

# Optimizing Health Care Delivery in Personal Care Homes in Newfoundland and Labrador

## September 2016

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# Acknowledgements

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Thanks to those who agreed to be interviewed for their committed participation and carefully considered input. Thanks also to Shaun Lane, president of the Personal Care Home Operators Association of Newfoundland and Labrador and Beverly Russell, president of the Quality Living Alliance for Seniors Association, who were our collaborators during the design of this study, providing the team with valuable information about the operation of personal care homes in Newfoundland and Labrador. Finally, thanks to Shannon Aylward, Réanne Kinsella, Nicole Porter, and Adam Pike (staff at Memorial University's Primary Healthcare Research Unit), who assisted the team with various aspects of this study, including data collection, analysis, and report preparation.

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# Executive summary

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## BACKGROUND

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- The proportion of seniors in the population is on the rise; personal care homes are a vital service for seniors in NL who can no longer live in their own homes but do not require the level of medical care provided in nursing homes.
- Unlike nursing homes, personal care homes are privately owned and operated, but the health care of their residents is monitored through Regional Health Authorities by the Department of Health and Community Services.
- This study explored issues related to how health care services for seniors living in personal care homes in NL could be improved by coordination and integration of key stakeholders in this industry.

## METHODS

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- In-depth key informant interviews with 25 stakeholders in the personal care home sector in NL.

## KEY FINDINGS

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- One of the major gaps in the coordination of medical care for PCH residents involves interactions between the PCHs and the ED. Nearly all participants reported problems specifically related to PCH-ED interactions.
- The problems inherent in these interactions were identified in three key areas: the referral process from the PCH to the ED, communication breakdowns in the transition of care, and misunderstandings about PCHs: the level of care offered and how PCHs differ from nursing homes.
- Coordination of care for PCHs is also affected by communication breakdowns on other levels including communication between case managers and the residents for which they are responsible, between case managers and family physicians, and between family physicians and policy makers.
- Family physicians' involvement with PCHs varied in terms of how they serviced the needs of residents of the home and when they were available to service the home. This unstructured, inconsistent approach to providing care to the residents of PCHs leaves those residents in a vulnerable position without adequate access to primary care.
- Related to these issues are concerns regarding adequate physician reimbursement. If family physicians are to provide care in this specialized environment and after hours, they must be compensated accordingly.
- PCHs may not be appropriately equipped with the level of programming and trained staff to ensure the well-being of residents.

- These concerns were expressed in relation to three key areas: dealing with level of care transitions, medication management, and the general lack of recreational programming at many of these facilities.

## RECOMMENDATIONS

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- A new model of care should be developed that has, at its core, a strong public-private partnership characterized by open lines of communication, trust, and a high degree of collaboration.
- Access to primary care for residents of PCHs should be improved.
- Coordination of care between PCHs and the ED should be improved.
- Personal care home residents should have their level of care monitored more frequently to reduce the number of emergency referrals to nursing homes.
- PCH staff should be encouraged to use existing resources, such as the Newfoundland and Labrador Health Line when making decisions regarding when/if to send a resident to the ED.
- Studies to determine the extent of medication dispensing errors among residents of PCHs should be undertaken to assess the degree to which this is a problem.
- Communication of PCH resident medical information should flow freely among the appropriate personnel to provide quality care for the resident.
- Family physicians' care for residents of PCHs should be provided with timely access to legible records about the resident's visits to the ED or admission to an acute care facility.
- PCHs should be encouraged to tap into local resources such as those offered by the Seniors Resource Centre or other community or church groups to provide more recreational services for their residents.

# Background

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The Canadian population is aging; that is, the proportion of seniors in the population is on the rise. This is nowhere more evident than in Newfoundland and Labrador where the most recent census indicated that 16 per cent of the population is aged 65 and over.<sup>1</sup> By 2025, it is anticipated that close to one quarter of our population will be comprised of senior citizens.<sup>2</sup> Even more important is the increase in the number of individuals aged 75+ (older seniors), one of the fastest growing subsets of the population.<sup>2</sup>

A report prepared by the Aging and Seniors Division of the Newfoundland and Labrador Department of Health and Community Services (DHCS) indicated that in 2004–2005, there were approximately 4,400 seniors living in long-term care facilities in this province, representing 6.6 per cent of the entire senior population aged 65+ at that time.<sup>3</sup> However, a study examining the demand, need and provision of institutional long-term care beds in Newfoundland and Labrador found that the mean age of clients recommended for placement over a one-year period was 81 years ( $\pm 9.5$  years).<sup>4</sup> The proportion of seniors requiring long-term care is higher in older seniors than their younger counterparts.

As the proportion of seniors (especially the old seniors) in our province grows, there will be an increasing need for long-term care facilities to appropriately care for our seniors in need of assistance. An important segment of this population includes those seniors who are no longer able to live safely in their own homes (level one, level two care), but who do not require or qualify for the care typically provided in nursing homes (level three, level four care). Instead, these individuals require facilities that attend to basic needs such as accommodations and assistance with activities of daily living. In Newfoundland and Labrador, this type of care is provided by private operators in personal care homes (PCHs), also known as care homes, residential homes, or residential care homes.

## PERSONAL CARE HOMES IN NEWFOUNDLAND AND LABRADOR

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PCHs in Newfoundland and Labrador are licensed and monitored for compliance with government and industry regulations, policies, standards and guidelines by each of the Regional Health Authorities (RHA), which have been entrusted with these responsibilities by the Department of Health and Community Services (DHCS).<sup>5,6</sup> These facilities are not nursing homes but rather multi-resident homes that provide accommodations, meals, personal care and supervision for senior citizens and other adults who require this type of assistance. PCHs do not provide medical care; residents are dependent on primary care practitioners (e.g., family physicians) in the community for their ongoing healthcare needs.<sup>5,6</sup> In the Eastern Health region, the regional health authority does, however, assign case managers to PCHs. Case managers are either registered nurses or social workers who are assigned to monitor the residents' care while they are residing in a PCH. They also regularly visit the PCHs and monitor these facilities to ensure compliance with provincial standards on a quarterly basis. In addition, they perform an annual assessment on residents to assess their level of care and ensure that they are properly placed in a PCH. If a higher level of care is required, case managers facilitate the transfer of these residents to nursing homes where level three and four care is provided. They also are involved with resident care issues, ordering medical supplies for subsidized residents, and handling resident complaints in consultation with the RHA.

It should be noted that as the level of health of residents in these homes decline, they are often transferred to nursing homes either directly or through the emergency departments or inpatient services of hospitals.

## STAKEHOLDER RELATIONSHIPS

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There are a variety of different stakeholders involved in the management and oversight of personal care homes and their residents. Several key linkages have been formed that are important for developing, implementing, and maintaining appropriate operational standards for PCHs. For example, the DHCS and representatives of the PCH programs in each RHA have formed a committee to review the standards set out in the Provincial Personal Care Home Operational Standards (revised 2007).<sup>6</sup> These groups work together to determine the direction of the personal care home programs. In addition, in the Eastern Health region, representatives of the RHA meet with the PCH operators bi-annually for the purposes of licensing or, as needed, if there are compliance issues. If requested, the PCH operators can also meet more frequently with the RHA. Eastern Health also hosts an annual education day to which all home owners/PCH staff are invited to attend.

These relationships are important but there remains a lack of coordination regarding the medical care of PCH residents among governing bodies, PCH operators, and healthcare providers. This lack of coordination serves as the general focus for this research. There is a distinct lack of communication between family physicians and other health professionals such as PCH case managers. Coordination of care is informal at best, and teamwork is not utilized to its full potential. As is the case in other areas of the health system, this lack of communication and integration leads to fragmented patient care. Because there are no formal lines of communication, family physicians caring for these residents are not always aware of medical policies and the available health care services that could lead to better care of the residents in these homes. Poor coordination of health services impacts the well-being of the residents and may lead to poor patient outcomes and increased visits to secondary and tertiary hospital facilities resulting in greater financial costs.<sup>7-9</sup>

The concept of coordinated, continuous, and integrated patient care continues to gain political and clinical importance in almost all healthcare contexts. In addition, the proportion of people who will require the use of PCHs continues to rise. Despite this, a search of the scientific literature carried out with the assistance of an experienced librarian, revealed a dearth of literature regarding these issues in the context of PCHs. That being said, we were able to find one article that characterized the relationship between privately owned residential care homes and public governing bodies in much the same way as we experience it here: “an awkward relationship ... that often lacks clarity or a systematic approach to its responsibilities when providing health care and support to older people who are not living in their own homes or in [nursing home] settings.”<sup>10</sup> The paper examined how the use of a quality of care improvement approach called Essence of Care benchmarking to promote coordination between nursing care and care home staff could improve older persons’ access to services, quality of care, and health outcomes. It also described some of the issues encountered when introducing approaches to collaborative working. Their limited review of the available evidence (case studies and descriptive reports) concluded that structured tools such as benchmarking could potentially increase coordination and quality of care, that coordination of efforts between primary healthcare providers and care home staff is necessary, and that the evidence base surrounding these issues is sorely lacking.<sup>10</sup>

Another two papers we found from England and the Netherlands describe the challenges of integrating public and private services in caring for the elderly.<sup>11,12</sup> These papers described the advantages and disadvantages of a hierarchical management system that developed in England compared with a partnership management system that was developed in the Netherlands.<sup>11,12</sup> The authors conclude that in both systems considerable mistrust was evident between the public and private sectors that inhibited integrated care development. The conclusion was the need for network building and development.<sup>11,12</sup>

Our study explored how health care services for seniors living in residential care homes in NL could be improved by coordination and integration of key stakeholders in this industry. It represents the first step of a research program aimed at understanding the current state of healthcare services for seniors living in residential care homes. We believe the knowledge gained from this study will inform policies, processes, and the development of targeted interventions to improve the coordination and quality of care provided to seniors living in residential care homes.

# Methods

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This study was approved by the Health Research Ethics Board of Memorial University of Newfoundland in St. John's, NL.

To gain a full appreciation of the issues surrounding coordination of care in person care homes in this province we conducted twenty-five in-depth key informant interviews with stakeholders in the personal care home sector in NL. Stakeholders included personal care home owners or managers in rural and urban settings, case managers with Eastern Health assigned to the personal care home program, family physicians caring for personal care home residents, officials with the provincial Department of Health and Community Services, representatives of the two provincial personal care home associations, and outpatient and Emergency Department staff. Participants were recruited using purposive sampling; potential participants were identified by members of the research team. These individuals were sent a formal letter of introduction and an invitation to participate in the research from the Principal Investigators.

The information gathered in the interviews allowed us to develop a comprehensive understanding of the process of health care delivery, including insights into barriers to quality health care services in personal care homes in this province. Conducting interviews with stakeholders in all areas of the province is very expensive and was beyond the means of our project budget. For this reason, project activities were geographically limited to the Eastern Regional Health Authority, including personal care homes in both urban and rural communities. The Eastern Regional Health Authority comprises a large and comprehensive geographic area, including all communities on the Avalon, Burin, and Bonavista peninsulas, as well as Bell Island.<sup>13</sup> We are confident we gained both urban and rural perspectives within this catchment area.

Trained research assistants from the Primary Healthcare Research Unit (PHRU) skilled in qualitative methods conducted 45-minute face-to-face or telephone interviews. The interview guide (see Appendix B on page 23) was semi-structured and focused on factors that facilitated or impeded the coordination of care in personal care homes. Issues discussed in the interviews included:

- the participant's role and experience in coordinating health care in personal care homes
- barriers or enablers, including policies or practices, that contribute to or inhibit the coordination of health care for seniors living in personal care homes
- how care providers or regulators provide input into policy decisions affecting personal care homes
- how care providers, particularly family physicians, can improve linkages with social workers, community health nurses and other allied health professionals that provide health care services for the homes
- how a coordinated service might improve quality of health care for seniors living in personal care homes and reduce health care costs

## DATA ANALYSIS

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Interviews were transcribed verbatim and coded independently by three team members. A team meeting was convened to compare and establish a standardized coding scheme. Interview data was analyzed using thematic and descriptive analysis:<sup>14</sup> a process of identifying, categorizing, and examining the responses of the participants to determine the various features that facilitate or inhibit the coordination of care in residential homes in NL. The objective of this analysis was to explore the various dimensions and rationale for the respondents' stated beliefs, understandings, and experiences.

# Findings

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All participants in this study lived and worked in the Eastern Health District of NL. In the following paragraphs we report on the major findings identified from our interviews. These consultations revealed problems regarding the interaction between personal care homes and emergency departments, communication challenges among stakeholders, inadequate access to primary care for residents living in personal care homes, and perceptions of inadequately trained staff and programming at personal care homes to ensure resident well-being.

## PERSONAL CARE HOME-EMERGENCY DEPARTMENT INTERACTIONS

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One of the major gaps in the coordination of medical care for PCH residents involves interactions between the PCHs and the ED. Nearly all participants reported problems specifically related to PCH-ED interactions. The problems inherent in these interactions were identified in three key areas: the referral process from the PCH to the ED; communication breakdowns in the transition of care; and misunderstandings about PCHs: the level of care that is offered, and how PCHs differ from nursing homes.

### The referral process

Respondents indicated a need for more family physician involvement to help make ED referral decisions, particularly during after-hours and on weekends when the resident's family physician is usually unable to be contacted. In view of this access issue, a case manager stated:

**“When I’m in the homes, and I see that there’s a concern with a resident, to me, it should be the GP should be called and say, ‘Okay, well this is the problem, how do you want to handle that?’ But I don’t see that happening all the time. A lot of the times, the first thought is send them to emerg and get them checked out. Whereas, I think if the GP were accessible and the home could talk to them [maybe we wouldn’t have to send them to the ED right away].”**

The general sentiment was that a medical professional not being involved in deciding whether to send residents to the ED may lead to an over-utilization of emergency services. Most physicians we interviewed reported that they do not provide after-hours or weekend care. They view PCH residents as being no different from their other elderly patients living in their own homes who generally do not obtain physician advice to make a decision whether to go to the ED. However, the PCH resident population differs from the general elderly population in that in the case of an acutely ill resident, PCH staff may be unfamiliar with crucial aspects of a resident's medical history and may not recognize when a resident's medical condition merits an ED visit. In addition, the PCH staff may not be particularly familiar with each resident's general state of health, and when they become acutely ill, staff may not be able to get in touch with the next of kin to help them to make a decision about an ED referral.

## Communication breakdowns in the transition of care

Respondents reported that poor communication between PCHs and the ED once a PCH resident is referred to the ED creates significant problems for everyone involved (the resident, the PCH, and the health system). In view of this, an administrator stated:

**“We’ve had some significant issues between EDs and personal care homes in terms of communication breakdown.”**

Residents in PCHs are by definition individuals—usually seniors—who need supervisory care that families cannot provide. For example, if residents are transported to the ED there is often no accompanying family member available. In this case, residents bring with them only a one-page form outlining some basic information about the resident’s medical condition. Residents who are ill enough to be sent to the ED may not be able to properly communicate with the attending physician. In addition, ED staff may require additional information about the residents’ mental status and ability to make decisions concerning their health care. However, it is not common practice for EDs to consult further with PCH staff to fill in these blanks. This can lead to inappropriate treatment and multiple visits to the ED before the correct diagnosis is made and the proper treatment initiated.

Communication between PCHs and EDs is hampered by interpretations of what information can and cannot be relayed to the PCH regarding a resident’s medical treatment in the interests of protecting patients’ privacy. For example, if a PCH staff member calls and try to discuss the case with the ED staff over the phone, the ED staff believe that they are not allowed (under current privacy regulations) to release confidential medical information to the PCH staff without the written consent of residents. On discharge, this leads to further problems because generally, PCH staff members are the primary care-givers for the residents. A case manager stated:

**“One of the things that always bothers me is that when a resident goes to the emergency department—or are hospitalized, for that matter—the information that comes back to the personal care home is limited, if any. I mean, I’ve had situations where [a] resident goes to the emergency department, and we have no idea what the diagnosis was or what they were even looking at.”**

Similar communication and confidentiality issues arise when residents are admitted and discharged from hospital.

ED staff also believe it would be helpful to communicate more openly with PCH staff regarding the resident’s medical care:

**“I think they are providing the care to the person so they do need to know ... anything that would impact care.”**

When some form of communication does occur, it was noted that there was more difficulty in communicating with a staff of smaller PCHs because they are less likely to have any staff people with

clinical training compared to the larger PCHs. This was believed to have a direct impact on resident care.

Poor communication between the ED and the family physician further compounds these problems. Situations arise where residents of PCHs visit an ED, and neither their primary care givers nor their family physicians have a proper account of what happened to them while they were there. It was acknowledged that discharge summaries from the ED are not sent to the family physician in a timely manner. In addition, they are often difficult to read because of the illegible handwriting and/or a barely readable carbon copy. There are also instances where changes in the patient's medication were not properly documented, and tests were done that were not forwarded to the family physician. Overall, there was the sense that the family physician is rarely "kept in the loop." A family physician summarized the problems with the lack of communication during transitions of care:

**“ The communication—the big danger is going from this place to this place to this place; it's those transitions going from this institution to the hospital, going from the hospital back to the institution. That's where the gaps are, and you get screwed up: the drugs get changed, the tests get done, and you never know what has happened, so that's the big gap with everybody. ”**

## Misunderstandings about PCHs

Misunderstandings about PCHs regarding the level of care that is offered and how PCHs differ from nursing homes represents another challenge in the interaction between PCHs and EDs. An ED administrator told us:

**“ People think they are discharging people back to PCHs where there are nurses; they don't see the difference between a personal care home and a nursing home. ”**

In many cases, the ED is unaware of the level of care provided at a PCH. One case manager stated,

**“ I don't think the hospitals really know that the personal care homes have untrained staff. ”**

Sometimes, the terms nursing home and personal care home are mistakenly used interchangeably. As another example, sometimes the ED staff will ask to speak to the "nurse" when calling the PCH. This is particularly problematic given that PCHs rely on hospitals to know whether it is in the best interests of the patients to be returned to their PCH. One respondent stated:

**“ The [personal care] home is relying on the hospital to know whether or not this person is safe to come back. ”**

Misunderstandings about the level of care that can be accommodated at a PCH have led to situations where residents are discharged by the ED to the PCH in the middle of the night or early morning hours. At these times, there is usually not enough staff available in the PCH to meet the resident's

medical needs nor does the ED give the PCH sufficient warning. In many cases, the resident is acutely ill and the PCH staff may not have sufficient clinical knowledge to provide the proper care or there may not be extra staff available. One PCH owner stated,

**“ You won’t let a person off the street go home (from the ED) if they’re not able to be cared for, and I can’t provide that care at this moment. ”**

Another commented,

**“ For them to send us a level three [care resident] at 12 a.m. in the night and expect us to just take them, I think that’s the biggest breakdown there. ”**

In addition, if there is further deterioration in a resident’s medical condition, PCHs often do not have the means or staff to properly assess or care for that resident. However, even if a resident’s level decreases to level three care, the standards now set by the department make it the responsibility of the PCH to care for that resident until an appropriate placement is found. Often an issue arises when PCHs are informed that they must take patients back from the ED. However, they often refuse because they cannot handle the level of care the resident requires.

**“ Clients are going to the ED, and ... the RHA may not know that they’ve advanced in the level of care ... until they get there, ... and then the home does not want to take them back. ”**

This was reported to lead to tension in the PCH-ED interaction and a mistrust of PCHs.

## COMMUNICATION BREAKDOWNS

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Beyond the communication problems between the ED and PCHs that we previously discussed, coordination of care for PCHs is also affected by communication breakdowns on other levels including communication between case managers and the residents for which they are responsible, between case managers and family physicians, and between family physicians and policy makers.

### Case manager-resident communication

Case managers indicated that large caseloads negatively influence optimal communication between themselves and the residents in their charge. Case managers are responsible for managing a very large number of cases (reported to be in the range of 120 residents per case manager). This involves monitoring their care, and compliance of their PCH with provincial regulations as well as yearly re-assessments of the resident’s level of care. Due to the high caseload, they believed there was really

not enough time to establish good relationships with residents. One case manager describes her work as being more focused on crisis management:

**“Right now, we’re called case managers but we’re not case managers. We respond to crises, do the supplies and those sorts of things, and we’re the ‘go-to’ person, but we don’t do case management, although that’s what our title is.”**

## Case manager-family physician communication

Sometimes, there may be issues with timely communication of a PCH with the case manager regarding a resident’s increased level of care. If notified sooner, this would give the case manager more time to allow for planning how to deal with that resident’s needs. This is especially important if a PCH resident is found to require level three care. In view of this, case managers believed there was a need to educate family physicians about the role of a case manager.

**“We’ve talked about this in some of our team meetings, ... maybe the nurse and the social worker for each home should sit down with the main physician for each home ... just to let them know what our role is.”**

**“One of the things I would like to see is that physicians understand the role of the case manager, and I would like physicians to be connecting more especially if they see any kind of deterioration. I would rather not wait until someone is really moving towards level three, I would rather for us to keep an eye on that [to avoid a situation in which] ... all of a sudden someone is in a crisis and we can’t move them.”**

Related to this point, some family physicians keep medical files for their residents they care for at the PCH while others keep the residents’ medical files at their practice location. If medical files are unavailable in the PCH, it is more difficult for other health care professionals such as case managers (social workers and registered nurses), physiotherapists and occupational therapists to have any medical information about the resident. The presence of the resident’s medical chart may also be critical in an emergency situation.

There is also inconsistency between the extent of communication between the family physician and the case managers in different PCHs. In some homes a family physician may work closely with the case managers but in other homes there may be no interaction between a family physician and the case managers. In general, however, case managers did not appear to work in concert with family physicians. This link between the resident’s family physician and the case manager is important

because case managers are critically involved in determining the level of care of residents or when there are issues involving the resident in the ED or in the hospital. One case manager stated,

**“When I’m in the homes and I see that there’s a concern with the resident, to me it should be the GP who is called and say, ‘Okay, while this is the problem, how do you want to handle that?’ but I don’t see that happening all the time. A lot of times, the first thought is to send them to the [ED] and get them checked out.”**

Privacy issues and access to patient information are a major concern for family physicians who are not employed by Eastern Health. Unless the family physician is working with Eastern Health, case managers reported that they must obtain written consent from the patient before the family physician can discuss the resident’s medical information with them.

## Family physician-RHA communication

Family physicians reported limited communication and interaction with the RHA. Overall, respondents reported that family physicians should have a voice in developing policies regarding medical care in PCHs and have input into decisions made by the department and the RHA. A family physician stated,

**“Well, if they want to make a policy, they should call together all family physicians who look after the personal care homes, have us all in one room and just listen to what we have to say and don’t throw it out the window which happens many times.”**

However, one family physician stated that it is more important for the NLMA to be involved in developing policy related to medical care of residents in personal care homes rather than individual family physicians. While many respondents believe they could provide valuable insight to the RHA and the DHCS when determining policy, they acknowledged the tight time constraints in which family physicians work and that physicians in private practice have limited time for meetings. Further, they feel they should be reimbursed if they do so, as any time they spend not seeing patients means a loss of income.

It was also noted that there is no formal arrangement for a medical advisory committee to meet with PCH family physicians as they do with family physicians working in nursing homes. One physician stated:

**“ I think for the personal care homes, there needs to better coordination, because everyone just goes off and they do their own thing. They have their own policies; some people do a really good job, some people don't, sometimes it's very much depending on who's running the home and how involved they are with the doctor. So in a smaller place you need really good communication between the people in the home and the doctor; you need good communication all of the time, but at least in a bigger place you've got a lot more structure built in to that sort of communication. ”**

## INADEQUATE ACCESS TO PRIMARY CARE

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Another major theme that emerged from our analysis with nearly all stakeholders is that family physicians' involvement with PCHs varied in terms of how they serviced the needs of residents of the home and when they were available to service the home. Case managers were asked about the physician coverage at the homes and residents access to primary care and stated:

**“ That ranges ... from none at all to constant, almost, and it depends on the physician. Personally, I see that's one area that's lacking, in the area of health care in personal care homes. ”**

Another stated:

**“ That's a big gap, ... the medical coverage. ”**

This seemingly unstructured, inconsistent approach to providing care to the residents of PCHs leaves those residents in a vulnerable position without adequate access to primary care. Related to these issues are concerns regarding adequate physician reimbursement. If family physicians are to provide care in this specialized environment and after-hours, they must be compensated accordingly.

### Level of service

While PCHs are not required to have a family physician who services the home, most of them have an arrangement with at least one family physician. In some PCHs one family physician services their facility. In others, there may be several family physicians who service the facility. Others still may have no family physician who visits the PCH so residents must attend their physician's office in much the same way they would if they were living in their own homes.

There is also much variety in the level of after-hours care provided to PCHs by the physicians who service these homes. Many participants reported concern regarding the after-hours care issue. While

some physicians who service PCHs are available to be called in around the clock, seven days a week, others offer no after-hours or weekend care.

## Physician compensation

It was generally recognized that improving access to after-hours care for PCH residents could reduce ED utilization but physicians who provide care to residents of PCHs must be adequately compensated for their time if they are to provide this service. One family physician we interviewed who provided 24/7 call services for a number of years indicated that he would not provide this service again without more adequate compensation:

**“If I were starting today and someone said, ‘Here’s a personal care home, there’s 40 people in it. You have to look after it, we’ll pay you for every patient you see, i.e., via MCP. However, you have to be on call 24 hours a day,’ I would say, ‘You know what you can do with that.’”**

Related to the reimbursement issue is the fact that visiting with PCH patients also sometimes means meeting with their families. These kinds of visits are very time-consuming and right now there is no specialized reimbursement code to cover the extra time required of the attending family physician:

**“To sit down for three hours and discuss patients and not get paid, no doctor wants that.”**

A number of stakeholders were interested in exploring the role that other types of health care providers (e.g., nurse practitioners) could play in caring for residents of personal care homes, feeling that this may be more cost-effective:

**“I think that a nurse practitioner probably would solve a lot of problems, because doctors say they don’t have the time and doctors are going to want to have a higher fee, ... [whereas] nurse practitioners [can be paid] a lower fee.”**

Personal care home operators would prefer to have consistent medical coverage for their PCHs, but currently the level of medical care varies from home to home. PCH operators understand the inconvenience for a family doctor to have to leave their practice to make a medical visit to the PCH and the associated financial disincentive. They are also aware that there is no special MCP fee for family physicians to visit PCHs.

## RESIDENT WELL-BEING

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A number of our respondents are not convinced that PCHs are appropriately equipped with the level of programming and trained staff to ensure the well-being of residents. These concerns were expressed in relation to three key areas: dealing with level of care transitions, medication management, and the general lack of recreational programming at many of these facilities.

## Level of care

If a resident is assessed at a level one or two care and deteriorates to level three care, PCHs are expected to continue caring for this resident until a suitable level three care nursing home can be found. One PCH operator stated in reference to an aggressive patient with dementia who their PCH could not handle:

**““ They brought her back [from the ED] within the hour ... and said she will have to be assessed for a level three. So, we still didn’t have anything in place for that lady, right? So to me, it was a dangerous situation; it was a danger for herself and for my staff, but there is nothing in between. ””**

The RHA does its best to find a level three care placement for residents but this may take several weeks or even months. During this time, PCHs—private businesses developed solely to accommodate level one or two care residents—are not provided with any additional compensation or assistance from the RHA or the DHCS to meet these increased needs. It was pointed out that if PCHs manage level three care residents, even for a short period, they require first and foremost personnel with the medical training necessary to cope with residents requiring this level of care in addition to hospital beds, a lifting device, and adequate bathing facilities. A revised evacuation plan in case of an emergency would also need to be prepared and implemented.

## Medication issues

In the current model, staff members at PCHs are not required to have any medical training. Yet they are sometimes responsible for dispensing medications to residents with minimal preparation and guidance. There is usually some oversight by the pharmacists who supply medications to the PCHs but there is no requirement for any of the workers to complete any coursework in the administration of medications. This represents a medical risk to PCH residents that was highlighted in our consultations:

**““ Medications are a huge risk area, and when you start talking to the nurses working in the personal care home program, they will talk to you about their concern about meds and med errors. ””**

**““ I mean, goodness you know, they’re dealing with as difficult cases as nursing homes are, and they don’t have any nurses in them. ””**

## Programming

A lack of timely access to allied health professionals and a lack of recreational activities can also negatively influence the well-being of impact residents. Generally, respondents reported poor access to physiotherapy and occupational therapy, especially in rural areas. These are critical areas especially because they could contribute to maintenance of the health of residents’ and injury prevention.

Recreational activities are also important in maintaining the health and well-being of residents, but it is not always available:

**“I would like to see all homes have recreation ... for the mobility and the mental health of the residents.”**

A number of the larger PCHs provide this service but the smaller homes do not feel they can support this level of programming without being supplemented with public funds.

# Conclusions/summary

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This study examined healthcare delivery and coordination of care in PCHs in the Eastern Health District of NL. The stakeholders we consulted included the DHCS, the RHA, PCH operators and/or managers, the heads of the two provincial PCH associations, family physicians who service PCHs, and ED staff. All stakeholders expressed a keen interest in ensuring appropriate and high quality health care is delivered to PCH residents. However, it is clear in the current model most stakeholders work in silos and there is limited, if any, formal communication between or among them. Furthermore, it was also noted that the various stakeholders are not fully aware of each other's responsibilities. Each stakeholder carries out their responsibilities to the best of their ability but there is no mechanism for their individual activities to be viewed or monitored. This results in fragmented healthcare delivery for the residents of PCHs—a point illustrated in the findings of this study.

Our consultations revealed that one of the major gaps in the coordination of medical care for PCH residents involves interactions between the PCHs and the ED. The problems inherent in these interactions manifest themselves in three key areas: the referral process from the PCH to the ED and at the time of discharge back to the PCH; communication breakdowns in the transition of care; and misunderstandings about PCHs: the level of care that is offered, and how PCHs differ from nursing homes. Beyond the communication problems between the ED and PCHs that we previously discussed, coordination of care for PCHs is also negatively influenced by communication breakdowns on other levels including communication between case managers and the residents for which they are responsible, between case managers and family physicians, and between family physicians and policy makers. Another major theme that emerged from our analysis is, under the current model of care, residents of PCHs are left in a vulnerable position without adequate access to primary care. Finally, PCHs may not be equipped with the level of programming and appropriately trained staff required to ensure resident well-being. These concerns were expressed in relation to three key areas: dealing with level of care transitions, medication management, and the general lack of recreational programming at many of these facilities. In the final section of this report, we propose recommendations to deal with these issues.

However, the initial task needed to start the process of improving healthcare delivery to PCHs is to increase communication and collaboration among relevant stakeholders. The government currently plays a regulatory and monitoring role with regard to healthcare delivery for residents of PCHs. The fact that PCHs are privately owned businesses inhibits more involvement by government because a more collaborative model for this public-private partnership has not yet evolved. A model that allows all of the stakeholders to work together in a more collaborative way is required. A more productive partnership between the government which is ultimately responsible for the delivery of health services and PCHs whose focus is meant to be the basic personal day-to-day needs of their residents should be fostered in order to provide quality, coordinated care for PCH residents. While this may involve financial investment from governing bodies, it will also help to streamline health care delivery potentially allowing for more efficient use of healthcare resources.

# Recommendations

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1. **A new model of collaboration is needed.** A new model of care should be developed that has, at its core, a strong public-private partnership characterized by open lines of communication, trust, and a high degree of collaboration. Policy makers, clinicians, and researchers should work together to identify and evaluate innovative public-private partnerships that have been formed in other jurisdictions or other contexts. These lessons can help to inform us before we embark on a process of reform.
2. **Improve access to primary care services.** Access to primary care for residents of PCHs should be improved. This might possibly be accomplished through the development of policy and new MCP codes for family physicians involved in caring for PCH residents. This should include policies around after hours and weekend care for PCHs. For example, physicians in defined geographic areas may wish to combine their efforts to care for these residents by developing a rotating call schedule. Another possibility would be to investigate how nurse practitioners may be able to fill the gaps in primary care coverage and possibly provide a more uniform service.
3. **Coordinate care between PCH and the ED.** Coordination of care between PCHs and the ED should be improved. This is hampered by the fact that ED staff are often not aware of the stark differences between PCHs and nursing homes. In addition, privacy regulations often prevent meaningful communication between the ED and PCH staff/owners. Education around these differences should be provided to ensure the best possible decisions are made for the patients involved. Privacy regulations should be modified to include PCH staff in the circle of care in a capacity that allows them to access and share residents' health information.
4. **Increase the monitoring of PCH residents' level of care.** Personal care home residents should have their level of care monitored more frequently to reduce the number of emergency referrals to nursing homes. Referrals that happen in this context are stressful for all parties involved. ED staff struggle with how to manage elderly patients who do not require admission or emergency services but cannot be returned to their PCH. The PCHs are in most cases not equipped to handle a patient with level three or four care needs but struggle with a sense of responsibility for their resident. Finally, and most importantly, PCH residents who experience these emergency transitions face losing their place of residence and familiar surroundings with no time to adjust or prepare. Researchers, clinicians, and policy makers should find and evaluate innovative methods to increase the frequency of level of care assessments, perhaps by using different methods of assessment, adjusting caseloads, or other measures meant to streamline the process.
5. **Improve PCH access to existing resources such as NL Health Line.** PCH staff should be encouraged to use existing resources, such as the Newfoundland and Labrador Health Line when making decisions regarding when/if to send a resident to the ED. This resource was not mentioned in connection with this issue suggesting that it is an underutilized resource for this population. Access to after-hours and weekend care from a primary care provider would also help to ensure that residents needing non-emergent care are not sent to the ED.

6. **Re-examine medication dispensing policies in PCHs.** Studies to determine the extent of medication dispensing errors among residents of PCHs should be undertaken to assess the degree to which this is a problem. Medication dispensing errors are of great concern even among qualified nursing staff in acute care and long term care facilities. However, the dispensing of medication to residents in most PCHs is done by medically untrained PCH staff. This is an issue that requires immediate attention and is an area that more collaboration is needed between PCHs and the DHCS/RHAs.
7. **Re-examine the flow of patient information.** Communication of PCH resident medical information needs to flow freely among the appropriate personnel to provide quality care for the resident. Current privacy regulations should be reviewed and a method developed that respects the resident's privacy but allows for the PCH to have enough information to be in the best position to help the resident with his/her medical needs. Residents should be consulted about the acceptability and structure of this approach. Policies around keeping resident's medical charts at the PCH should also be developed.
8. **Improve flow of resident's health information to family physicians.** Family physicians care for residents of PCHs should be provided with timely access to legible records about the resident's visits to the ED or admission to an acute care facility. Personal care home residents may not have the mental capacity or the help of a concerned family member to know how to deal with instructions given by the hospital physician or how to deal with his/her follow-up care. Neither do PCH staff members, due to privacy regulations, have medical information that can help them care for the resident.
9. **Improve access to recreation programs to PCHs.** Recreational services, including provision of social outings, are noted to maintain residents' health, level of care and sense of well-being. PCHs should be encouraged to tap into local resources such as those offered by the Seniors Resource Centre or other community or church groups in order to provide more recreational services for their residents.

# Appendix A: Terms and abbreviations

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The following are a list of terms used throughout this report:

## Level of care

**Level one care:** Residents at this level are independently mobile with or without mechanical aids; they may need limited assistance with their activities of daily living such as bathing, toileting, dressing and grooming; they have full use of their mental functions but can have some mild difficulties with perception, orientation and memory; they may have stabilized medical problems; they may require accompaniment for medical visits.<sup>15</sup>

**Level two care:** Residents at this level are independently mobile with or without mechanical aids but may need limited assistance with transfers; they may need a moderate amount of assistance with bathing, toileting, dressing and grooming; they may need assistance with their meals; they may have moderate cognitive impairment and may need some supervision for minor behavioural challenges; they may wander but are able to be contained; they are medically stable but may require assistance with therapies or procedures.<sup>15</sup>

**Level three care:** Residents at this level may require nursing care on a regular basis throughout the day; they may be safely independently mobile with or without mechanical aids but may consistently need assistance or supervision; they may consistently require help with bathing, toileting, dressing and grooming; they may have advanced cognitive impairment or behavioural (LOC) challenges, they may require assistance with eating or require feeding; they have medical problems which require continuous or frequent supervision.<sup>15</sup>

**Level four care:** Residents at this level are bedridden and require continuous nursing care including the possible use of medical devices to maintain life.<sup>15</sup>

**DHCS:** Department of Health and Community Services

**RHA:** regional health authority

**ED:** emergency department

# Appendix B: Interview guides

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## PERSONAL CARE HOME ASSOCIATION DIRECTORS

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1. Describe your role within your organization.
2. Describe your interaction with personal care homes in NL.
3. Describe the role that your association plays in the PCH industry.
4. Describe the role that government plays in regulating PCHs.
5. In terms of personal care homes, what does “coordinated health care” mean to you?
6. Describe the role that your association plays in coordinating health care services in personal care homes.
7. Describe the role that government plays in coordinating health care services in personal care homes.
8. What are some of the challenges you observe regarding the coordination of health care services in PCHs?
9. What is the nature/causes of those challenges? For example, health care services not available, geography, costs, bureaucracy (red tape), lack of willingness to provide service, etc.
10. What are some of the major barriers to coordinating health care services in NL?
11. What would you change to improve the coordination of health care services in personal care homes?
12. Is there anything that I didn't ask you that you would like to add to our conversation?

## ADMINISTRATORS OF PERSONAL CARE HOMES

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1. Describe your role within your organization.
2. Describe your facility.
3. Describe the residents in your facility:
  - Approximately how many level one and level two residents in the PCHs you are involved with?
  - Approximately what is the percentage of subsidized patients?
  - Approximately what is the percentage of seniors?
  - What is the balance between the administrative duties for the home and your work with individual residents?
  - Are there any differences healthcare wise, dealing with subsidized or non-subsidized residents?
4. What health care services are offered to residents within your facility?
5. Describe the health care services that are provided within your facility by employees of your facility.
6. Describe the health care services that are provided within your facility that are brought in from outside or provided by personnel that are not employed by your facility.
7. How much interaction do you have with [ask the nature of the interaction for each]:
  - Eastern Health case managers
  - Eastern Health coordinator
  - Family physicians
  - Officials from the Department of Health and Community Services
8. In an ideal world, what would the coordination of care for residents of personal care homes look like? (how should personal care homes, Eastern Health, Department of Health and Community Services and family physicians work together to provide residents of PCHs with care that is efficient and coordinated?)
  - How do social workers and nurses (who are case managers) coordinate their responsibilities for residents in PCHs?
  - What are your experiences dealing with family physicians who care for residents in PCHs i.e. are they difficult to contact, do they get involved with case managers in individual care of residents?
  - What are your linkages with occupational therapists, physiotherapists, dietitians?
  - Are case managers called when residents are sent to the ED?
  - How much interaction do you have with nursing or social workers attached to the ED who are seeing residents?
9. What are some of the challenges you experience when coordinating health care services for your residents?
  - What are the nature/causes of those challenges? For example, health care services not available, geography, costs, bureaucracy (red tape), lack of willingness to provide service, etc.

10. What are some of the major barriers to coordinating health care services for your residents? [prompt: gaps that still exist, other supports you require]
11. What would you change to improve the coordination of health care services for your residents?
12. Is there anything that I didn't ask you that you would like to add to our conversation?

## OFFICIALS WITH THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

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1. Describe your role within your organization.
2. Describe your interaction with personal care homes in NL.
3. Describe the role that government plays in regulating personal care homes (PCHs).
4. In terms of personal care homes, what does “coordinated health care delivery” mean to you?
5. Describe the role that government plays in coordinating health care delivery in personal care homes. For example, are there specific formal or informal meeting with stakeholders such as personal care home operators, physicians or case workers to discuss the health care needs/problems?
6. What are some of the challenges you observe regarding the coordination of health care delivery in PCHs? For example, how is the quality of resident medical care monitored, if at all? Is there monitoring of the use of EDs by personal care home residents? Are these issues the responsibility of the DHCS or the RHA or are they shared?
7. What is the nature or what are the causes of those challenges? For example, services not available, geography, costs, bureaucracy (red tape), etc.
8. What are some of the major barriers to coordinating health care delivery in personal care homes in NL?
9. What would you change to improve the coordination of health care delivery in personal care homes?
10. Are there any new initiatives by the DHCS for health care delivery in personal care homes besides the current pilot project assisting PCHs with higher level of care residents?
11. Is there anything that I didn't ask you that you would like to add to our conversation?

## OFFICIALS WITH EASTERN HEALTH

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1. Describe your role within your organization.
2. Describe your interaction with personal care homes in NL.
3. Besides your contact with the case managers, do you have any direct contact with residents or with the personal care home operators?
4. Describe the role that Eastern Health plays in coordinating health care services in personal care homes. In matters of medical care, do you play a role in implementing policy by DHCS or do you have any input in developing policy for PCHs? Does your position provide a link between DHCS and Eastern Health?
5. Describe the role that Eastern Health plays in regulating PCHs.
  - Do you have any role in coordinating the work of case managers in regards to medical care issues involving the PCHs?
  - How much interaction do you have with (ask the nature of the interaction for each):
    - Personal care home managers
    - Family physicians
6. In an ideal world, what would the coordination of care for residents of personal care homes look like? (How should personal care homes, Eastern Health, Department of Health and Community Services and family physicians work together to provide residents of PCHs with care that is efficient and coordinated?)
7. How do social workers and nurses (who are case managers) coordinate their responsibilities for residents in PCHs? Are you involved in this at all, or is this left to the case managers to determine? How do case managers report to you? Is medical care the major issue that they face at PCHs?
8. What are your linkages with OT, physiotherapists, dietitians?
9. Are case managers called when residents are sent to the ED? (this is probably a better question for the case managers—you may want to ask coordinators if there are statistics on the numbers of residents sent to ED)
10. Do case managers get involved with nursing or social workers attached to the ED who are seeing residents? (“Have there ever been any initiatives to coordinate resident care at the ED with case managers?”)
11. What are some of the challenges you observe regarding the coordination of health care services in PCHs? What are the nature/causes of those challenges? For example, health care services not available, geography, costs, bureaucracy (red tape), lack of willingness to provide service, etc.?
12. What are some of the major barriers to coordinating health care services in NL?
13. What would you change to improve the coordination of health care services in personal care homes?
14. Is there anything that I didn’t ask you that you would like to add to our conversation?

## CLINICAL STAFF WITH REGIONAL HEALTH AUTHORITIES (CASE MANAGERS)

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1. Describe your role within your organization.
2. Describe your interaction with residential care homes.
3. Describe the residents that you work with:
  - Approximately how many level one and level two residents in the PCHs you are involved with?
  - Approximately what is the percentage of subsidized patients?
  - Approximately what is the percentage of seniors?
  - What is the balance between the administrative duties for the home and your work with individual residents?
  - Are there any differences healthcare wise, dealing with subsidized or non-subsidized residents?
4. In terms of residential care homes what does “coordinated care” mean to you?
  - How do social workers and nurses (who are case managers) coordinate their responsibilities for residents in PCHs?
  - What are your experiences dealing with family physicians who care for residents in PCHs, i.e., are they difficult to contact, do they want to get involved with case managers in individual care, do they call looking for help for residents?
  - What are your linkages with OT, physiotherapists, dietitians?
  - Are case managers called when residents are sent to the ED?
  - Do case managers get involved with nursing or social workers attached to the ED who are seeing residents?
5. What are some of the challenges you experience when working with Residential Care Homes?
6. What is the nature/cause of those challenges? For examples, services not available, geography, costs, bureaucracy (red tape), lack of willingness to provide service etc.
7. What are some of the major barriers to coordinating care for PCHs?
8. What would you change to improve the coordination of care for residential care homes in your jurisdiction?
9. Is there anything that I didn't ask you that you would like to add to our conversation?

## PHYSICIANS PROVIDING CARE IN PERSONAL CARE HOMES

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1. Describe your medical practice.
2. What is your affiliation with residential care homes?
3. Describe the residents in your care.
4. What services do you offer to residents in your care?
5. In terms of residential care homes, what does “coordinated care” mean to you?
6. What are some of the challenges you experience when coordinating care for your residents?
7. What is the nature/causes of those challenges? For example, services not available, geography, costs, bureaucracy (red tape), lack of willingness to provide service, etc.
8. What are some of the major barriers to coordinating care for your residents?
9. What would you change to improve the coordination of care for your residents?
10. Is there anything that I didn't ask you that you would like to add to our conversation?

## EMERGENCY DEPARTMENT NURSES OR SOCIAL WORKERS

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1. Describe your facility and your role.
2. What is your interaction with personal care home residents?
3. What is your interaction with personal care home staff or administration?
4. What is your involvement with case managers assigned to residents of personal care homes?
5. What type of involvement do you have in the care of personal care home residents when they present to the ED?
6. To your knowledge, are residents of personal care homes treated any differently from other patients presenting to the ED in view of the fact that they are from a personal care home i.e. are there any official or unofficial ED policies in place?
7. Is there a policy for providing case managers with information about PCH patients who have visited the ED (or admitted to hospital)? If so, what information are they given (e.g. ED record)?
  - Is there a need to improve communication between the ED and case managers (e.g. in the case of patient re-assessment)?
8. How is information regarding the patient communicated back to the PCH or the individual's physician? Prompt re: discharge forms or reports? Is there any difference in the communication of the discharge information as compared with non-PCH patients?
  - In your opinion, is there a need to improve communication between the ED and individual PCHs or physicians? If so, how?
9. How would you compare the ED care and management of personal care home patients with long-term care patients from nursing homes?
10. In general, are there any challenges regarding ED visits that are specific to residents of personal care homes? If so, can you describe them?
11. Are you aware of the levels of care offered by personal care homes? (The different care levels (1-4) of patients as compared with a nursing home).
12. How would you describe the awareness of emergency physician colleagues of the levels of care offered by personal care homes?
13. How would you describe the awareness of medical trainees (residents, clerks, medical students) of the levels of care offered by personal care homes?
14. How would you describe the awareness of your fellow medical staff (RNs, LPNs, social workers) of the levels of care offered by personal care homes?
15. Are there currently any gaps or challenges that you would identify when you think about the coordination of care for residents of personal care homes?
16. Is there anything you would suggest to improve the coordination of health care services for PCH residents, particularly in relation to ED visits? Prompt, improved communication between ED and PCH or physicians?

17. Is there anything that I didn't ask you that you would like to add to our conversation?

## EMERGENCY DEPARTMENT PHYSICIANS

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1. Describe your facility.
2. Describe your medical practice.
3. What is your interaction with personal care home residents?
4. What is your interaction with personal care home staff or administration?
5. To your knowledge, are residents of personal care homes treated any differently from other patients presenting to the ED in view of the fact that they are from a personal care home; i.e., are there any official or unofficial ED policies in place?
6. How would you compare the ED care and management of personal care home patients with long-term care patients from nursing homes?
7. Are you aware of the involvement, if any, of a social worker in the care of personal care home residents when they present to the ED?
8. In general, do residents of personal care homes present any special challenges for ED visits and if so, can you describe them?
9. Are you aware of the levels of care offered by personal care homes?
10. How would you describe the awareness of your emergency physician colleagues of the levels of care offered by personal care homes?
11. How would you describe the awareness of your medical trainees (residents, clerks, medical students) of the levels of care offered by personal care homes?
12. How would you describe the awareness of your other medical staff (RNs, LPNs, social workers) of the levels of care offered by personal care homes? In terms of personal care homes, is there any special coordination of health care?
13. What does “coordination of health care” mean for you in terms of personal care homes and the ED?
14. Is there anything that I didn't ask you that you would like to add to our conversation?

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