Nurse-led geriatric clinics –The older persons perspective

Running title: Experience of geriatric clinics

Charlotta Simmons, Nurse[1,] and Jasmine Hylkén, Nurse[1]

[1] Department of Health Sciences, Faculty of Medicine, Lund University, SE 221 00 Lund, Sweden

*Corresponding author:

Charlotta Simmons

The Faculty of Medicine

Department of Health Sciences

P.O. Box 157

221 00 Lund, Sweden

Ch1662si-s@student.lu.se

Acknowledgements

We thank Lina Behm for participating in this study and for editing a draft of this manuscript.

ABSTRACT

Objective: The Aim of this study was to investigate older persons experience of nurse-led geriatric clinics. **Design:** The study was based on a qualitative method. **Sample:** 12 older persons (75+) were interviewed about their experience of nurse-led geriatric clinics. All participants were Swedish-speaking, varied in age and were patients from five different geriatric clinics within primary healthcare in Skåne, Sweden. **Measures:** A semi-structured interview-guide with one main open question and five follow up questions was being used. A pilot-interview was held to ensure the quality of the interview-guide. **Results:** The participants described the importance of having a nurse-led geriatric clinic. To have one nurse who knows the patients and their history, captures their needs and helps to organize the care is appreciated. **Conclusions:** The result indicates that if the nurses' care in the geriatric clinic is person-centred and based on patients' experience, improvement can be made. A permanent contact brings continuity, security and makes the patients feel taken care of.

Keywords: Geriatric Nursing; Patient relationships, Nurse; Primary Health Care; Patient-Centred Care; Qualitative Research

Background

Seventeen percent of Sweden's population is 65 years and older and this number is expected to increase during the following years (Lennartsson & Heimerson, 2009). In year 2028 the population is estimated to be 11 million. The same year, Swedish people aged 80 years or older are estimated to be 50 percent more than today. This increase will lead to more people with multiple diseases and more people that need help from the healthcare system. This increase will put demand on the healthcare system to provide care that is suitable for older persons needs. Today many countries are ill -prepared for this increasing need (Statistics Sweden [SCB], 2018). One measure taken by the Swedish government to address this need is to start nurse-led clinics for older persons. However, research concerning those clinics is sparse.

The risk that an older person should suffer from mental illness, sleeping disorder or anxiety, increases with age due to social, biological and psychological factors. Among the oldest persons (85+), every fifth man and every third woman are estimated to suffer from anxiety. Persons with comorbidity are in need of coordination within healthcare (Lennartsson & Heimerson, 2009) and patients feel that primary care has a central role in coordinating care from different units and by using person-centred communication; the quality of care is enhanced (Abu Al Hamayel et al., 2018). Cost-effectiveness and an improved care-process can occur if cooperation is found in the care of older persons with complex clinical diseases (Trivedi et al., 2013). Concerning older persons, studies show the importance of continuity when having diseases that are treated by different healthcare institutions (Haggerty et al., 2003; Rhodes, Campbell & Sanders, 2016). Preventive care has shown to reduce the number of hospital-stays and emergency-visits (Kristensson, Rahm Hallberg & Jakobsson, 2007)

and a personalised plan and self-management education can reduce unscheduled visits in primary healthcare (Sridhar, Dawson, Roberts & Partridge, 2007). For the older person and its care it is of great importance to have a specialised nurse with expanded knowledge who can identify possible nursing issues and have good problem-solving abilities (King, Boyd, Dagley & Raphael, 2017). Geriatric care should be person-centred since all people have different needs so it is important to involve all aspects of the patient and its care (Shaller, 2007). Furthermore, research shows that preventive care for older persons can make them feel safe and taken care of (Tøien, Bjørk & Fagerström, 2015).

Nurse-led clinics in primary healthcare was initiated in Sweden in the 1980´s, the most common being asthma and chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), diabetes, hypertension and incontinence (Drevenhorn & Österlund Efraimsson, 2013). During the last couple of years primary healthcare has been starting up geriatric clinics for coherent care and to create security among older persons. A nurse-led geriatric clinic has better access and more time for older persons who often have multiple diseases, so that all problems can be addressed (Lennartsson & Heimerson, 2009). Longer visits can lead to fewer consultations and a reduced number of hospital admissions (Swan, Ferguson, Chang, Larson and Smaldone, 2015; Zakrisson, Theander & Anderzén-Carlsson, 2014). Patients and caregivers appreciated nurse-led clinics specialising in geriatric needs, since they felt they were being listened to (Hansen et al., 2017). Other nurse-led clinics have shown to increase the patient's knowledge (Hill et al., 2010) and reduce symptoms for example patients with asthma and COPD (Löfdahl et al., 2010), ear-care (Fall et al., 1997) and CVD (McPherson, Swenson, Pine & Leimer, 2002; Voogdt-Pruis,

Beusmans, Gorgels, Kester & Van Ree, 2010). Research from the older persons perspective of geriatric clinics is important to be able to provide good care which is consistent with their preferences and needs. However, despite major economic investments in these clinics, there is a lack of studies from the older persons perspective. The aim of this study is therefore to investigate older persons experience of nurse-led geriatric clinics.

Methods

Design and sample

A qualitative method with semi-structured interviews was chosen to investigate older persons experience of nurse-led geriatric clinics. Patients from five different geriatric clinics within primary healthcare in Skåne were included in the study. The participants were chosen by the nurse at the geriatric-clinic with a varied selection in terms of age, gender, Swedish speaking and from different geriatric clinics. The geriatric clinics and the participants were selected by the following criteria: The primary unit must have a nurse-led geriatric clinic with visiting-hours and work according to Region Skåne (2018) accreditation; Patients must not suffer from dementia or other memory-loss; Patients should have regular contact with the nurse at the geriatric clinic and the possibility for visits.

Operation-managers at 23 different primary healthcare units in Skåne that followed the inclusion-criteria were contacted by e-mail, seven of them gave positive response and wanted to participate. Those that chose not to participate referred to shortage in staff and that they didn't have a clinic connected to the geriatric-nurse, didn't reply the e-mail or had too many requests at the time. When the study was approved by the

operation-manager, the nurse at the geriatric clinic was contacted and an information-letter was sent out. The nurse at the geriatric clinic then selected and recruited participants, according to the inclusion-criteria, for the study. The participants i.e the older persons received an information-letter and verbal information about the study. If the patients approved to participate in the study, their name and phone-number were given to the authors. The participants were able to decide where and when the interview was going to take place. Oral and written information were given again at the interview and a consent form was signed. In the end, older people from five geriatric clinics participated, as patients from two of the geriatric clinics became too weak to participate.

Setting

According to Region Skånes accreditation, a primary healthcare unit with at least 250 older persons listed, can initiate a nurse-led geriatric clinic for persons that are 75 years or older. The accreditation determines that information must be given both verbally, on the units´ website and on the website for Caregivers (1177.se). Patients must have access to a separate phone for at least 10 hours per week, with no button selection. The clinic must have access to a specialist-nurse and a doctor in general medicine or geriatrics. The nurse and/or doctor must have the opportunity to do home-visits. The geriatric clinic should also offer preventive and health-oriented interventions (Region Skåne, 2018).

Measures

A semi-structured interview-guide with one main open question and five follow up questions has been used. The main question was; tell me about your experience with the nurse-led geriatric clinic. To deepen the answers the authors used probing questions (appendix 1). A pilot-interview was held by both authors to ensure the quality of the interview-guide (Danielson, 2017). The interviews were recorded digitally and lasted for an average of 18 minutes (range: 10-60 minutes). All interviews were verbatim transcribed by both authors (CS and JH) before analysis. Interviews were conducted until no new experiences arose (Polit & Beck, 2016). Characteristics of the study participants can be seen in table 1 (appendix 2).

Insert table 1 about here

The study was guided by the ethical principles (Northern Nurses´ Federation, 2003) and the ethical research requirements according to recommendations from the Helsinki Declaration (World Medical Association, 2018). The participants received oral and written information about the study, that it was voluntary and they could terminate their participation at any time without consequences (Danielson, 2017). The interviews were not intended to address issues of sensitive nature but if sensitive matters came up, it was not transcribed and the participant was guided to the right care. The data were kept on an encrypted USB-memory and only the authors and the supervisor had access to the files. To protect the identity of the participants each interview received a number (1-12). The data from the study will be destroyed after

the study and examination is completed. The Vårdvetenskapliga etiknämden in Lund, Sweden approved the study (no 26-19).

Analytic strategy

Qualitative content analysis was used in accordance to Graneheim and Lundman (2004), which is suitable when a smaller number of interviews are being analysed (Danielson, 2017). Content analysis focuses on interpretation and is used within healthcare-science and in nursing-research. First, the text from the interviews were read several times. In the second step, the text were divided into meaning units and condensed. In step three, the condensed meaning units were abstracted and given a code. In the next step the coded material were divided into categories and sub-categories, which describe similarities and differences of the content. No data were between two categories or fit in to more than one (Graneheim & Lundman, 2004). No themes were found in the content analysis. Example of the content analysis can be seen in table 2 (appendix 3).

Insert table 2 about here

Results

The analysis of the interviews resulted in two categories and five sub-categories, which can be seen in table 3 (appendix 4). The categories and sub-categories represent the experience of the nurse-led geriatric clinic. The first category is *The*

importance of having a permanent contact consists of the subcategories *Gives a sense of continuity* and *Adds security*. The second category *The content of the geriatric clinic* consists of the subcategories *Preventive measures, Coordinated care* and *Access*.

Insert table 3 about here

The importance of having a permanent contact

Participants valued the relationship with the nurse at the geriatric clinic, which gave them continuity and made them feel secure. The category *The importance of having a permanent contact* is described by the two subcategories *Gives a sense of continuity* and *Adds security*.

Gives a sense of continuity

The participants explained the importance of having one nurse and one clinic to turn to, which made them feel calm and gave them continuity. Earlier they had to speak to different nurses each time, which was time-consuming because they had to repeat their medical history.

"Det är ju det här med att det är samma person… det kan jag tycka är bra. Så man får en kontinuitet, för då slipper man att dra hela paketet med ens sjukdomar och historia varje gång… ju sämre man är, inte minst mentalt är det viktigare att man känner personen som man kommer till." (Intervju 10, 80 år).

The participants also appreciated to have one nurse who knew them and their history and would if possible also like to have the same doctor. Furthermore, the participants described continuity when the geriatric-nurse knew and recognised them and they experienced that more empathy was shown. By having a relation and continuity with one nurse at the geriatric clinic, the participants felt confident to open up, talk about difficult but important matters and speak more freely. By having continuity the participants felt the nurses had a better touch and reacted faster if something was abnormal.

Adds security

The participants stressed that the benefit of the geriatric clinics was that geriatric-nurses were engaged and supportive which increased their feeling of security. To have a relation with the nurse at the geriatric clinic, especially for those participants that called regularly, made them feel secure since they got to talk to the same person each time. The participants stressed that the nurse was a good listener that always had time for them and an advisor who could support and counsel lonely persons.

"...hon känns som ett stöd och jag vet att hon finns och skulle jag känna så kan jag ringa till henne vilken dag jag vill…så det känns väldigt bra. Det är en trygghet att ha henne på äldrevårdsmottagningen..." (Intervju 6, ålder 83).

The feeling of security was also linked to the fact that the participants knew who they were meeting when coming to the geriatric clinic. Time was never an issue when visiting the nurse at the geriatric clinic who captured the participants' needs, which made them, feel secure, seen, calm and cared for. The participants stressed that they

understood the geriatric-nurse, that things were explained well and they dared to ask if they did not understand something. The feeling of security was linked to the fact that the participants knew where to turn and that they could always call the clinic-phone if they had something on their mind. The participants also stressed the fact that the nurse could see missed calls and call back and that they could leave a message. When the participants spoke to the geriatric-nurse they felt secure and could talk about questions they probably never would mentioned to a doctor. Doctors' appointments could be stressful and many topics weren't discussed.

The content of the geriatric clinic

The participants described *The content of the geriatric clinic* and the nurses' work as *Preventive measures*, *Coordinated care* and *Access*.

Preventive measures

The geriatric-nurse made preventive calls to check up on and support the participants even though sometimes nothing was decided in advance. Due to the preventive phone-calls, the participants described that the number of visits to the geriatric clinic and to the doctor have decreased. The geriatric-nurse also made preventive home-visits to the participants.

"…hon tar hand om mig ordentligt… jag har aldrig behövt en läkare på vårdcentralen sen jag började på äldrevårdsmottagningen" (Intervju 8, ålder 82).

Furthermore the participants stressed that being offered a pharmaceutical review by the nurse at the geriatric clinic due to possible drug-related symptoms, prior to the

doctors-visit was reassuring. Participants stressed that preventive measures and follow-ups' were taken by the geriatric-nurse. Loneliness was quite common and the participants considered geriatric-groups as a preventive measure that could be positive mentally, physically and socially.

Coordinated care

The participants experienced that the geriatric clinic could coordinate their care. They stressed that the nurse at the geriatric clinic captured their needs and helped to organize the care accordingly.

"…nu när jag hade lunginflammation och sen när benen började svullna…då ringde jag äldrevårdssköterskan med detsamma som i sin tur kontaktade läkaren…och de kunde inte på något sätt ta emot mig, utan hon rekvirerade Falcks läkarbil som var här inom två timmar…" (Intervju nr 4, ålder 88).

The nurse at the geriatric clinic monitored and coordinated medical visits, sometimes from different care-units. When changes or monitoring of medication was made, the doctor was responsible for this but it was the nurse that was coordinating and had contact with the participants. Coordination with the responsible doctor could be during a phone-call or a visit.

Access

The participants preferred to call the geriatric clinics phone because of better access and the fact that they got to speak to the nurse they knew and had a relationship with. By calling this phone the participants did not have to wait in line for what could be a long time, which was common, when calling primary healthcare. The participants

stressed that the older they become the more important was better access and contact with nurse at the geriatric clinic. If advice or insecurity of where to turn or if a doctors-appointment was needed the older patients chose to contact the nurse at the geriatric clinic for guidance.

"… jag har väldigt bra kontakt med äldrevårdsmottagningen och kan ringa dit varje vardag och jag har alltid fått hjälp när jag ringt… jag har nämligen haft olika besvär och så, som jag fått råd och tips om " (Intervju 6, ålder 83).

The participants experienced that they sometimes had to call the geriatric clinic phone several times with no answer and asked for increased availability. However they generally experienced having good access. When being in contact with the geriatric clinic it was always easy to get an appointment when needed. Having access to a physical nurse-led geriatric clinic where the participants can turn for support and visits was reassuring. Participants stress that they also like the geriatric clinic to be open all day, every day so they don't have to contact other care units where they don't feel safe and seen. Participants tend to worry when the geriatric clinic was closed more than two days and have spoken to the geriatric-nurse about this. After talking to the nurse participants felt calm and knew where to turn if needed.

Discussion

Method-discussion

The aim of this study was to investigate older persons experience of nurse-led geriatric clinics. A qualitative design, using semi-structured interviews was considered as a suitable way to investigate this topic. A varied selection when

choosing participants is preferred (Polit & Beck, 2016) and is of great importance for trustworthiness (Graneheim & Lundman, 2004), which was aimed for in the study. The study was conducted at different geriatric clinics and for *credibility* the study has, according to Graneheim and Lundman (2004), a varied selection of participants in terms of age, gender and background. To be included in the study the participants had to speak Swedish, which excluded a great deal of the Swedish population. If non Swedish-speaking participants had been included the result might have been different. This is a limitation of the study and lowers the *transferability* in many settings. Another inclusion-criteria was that the geriatric clinic had to have visiting hours which is not a demand from Region Skåne (2018). This fact narrowed down the selection of clinics, since many just had a special phone-line and made home-visits to the geriatric patients.

Participants from five different geriatric clinics in Skåne were included in this study. The result might have been different if the study had included participants from the whole country, since every region has their own accreditation. One of the strengths with this study is that the participants came from both small and large geriatric clinics and no exception was made if it was countryside or city. Only well-functioning geriatric clinics were included in the study, this can both be seen as strength and a weakness. The interviews became shorter than expected before the beginning of the study, but no new experience arose when the 12 interviews had been conducted which also increased the *credibility* of the study (Graneheim & Lundman, 2004; Shenton, 2004). Both authors read the interviews several times separately, then the texts were analysed and to achieve *credibility* the most suitable meaning units were selected

(Graneheim & Lundman, 2004). The process of the analysis is shown in a table to increase the *credibility*. The five sub-categories were also illustrated with quotes.

The semi-structured interview-guide that were used had one comprehensive question, which could give the participants a deeper description of the phenomenon that was being investigated. The pilot-interview, held by both authors, went well and the questions corresponded to the aim. Before the study began, each interview was calculated to last for 30-45 minutes. However, the interviews became shorter which can be due to that the authors were inexperienced. This could have implications for the study, the material may have been deeper if the authors were more experienced in interviewing which can increased the study's trustworthiness and *transferability*. According to Graneheim and Lundman (2004) and Shenton (2004) the characteristics and selection of participants, data collection, analysis and quotations from different participants are described in the study for increased *transferability* (ibid.). The authors believe that the findings of the study are transferable to other nurse-led geriatric clinics.

A strength with the study is that all interviews were held and transcribed by both authors during spring 2019, so the material never got out-dated which increases the *dependability* (Graneheim & Lundman, 2004; Shenton, 2004). The findings of the study are the result of the participants' experience of nurse-led geriatric clinics and the authors have analysed the content objectively to get *confirmability* (Shenton, 2004).

Result-discussion

The participants' experience of nurse-led geriatric clinics was summarized in the two categories: *The importance of having a permanent contact* and *The content of the geriatric clinic*. A relationship with the nurse brought the participants a feeling of increased security, reliability and continuity. Participants highlighted their appreciation of the nurses' efforts at the geriatric clinic where their care was being coordinated.

The participants expressed the importance of continuity when being in contact with the geriatric clinic. To have the same nurse during visits or in the phone that knows the older person was valuable which was supported by another study where the participants preferred to speak to a nurse that already knew them and their history (Holmström, Nokkoudenmäki, Zukancic & Sundler, 2016). This is also consistent with PCC and the key to PCC is to know the patients' history which is the foundation in building a relationship (Kristensson Uggla, 2014). Nurses describe the importance of PCC for older people in an acute medical ward and confirm that through continuity a relation was built when the nurses knew their patients' history and the care then became person-centred (Nilsson, Edvardsson & Rushton, 2019). When a relationship had continuity it was easier to talk about difficult things with the nurse at the geriatric clinic. By having continuity the patients' experience that they get their voices heard, their needs captured, abnormalities are noticed earlier and nursing interventions can be implemented, which is both time-effective and can be cost-effective for society. A geriatric clinic, promotes both the individual and society which is why investments should be made in these clinics.

The participants got a feeling of security when having a relationship with the nurse at the geriatric clinic. In a Swedish study the meaning of security for older people is being highlighted which had positive impact on their self-esteem when the personnel acted professionally (Theander & Edberg, 2005). The participants in this study described the nurse as someone who always had time for the patients, captured and respected their needs. An ethical approach and respect for the patients' autonomy are fundamental when working with PCC (Ekman et al., 2014). Trust is necessary to build a relationship when engaging older people in nurse-led prevention programs. A relationship is established when patients dare to ask and talk about their issues (Ligthart et al., 2015). The feeling of security made the participants in this study talk to the nurse about difficult matters and questions. Older people felt satisfied, both during visits and during phone advising, with the nurses' care and felt secure when being listened to and taken seriously (Holmström et al., 2016; Hansen et al., 2017). Patients' confidence and the feeling of security increased, if the nurses worked with PCC (Wolf et al., 2017). The feeling of security made the participants in this study to open up and speak more freely. Older peoples experience of phone-communication with the nurse, as when time was given for being listened to they felt they were being seen and trusted the nurse to follow through on actions (Waterworth, Rapael, Parsons, Arroll & Gott, 2018). The meaning of encouragement and PCC is described in a study about cardiovascular care. By having an open mind and by listening to the patient, their inner strength can be a resource in the situation. With PCC a relationship can be established and is a good base for planning patients' care (Kristensson Uggla, 2014). The nurse at the geriatric clinic works to promote good health and well-being among older people in the society.

In this study the nurse at the geriatric clinic coordinated and organized the participants' care sometimes from different care-units, which made the patients' feel well taken care of. The nurse should work with PCC, and the starting point should be the person's condition and life-situation in the decision-making of the care (Ekman et al., 2011; and Ekman et al., 2014). Profits for society are achieved working with PCC (Dudas, Kaczynski & Olsson, 2014). The participants in the study claimed that when the nurse made preventive phone-calls for support and check-ups, they experienced that the number of visits had decreased. If support and check-ups really decrease the number of visits to healthcare is unclear however from that perspective, geriatric clinics should be invested in. In another study older patients wanted their nurse in primary healthcare to make follow-up and check-up phone-calls on their condition (Holmström et al., 2016). Confidence for the nurse, among older persons, in primary healthcare increased, when their care was coordinated and followed-up (Waterworth et al., 2018). Older people in cardiovascular prevention programs reported that a feeling of control, security and being well taken care of enhanced, when the nurse offered regular check-ups (Ligthart et al., 2015).

Conclusion and implication

The results imply the relevance of having a nurse-led geriatric clinic and the older person's experience. A permanent contact brings continuity, which make them feel secure and taken care of. The clinic gives the older person preventive care, better access to healthcare and a possibility for the older person to get the care coordinated. The result of the study can be used as a complement to the accreditation when working in a geriatric clinic or when starting up a geriatric clinic. The study can also be used when evaluating an existing clinic. However more studies with bigger

population and different context and other methods and perspectives, needs to be done. If comparing patients experience of nurse-led geriatric clinics in different regions in Sweden, the well-functioning bits could be chosen and applied in other geriatric clinics for better care for the older patients.

References

Abu Al Hamayel, N., Isenberg, S. R., Hannum, S. M., Sixon, J., Smith, K. C., & Dy, S. M. (2018). Older Patients' Perspectives on Quality of Serious Illness Care in Primary Care. *American Journal of Hospice and Palliative Medicine®*, *35*(10), 1330-1336

Danielson, E. (2017). Kvalitativ forskningsintervju. Henricsson (Ed.), *Vetenskaplig teori och metod* (p.143–154). Lund: Studentlitteratur.

Drevenhorn, E., & Österlund Efraimsson, E. (2013). Distriktssköterskans mottagningar. I C. Bökberg (red) *Omvårdnad i primärvården* (ss. 125-143). Lund: Studentlitteratur.

Dudas, K., Kaczynski, J., & Olsson, L-E. (2014). Implementering av personcentrerad vård i slutenvården. I I. Ekman (Red.), *Personcentrering inom hälso- och sjukvård.* (pp. 172-197). Stockholm: Liber

Ekman, I., Norberg, A., & Swedberg, K. (2014) Tillämpning av personcentrering inom hälso- och sjukvård. I I. Ekman (Red.), *Personcentrering inom hälso och sjukvård: från filosofi till praktik.* (pp. 69-92). Stockholm: Liber

Ekman, I., Swedberg, K., Taft, C., Lindstedt, A., Norberg, A., Brink, E., ... Stibrant Sunnerhagen, K. (2011). Person-centered care- Ready for prime time. *European Journal of cardiovascular Nursing, 10*(4), 248-251.

Fall, M., Walters, S., Read, S., Deverill, M., Lutman, M., Milner, P., & Rodgers, R. (1997). An evaluation of a nurse-led ear care service in primary care: benefits and costs. *Br J Gen Pract*, *47*(424), 699-703.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse education today*, *24*(2), 105-112.

Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: a multidisciplinary review. *Bmj*, *327*(7425), 1219-1221.

Hansen, K. T., McDonald, C., O'Hara, S., Post, L., Silcox, S., & Gutmanis, I. A. (2017). A formative evaluation of a nurse practitioner-led interprofessional geriatric outpatient clinic. *Journal of interprofessional care*, *31*(4), 546-549.

Hill, K., Mangovski-Alzamora, S., Blouin, M., Guyatt, G., Heels-Ansdell, D., Bragaglia, P., ... Goldstein, R. (2010). Disease-specific education in the primary care setting increases the knowledge of people with chronic obstructive pulmonary disease: a randomized controlled trial. *Patient education and counseling*, *81*(1), 14-18.

Holmström, I. K., Nokkoudenmäki, M. B., Zukancic, S., & Sundler, A. J. (2016). It is important that they care–older persons' experiences of telephone advice nursing. *Journal of clinical nursing*, *25*(11-12), 1644-1653.

King, A. I. I., Boyd, M. L., Dagley, L., & Raphael, D. L. (2017). Implementation of a gerontology nurse specialist role in primary health care: Health professional and older adult perspectives. Journal of Clinical Nursing, 1-12.

Kristensson Uggla, B. (2014) Personfilosofi – filosofiska utgångspunkter för personcentrering inom hälso- och sjukvård. I I. Ekman (Red.), *Personcentrering inom hälso- och sjukvård: från filosofi till praktik.* (pp. 21 68). Stockholm: Liber.

Kristensson, J., Rahm Hallberg, I., & Jakobsson, U. (2007). Healthcare consumption in men and women aged 65 and above in the two years preceding decision about long-term municipal care. *Health and Social Care in the Community, 15*(5), 474–485.

Lennartsson, C. & Heimerson, I. (2009). Folkhälsorapport 2009. Retrived from the website of Socialstyrelsen: https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8495/2009 126-71.pdf

Ligthart, S. A., van den Eerenbeemt, K. D., Pols, J., van Bussel, E. F., Richard, E., & van Charante, E. P. M. (2015). Perspectives of older people engaging in nurse-led cardiovascular prevention programmes: a qualitative study in primary care in the Netherlands. *Br J Gen Pract*, *65*(630), e41-e48.

Löfdahl, C. G., Tilling, B., Ekström, T., Jörgensen, L., Johansson, G., & Larsson, K. (2010). COPD health care in Sweden–a study in primary and secondary care. *Respiratory medicine*, *104*(3), 404-411.

McPherson, C. P., Swenson, K. K., Pine, D. A., & Leimer, L. (2002). A nurse-based pilot program to reduce cardiovascular risk factors in a primary care setting. *The American journal of managed care*, *8*(6), 543-555.

Nilsson, A., Edvardsson, D., & Rushton, C. (2019). Nurses' descriptions of person centred care for older people in an acute medical ward—On the individual, team and organisational levels'. *Journal of clinical nursing*, *28*(7-8), 1251 1259.

Northern Nurses´ Federation. (2003). *Ethical guidelines for nursing research in the Nordic countries.* Retrived 2019 February 12 from http://ssn-norden.dk/wp content/uploads/2016/01/SSNs-etiske retningslinjer.pdf?fbclid=IwAR0lx35rdHZHPvEpmWu1 wCmOAtshQj0zr21hhAwyjUAs812sLtQZPLwhmw

Polit, D. F., & Beck, C. T. (2016). *Nursing research Generating and Assessing Evidence for Nursing Practice* (10. ed.). Philadelphia: Wolters Kluwer.

Region Skåne. (2018). *Förfrågningsunderlag för Avtal avseende Vårdcentral I Vårdval Skåne gällande år 2019- Förtydligande till förändringar.* Retrived 2019 January 2 from https://vardgivare.skane.se/siteassets/4.-uppdrag-och avtal/lov-lol-lof/ackreditering---fillistning/fortydligande-vc-2019.pdf

Rhodes, P., Campbell, S., & Sanders, C. (2016). Trust, temporality and systems: how do patients understand patient safety in primary care? A qualitative study. *Health Expectations*, *19*(2), 253-263.

Shaller, D. (2007). Patient-centered care: What does it take? (Commonwealth Fund pub. no. 1067). Retrived from the website of The Commonwealth Fund: https://www.commonwealthfund.org/sites/default/files/documents/___media_ iles_publications_fund_report_2007_oct_patient_centered_care__what_does_ t_take_shaller_patient_centeredcarewhatdoesittake_1067_pdf.pdf

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63-75.

Sridhar, M., Dawson, S., Roberts, N., & Partridge, M. (2007). A nurse led intermediate care package in patients who have been hospitalised with an acute exacerbation of chronic obstructive pulmonary disease. *BMJ*, 63(3), 194-200.

Statistiska centralbyrån. (2018). Störst folkökning att vänta bland de äldsta. Retrived 2019 January 2 from https://www.scb.se/hitta-statistik/statistik-efter amne/befolkning/befolkningsframskrivningar/befolkningsframskrivningar/po g/statistiknyhet/sveriges-framtida-befolking-20182070/

Swan, M., Ferguson, S., Chang, A., Larson, E. & Smaldone, A. (2015). Quality of primary care by advanced practice nurses: a systematic review. International Journal for Quality in Health Care, 27(5), 396-404.

Theander, E., & Edberg, A. K. (2005). Preventive home visits to older people in Southern Sweden. *Scandinavian journal of public health*, *33*(5), 392-400.

Trivedi, D., Goodman, C., Gage, H., Baron, N., Scheibl, F., Iliffe, S., ... & Drennan, V. (2013). The effectiveness of inter-professional working for older people living in the community: a systematic review. *Health & social care in the community*, *21*(2), 113-128.

Tøien, M., Bjørk, I. T., & Fagerström, L. (2015). Older users' perspectives on the benefits of preventive home visits. *Qualitative health research*, *25*(5), 700 712.

Voogdt-Pruis, H. R., Beusmans, G. H., Gorgels, A. P., Kester, A. D., & Van Ree, J. W. (2010). Effectiveness of nurse-delivered cardiovascular risk management in primary care: a randomised trial. *Br J Gen Pract*, *60*(570), 40-46.

Waterworth, S., Raphael, D., Parsons, J., Arroll, B., & Gott, M. (2018). Older people's experiences of nurse–patient telephone communication in the primary healthcare setting. *Journal of advanced nursing*, *74*(2), 373-382.

World Medical Association. (2018). WMA declaration of helsinki – ethical principles for medical reserch involving human subjects. Retrieved 2019 February 13 from https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical principles-for-medical-research-involving-human subjects/?fbclid=IwAR39gGh-MVDg0p-w 135NvZjx_rS5KRJrAs5tGMQinU3XJcAsC8XkfFp33g

Wolf, A., Moore, L., Lydahl, D., Naldemirci, Ö., Elam, M., & Britten, N. (2017). The realities of partnership in person-centred care: a qualitative interview study with patients and professionals. *BMJ open*, *7*(7), e016491.

Zakrisson, A. B., Theander, K., & Anderzén-Carlsson, A. (2014). How life turned out one year after attending a multidisciplinary pulmonary rehabilitation programme in primary health care. *Primary health care research & development*, *15*(3), 302-311.

Intervjuguide

Vi vill intervjua dig om dina upplevelser av äldrevårdsmottagningen på din vårdcentral.

Huvudfråga:
Berätta om dina upplevelser av äldrevårdsmottagningen?

Följdfrågor:
Kan du berätta om ditt senaste besök på äldrevårdsmottagningen? Du behöver inte berätta vad du gjorde där, men gärna kring dina upplevelser av detta besök och vad som du upplevde som bra och dåligt med detta besök.
Vad är dina förväntningar av äldrevårdsmottagningen?
Vilken betydelse har äldrevårdsmottagningen för dig och hur har den hjälpt dig?
Vad är skillnaden för dig av att gå via äldrevårdsmottagningen istället för vanliga vårdcentralen?
Har du berättat för dina vänner om äldrevårdsmottagningen och om ja, vad berättade du då?
Om du hade fått önska, hur tycker du äldrevårdsmottagningen skulle fungerat?
Finns det något du vill berätta mer om eller utveckla?

Frågor för att fördjupa innehållet i frågorna:
Kan du ge exempel på...
Berätta mer om…
Kan du utveckla eller förtydliga…?
Kan du beskriva en situation?
På vilket sätt…?

Table 1 Characteristics of the study participants (n = 12)

Characteristics	Number of participants (n=12)
Age (range 79-92, median 82,5)	
Did you know about the geriatric clinic before you got in contact with it?	
Yes	4
No	8
How long have you been in contact with the geriatric clinic for?	
1-6 months	0
6-12 months	1
1-2 years	4
More than 2 years	7
How often do you visit the geriatric clinic?	
Every week	2
Once a month	4
Once every 6’th months	6

Table 2 Example of the content analysis

Meaning units	***Condensed meaning units***	***Code***	***Sub-categories***	***Categories***
"The thing that is good about calling the geriatric-phone is that it's always the same nurse and she knows me and my health problems"	Same nurse that knows the patient and the health problems	Patient awareness	Gives a sense of continuity	The importance of having a permanent contact
"If I don't leave a message when I call her she can see the missed call and will then call me back"	Nurse returns missed calls	Reliable	Adds security	The importance of having a permanent contact

Table 3 Overview of categories and sub-categories

Sub-categories	***Categories***
Gives a sense of continuity *Adds security*	The importance of having a permanent contact
Preventive measures *Coordinated care* *Access*	The content of the geriatric clinic

Brev till verksamhetschef:

Till verksamhetschef

Förfrågan om tillstånd att genomföra studien ”Patienters upplevelse av äldrevårdsmottagning”.

Äldrevårdsmottagningar har blivit vanliga inom primärvården och vänder sig till personer som är 75 år och äldre. Syftet med äldrevårdsmottagningen är att patienter ska få ökad tillgänglighet till vård, ökad trygghet och kontinuitet. Det finns, trots stora ekonomiska satsningar, sparsamt med studier kring denna typ av mottagning, varför det vore intressant att undersöka detta.

Vi önskar intervjua patienter över 75 år som har regelbunden kontakt (minst 4 besök/år) med äldrevårdsmottagningen. Deltagarna får inte lida av minnessvårigheter eller demens. Vår önskan är att intervjua cirka 12 personer och från er vårdcentral önskas kontakt med 4-5 patienter. Intervjun beräknas ta 30-45 minuter. Intervjun kommer hållas på en plats som deltagaren väljer.

Efter godkänt samtycke från dig kommer kontakt med berörd äldrevårdssjuksköterska tas. Därefter lämnar sjuksköterskan informationsbrev till tänkbara deltagare som vid intresse av att delta i studien, meddelar sjuksköterskan om detta. Författarna kommer därefter kontakta de patienter som lämnat intresse för att medverka i studien och därefter kommer tid för intervju att bokas. Samtyckesblanketten fylls i av patienten och lämnas vid intervjun. Allt intervjumaterial kommer vara kodat och förvaras på ett USB som endast författarna och handledaren har tillgång till. Intervjumaterialet kommer förstöras när uppsatsen godkänts. De bearbetade intervjuerna kommer att redovisas på gruppnivå så att inga enskilda personer kan identifieras.

Ansökan kommer att skickas till Vårdvetenskapliga etiknämnden (VEN) för rådgivande yttrande innan den planerade studien genomförs.

Allt material kommer att förvaras inlåst på ett USB som enbart författarna och handledare har tillgång till.

Studien ingår som ett examensarbete i Distriktssköterskeprogrammet.

Om Du har några frågor eller vill veta mer, kontakta gärna oss.

Brev till sjuksköterska:

Till sjuksköterska på äldrevårdsmottagning

”Patienters upplevelse av äldrevårdsmottagning”

Vi skulle uppskatta om du ville vara behjälplig med att tillfråga äldre personer (75+) som regelbundet har kontakt med er äldrevårdsmottagning till ovanstående studie.

Äldrevårdsmottagningar har blivit vanliga inom primärvården och vänder sig till personer som är 75 år och äldre. Syftet med äldrevårdsmottagningen är att patienter ska få ökad tillgänglighet till vård, ökad trygghet och kontinuitet. Det finns, trots stora ekonomiska satsningar, sparsamt med studier kring denna typ av mottagning, varför det vore intressant att undersöka detta.

Vi önskar intervjua patienter över 75 år som har regelbunden kontakt (4 besök/år) med äldrevårdsmottagningen. Deltagarna får inte lida av minnessvårigheter eller demens och måste vara svensktalande. Vår önskan är att intervjua cirka 12 personer och från er vårdcentral önskas kontakt med 4-5 patienter. Intervjun beräknas ta 30-45 minuter. Intervjun kommer hållas på en plats som deltagaren väljer. Vid deltagande kommer samtyckesblankett fyllas i och intervjuerna kommer att spelas in. Intervjumaterialet förvaras på ett säkert sätt och endast författarna och handledaren har tillträde till det och efter uppsatsen är godkänd förstörs intervjumaterialet.

Vi skulle önska att du förmedlar informationsbrev till cirka 4-5 patienter inom önskad urvalsgrupp som kan vara tänkbara deltagare i vår studie. Patienterna anmäler därefter sitt intresse till dig om de önskar delta i studien. Därefter önskar vi att få tillgång till personens namn och telefonnummer så att kontakt kan tas.

Deltagande i studien är frivilligt och deltagaren kan när som helst avbryta utan att behöva ange orsak. Information deltagaren lämnar kommer att behandlas konfidentiellt, d.v.s. så att inte någon obehörig får tillgång till den. De bearbetade intervjuerna kommer att redovisas på gruppnivå så att inga enskilda personer kan identifieras.

Studien ingår som ett examensarbete i Distriktssköterskeprogrammet.

Om Du har några frågor eller vill veta mer, kontakta gärna oss.

Appendix 7 (8)

Brev till deltagare:

Patienters upplevelse av äldrevårdsmottagning

Du tillfrågas om deltagande i ovanstående intervjustudie.

Äldrevårdsmottagningar har blivit vanliga inom primärvården och vänder sig till personer som är 75 år och äldre. Syftet med äldrevårdsmottagningen är att patienter ska få ökad tillgänglighet till vård, ökad trygghet och kontinuitet. Det finns, trots stora ekonomiska satsningar, sparsamt med studier kring denna typ av mottagning, varför det vore intressant att undersöka detta.

Vi skulle vilja göra en intervju med Dig. Den beräknas ta cirka 30 - 45 min och genomförs av Charlotta Simmons eller Jasmine Hylkén. Vi erbjuder plats för intervjun alternativt att DU själv föreslår plats.

Med Din tillåtelse vill vi gärna spela in intervjun. Inspelningen kommer att förvaras inlåst.

Studien är inte på uppdrag av hälso- och sjukvårdens verksamhet och kommer därmed inte påverka din kontakt med äldrevårdsmottagningen. Intervjun är en del av en magister uppsats vid Lunds Universitet. Deltagandet är helt frivilligt och Du kan avbryta när som helst utan att du behöver ange varför. Den information Du lämnar kommer att behandlas konfidentiellt, d.v.s. så att inte någon obehörig får tillgång till den.

Om Du vill delta ber vi Dig underteckna samtyckesblanketten och överlämna den i samband med intervjun.

Allt material kommer att förvaras inlåst på ett USB som endast författarna och handledaren har tillgång till.

Studien ingår som ett examensarbete i Distriktsköterskeprogrammet.

Om Du har några frågor eller vill veta mer, kontakta gärna oss.

Background depth

Theoretical framework

The study´s theoretical framework is based on person-centred care (PCC). PCC is according Kristensson Uggla (2014), based on three elements, the patient's story, partnerships and documentation, which together reinforce each other. It is the patient's life-situation that should be focused on in PCC and not the patients´ condition. The patients' story is the foundation in the partnership between the patient and health-care personnel when planning the patients care and treatment. To facilitate the partnership the patients´ experience and beliefs should be documented (ibid.). In PCC the patient is involved in the decision-making of the care and the starting point should be the person's condition and life-situation. Furthermore, it is of importance to get to know the person behind the patient and not just the patient's condition (Ekman at al., 2011; Ekman, et al., 2014). To be able to build a relationship between patient and personnel, the patient's story is the key to PCC (Ekman, et al., 2014). To be able to give the right care the geriatric-nurse is basing her work on the patient's history since all patients have different conditions and life-situations. All care should be person-centred but although staff believes they work according to PCC, only some of them work consistently and systematically with PCC. With PCC the environment have shown to become more hospitable (Edvardsson, Sandman and Borell, 2014). Moving away from medical practice with minimum communication into open communication, PCC involves all aspects of the patient and its care (Shaller, 2007). In primary, it was shown that a nurse-led personalised plan and self-management education reduced the need for unscheduled visits (Sridhar, Dawson, Roberts & Partridge, 2007).

Older persons national and international

Seventeen percent of Sweden's population is 65 years and older and this figure is expected to increase during the following years (Lennartsson & Heimerson, 2009). The Swedish population has increased during the last couple of years and in year 2028 the population is estimated to be 11 million. The same year, Swedish people

aged 80 years or older are estimated to be 50 percent more than today (SCB, 2018). Furthermore, the World Health Organisation (WHO, 2017) expects the percentage of older persons globally to increase between years 2015 to 2050 from 12 to 22 percent. As older persons often have multiple chronic conditions or geriatric syndromes it is important that the healthcare-system can provide care that is suitable for them. The care should be person-centred and integrated and focus on maintaining capacities. Today many countries are ill -prepared for this increasing need (ibid.).

Older persons health

The increased life expectancy means a longer period of illness and that older people are likely to suffer from multiple diseases. This can affect the person's quality of life, the functional ability of the older person and increase the need for help from the healthcare system. Common physical problems or diseases among older persons can be osteoporosis, heart and vascular disease, cancer, impaired vision / hearing, dementia, stroke, heart attack, malnutrition, obesity and incontinence. Due to social, biological and psychological factors, the risk of an older person to suffer from mental illness, sleeping disorder or anxiety also increases with age. Older persons don’t have enough knowledge about their diseases or the risk of malnutrition, drug related problems, risk for falling and the increasing risk of anxiety. With a nurse-led geriatric clinic these concerns can be taken care of with PCC. Among the oldest persons (85+), every fifth man and every third woman are estimated to suffer from anxiety. Persons with comorbidity are in need of coordination within healthcare, which there unfortunately is a great shortage of today (Lennartsson & Heimerson, 2009). Preventive care for older persons with multiple diseases reduces the number of hospital stays and emergency-visits (Kristensson, Rahm Hallberg & Jakobsson, 2007). With a self-management education and a nurse-led personalised plan, the need for unscheduled visits was reduced in primary care (Sridhar, Dawson, Roberts & Partridge, 2007). Primary healthcare is currently working on a compensation system where quick visits are encouraged. This makes it more difficult for older persons with multiple diseases that often have several and complex problems. A nurse-led geriatric clinic has better access and more time for these people with multiple diseases, so that all complex problems can be addressed (Lennartsson & Heimerson, 2009).

The primary healthcares responsibility

The social service act (SFS 2017:30) describes that patients are entitled to choose a permanent medical contact within primary healthcare. The “treatment guarantee” claims that patients should be able to get in contact with their primary unit within a certain time. The primary unit has the responsibility for the patients planned care. The primary care is according to the social service act, care with no limitation regarding age, diseases or patient groups. They also has the responsibility for basic medical treatment, nursing, preventive work and rehabilitation (ibid.).

The role of the district nurse

The district nurse role includes working to promote health, to prevent disease, restoring heath, relieve suffering and treat the person and family in all stages of life based on mental, physical, cultural, social and existential health. The district nurse react to changes in health status and have advanced knowledge to adequately address these. He or she also use techniques, such as PCC, to strengthen the patient´s decision-making and power (Svensk sjuksköterskeförening, 2008). To be able to deliver good care and to work person-centred at the nurse-led geriatric clinic, studies that show patients experience are of great importance.

Nurse-led clinics and interventions

Nurse-led clinics in primary healthcare started to pop up in the 1980´s. The most common ones are for persons with asthma and chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), diabetes, hypertension, incontinence and addiction. The clinic must have a district nurse or a nurse with special education with at least 7,5-15 credits within the field. At the clinic a district nurse and a doctor cooperates with other professions. A part of the foundation in the clinics structure is PCC, education and preventive measures (Drevenhorn & Österlund Efraimsson, 2013). A specialised nurse with expanded knowledge is of great importance for the

older person and its care. It is necessary that the specialist nurse can identify possible problems and have good solving abilities (King, Boyd, Dagley & Raphael, 2017).

According to Region Skåne accreditation (2018) a primary care unit with at least 250 older persons listed, can initiate a nurse-led geriatric clinic for persons that are 75 years or older. The accreditation determines that information must be given both verbally and on the units´ website and 1177.se. Patients must have access to a separate phone for at least 10 hours per week, with no button selection. The clinic must have access to a specialist-nurse (a public health nurse or a geriatric-nurse) and a doctor in general medicine or geriatrics. The nurse and / or doctor must have the opportunity to do home visits (ibid.). It is not evaluated whether the accreditation is enough to deliver good care that are adapted to the older persons preferences and needs or if more guidance is needed.

Until today, very few studies have been done about nurse-led geriatric clinics, although many studies have evaluated nurse-led clinics in more specific conditions such as COPD and CVD. According to Swan, Ferguson, Chang, Larson and Smaldone (2015) a special nurse-led clinic utilizes longer time compared to a doctors consultations because the nurse educate the patients. This leads to fewer consultations over time and is more cost effective (ibid.). Nurse-led ear-care in primary healthcare increased patients' knowledge about how to care for their ears and the patients were more satisfied with the treatment. The study also showed reduced treatment costs and reduced use of antibiotics (Fall et al., 1997).

A nurse-led structured pedagogical intervention program in primary healthcare with patients who has COPD shows a reduction of symptoms. The patients' activities increased and the impact of COPD decreased on their psychosocial health (Efraimsson, Hillervik & Ehrenberg, 2008). With nurse-led education the exacerbations decreased (Löfdahl, Tilling, Ekström, Jörgensen, Johansson & Larsson, 2010) and the knowledge increased (Hill et al., 2010). Through PCC-education the patients' perceptions and limitations with the disease COPD improved. The patient accepted the disease, reduced concern for the disease and increased quality of life that led to a lifestyle change. Some reduced their medication and stopped smoking. Through continuous and regular follow-up and confidence in healthcare the disease

awareness increased (Zakrisson, Theander & Anderzén-Carlsson, 2014). With the experience from older persons about the nurse-led geriatric clinic, the clinics can work to increase the safety of the patient and reduce hospital admissions and visits to primary care.

Patients underwent a nursing based intervention program to reduce CVD risk factors that included risk assessment, patient education and guidance. The result shows significant reduction in blood pressure, cholesterol and tobacco use (McPherson, Swenson, Pine & Leimer, 2002). People with CVD who did their follow-up with a nurse instead of a doctor got consultation about the risk factors. The results in the nurse-led group showed that cholesterol had changed for the better (Voogdt-Pruis, Beusmans, Gorgels, Kester & Van Ree, 2010).

A study by Hansen et al. (2017) shows that a nurse-led clinic specialising in geriatric problems is successful and appreciated by both patients and caregivers. The patients felt that they were being listened to and that their needs were being taken care of (ibid.). This study is of great importance for geriatric clinics, but further research is needed to be able to understand the preferences and needs of the older person.

REFERENCES

Drevenhorn, E., & Österlund Efraimsson, E. (2013). Distriktssköterskans mottagningar. I C. Bökberg (red) *Omvårdnad i primärvården* (ss. 125-143). Lund: Studentlitteratur.

Edvardsson, D., Sandman, P. O., & Borell, L. (2014). Implementing national guidelines for person-centered care of people with dementia in residential aged care: effects on perceived person-centeredness, staff strain, and stress of conscience. *International Psychogeriatrics*, *26*(7), 1171-1179.

Efraimsson, E. Ö., Hillervik, C., & Ehrenberg, A. (2008). Effects of COPD self-care management education at a nurse-led primary health care clinic. *Scandinavian journal of caring sciences*, 22(2), 178-185.

Ekman, I., Norberg, A., & Swedberg, K. (2014) Tillämpning av personcentrering inom hälso- och sjukvård. I I. Ekman (Red.), *Personcentrering inom hälso- och sjukvård: från filosofi till praktik.* (pp. 69-97). Stockholm: Liber

Ekman, I., Swedberg, K., Taft, C., Lindstedt, A., Norberg, A., Brink, E., ... Stibrant Sunnerhagen, K. (2011). Person-centered care- Ready for prime time. *European Journal of cardiovascular Nursing*, *10*(4), 248-251.

Fall, M., Walters, S., Read, S., Deverill, M., Lutman, M., Milner, P., & Rodgers, R. (1997). An evaluation of a nurse-led ear care service in primary care: benefits and costs. *Br J Gen Pract*, *47*(424), 699-703.

Hansen, K. T., McDonald, C., O'Hara, S., Post, L., Silcox, S., & Gutmanis, I. A. (2017). A formative evaluation of a nurse practitioner-led interprofessional geriatric outpatient clinic. *Journal of interprofessional care*, *31*(4), 546-549.

Hill, K., Mangovski-Alzamora, S., Blouin, M., Guyatt, G., Heels-Ansdell, D., Bragaglia, P., ... Goldstein, R. (2010). Disease-specific education in the primary care

setting increases the knowledge of people with chronic obstructive pulmonary disease: a randomized controlled trial. *Patient education and counseling*, *81*(1), 14-18.

King, A. I. I., Boyd, M. L., Dagley, L., & Raphael, D. L. (2017). Implementation of a gerontology nurse specialist role in primary health care: Health professional and older adult perspectives. Journal of Clinical Nursing, 1-12.

Kristensson Uggla, B. (2014) Personfilosofi – filosofiska utgångspunkter för personcentrering inom hälso- och sjukvård. I I. Ekman (Red.), *Personcentrering inom hälso- och sjukvård: från filosofi till praktik.* (pp. 21-68). Stockholm: Liber.

Kristensson, J., Rahm Hallberg, I., & Jakobsson, U. (2007). Healthcare consumption in men and women aged 65 and above in the two years preceding decision about long-term municipal care. *Health and Social Care in the Community, 15*(5), 474–485.

Lennartsson, C. & Heimerson, I. (2009). Folkhälsorapport 2009. Retrived from the website of Socialstyrelsen: https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8495/2009-126-71.pdf

Löfdahl, C. G., Tilling, B., Ekström, T., Jörgensen, L., Johansson, G., & Larsson, K. (2010). COPD health care in Sweden–a study in primary and secondary care. *Respiratory medicine*, *104*(3), 404-411.

McPherson, C. P., Swenson, K. K., Pine, D. A., & Leimer, L. (2002). A nurse-based pilot program to reduce cardiovascular risk factors in a primary care setting. *The American journal of managed care*, *8*(6), 543-555.

Region Skåne. (2018). *Förfrågningsunderlag för Avtal avseende Vårdcentral I Vårdval Skåne gällande år 2019- Förtydligande till förändringar*. Retrived 2019 January 2 from https://vardgivare.skane.se/siteassets/4.-uppdrag-och-avtal/lov-lol-lof/ackreditering---fillistning/fortydligande-vc-2019.pdf

SFS 2017:30. *Hälso- och sjukvårdslagen.* Stockholm: Socialdepartementet.

Shaller, D. (2007). Patient-centered care: What does it take? (Commonwealth Fund pub. no. 1067). Retrived from the website of The Commonwealth Fund: https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2007_oct_patient_centered_care__what_does_it_take_shaller_patient_centeredcarewhatdoesittake_1067_pdf.pdf

Sridhar, M., Dawson, S., Roberts, N., & Partridge, M. (2007). A nurse led intermediate care package in patients who have been hospitalised with an acute exacerbation of chronic obstructive pulmonary disease. *BMJ,* 63(3), 194-200.

Statistiska centralbyrån. (2018). Störst folkökning att vänta bland de äldsta. Retrived 2019 January 2 from https://www.scb.se/hitta-statistik/statistik-efter-amne/befolkning/befolkningsframskrivningar/befolkningsframskrivningar/pong/statistiknyhet/sveriges-framtida-befolking-20182070/

Svensk sjuksköterskeförening. (2008). *Kompetensbeskrivning för legitimerad sjuksköterska med specialistsjuksköterskeexamen Distriktssköterska*. Retrieved 2019 February 13 from https://www.swenurse.se/globalassets/01-svensk-sjukskoterskeforening/publikationer-svensk-sjukskoterskeforening/kompetensbeskrivningar-publikationer/distriktskoterksa.kompbeskr.webb.pdf

Swan, M., Ferguson, S., Chang, A., Larson, E. & Smaldone, A. (2015). Quality of primary care by advanced practice nurses: a systematic review. International Journal for Quality in Health Care, 27(5), 396-404.

Voogdt-Pruis, H. R., Beusmans, G. H., Gorgels, A. P., Kester, A. D., & Van Ree, J. W. (2010). Effectiveness of nurse-delivered cardiovascular risk management in primary care: a randomised trial. *Br J Gen Pract*, *60*(570), 40-46.

World Health Organization. (2017). 10 facts on ageing and health. Retrieved 2018 November 21 from https://www.who.int/features/factfiles/ageing/en/

Zakrisson, A. B., Theander, K., & Anderzén-Carlsson, A. (2014). How life turned out one year after attending a multidisciplinary pulmonary rehabilitation programme in primary health care. *Primary health care research & development, 15*(3), 302-311.