positions as nursing home doctors. The remaining 36 were general practitioners with a 20 per cent position as medical supervisors. Most of these had split this 20-per cent position into 40 per cent attendance and 60 per cent availability on demand.

The hospital doctors

We planned and conducted one focus group interview with up to eight participants in each of the eight medical departments to which elderly patients are most often admitted: Section for Gastroenterology, Geriatric Medicine, Haematology, Cardiology, Infectious Medicine, Nephrology, Neurology and Pulmonary Medicine.

We interviewed 41 out of a total of 82 doctors employed in these departments (17 of 34 specialty registrars and 24 of 48 senior consultants), with four to seven participants in each interview. The doctors had medical experience ranging from less than one to 40 years, and 26 of the 41 participants were men. In the last three hospital interviews we felt that we had achieved saturation.

The interviews

The interviews lasted for approximately 60 minutes. RP and RF alternated in the role of main interviewer, while MR participated as co-interviewer in all interviews. We used a semi-structured interview guide that included multiple topics, such as:

- Topic 1: How are decisions regarding treatment of seriously ill nursing home patients made?
- Topic 2: Doubts or disagreement about treatment or treatment level
- Topic 3: Dialogue and collaboration between the nursing home and hospital doctors

Questions also included disagreement between the levels, what was working and not working, and suggestions for improvements.

The analysis

We received many detailed answers to the topics that we wanted to elucidate, and we therefore used manifest content analysis (11). The interview was discussed by the interviewers immediately, and a written summary was discussed by email. The interviews were recorded on an audio device and transcribed verbatim. We used the four steps of systematic text condensation in the processing of the material.

- The authors started by reading repeatedly through the nursing home interviews followed by the hospital interviews: First to obtain a general impression, and then to identify main topics. With regard to the analysis presented in this article, the interviews were repeatedly studied with particular attention to descriptions of coordination between the levels, highlighting relevant text.
- All authors discussed the selected texts and agreed on categories, categorised the texts and adjusted the categories as needed.
- Subsequently, the categorised text was systematically reviewed and condensed, analysed further and discussed again. The categories were inspired by the questions in the interview guide and our previous knowledge of the theoretical and empirical aspects of this area, and they were adjusted as the work progressed and more suitable categories were found.
- The condensed text in each category was summarised into analytical text. The selected quotations are clear, illustrative and typical examples that expand on the text.

The titles of the final categories have also been used to structure the chapter on results: the attitudes of nursing home and hospital doctors to treatment of nursing home patients; coordination during admission, during hospitalisation and at discharge; and proposals for improvements.

Research ethics

The study has been approved by the South-Eastern Regional Committee of Medical and Health Research Ethics (ref. 2009/1584a-1). The doctors were provided with oral and written information about the study, including about voluntary participation, the opportunity to withdraw, and a guarantee of full anonymity. Written consent was obtained from all participants.

Results

Attitudes to treatment of nursing home patients and coordination during admission to hospital

The nursing home doctors emphasised avoidance of admissions, and many reported that they enter a note into the patient record

beforehand, saying that the patient should not be admitted. They were concerned with restricting active, life-prolonging treatment, which they often described as distressing as well as undignified. They described how the out-of-hours doctors who were called out/contacted invariably initiated treatment or admitted the patients to hospital, and some said that they made sure to be present to prevent this from happening. Many had been exposed to pressure from relatives or staff members to send patients to hospital.

Many of the nursing home doctors believed that the patients were overtreated while in hospital. It was nevertheless recognised that overtreatment could occur in emergency situations, because the hospital doctors were unfamiliar with the patients and because the hospital doctors were seen as having little time. Many were concerned with communicating the best possible information about the patient upon admission.

The nursing home doctors reported that they were frequently met with scepticism and a negative attitude from the hospital doctors on occasions when they needed to hospitalise patients, although this differs from one doctor and department to another. Some said that they exaggerate the gravity of the situation to avoid discussions with their hospital colleagues.

Coordination? I would rather prefer not to discuss it ... (chuckles). Well, it differs from one department to another, I guess. Some places it works really well, the department of geriatrics and the colleagues there are outstanding people to turn to. But I feel that needing a referral at every twist and turn to be admitted, despite the fact that they have stated in the records that the patient in question has an open return ... it's such a hassle every time to get them admitted.

From their perspective, the hospital doctors in the study were concerned with inappropriate admissions. They portrayed an image of elderly, ill patients who could not account for themselves at admission, and of insufficient information provided by the nursing home. They described how patients were often sent off by nursing home staff or doctors who lacked confidence in the situation, or were unfamiliar with the patient. The next of kin would often be asked to provide more information about the patient, or a nurse would call the nursing home to obtain information.

The doctors were rarely in dialogue with the nursing home; they felt that this was time-consuming and not very productive. Some of the doctors noted that the quality of the admission documents was frequently high, and that the dialogue with the nursing

home doctors about daytime admissions mainly worked well.

The hospital doctors were critical of the quality and continuity of the medical services in the nursing homes, while claiming that nursing home treatment was the best solution for elderly patients. Despite their frequent claims that the hospital represented a wrong level of treatment, they would almost invariably initiate a full examination and treatment. They admitted to engaging in overtreatment at the hospital, but explained this by noting that they had little knowledge about the patient and assumed that full treatment was desired, since the patient had been admitted.

The biggest challenge is lack of information from the nursing home, typically when you are on duty, a seriously ill, nearly dead patient comes in, you know nothing about him, and the only thing you have is perhaps at best a note from the nurse in the nursing home. That's quite a challenge... It happens quite often.

I believe, then, better availability of doctors in the nursing home situation, better competence, of course we need to do something about our own competence as well, but I rarely feel that we are facing dilemmas if we have been in contact with the nursing home doctor. That occurs more often when the patients have been admitted by others. Uh, so I feel that communication, when we already have a dialogue, is not much of a problem, but ... really, I personally feel that we are very rarely in a dialogue with the nursing home doctor.

Conferring with each other

The nursing home doctors might call to confer directly with a senior consultant in the different medical departments, in connection with as well as independently of any admission. Doctors at both levels held exclusively positive opinions about this dialogue. The nursing home doctors described the hospital doctors as obliging, they received answers to medical questions and support for more complex cases. They respected the hospital doctors' medical competence.

The hospital doctors, for their part, were understanding of the nursing home doctors' need for advice and support, and had seen that this often helped ensure that the patients' problems could be addressed outside hospital.

Coordination during the hospitalisation period

The participants reported that little or no coordination took place between the nursing

home doctors and the hospital doctors during the patients' hospitalisation period. None of the interview participants reported to perceive this as problematic.

None of the nursing home doctors had ever been called by the hospital requesting information or dialogue regarding a hospitalised patient. Some stated that they might appreciate being contacted, while others said that such calls could disturb them in their daily work.

The hospital doctors tended to believe that the insufficient availability of medical resources in the nursing home would render it difficult to contact the doctor.

Coordination upon discharge

In the interviews, the nursing home doctors stated that the dialogue upon transfer to the nursing home was non-existent and saw this as a problem. Many of them believed that the hospital doctors' approach to the patients was not sufficiently comprehensive, that they only addressed acute medical conditions and that the patients were discharged too quickly. They were concerned about the unethical aspects of exposing seriously ill patients with unclarified conditions to a transfer and possible readmission. Some also referred to resistance to readmissions on the part of the hospital.

Information from the hospitalisation is a purely clinical discharge summary. The nursing home doctors were not contacted for discussion of medical, practical or ethical questions, not even when seriously ill patients were discharged during ongoing medical treatment.

It's not a problem in itself that patients who need to continue their intravenous therapy are transferred to us, but the problem is when this is not clarified and they have not been stabilised into this therapy. It would have been better if they had seen that this is effective, the patient has been stabilised, things are clear, what should be done after the end of the intravenous therapy and how long it should continue. Then it's OK. But when the patient is so poorly and nothing has been clarified, then I believe that this is wrong.

The nursing home doctors also raised the issue of the contrast between advanced hospital treatment and their own emphasis on palliative treatment and care in the nursing home. They felt that the hospital doctors engaged too little in dialogue with the patients and their next of kin, especially with regard to life-prolonging treatment, and that they rarely provided any indication about treatment types and levels after discharge.

The nursing home doctors had to inform the next of kin and apprise them of the reality, correct high expectations for treatment and recovery, discontinue treatment that had been initiated, and find themselves left with a number of difficult ethical dilemmas. Some, however, felt that the hospital staff were good at informing the next of kin and assessing treatment levels.

... the only real ethical dilemma is often about things that the hospital has initiated and whether they should be continued, and the expectations this raises in the next of kin and all that. And then there are terminally ill patients discharged from the hospital with a nasogastric tube, and when I call them, they cannot give any answer as to what they had in mind and why they did this. And there's no note in the discharge summary, and then we need to decide what is to be done about the whole thing, and ... In such cases the coordination is not good enough, really it isn't.

The hospital doctors confirmed that they never contacted the nursing home doctor directly at discharge to inform about or discuss the patient, they sent a discharge summary. They referred to lack of time as the reason for this. Many of them said that they saw their job as resolving an emergency situation, they had no time to speak with the patient or the next of kin, and believed that at discharge it was still too early to draw conclusions about the prognosis.

Some stated that they deliberately provided general recommendations in the discharge summary, while others admitted to having a potential for improvement. Any recommendations provided were most often focused on avoiding a readmission, and in some cases on communicating a decision not to initiate cardiopulmonary resuscitation. Some reported to have experienced that their message failed to reach the nursing home and that the patient was readmitted, others had succeeded in establishing a positive collaboration with the nursing homes.

It is much faster to write a sentence in the discharge summary than to make a phone call, where you first have to reach someone who needs to go and find somebody else who has the time, and then you are on the phone for 15 minutes, and often you don't have that time.

But, obviously, if we haven't had a proper dialogue with the next of kin, and they can see that dad now has a tube and he is fed ... Because they are in shock when they come to us, and

there's denial, and then they come to the nursing home and have the feeling that the hospital doctors have taken this optimistic, aggressive approach. And then the nursing home doctor comes as an apostle of death and has that role, and that's not OK, is it? However, I don't think we do it deliberately, but it could be linked to our roles, that we need to push people through the system, everything happens in a rush, then they come to the nursing home and two more weeks go by, and then the nursing home staff are the ones to assume that «death role».

The doctors' proposals for improvement of coordination and patient treatment

Ideas and input from the doctors were provided spontaneously or in response to questions about proposals for improvement of the coordination. The nursing home and hospital doctors focused on different issues, and the answers pertained not only to better coordination, but also to better patient treatment.

The nursing home doctors would like more help for diagnostics and treatment. Some said that they wished to have an opportunity to hospitalise patients for purposes of diagnostics and initiation of treatment, and then assume responsibility for treatment at the earliest appropriate time. Other proposals included «outpatient emergency diagnostics» and supervision by a specialist in internal medicine at the nursing home.

The hospital doctors felt that the nursing homes needed more medical resources, to enable more patients to be treated in situ. They meant that the nursing home doctors ought to become better at advanced care planning. They wanted better information and a more well-defined «order» when nursing home patients were admitted. Many of them claimed that if the nursing home doctors called them to confer more frequently, this could help avoid admissions. In addition, it was proposed that the nursing home doctors could be seconded to the hospital to learn more about how the different departments work.

Discussion

The doctors included in this study perceived that only a minor degree of coordination took place in the context of hospital admission of nursing home patients. This collaboration is statutory, the content is described in detail in national guidelines and local coordination agreements, but clear challenges remain – at multiple levels – in establishing an appropriate dialogue in practice.

The nursing home and hospital doctors

had different perspectives and approaches to coordination, but the hospital doctors' descriptions of their coordination with the nursing home doctors shared clear features with those provided by their counterparts. There was also a certain variance internally in the groups, but this was far less conspicuous.

Strengths and weaknesses

We interviewed 80% of the doctors in the nursing homes in the county in question, including general practitioners with a medical supervisory function as well as doctors employed directly by nursing homes, in all types of departments and all types of nursing homes. In the hospital we interviewed doctors in all relevant medical departments.

This is a qualitative study that provides us with knowledge about the doctors' perceptions of the coordination. In the text we have used quantifiers such as «many» and «some» to indicate the main emphasis of the statements and to show nuances and contradictions in the interviews. We cannot generalise on the basis of numbers and proportions, but we nevertheless believe that the article provides an adequate description of the issues involved.

This is a sub-study of a large-scale project, in which all nursing homes in a county were provided with training in intravenous therapy. The interviews were conducted after the completion of the training programme. The objective of the training was not to improve or change the coordination between the levels, but the improved competence in the nursing homes may nevertheless have provided a better framework and heightened interest in coordination between the nursing home and the hospital. If so, this may imply that little or no coordination may be even more characteristic of other locations.

The researchers involved in this project were not responsible for implementation of the training programme in the nursing homes. The first author had the main responsibility for the collection of quantitative and qualitative data, was part of the project group and remained in close contact with the training team. Having close familiarity with both the training project and the individual nursing homes was a clear advantage, and the second or third authors, who were not involved in the project, conducted the interviews.

In focus group interviews there will always be a risk that the informants adapt their responses to what they believe is expected or desired by the interviewer or the other informants. We cannot exclude the possibility that some informants may have exaggerated or spoken in unbalanced terms

to put their points across. Contrary to this, any self-censorship on the part of the participants will imply that the coordination is even less adequate than the results indicate. However, we had the impression that the doctors answered clearly and honestly, and their statements were consistent across the different interviews. Thus, we do not believe that the results are fraught with any significant bias.

Attitudes

Doctors at both levels claimed that as a rule, nursing home patients are best served by being treated in the nursing home. This notwithstanding, they reported very different approaches to examination and treatment in nursing homes versus hospitals. The nursing home doctors attempted to avoid hospitalisations and restrict life-prolonging treatment, whereas the treatment imperative was the overriding principle for the hospital doctors. Many of the nursing home doctors were critical of overtreatment and too narrow a medical approach in the hospital, while many of the hospital doctors were critical of the quality and continuity of the medical services provided in nursing homes.

Most of the hospital doctors admitted that patients are overtreated, while many were of the opinion that the responsibility for restricting active treatment and dialogue with the patients and their next of kin rests with the nursing home doctor who is familiar with the patient, and they rarely raised the issue that treatment needs to be clarified on an ongoing basis.

Admissions authorised by out-of-hours services or by telephone and other sub-optimal solutions in the nursing home doctor's absence may seem to have a major influence on the hospital doctors' perception of the quality and necessity of admissions. We have no representative data for this, but von Hofacker and collaborators have previously shown that many critically ill nursing home patients fail to obtain an adequate medical assessment before admission to hospital (12). In a study of 26 patients who died within 48 hours of being admitted, two had been admitted via out-of-hours services, six after telephone contact with the out-of-hours doctor on duty and eight by a nurse without any contact with a doctor. Most likely, however, the actual volume of inappropriate admissions is less extensive (12, 13).

Lack of contact

Both groups of doctors described communication failure at all stages of the patient pathway. The hospital doctors often felt that they received little information upon admission, the nursing home doctors received insufficient information upon discharge, and the

reports referred to little shared thinking with regard to holistic treatment and patient pathways. The hospital doctors referred to lack of time as an explanatory factor. At the same time, we had the impression that it was easier for them to spend time and resources on examinations and treatment than to invest in communication, which could probably economise on resources and result in more individualised patient treatment (4, 14, 15).

Preconceived notions, negative experiences and lack of communication are detrimental to coordination, undermine trust and mutuality and increase the risk of over- and undertreatment. Large differences in tasks, objectives and incentive structures in the institutions where the doctors work may also be obstacles to appropriate coordination. However, attitudes to patient treatment and to their counterparts varied from one person and one department to another, and it is important to note that both parties referred to their positive experience of collaboration on those occasions when they actually established contact.

Improvements

The doctors' proposals for improving coordination and patient treatment focused on avoiding unnecessary admissions, improving information exchange and raising the quality and continuity of examinations and treatment in nursing homes. These challenges have been a recurring topic in the Journal of the Norwegian Medical Association for 15 years (16, 17) and a number of solutions have been proposed, for example out-of-hours services in nursing homes (18).

Practices with regard to admissions vary considerably between the nursing homes (7, 19). The decision-making processes linked to potential admissions are complex and include a wide range of factors, from patient-specific to organisational issues (19). Most likely, a higher density of doctors and increased competence in nursing home medicine might reduce unfortunate practices with regard to admissions: unnecessary admissions could be reduced, thus permitting more patients who stand to benefit from them to be admitted (7, 13, 20).

There is little doubt that better coordination with regard to potential as well as actual transfers of patients between nursing homes and hospitals, will result in better patient treatment at both levels. Increased competence in geriatrics in the hospitals, in the emergency departments as well as in the wards, has also been demanded for years (21).

The nursing home doctors were interviewed immediately before the Coordination Reform with its requirements for local agreements came into force, and the hospital

doctors immediately afterwards (22). Nationally as well as locally, in the municipal health services as well as the hospitals, efforts have later been made to establish agreements, procedures and electronic communication channels.

We do not know for certain how the reform has changed coordination practices regarding patients in general or nursing home patients in particular. We have no doubt, however, that the results from this study are nevertheless relevant and important, even after the introduction of the Coordination Reform. Change takes time, and we know that a lot of work remains to be done, for example in terms of the content of the information exchange and actual collaboration on transfer of patients.

According to reports from NOVA Social Policy Research Institute, the coordination agreements have not caused significant changes in the perceived collaboration between the parties (23). The report *Informasjonen var mangelfull og kom ofte for sent. Oppsummering av landsomfattende tilsyn i 2015 med samhandling om utskrivning av pasienter fra spesialisthelsetjenesten til kommunen* [The information was insufficient and often came too late. Summary of nationwide inspections in 2015 of coordination on discharge of patients from the specialist health services to the municipalities] from the Board of Health Supervision concludes as follows: «The inspection also revealed serious failure of coordination between the hospitals and the municipalities. Transfer of information between the hospitals and the municipalities was the area where the county governors found the most frequent violations of prevailing legislation and potential for improvement» (24).

A recent study from the Office of the Auditor General on resource utilisation and quality in the health services after the introduction of the Coordination Reform confirms that the collaboration between the primary and specialist health services leaves something to be desired (25). The report recommends that the Ministry of Health and Care Services should consider measures to improve this collaboration, including the quality of the information exchanged. Here, the doctors play a key role.

Coordination is described as a distribution of tasks that in order to reach a shared, consensual goal (22). To nursing home patients between the nursing home and the hospital, the path ahead and the goal are often unclarified and characterised by medical and ethical complexity. Nursing home patients who fall acutely ill place great demands on communication and coordination, and a better dialogue between the nursing home and the hospital is absolutely necessary. The expression

«to play to each other's strengths» could perhaps provide inspiration in this effort to achieve change. Nursing home and hospital doctors could obviously benefit more from each other – in the patient's best interest.

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