CONTINUITY OF CARE FOR OLDER ADULTS IN A LONG-TERM CARE SETTING

Master's Thesis

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ABSTRACT

In Ontario, the population of older adults is increasing. While the provincial government is taking action to address increasing demand on health systems, older adults are still suffering the consequences of a health system that is not able to meet their complex care needs. Older adults face barriers to continuity of care including difficulties with memory, reliance on informal caregivers, frailty, and difficulties scheduling appointments. These barriers also exist within the long-term care setting. Long-term care facilities are making efforts to provide more effective care, including designing care approaches aimed to meet the complex care needs of older adults. Aspects of a goal-oriented approach suggest that it has the potential to reduce fragmentation and positively impacting continuity of care. However, the impact of goal-oriented care on continuity of care in a long-term care setting has yet to be explored. This thesis uses an exploratory case study methodology to describe how a goal-oriented care approach influenced continuity of care in a long-term care setting, as perceived by residents, staff, and administrators. The case study setting is the Perley & Rideau Veterans Health Centre in Ottawa, Ontario, where the *SeeM*e program, a frailty-informed approach with a goal-oriented component, was recently introduced. Factors associated with the *SeeMe* program and other organizational factors perceived to facilitate and inhibit informational, relational and management continuity were identified. Aspects of the *SeeMe* program that facilitated informational continuity were: goals-of-care meetings with residents, their care team and family; care conferences that helped residents understand their care options; and, procedures that ensured consistency in where resident's goal information is stored. Aspects that facilitated relational continuity were: understanding residents' values and preferences; staff increasing awareness of the program for families; and, integration of the family perspective into a resident's care. Program aspects that facilitated management continuity were: discussions that led to informed decision-making; use of assessments as a reference tool in the case of an acute health event; discussions that empowered residents to talk to external care providers; and, creation of a structure that facilitated consistencies in care. These factors can be targeted when designing care approaches aimed to improve continuity in long-term care settings.

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I would like to dedicate this thesis to the 12 residents of the Perley & Rideau Veterans Health Centre who passed away during the pandemic of 2020, and to all long-term care residents and their families.

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CHAPTER 1: INTRODUCTION

1.1. Background

The population of older adults in Canada is expected to increase from 17% to 21% of the Canada's population in the next 10 years (1). In anticipation of this projected increase, Canadian provinces are launching plans for older adults, including Ontario's 2017 action plan Aging with Confidence which aimed to, "…help older adults remain independent, healthy, active, safe and socially connected" (2). The action plan outlined Ontario's progress toward supporting older adults including, for example, removing the Ontario Drug Benefit Program deductible, investing $11.5 million annually to support Senior Active Living Centres, introducing free exercise and falls prevention classes for seniors, establishing community paramedicine programs, significantly increasing home care funding, and increasing the number of long-term care beds across the province.

As a consequence of greater efforts to help older adults remain independent at home, they are entering long-term care settings when they are older, frailer and in need of more assistance than in the past (3). In Canada, long-term care facilities are provincially legislated facilities that provide living accommodations for people who require 24 hour care (4). This means that these facilities must operate under strict regulations, including adherence to the Resident Assessment Instrument, a tool that collects data on indicators for monitoring care in long-term care facilities (5). There are currently 626 licensed long-term care facilities in Ontario, 58% of which are privately owned, 24% are non-profit organizations, and 16% are municipally owned (3).

There has been increased attention to providing effective, high quality care to older adults. Continuity of care has been proven to improve resident satisfaction, improve health status and decrease the use of hospital services (6). However, most research on continuity of care focuses on the primary care setting, and relatively little work has been done to assess continuity of care in long-term care settings. (6). The concept of continuity of care is “the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the residents’ medical needs and personal context” (7). Current long-term care research supports continuity of care as a way to achieve desirable outcomes in a long-term care setting (6,8,9), but there is little research on how to achieve continuity of care in this setting. This thesis examines continuity of care in a long-term care setting.

1.2. Review of Literature

In this section I review the literature on goal-oriented care approach and provide context as to what this approach looks like in practice. Since goal-oriented care is a relatively new approach to care, its effects on continuity of care have yet to be explored. To understand the potential link between goal-oriented care and continuity of care, these concepts will be outlined in general, and then continuity of care for older adults will be explored in more depth. Finally, I provide an overview of the long-term care context in Ontario and describe continuity of care in this context.

Goal-Oriented Care

Multimorbidity has been referred to as the most common chronic condition, as it is rare for people to have only a single chronic condition (10). Despite this, care delivery and assessments of quality of care in health settings are often based on disease-specific processes that focus on condition-specific indicators (11). While these approaches to treatment and measurement may be effective for patients with one condition, they are likely inadequate for patients who have multiple coexisting conditions.

Goal-oriented care is a different approach to care for individuals with multiple chronic conditions, focusing on a patient's health goals across physical and social dimensions (12). Goal-oriented care involves the patient outlining their preferences and care goals, and then the patient and physician working together to determine a care plan that aligns with those priorities (12). For example, if a person living with arthritis and cancer wants to go to church on Sunday, their care plan may include control of pain to perform this activity, versus just a disease-specific plan to treat the cancer.

A goal can be defined "as a state or change in state that an intervention or course or action intends to achieve" (13). The application of this definition is seen in clinical practice and health systems research. Definitions of goal-setting in goal-oriented care often involve a collaborative process between patients and care providers and often include family and/or caregivers to set "goals of care" (14). The collaborative process of setting goals in this way is closely related to the concept of shared decision making, a process where clinicians and patients work together to make decisions (15). The concept and ideas around goal-oriented care are also closely linked to concepts such as care planning, person-centered care, and collaboration (16).

In their seminal paper on goal-oriented care, Mold and colleagues compared the approach with a more traditional problem-oriented approach (12). They highlighted a major difference in the way health is defined, from "absence of diseases as defined by the healthcare system" in a problem-oriented model, to "maximum desirable and achievable quality of life as defined by each individual" in a goal-oriented care approach (12). Reuben et al. outline this difference is a unique advantage of the goal-oriented approach, as by treating patients in terms of their individual desires, rather than universally applied health guidelines, a patient's perceptions of certain healthcare treatments and their potential effects can be taken into account to work toward achieving a specific individuals maximum quality of life (11). With the definition of health redefined in a goal-oriented approach, the purpose of healthcare shifts from preventing death and eliminating disease to achieving the maximum health potential for a patient (12). In a goal-oriented care approach, it is the patient that evaluates their success, rather than the physician. Success of a goal-oriented approach to care is measured by the degree to which patients' goals are met, rather than the outcomes of their health conditions.

In a traditional problem-oriented approach, the health of an individual is addressed by a process of diagnostic assessment, a decision on appropriateness of treatment and efforts to treat the disease (12). In a goal-oriented approach, the process starts with defining health goals for a specific patient and then determining and implementing strategies that align, while focusing on encouragement, advocacy and empowerment. To treat a patient this way, both subjective and objective data is used. Information on their medical history, physical exams and other lab and test results is still required, however, additional information on values, strengths, resources, interests and needs is equally important. Reuben highlights that a goal-oriented approach often simplifies decision-making for patients with multiple conditions as the approach focuses on outcomes that span multiple conditions rather than prioritizing conditions and their treatments (11). As well, this approach to care helps patients articulate which health states are important to them, ensuring patients are in control when treatment options require trade-offs.

In practice, goal-oriented care discussions should begin with a conversation on the patient's priorities and concerns. It is often recommended that the patient prepares this information in advance to avoid feeling overwhelmed or forgetting information during this conversation. Charette et al. explain that the next step in this process is to assess what the patient knows about their own health status and medical conditions. This conversation involves discussing a patient's understanding of diagnoses and test results and considering trade-offs between various treatment options. At this point, the patient can start to develop goals, beginning with the goal of the highest priority to the patient. Charette et al. point out that putting aside personal interests and opinions and listening to a resident's goals and preferences requires a skill set that involves training of care providers (17). Goals should be documented and reassessed over time.

While the concept of goal-oriented care has been around for decades, as Mold et al.'s paper was among the first published on this concept in 1991 (12), goal-oriented care has recently reemerged in the health services literature. Few empirical studies on the effects of goal-oriented care have been conducted, however, there are a few recent studies that examine goal-oriented care in the primary care setting. One example of empirical research on a goal-oriented care model is the 2016 ISCOPE (Integrated Systematic Care for Older People) study by Blom et al. *(18).* The study included participants aged 75 and older with complex problems across 59 general practices in Leiden, Netherlands. The intervention, described as a proactive, goal-oriented, integrated care model, included GPs or practice nurses designing integrated care plans for their patients. To create the care plan, the GP or nurse first created an inventory of existing health problems, and then met with the older person and their informal caregiver to discuss their goals. After this discussion, the GP or nurse, together with the older adult, formulated actions and an evaluation plan for follow up. The control group received care as usual. The study authors found that GPs felt they had a better overview of care needs using the care plans, however, the older persons receiving the intervention care model showed no significant improvement in quality of life or functional status compared to those in the usual care group.

Another study by Steele Gray et al. assessed the usability and feasibility of an electronic tool designed to support goal-oriented primary care delivery, called the Patient Report Outcome (ePRO) tool (19). With the ePRO tool, patients and providers "collaboratively develop healthcare goals on a portal linked to a mobile device to help patients and providers track progress between visits." The study included six providers and 11 patients over a 4-week period. After the 4weeks, focus groups and interviews were conducted with patients and providers and data from the ePRO system was extracted. The authors found that some patients reported that the tool helped them self-manage, catalyzed a sense of responsibility of their care, and improved patient-centered care delivery. Providers found the tool helpful in focusing conversations on goal-setting, however; they found that the goal monitoring questions in the tool did not address individual patient needs, the tool did not fit well with provider workflow, and found the tool made daily reporting more time consuming. Based on the feedback from this pilot study, the tool is being redeveloped and retested.

While goal-oriented care is becoming more common in practice, there are barriers to this approach to care that often make it difficult to implement (17). These barriers can be classified into three categories: (1) system-level barriers; (2) clinician-level barriers; and, (3) patient-level barriers. System-level barriers include existing resource allocation that supports and incentivizes disease-oriented practices in medicine, time constrained patient-care provider encounters, and a lack of continuity of care across health settings. Clinician-level barriers include a lack of emphasis on a goal-oriented approach in academic curricula, lack of cultural competence required to effectively personal patients and their values, and a failure to adjust standards, values and the conceptualization of quality of life when a patient experiences changes in their health status. Finally, patient-level barriers include difficulty making decisions, variability in degree of health literacy, and setting of unrealistic goals (17). One review on the process of shared decision making highlighted that patients need both knowledge and power to participate in shared decision making and the power balance in the doctor-patient relationship often leaves patients with a lack of empowerment to make decisions about their care (20).

Researchers emphasize the importance of patient-centeredness in long-term care settings as a way of achieving better health outcomes for older adults (21); and, while goal-oriented care is considered a resident-focused approach to care (17), its influence on continuity of care has yet to be examined. In the next section, continuity of care will be defined, and the relevant issues explored.

Continuity of Care

As previously mentioned, Haggerty et al. define continuity of care as “the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patients’ medical needs and personal context” (7). Continuity can be considered both as the experience of care and the delivery of care (22). In terms of the experience of continuity, conceptually it is an evaluation of a person’s satisfaction with the “interpersonal aspects of care, and coordination of that care” (22). Delivery of care, on the other hand, focuses on aspects of service such as how a care team works together and case-management.

There are three types of care continuity: relational continuity, informational continuity, and management continuity. *Relational continuity* is described as the relationship between the resident and the care provider (23). According to Reid et al., this element of continuity acknowledges the importance of “knowledge of the patient as a person,” recognizing that the relationship between a patient and a provider is what connects care over time (24). This means that these ongoing therapeutic relationships do not only bridge discrete events in the past, they also provide a link to future care. For example, in the event of a new health problem, the patient would know who to contact. *Informational continuity* includes the use of information to make decisions for a patient's care. This type of continuity involves the use of information about past health events to make informed decisions about current health events (24). While there is usually more emphasis on documentation of health conditions, it is important to recognize that information on patient values, preferences, and their social context is also extremely important for effective informational continuity. Finally, *management continuity* describes the overall management of care, including care planning and care coordination (23). Care planning can be defined by "the process by which healthcare professional and patients discuss, agree, and review an action plan to achieve the goals or behaviour change most relevant to a patient" (25) and care coordination refers to "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services" (26)

Continuity of care looks different across healthcare settings (7). For example, according to Haggerty et al., in a primary care setting continuity of care is usually focused on the relationship between a single practitioner and a patient, beyond just specific episodes of illness. In contrast, in mental healthcare settings the experience of continuity is usually based on the relationship with a team of providers, specifically, the coordination of various services and the stability of the patient-provider relationship over time. Since care is provided by multiple providers in the mental healthcare setting, there is greater emphasis on care providers working together on a common purpose and plan. Similarly, in nursing literature on continuity there is a focus on care providers working together to provide coordinated care over time. In the nursing literature, the goal of maintaining a consistent approach to care across all nurses providing care to a patient is emphasized. Whereas in disease management literature, continuity of care is often described as a continuum of care, where various care providers deliver care in a coherent, logical and timely manner. This body of literature focuses on care protocols and management strategies to achieve continuous care.

The effect of continuity of care on patients, providers and the health system in various health settings has been examined by many studies in the past few decades. A systematic review conducted in 2010 by Van Walraven et. al that included studies examining continuity for ambulatory patients in the clinic, patients discharged from hospital and patients in the emergency department, concluded that there is a statistically significant association between increased continuity and decreased health resource utilization, as measured by hospitalization and emergency department visits (27). They also found an association between care continuity and increased patient satisfaction. Included studies focused primarily on provider continuity and highlighted that more research is required on the outcomes of information and management continuity. Another systematic review by Gray et al. in 2018, that included studies investigating continuity with a primary care physician or specialist, found that continuity of care increased patient satisfaction, reduced hospital use, and increased adherence to medication (6). The study highlighted the importance of a consistent care plan across care providers, as well as flexibility to adapt to changes in a patient’s care needs (24). Similarly, a systematic review by Koa et al. in 2019 found that increased continuity of care in outpatient settings was associated with fewer hospitalizations for people with ambulatory care sensitive conditions (28). These systematic reviews support the idea that continuity of care is desirable in long-term care settings as a means to help achieve better quality of care and health outcomes.

Continuity of Care for Older Adults

Many older adults experience fragmentation in their care due to the number of physicians and health teams with whom they need to interact, professionals who tend to work in silos with limited communication (29). Older adults are more vulnerable to siloed healthcare since they face barriers to accessing care including difficulties with memory, reliance on multiple informal caregivers, and difficulties scheduling and getting to appointments (30). As well, older adults are more likely to require specialized tests or procedures from providers who are not part of their regular care team, increasing the probability of a breakdown in coordination and continuity of care (31). These psychological and physical complexities experienced by older adults mean that an approach unique to this population and setting is required to achieve continuity of care. For example, Marshall et al. suggests that "frail older adults living in long-term care facilities have high rates of complex comorbidity and benefit from coordinated comprehensive primary care" (32).

Most research on continuity of care focuses on the primary care setting, and relatively little work has been done to assess continuity of care in long-term care settings. One of the few studies focusing on continuity of care in the long-term care setting was conducted to assess the new "Care by Design" program implemented in long-term care facilities in Halifax, Nova Scotia (32). After examining long-term care in Halifax, several concerns were identified through the Primary Care of the Elderly (PCOE) project including frustration among medical directors with the lack of care coordination, and a reduced number of family physicians working in long-term care settings. Further, there were high rates of transport from long-term care facilities to emergency departments. To address these concerns, in 2009 the Capital District Health Agency implemented the "Care by Design" model for long-term care facilities (32) that designated a ratio of one family physician for every 30 residents, with overnight calls shared by family physicians. The new model aimed to create an interdisciplinary approach to care that included regular meetings with care teams in an effort to provide better coordinated care, provide increased continuity of care, reduce ambulance transport rates to the ED, reduce rates of polypharmacy and reduce health care costs. The study evaluating this new model of care concluded that there was an improvement in continuity of care as well as decreased emergency department visits (32). The study identified four key features that facilitated continuity: (1) a “standard of care” agreement between facilities and physicians that included a physician’s responsibility to respond within 30 minutes to any requests from nurses; (2) physicians on site providing regular care at least one day a week; (3) care teams preparing for physician on-site days by prioritizing patient needs in advance of physician visits; and, (4) facilities participating in a new governance structure for all clinical activities to create consistency in medical care (e.g., notes in charts and care directives).

Another study was conducted in Norway in 2016 that examined patients’ and families’ perspectives of continuity of care in a long-term healthcare setting (33). In-person and telephone interviews were used to collect data to assess if the number of providers in a care team influenced the residents’ perception of continuity. The authors concluded that having more care providers was not a barrier to continuity of care, according to patients; however, patients with trusting relationships with their current providers were more likely to be open to having more care providers.

While long-term care facilities may have the potential to provide more continuous care due to the fact that care teams are working within one facility, research suggests that this is not the case (34). According to the Registered Nurses Association of Canada, long-term care funding has failed to keep up with increasing care needs (34). Funding supports 2.9 hours of care per day per resident, while research shows that just over 4 hours of care per day is required to avoid jeopardizing the health and safety of residents As such, there is little time for care providers to effectively record and transfer information, create the relationships with residents, and ensure consistency and flexibility in care required for a continuous care experience. As well, shift work and rotations can result in high staff turnover. Better aligned staff resources and increases in funding are required to keep pace with the complex needs of residents and facilitate continuity of care.

The Ontario Long-Term Care Context

Long-term care is an “umbrella concept used in Canada to describe a complex service delivery system comprising a full range of care and support for persons who have, or are at significant risk of having, progressive and/or chronic conditions, and who require services to meet their long-term functional needs” (35). Long-term care is the responsibility of the Ministry of Health in each province; however, not all provinces have legislated provisions for long-term care. Since each province has the autonomy to make choices on legislation for long-term care, the system varies across provinces. In this thesis, I focus on the Ontario context.

In June 2019, under the Ford provincial government, the Ministry of Health and Long-term Care were spilt into two separate ministries (36). Currently, in Ontario, long-term care is regulated under the 2007 Long-Term Care Homes Act (37), where care is contracted out by the provincial government to private corporations, publicly traded companies, non-profits, and municipal governments (3). Co-payments are required by residents for their long-term care residency, ranging from $1800-$2600 per month, depending on whether the room is private or semi-private, and with subsidies for residents who cannot afford the co-payment. To be eligible for long-term care in Ontario, a person must be “18 years of age or older, have a valid OHIP card, have care needs that include 24-hour nursing and personal care, frequent assistance with activities of daily living, and/or on-site supervision or monitoring to ensure safety or well-being, have care needs that cannot safely be met in community based services, and have care needs which can be met in a long-term care home" (38). Ontario has 628 long-term care homes providing care to over 78,000 residents (39). The average wait time for placement into long-term care in 2017 was 143 days, and approximately 34,000 people in Ontario were waiting for placement (3). Long-term care facilities must operate under strict regulations, including adherence to the Resident Assessment Instrument that aims to standardize the assessment and care planning process (5). This tool is designed to "collect the minimum amount of data to guide care planning and monitoring for residents in long-term care," and the data collected provides indicators for care quality at an individual and facility level (40). For example, data on accidents is reported through indictors on incidence of new fractures and prevalence of falls. Other data includes behavioural and emotional patterns, clinical management, cognitive patterns, elimination and continence, infection control, nutrition and eating, physical functioning, psychotropic drug use, quality of life and skin care.

The 2018 report from the Ontario Long-Term Care Association reported that a cultural shift is occurring in the long-term care context, from an older "institutional" model that focused on physical and medical care to a model that is "resident-centered," where care is provided through understanding an individual's needs (3). The National Institute on Aging in Canada outlines three principles to guide long-term care systems in Canada (41). These include: (1) "enabling evidence-informed integrated person-centered systems of long-term care"; (2) "supporting system sustainability and stewardship through improved financing arrangements, a strong healthcare workforce, and enabling technologies"; and, (3) "promoting the further adoption of standardized assessments and common metrics to ensure the provision of consistent and high-quality care no matter where Canadians need it.” The National Institute on Aging adopts the World Health Organization’s (WHO) model for an older-person-centered system of long-term care. The model puts the older person at the Centre of care with their needs dictating the support and services provided and the role that unpaid caregivers should play in the older persons healthcare. This model emphasises the importance of providing a range of support services and ensuring that care providers have the training to provide high quality of care. As well, a person-centered system must use available data to understand current utilization patterns, understand unmet needs, inform decision-making, promote research, share best practice and promote knowledge translation.

According to Health Quality Ontario, the current wait times for long-term care homes in Ontario is 161 days from the community or 90 days from the hospital. Numerous indicators point to low quality care, including: 19% of residents not living with psychosis are given antipsychotic medication, 16.6 % of residents have fallen, 3.9 % were physically retrained, 2.6% have pressure ulcers, 5.2% experience pain, and 22.8% have worsened symptoms of depression (42). One study of Ontario long-term care homes found that residents living in for-profit long-term care homes had an adjusted 10% higher risk of mortality and 25% higher risk of hospitalization in the 3 months immediately after admission (43). The differences in outcomes in for-profit homes in comparison with not-for-profit homes has been hypothesized to be related to reinvestments into patient care that occur in not-for-profit homes that would be considered profit in for-profit facilities.

While it has been established that continuity of care has the potential to achieve better health outcomes and quality of life for older adults, there is a lack of effective care models that achieve continuity in long-term care settings. Goal-oriented care has the potential to improve care continuity, and this will be examined in this thesis.

1.3. Purpose and Objectives

The purpose of this thesis is to provide insight into whether and how a goal-oriented care approach influences continuity of care in a long-term care setting, as perceived by residents, staff, and administrators. To do this, I conducted an in-depth case study of a long-term care centre using documentary evidence and data from semi-structured interviews. Documentary evidence included a review of relevant literature and program information provided by the long-term care organization. Qualitative interviews were conducted with residents, providers, and administrative staff. This information has been framed within Reid et al.'s continuity of care model, and conclusions are drawn through thematic analyses.

The research questions guiding the thesis are:

1. How do residents, providers, and administrators perceive continuity within the long-term care setting?
2. From the perspectives of administrators, care providers and residents, what aspects of the goal-oriented care approach facilitate or inhibit continuity of care in this setting?
3. What other factors influence continuity of care in this setting?

1.4. Rationale

Despite efforts to improve healthcare for older adults, many experience a lack of care continuity because of their complex care needs (e.g., numerous specialists, polypharmacy, no family physician) (29). These complex care needs are often compounded by difficulties with memory, reliance on informal caregivers, frailty, and difficulties scheduling appointments, among other challenges (30). As their health deteriorates and they face multiple comorbidities, older adults often face fragmentation in their care. This is also a problem when older adults are relocated to long-term care, where they often continue to experience fragmented care delivered by multiple providers who face strict time constraints in a stressful work environment (44). This may be due to the fact that many “promising practices” in long-term care research have not been implemented in Canadian long-term care facilities (44). These promising practices include: use of permanent staff instead of contract workers to promote low turnover and a deeper understanding of resident preferences, home-like environments where attention is paid to light, décor and social arrangement of furniture, celebration of the individual interests and achievements of residents, high staff-to-resident ratios, responsive management, empowering staff to work autonomously, a team-oriented approach focusing on the residents’ quality of life, and physical integration with the community. Currently, many organizations have constantly changing staff, a lack of training for staff, staff who have insufficient time allocated to spend with residents, a lack of effective leadership to implement promising practices, privatized and off-site support services, a lack of focus on residents’ quality of life, and/or a lack of commitment to ensuring staff, residents, and family members can provide input to improve care approaches to meet a resident’s needs. All of these factors may contribute to a lack of high-quality care for older adults in a long-term care setting, and more specifically, their experience of continuity of care. For example, constantly changing staff may inhibit consistency of personnel and the ongoing patient-provider relationship, indicators of relational continuity. As well, low staff to resident ratios are likely to have a similar effect on relational continuity and may also impact informational continuity as care provider time constraints can often inhibit documentation and effective transfer of information, thus impacting informational continuity. Also, without a team-oriented focused approach to improving resident's quality of life, there are likely inconsistencies in the care being provided to residents, inhibiting management continuity.

In studies of long-term care settings, researchers emphasize the importance of resident-centeredness in achieving high quality care for older adults. A resident-centered approach involves staffing that facilitates continuity of care including a team-oriented focus, in-house services, and documenting needs in a "resident-centred" way (44). Goal-oriented care, an approach to care that focuses on a resident's personal health goals, is a potential approach to achieving resident-centered care (11). Goal-oriented care in this setting relies on residents and family members to determine goals of care (14), recording a resident's goals in a way that is accessible to their care providers, (17), and a common purpose among care providers to achieve a resident's goals (12). Aspects of the goal-oriented care approach suggest that this approach has the potential to reduce fragmentation, thus positively impacting continuity of care. However, the impact of goal-oriented care on continuity of care in a long-term care setting has yet to be explored. I hypothesized that various aspects of the goal-oriented care approach had the potential to impact all three types of continuity. For example, by recording resident's goals in a way that is accessible to their whole care team, the transfer of information may be improved, leading to improved informational continuity. As well, residents and family members working with care providers to determine goals of care would likely contribute to a positive patient-provider relationship, leading to improved relational continuity. Finally, a common purpose among care providers to achieve a resident's goals may facilitate consistency in care, leading to improved management continuity.

We know that more continuous, resident-centered care in long-term care settings could improve health outcomes, resident satisfaction, and decrease use of hospital services (6).

However, we need to conduct research to establish an approach to care that facilitates continuity. If a goal-oriented care approach does positively impact continuity of care of residents in a long-term care setting, it may offer a low-cost and relatively easily implemented change in care for long-term care organizations that could achieve high quality care, including a high degree of continuity of care. The first step is to determine if a goal-oriented approach impacts continuity of care in a long-term care setting by exploring the perspectives of residents, staff and administrators in a specific case in this setting.

1.5. Theoretical Framework

One of the first conceptual models of continuity of care was developed by Hennen et al. in 1975 and included four dimensions of continuity: chronological, geographic, interdisciplinary, and interpersonal (45). Hennen's model included measurable aspects of continuity of care, as well as favourable outcomes such as resident satisfaction, provider satisfaction, and reduced cost of care. In 1980, Rogers and Curtis added three dimensions to this original framework: informational, stability, and accessibility (46). The revised model suggests that continuity of care is based on a medical encounter where the provider and patient have some prior knowledge of each other. This prior knowledge depends on age, and biomedical and psychosocial factors of the patient.

In 2002, Reid et al. proposed three types of continuity: informational, relational, and management continuity (24). Within each of these, the model outlined measurable outcomes (Figure 1). The model emphasized that each element of continuity can be viewed as either being person-focused or disease-focused, depending on the setting. For example, person-focused features of continuity tend to be more salient in primary care and mental healthcare, where there is emphasis on elements of continuity such as provider-patient relationships. Disease-focused elements of continuity, on the other hand, appear more in acute and ambulatory care, where the focus may be more on information transfer.

In 2003, Haggerty et al. conducted a review of models of continuity of care that showed that measures of continuity depend greatly on the setting of care (7). The review included 583 studies, including 226 in primary medical care, 109 in mental healthcare, 92 in disease specific care, 74 in nursing, 61 outside these domains, and 21 focusing solely on measures of continuity. Haggerty's systematic review noted that the importance of each type of continuity differs across providers and the context of care. Haggerty also demonstrated that two elements of continuity exist across all settings: a process of care over time and the focus on individual patients. Care over time distinguishes continuity from other attributes of care, as it describes the longitudinal relationships over a time period, rather than just the experience of a single encounter. The focus on an individual patient distinguishes continuity from other attributes of care by shifting focus from aggregating individual experiences at the group level to the individual level.

For the purpose of this thesis, I have used the framework proposed by Reid and colleagues (24). This framework has been used frequently, however, mostly in primary care. Most research that has used the framework has focused on what continuity of care looks like in this setting from the perspective of patients. While most of the framework's application has been in primary care, some studies have applied this framework in a long-term care setting. For example, the study previously mentioned by Marshall et al. exploring the effects of continuity of care for long-term care residents in Halifax, Nova Scotia, is one example of Reid's framework for continuity being applied in a long-term care setting (24). In this study, the authors distinguish between the three types of continuity in the model.

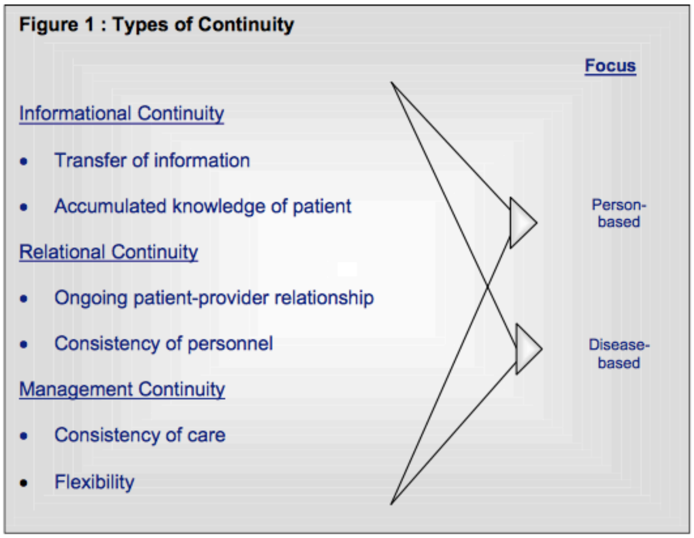

Figure 1: Types of Continuity (24)

I chose this framework as it provided specific domains of continuity to help guide the design of my semi-structured interview questions as well as provided the foundation for organizing my results. The definitions of the three types of continuity, according to Reid et al.'s framework, are outlined in Table 1.

Table 1. Definitions of Continuity

Type of Continuity	**Definition**
Informational	The use of information to make decisions about a patient's care. • Information includes not only documents on health conditions, it also includes information on patient values, preferences and social context.
Relational	Relationship between patient and care provider. • Therapeutic relationships do not only bridge discrete events in the past, they also provide a link to future care.
Management	The overall management of care. • Includes care planning and care coordination.

I viewed the three domains of continuity in the framework as processes that needed to be in place to achieve each type of continuity. Specifically, it provided structure to my interview guide as it was used to design questions that would elicit data relevant to each of the three types of continuity. The framework also distinguished between a focus on person-based continuity and disease-based continuity in the analysis of the data. In terms of data analysis, the framework provided deductive themes for use in coding of interview transcripts. Finally, I compared findings to the framework and Haggerty et al.'s systematic review to understand how the results of the case study differ from the literature.

CHAPTER 2: METHODOLOGY

In this section, I present the methodology used in my thesis, including my philosophical paradigm and analytic approach, a description of the case, my approach and rationale, data collection, and data analysis.

2.1. Philosophical Paradigm & Analytic Approach

In this case study, I use a constructivist paradigm to understand the perspectives of administrators, care providers and residents on the care provided at the Perley & Rideau Veteran's Health Centre, in particular through the *SeeMe* program. According to Guba (47), in a constructivist paradigm, realities are based on intangible mental multiple constructs. These constructs are unique to the individual or group holding the construct. While my methodology is informed by Yin's case study approach (48), who does not classify as constructivist, Stake's research provides an example of a researcher who identifies as a constructivist and uses a case study approach (49). Stake's approach is "underpinned by a strong motivation for discovering meaning and understanding of experiences in context." By conducting semi-structured interviews, I aimed to understand the experiences of the participants, and discover meaning through these experiences. By interacting with the leadership team and research coordinator to collect documentary evidence and by interviewing administrators, staff and residents, I interacted with the case, creating the findings as the investigation advanced (47). Since this is the initial research into this phenomenon, analyzing the potential relationship between goal-oriented care and continuity of care, a constructivist paradigm was appropriate to focus on understanding experience, however, future more practical and applied research may be best suited for a pragmatic approach.

An interpretive description approach was employed throughout the design, analysis and dissemination of this research (50). This approach requires both a practical goal and an understanding of what is known and unknown based on empirical evidence. Using this approach, the practical goal of this research was to contribute to efforts to improve care for older adults in a long-term care setting by investigating a specific approach to care. It is important to state this goal, as all aspects of the research design and dissemination revolve around achieving this goal. As well, it is important to recognize that this thesis is based on a foundation of research in long-term care, continuity of care, and goal-oriented care approaches. With this foundation, questions were generated. The foundation for this thesis can be summarized by stating that long-term care research suggests that a "patient-centred" approach to care improves quality of care and health outcomes in a long-term care setting, generating questions on the effects of a goal-oriented care approach on continuity of care in a long-term care setting.

2.2. The Case

The case at the focus of this thesis is the care provided through a newly implemented approach to care at the Perley & Rideau Veterans Health Centre called the *SeeMe* Program.

Perley & Rideau Veterans Health Centre

The setting for this research is the Perley & Rideau Veterans Health Centre (from here on referred to as the 'Perley & Rideau'), a 450-bed community health long-term care Centre in Ottawa, Ontario (51). The Centre is one of the largest long-term care facilities in the province, including seven buildings and eight onsite clinics (52). The vision of the Perley & Rideau is "leading innovation in frailty-informed care to enable seniors and Veterans to live life to the fullest" with a mission of "achieving excellence in the health, safety and well-being of seniors and Veterans with a focus on innovation in person-centered and frailty-informed care and service" (52). There are over 600 residents living at the Centre: 450 seniors living in long-term care plus an additional 150 tenants in independent living apartments on the premises. The organization prides itself on having the infrastructure, capacity and expert staff required to innovate, while remaining small enough to "readily implement various models of care" (52).

The organization's strategic plan includes four pillars: (1) excellence in resident care and services, (2) ensuring sustainability, (3) maintaining a quality workforce, and (4) being a leader and advocate for change. They are currently entering stage three of their strategic plan which involves being recognized as a Centre of excellence in frailty-informed care. As part of their strategic plan, in early 2019, the Centre introduced a new approach to coordinating care for residents, the *SeeMe* program. This program includes the elicitation of resident goals and the creation of a care plan developed with various providers in a resident's care network.

***SeeMe* Program**

The *SeeMe* program is a newly implemented approach to care at the Perley & Rideau. The program has two components: a comprehensive frailty assessment and a care conference where a resident sets goals in collaboration with their family members and care providers. The care conference and the resulting goal-setting components of the *SeeMe* program align with the basic principles of a goal-oriented care approach. This study focuses on this aspect of the program, examining if and how the goal and priority setting components of the *SeeMe* program are a key mechanism influencing care continuity. Other factors that are not elements related to the *SeeMe* program that may be influencing continuity of care in this setting are also explored. The program is further described in the results section of this study based on information collected in the documentary evidence review.

2.3. Approach & Rationale

An exploratory case study (48) was conducted including analysis of documentary evidence and information collected through semi-structured interviews with administrators, care providers and residents. Yin's case study approach was used as a guide to provide the foundation for understanding when case studies are appropriate, how to develop effective case study research questions, understanding the various types of case studies, and determining what sources of evidence are most effective (48). Case study methodology was chosen to facilitate an in-depth analysis of the complex relationship between a goal-oriented approach and continuity of care in a real-life long-term care setting (53). Since the thesis aimed to explore the potential relationship between goal-oriented care and continuity of care, the case study can be considered exploratory. This relationship would be too complex to evaluate with a survey or an experiment, and instead requires a case study approach that includes different forms of data collection (48). Since my research purpose and one supporting question were "how" questions, a case study methodology was an appropriate approach (54). As well, the boundaries between the context of the study and the phenomenon of continuity of care were not clear. This means that it would have been difficult to gain a true understanding of continuity of care without understanding the context, another condition that implies a case study approach was appropriate.

By using multiple sources of data collection, the *SeeMe* program was analyzed to identify themes and develop assertions about the overall meaning derived from the case (51). The Perley & Rideau is a unique case, since the Centre is implementing an approach to care that is different from that of many other long-term care facilities. This means that this thesis is an intrinsic case study, aiming to explore a unique case (48). The parameters of this system include care provided to Perley & Rideau residents who are enrolled in the *SeeMe* program, and all actors and organizational factors that are involved in this care.

2.4. Data Sources & Collection

Ethics approval was obtained from the University of Ottawa Ethics Board (S-05-19-2880) and approval was granted by senior management of the Centre. Informed consent was obtained from interview participants and all procedures followed the University of Ottawa institutional guidelines (55).

Data sources included documentary evidence and semi-structured interviews with administrators, care providers and residents. The document analysis was intended to provide the basis for understanding the *SeeMe* program and its elements, and to provide a foundation to refine the interview guide to further explore contextual factors influencing continuity. To determine whether a document should be included in the study, I assessed whether it was relevant to the *SeeMe* program. Relevancy was determined by deciding whether a document provided contextual information on the *SeeMe* program and/or whether a document provided information to make inferences that could be further explored in the semi-structured interviews (48). For example, if a document provided information a specific aspect of the program that I hypothesized might influence continuity, the document was considered relevant as this factor could be further explored in the semi-structured interviews. The documentary evidence was collected from January 2019 to February 2020. Documents were obtained from the organization's leadership team, the care coordinator and the research coordinator, and the organization's publicly accessible website. The care coordinator and research coordinator work at the Perley & Rideau and helped facilitate my data collection. I worked with the research coordinator to recruit participants; they sent the initial recruitment emails to administrators and care providers and delivered the letters to residents. They also met with me to discuss changing the recruitment strategy for care providers, after receiving interest from only two participants from the original recruitment email, and ensured I had "visitor" access when I visited the center.

Semi-structured, one-on-one interviews were conducted with administrators, care providers, and residents to elicit descriptions and perceptions of continuity, the *SeeMe* program and other aspects of care experienced by residents at the Perley & Rideau. I selected interviews as my method of data collection since interviews provide in-depth data in the study setting, allowing me to collect data from the perspectives of three parties involved in this experience. Administrators were defined as people working for the Perley & Rideau in a role where they did not provide care directly to residents. Care providers were defined as people who were providing direct care to residents at the Centre, including physicians, nurses, registered practical nurses (RPN), and personal support workers (PSW). Residents were defined as people living at the Centre. Eligible administrators and care providers must have had worked for the organization for at least three months, to help ensure that they have a sense of the organizational structure, culture, and how care is provided. As well, administrators and care providers were required to have some involvement in the *SeeMe* program, either by providing care as part of the program or be involved of the development, implementation, or training for the program. Eligible residents were 65 years or older, lived at the Perley & Rideau for at least three months, spoke English, and had been enrolled in the *SeeMe* program. I excluded residents who had cognitive impairment and could not provide informed consent. I used the Cognitive Performance Score (56), a validated measure used to determine cognitive impairment in long-term care settings, that was recorded in a resident's electronic medical record to determine level of cognitive impairment. The score ranges from 0 (intact) to 6 (severe impairment). Eligible residents were required to have a

Cognitive Performance Score less than 1 to be included in the study. I intended to interview five of each participant type, for a total of 15 interviews. I selected this number of interviews as this was the point at which I predicted I would be able to reach thematic saturation, while still ensuring that my study was feasible for my Master's thesis. I decided not to interview family members as part of this study as the feasibility, specifically in terms of recruiting family members, was not within the scope of my thesis.

Prior to conducting data collection for this thesis, I conducted a pilot study, as research for a Qualitative Methods course (MGT5102) at the University of Ottawa. The research collected in the pilot study is included in the results of this thesis. For my thesis, administrative participants were recruited through an email sent by the research coordinator on my behalf. Six administrators met inclusion criteria in the organization. A recruitment email was sent to only three of these, as I had already interviewed two in my pilot study and one was a care coordinator who was involved in the development of my research study methods and therefore had insight into the research purpose, questions and design that may have biased their responses during an interview. Care providers were recruited using a listserv email sent from the research coordinator. The research coordinator formulated a list of eligible care providers based on human resources data that indicated their start date with the organization and whether they had been trained on the *SeeMe* program. With a low response rate from care providers (13%, n=2), I shifted my recruitment strategy and asked the care providers who had already participated to pass on the recruitment email to others who they felt might be interested. This strategy was effective in recruiting two additional care providers. A copy of the consent form was emailed to administrators and care providers in advance, so they had time to review it prior to the interview. To recruit residents, the research coordinator distributed paper letters directly to residents by visiting them in their room. I visited residents with the research coordinator three days after the letters were distributed to reach out to residents and provide them with more information on the study. If they demonstrated interest in participating, I went over the consent form with residents to ensure they understood the study and what it meant to be a participant. Interviews were either held immediately after participants expressed interest or were scheduled for a later date that was more convenient for the resident.

Care providers were offered $30 in the form of a Shoppers Drug Mart gift card to partially compensate them for their time away from work. This amount was chosen based on an average of the hourly wages of the care providers (from lowest wage-earning participants such as personal support workers to highest wage-earning participants such as physicians). The amount was chosen with consideration of not being too much to coerce care providers (such as personal support workers) to participate. It was important to provide some form of compensation to providers as many of them, in particular personal support workers, work on an hourly basis (i.e., are not salaried). Administrators were not compensated because they are salaried and the organization gave permission for these interviews to take place during regular work hours. As well, to avoid coercion, residents were not compensated for their time. No explicit link was made between residents and their care providers, meaning I did not intentionally seek to interview the care providers of participating residents.

The interviews followed an interview protocol (Appendix I), and probes were used as needed to add depth. Contact summary forms (57), structured memos for recording important findings after conducting interviews, were completed after each interview.

2.5. Data Analysis

Documents collected in the documentary evidence review were summarized in a table which was used to provide an in-depth description of the *SeeMe* program and identify factors that could be further explored in the semi-structured interviews. Information was considered “important”, and included in the table, if it was relevant to understanding the context of the program or if it was considered to be an element that related to my research questions that should be further explored in the interviews. Having an in-depth understanding of the *SeeMe* program in advance of the semi-structured interviews facilitated designing interview questions that provided in-depth information on experiences with the program, rather than using interview time to gain an understanding of the contextual elements of the program itself.

Interviews were transcribed by a professional transcriber. Interview transcripts were imported to NVivo 12, a software program for coding qualitative data. Thematic analysis was used to identify, organize, describe and report themes within the data (58). Due to the nature of the research questions, specifically in terms of the focus on understanding the experience of continuity, initial codes were added to the codebook using information from the conceptual framework including “informational continuity”, “management continuity”, and “relational continuity” (24), as well as codes from the documentary evidence review pertaining to the *SeeMe* program including “care conference” and “comprehensive frailty assessment”. Three interviews (including one from each category of participant) were coded independently and in duplicate by myself and my thesis supervisor using this preliminary codebook. After coding each interview, we met to determine inductive codes that should be added to the code book until a codebook was finalized. The codebook was then applied to the remaining interviews. The codebook can be found in Appendix II.

After coding all thirteen interviews, the data within each of the codes and sub-codes was extracted from NVivo as a node report. Codes and sub-codes were analyzed one by one, pulling out important themes and associated quotes. Relationships between themes were explored iteratively by mapping ideas and combining themes that were similar across codes. Thematic saturation was defined as the point in which no new themes were emerging in the data (59). After coding all 13 interviews, no additional inductive codes were emerging within each participant group and therefore I determined that I had reached thematic saturation.

Themes relating to participants' perceptions of continuity were spilt by participant type (i.e. resident, care provider and administrator) and then spilt into Reid et al.'s three types of continuity (24). Once similar concepts were grouped, the themes were summarized by forming a "factor" that was used to describe the themes. The themes that related to perceptions of how the *SeeMe* program or other elements influenced continuity were mapped to determine relationships between factors. To determine how a factor influenced continuity, I spilt up the factors into facilitators and inhibitors of continuity. Based on the analysis, it was evident what factors were directly related to the *SeeMe* program and what factors related to other elements influencing continuity of care in the study setting, and as such, factors were divided this way.

2.6. Data Storage & Quality

Interviews were audio recorded and transcribed verbatim by a professional transcriber. In preparation for data analysis, identifiers were removed from the interview transcripts to ensure anonymity (60). Codes were assigned to participants and a master list of all these codes was stored on a password protected computer. All data collected (i.e., audio recordings, interview transcripts, and handwritten notes) were kept in a secure manner.

To enhance the reliability of the study detailed notes were taken during each interview and summary forms were completed after each interview (61). Objectivity of the study has been enhanced through the transparency and explicitly of the research design and methods (57). This facilitates the audience’s understanding of the sequence of data collection and processing and displays how conclusions were drawn. As well, objectivity in the analysis was enhanced by having my supervisor double code the first three transcripts. Excerpts from the interviews are included in the results section to provide examples of the results presented and depth to the content.

To enhance the quality and credibility of my research I used triangulation. This process involves using multiple sources of data and multiple methods to provide corroborating evidence (51). Documentary evidence was used to provide a base of knowledge that was further explored and verified through the qualitative interviews. As well, by including various types of participants, evidence was corroborated across participant type.

Another method to ensure the study is of high quality is to present a negative case analysis, where viewpoints or experiences differ from the majority of the evidence are explored (61). Participants perspectives that differed from the perspectives of most participants have been highlighted in the results section. As well, data from the interviews has been compared to data from the initial documentary evidence review. I identified differences between the program intent and goals, as outlined in the documentary evidence, and the perceived effect of the program, as captured through the in-depth interviews. By reporting on evidence that does not fit the common patterns of themes in the data, my analysis provides a more realistic assessment of the phenomenon of continuity of care in this setting (61)

A rich description, where detail is added by including quotes from the interviews, is presented in the findings of the case study to increase the quality of the study. Using a rich description, specific factors perceived to be influencing continuity of care in this study setting can be explained. A rich description of the case emphasizes the influence of the study context, allowing the reader to make decisions about whether the study results can be transferred to other settings (61).

While measures have been taken to ensure high quality research, it is important to acknowledge that my own thoughts and biases as a researcher affect the interpretation and analysis of the data. As an individual with no family member living in a long-term care setting, I have limited knowledge of the experience of residents and staff in these organizations, and the knowledge I do have comes from my experience at the Perley & Rideau while conducting this study. This has the potential to bias my analysis, as my experience at the Perley & Rideau was extremely positive and gave the impression that the organization is a positive place to live and work. As well, my undergraduate degree in commerce may also create biases, as much of my thinking around organizational processes, human resources and consumer experience comes from traditional business theories that often do not apply in publicly funded settings. This has the potential to bias my thinking around the way things “should” work in these settings. As a student researcher, I have limited experience in health systems research, particularly in the long-term care setting, meaning that I do not have a complete understanding of many of the challenges in long-term care, and the exposure I do have comes from my research for this thesis. By acknowledging these potential biases, I have made an effort to try and overcome these ways of thinking and the reader can use this information to think critically when interpreting my results.

CHAPTER 3: FINDINGS

In this section, I present the findings of my documentary evidence review, followed by the findings of my semi-structured interviews. The findings from the interviews are divided into three sections: (1) participants' overall perceptions of continuity of care; (2) aspects of the goal-oriented care approach influencing continuity; and, (3) other factors influencing continuity in this setting. The factors perceived to be influencing continuity have been categorized using Reid et al.'s framework for continuity of care by breaking the findings into each of the three types of continuity: informational, relational and management (24). Both facilitators and inhibitors of continuity were identified and will be presented within each section.

3.1. Documentary Evidence Review

The documentary evidence search identified six documents that were used to inform the semi-structured interviews. A summary of this evidence is shown in Table 2. All documents were authored by the Perley & Rideau, The Strategic Plan was available on the organization's website and all other documents were obtained through the care coordinator.

Table 2. Summary of documentary evidence

Type of Document, Source and Description	***Summary of Findings***
The Perley & Rideau Veterans' Health Centre Strategic Plan, 2017, Describes the organizations strategic plan for the year of 2017 (Source: Organization's website)	• The Perley & Rideau mission is: "achieving excellence in the health, safety and well-being of seniors and Veterans with a focus on innovation in person-centered and frailty-informed care and service" • Goal to develop and deliver new models and types of care along with relevant best practices (e.g., person-centred and family-centred care) • Goal to continually improve alignment with provincial strategies in healthcare and long-term care
SeeMe Information Package and Care Conference Agenda, 2019, Document to distribute to residents and family	• Program was developed through an understanding that frailty is a strong predictor of health outcomes

members to describe the SeeMe program and outline the care conference agenda (Source: Care coordinator)	and that recognizing frailty is crucial to providing good care • Program recognizes and assesses frailty as part of a person's overall health and supports residents and their families to make informed decisions around treatment that may be helpful or harmful within the context of frailty • Care conference agenda includes welcome and introductions, an interdisciplinary care overview, quality of life discussion, medical overview, resident values and beliefs discussion, goals of care and future health and personal care preferences discussion and timelines for follow-up • Goals of care checklist includes various options and space for comments about specific goals. Options include: (1) focus on comfort/symptom management, quality of life; (2) focus on managing illness while maintaining current function/independence; (3) focus on treatment of illness; and, (4) focus on extending life • Future health and personal care preferences checklist includes Yes or No options for: CPR and defibrillator; transfer to ED for advanced/urgent diagnostics and treatment; stay at Perley Rideau for diagnostics and treatment; and, stay at Perley Rideau for: palliative/comfort care, chemotherapy, surgery, medications, dialysis, tube feeding, and ventilator
Powerpoint Presentation outlining rollout of program, 2019, High-level outline of the program intended for leadership team (Source: Care coordinator)	• Program involves a true partnership between healthcare team and person/family • Program is a holistic approach to care that recognizes and assesses frailty as part of a person's overall health • Program aligns provision of care with a person's level of frailty and healthcare preferences • Program involves an iterative process of a comprehensive frailty assessment, dialogue about impact of frailty on care, and aligning care with quality of life goals • Roll-out milestones include care process being implemented on another 2 units every 2 months starting March 2019 • *Train the Trainer* model, including core champions and *SeeMe* champions to train staff • Aim to improve care for residents by enhancing understanding of resident's level of frailty and individualized drivers of frailty as well as improve communication about goals of care during acute health events

Powerpoint Presentation to introduce program to staff, 2019, In-depth description of the SeeMe program intended for care providers and administrators at the organization(Source: Care coordinator)	• Introduction to frailty informed care: an approach to care that recognizes and assesses frailty as a part of a person's overall health • The resident and family are at the centre of the model due to the core value of person and family-centred care • Care of the resident is viewed through a frailty perspective • The key stages of frailty-informed care are the comprehensive frailty assessment, dialogue about the impact of frailty on care, and provisions of care aligned with QOL goals. • *SeeMe* provides a whole-person approach to understanding residents and their family's health story • Team engages family and residents in an open, transparent and non-judgmental way to facilitate respectful and honest relationship • Residents and their families are provided with information to make informed decisions and be supported in those decisions • Staff should be available to support residents and their families, especially during a health crisis
Evaluation Framework, 2019, Chart used by leadership team to evaluate the success of the SeeMe program (Source: Care coordinator)	• Program has 4 main objectives including: (1) to optimize health outcomes for residents; (2) to educate residents and families about *SeeMe;* (3) to deliver an effective frailty-informed care education program for staff; and (4) to implement *SeeMe* tools and processes across the home • For each objective, there are evaluation questions, indicators, data sources and a timeline
Program Logic Model, 2019, Visual depiction of logical flow of development and implementation of the SeeMe program (Source: Care coordinator)	• Goal of program is to integrate the assessment and management of frailty as part of standard clinical practice in long-term care • Inputs include registered staff time, frontline staff time, physician time, management time and technology • Outputs include creating and implementing new processes, creating new training tools, mentoring/training staff, educating families and residents about the program and frailty, assessing frailty status of residents, conducting care conferences using new processes, and listening and documenting goals of care of residents • Short-term outcomes include satisfaction of families with information provided, satisfaction of families and residents with care and new processes,

	satisfaction of staff with training, and improved knowledge and competency in program delivery • Medium term outcomes include adoption of *SeeMe* tools, goals of care being documented and followed during acute health events, decrease in number of unwanted hospital transfers and all registered staff being trained • Impact of the program is to establish resident/family centered approach to care, optimize health outcomes for residents, improve quality of life for residents, improve capacity in the assessment and management of frailty in long-term care, develop replicable model that can be shared with others

Based on the information collected in the documentary evidence review, an in-depth description of the *SeeMe* program is detailed below.

***SeeMe* Program Description**

The *SeeMe* program was introduced in January 2019 and has been gradually implemented, by including the *SeeMe* process as part of usual care, throughout the organization (62). At the time of data collection for this study, the program had been implemented in approximately half of the organization and has since been implemented across the organization. The program is based on the Perley & Rideau's "Frailty-Informed Care Framework" (63). The Centre defines frailty as "a state of increased vulnerability, with reduced physical reserve and loss of function across multiple body systems" (63). The concept of "frailty informed" involves acknowledging that frailty is a strong predictor of health outcomes and that recognizing frailty is critical to providing high quality care (62).

The Perley & Rideau developed this framework with the goal to "become a frailty-informed healthcare facility that identifies and assesses frailty as a standard clinical practice" (63). The framework is based on five key elements: (1) "a true partnership between the healthcare team and person/family; (2) a holistic approach to care that recognizes and assesses frailty as a part of the person’s overall health; (3) an approach to care that considers the whole person and what matters to them as an individual; (4) aligning provision of care with a person’s level of frailty and healthcare preferences; and, (5) facilitating informed decision-making around care and treatment that may be helpful or harmful” (63).

The *SeeMe* program aims to align care with quality of life goals, incorporating a true understanding of what quality of life means to an individual (62). In the program’s information package, the *SeeMe* program is described as “the heart’s cry of residents” and “a call to be seen and known during a period of life when they may not have a voice” (62). It is the Centre’s frailty-informed care model, involving an iterative process of comprehensive frailty assessments, dialogue to determine the impact of frailty on care, and assessment of how care is aligned with quality of life goals. The first step of the program involves the Centre’s Comprehensive Frailty Assessment that provides information on different drivers of frailty, focusing on major drivers such as cognition, function and mobility (62). With the results of the assessment, a resident is assigned an overall Clinical Frailty Score. Following the frailty assessment, a care conference is held with the resident and their family to discuss the overall health picture and considerations for future decision making. During this meeting residents are asked to discuss their goals, values and preferences with the care team. Treatment options are considered in the context of their frailty as well as their goals, values and preferences. The agenda for the care conference includes an introduction, an interdisciplinary care overview and quality of life discussion, a medical overview, a discussion of resident values and beliefs, goals of care, future health and personal care preferences, a follow-up schedule, most responsible person discussion, and a projected timeline. Four main goals of care options are intended to guide the goals of care conversation and then residents are asked to make personal goals in their own words. The options include: (1)

focus on comfort/symptom management, quality of life; (2) focus on managing illness while maintaining current function/independence; (3) focus on treatment of illness; and, (4) focus on extending life. Resident goals provided the foundation for discussing a residents' future health and personal care preferences, which include decisions on using cardiopulmonary resuscitation and defibrillator; transferring to Emergency Department for advanced/urgent diagnostics and treatment; staying at Perley & Rideau for diagnostics and treatment; and, staying at Perley Rideau for: palliative/comfort care, chemotherapy, surgery, medications, dialysis, tube feeding, and ventilation. All information from the frailty assessment and care conference is recorded in the resident's electronic medical record. Ongoing conversations outside of care conferences occur, especially when there are changes in a resident's condition. The care conference and the resulting goal-setting components of the *SeeM*e program align with the basic principles of a goal-oriented care approach. The similarities between the *SeeMe* program and a typical goal-oriented program are outlined in Table 3.

Table 3. Similarities between the Goal-oriented Approach & *SeeMe* Program

Goal Oriented Care Approach	***SeeMe* Program (62)**
Person-centered approach	"The resident and family are at the centre of the model due to the core value of person and family-centred care"
Focuses on a patient's goals across physical and social dimensions	*SeeMe* provides a whole-person approach to understanding residents and their family's health story
Patients outline preferences and care goals	Care conference agenda includes outlining goals of care
Care providers work to ensure care plan aligns with patient's priorities	Care conference agenda includes outlining values and preferences
Collaborative process between care team, patient and family	"Program involves true partnership between healthcare team and person/family"

Aims to achieve maximum quality of life as defined by an individual	Program aims to "align care with quality of life goals, incorporating a true understanding of what quality of life means to an individual"

The key difference between the *SeeMe* program and a goal-oriented program is the frailty assessment component of the program, as most goal-oriented programs don't include the focus of understanding a resident's level of frailty to help guide care. This study focuses on the care conference aspect of the program, examining if and how the goal and priority setting components of the *SeeMe* program are a key mechanism influencing care continuity in this setting.

This information on the Perley & Rideau organization and *SeeMe* program provided the foundation for understanding the program and building the interview guides for the semi-structured interviews. By having an in-depth understanding of the structure and intent of the program, I developed an interview guide that went deeper than surface level information about the program. This allowed me to focus the interview guide on gaining an understanding of effect of the program on residents from perspective of participants. For example, by understanding the care conference agenda and what specific information was discussed during this meeting, I designed the interview guide to ask questions about how this information was communicated to the care team and whether members of the care team were aware of a resident's goals after this process.

3.2. Semi-structured interviews

Thirteen individuals participated in interviews including four administrators, four care providers and five residents. Table 4 presents an overview of the study participants including the role of the care providers. Two interviews were piloted for this study on February 27th, 2019 and

March 13th, 2019 and the remaining interviews were conducted between September 19th, 2019 and November 14th, 2019. The pilot interviews were conducted using an early draft version of the interview guide designed to answer the same research questions as this study and the pilot interview data was included in this study. Interview duration ranged from 12 to 52 minutes, with a median interview length of 25 minutes. Four interviews were conducted over the phone and the other six were conducted in person.

Table 4. Overview of study participants

Participant Type	n
Administrators	4
Care Providers	4
Physician	1
Nurse	2
RPN	1
Residents	5

3.3. Overall Perceptions of Continuity

Perceptions of care continuity will be addressed in this section, first from the point of view of administrators, then care providers, and finally residents.

Administrators

Administrators defined continuity very similarly: consistency in the care provided to residents by aligning care with a resident's goals, values and preferences. A consistent approach means that everyone providing care to a resident is integrating this information into their care. One administrator described it as follows:

> *So to me, continuity of care would look like kind of seamless care from shift to shift…So to me it's all about kind of all 3 shifts, all disciplines working from the same plan of care that's aligned with the values and the beliefs of the resident. And so everyone has the information that they need to meet the needs in the way that they need to be provided.*
> – Administrator 4

In discussing continuity at the Centre, administrators often noted the importance of consistency in care providers in order for a care team to all be aware of a resident's plan of care and provide a consistent approach to care.

> *That the inter-professional team has a plan of care and consistently applies that approach to care to the resident, ideally with the least number of faces... everybody understands the flows and plan for the resident. Plan of care and goals of care go hand in hand. Everybody knows it's not just the nursing staff.* – Administrator 3

This administrator also noted that for them, continuity of care includes the whole care team working around the needs of a resident. This stems from an organizational culture of ensuring that all care providers understand the organization's vision, mission, values and the way in which care is provided at the Centre: around the resident's unique needs. This is captured by the following quote:

> *So that you have a philosophy of care and a code of contact and a mindset and value stream that supports the SeeMe philosophy. It's orientation, it's how we do this, it's how we work here. And having that on the way into the facility if you're in finance, or if you're in the loading dock, everybody has the same vision, mission and values and understands it.* – Administrator 3

Most of the administrators noted the importance of not only continuity of care within the Centre, but continuity of care for residents when they are transferred to another healthcare setting, such as the hospital.

> *So to me continuity of care means that no matter where I go, my care is aligned with my values and my beliefs and what's important to me. So if I'm in long-term care, and I'm transferred to hospital, or if I go back to the community, my caregivers have the information that they need to provide me the care that I require that is aligned with my values and my preferences*. – Administrator 4

Administrators noted a breakdown in continuity often happens when residents living at the Perley & Rideau are transferred to hospital. While a resident's goals of care and care plan is sent with them to hospital, care providers question the extent to which this document is used in these settings. Administrators felt that without this critical information about what a resident wants from their care, care providers in these settings are not providing care that is continuous with the care being provided at the Perley & Rideau.

> *We send all the information and what people do with that on the other end is again their protocols and decisions. But we do send. That doesn't necessarily mean that the continuity of care piece continues. I think I find that flows into long-term care better then it flows out to other providers.* – Administrator 3

While most administrators perceived that residents at the Perley & Rideau experience continuity of care, almost all of them noted that there is room for improvement. Administrators felt that the tools and processes in place can be further modified to ensure that all important information is being collected and communicated to all members of a care team.

> *I would say patients do experience continuity…So I think that we are trying to maximize how our current tools and processes are being used to ensure everyone is on the same page. I mean we are not perfect and we are always trying to improve. But I think our organization breaks down those barriers to ensure that everyone has access to that same information.* – Administrator 2

One administrator noted that if the results of the *SeeMe* assessments forced notifications in a resident's Electronic Medical Record (EMR), the results of these assessments could be more effectively communicated to care providers what changes in their care need to be made.

> *I think if we could force function certain actions based on the results then that could drive a little bit more of the continuity and the impacts on the day-to-day care. So I think yeah, so it's kind of making the information accessible, consistent so that it drives the actions.* – Administrator 4

All administrators who participated felt that the integration of the *SeeMe* program into care at the Perley & Rideau positively influenced continuity of care for residents, though their specific reasons differed. One administrator said the main improvement of the program is it empowers residents and their family members to talk to external care providers during their appointments about their goals and preferences, improving continuity across care settings. Another administrator noted that information transfer is improved because with *SeeMe*, all important information is kept in one spot. Another administrator noted that in the case of an acute health event, *SeeMe* supports continuity as they have a foundation on which to base decisions through the goals of care tool.

> *I think it brings continuity of care, especially in terms of if an acute event happens. Because they have stated their future health and personal care preferences and their goals of care. So if in the future, no matter what shift or who's on the shift, or even if they're transferred to a different unit, people will know what is important to that resident and their family and what some of their stated health preferences are, or what they want to see at the end of life.* – Administrator 2

Care providers

Care providers differed in the way they defined continuity of care at the Perley & Rideau, as some care providers conceptualized continuity as consistency in care, some focused on consistency in care providers, and some focused on the relationships between care providers and residents. For example, in conceptualizing continuity of care at the Centre, two participants defined continuity as consistency in care provided to a resident. One care provider explained:

> *That the resident receives the same care no matter who is providing the care. And that everyone understands what needs to be done.* – Care provider 2

Another care provider felt that consistency in care comes from everyone "speaking the same language" in the organization. They believed that this comes from an organizational culture of understanding frailty-informed care and the education and training associated with the *SeeMe* program:

> *However, you know, continuity of care for me is … we're provided with the education again to speak the same language, to provide individualized approaches to care. But then we're all kind of on the same page. So we all understand frailty, we understand trajectory, we understand terminal illness, we understand those drivers of frailty.* – Care provider 1

Another care provider also focused on consistency, but instead defined continuity in terms of the consistency in the care providers. They emphasized the importance of having consistency in care providers in order to get to know residents on a personal level, to understand the resident and what they want for their care:

> *Oh, to me it's to have regular staff. That's very important. That's like number one right at the top. Knowing when a person, you know, gets up, likes to eat. You want to continue that sort of routine, especially with somebody with a cognitive deficit. Because if you change a lot, you're going to end up with behaviours. And we're all human. We have routines that we like to follow and that. So having the same staff all the time, that's continuity of care, right.* – Care provider 4

Similarly, in defining continuity of care, another care provider focused on the importance of the relationship between care providers and residents to achieve continuity, including being able to foster a relationship that can take a resident through their care trajectory.

> *Continuity of care means taking care of the resident from A to Z. And in long-term care, is taking care of them from day 1 from admission until they die. That's continuity of care. And usually it's better achieved with staff that know the resident. So usually it's a team of, you know, the nursing team, the physician, pharmacist, social worker that usually we admit the patient there, we build a relationship with them, and we follow through knowing that, you know, their condition will decline and they will die one day.*
> - Care provider 3

In terms of the impact of the *SeeMe* program on continuity of care, all four care providers interviewed reported that the *SeeMe* program positively influenced continuity of care for residents at the Centre. Two care providers noted that the main driver of continuity was an understanding of what a resident wants for their care through their goals of care document. Another care provider noted that the *SeeMe* program improves communication between care providers because everyone has access to important information about residents. Finally, one care provider noted that the *SeeMe* program drives standardized processes in the organization, so everyone is providing care in a similar way.

Residents

Residents were asked questions on their perceptions of the extent to which information is shared between their care providers, their knowledge and their care providers' knowledge of their health status, their relationship with their care providers, the consistency of their care providers, the flexibility in their care and the overall consistency in the care provided to them. Important themes that emerged from these questions are discussed below.

Residents felt that care providers were not communicating with each other about their care. Residents described that as a result of this they found themselves repeating information often.

> *I know I have improved a lot. But do they [care providers] go around telling each other, "Hey, [participant] has lost a lot of liquids and she's very happy about it"? I don't think [so].* – Resident 5

Other residents, however, expressed that their care providers did know about their health status and health needs, but had mixed feelings on the extent to which their care providers were aware of personal information such as their interests, hobbies and family life. Some residents felt that their care providers did not have time to get to know them personally, while others felt that their care providers were aware of some of their personal information.

> *First of all, they're often pressed for time. They don't have too much time for personal information, you know, conversations. Now and then we do speak. But I really don't think that… They are pressed for time, I must say. You know, it's not the heaviest of floors but it's quite heavy. There's a lot of people who need much more care than myself or my husband, you know. So they have quite a load of things to do. They do their best,*
> - Resident 5

Overwhelmingly, residents noted that there was very little consistency in their care providers. They explained that care on weekends was increasingly difficult as there was almost always a new care team providing care to them, as demonstrated below:

> *Now, we have a problem on weekends because a lot of the regular staff is off. The temporary staff is on. They don't know us; we don't know them. And it's shaky, you know. I hate having to tell people what to do. But they don't know. So that's the only problem we have.* – Resident 2

Despite this, residents seemed to be satisfied with their care.

As previously mentioned, all residents who participated expressed that they were unaware of the *SeeMe* program, and only one resident was aware of having set goals. Since most residents were unaware of the *SeeMe* approach, they were not able to comment on the program or how it influenced their care. Interestingly, most care providers and administrators perceived that residents and their families were aware of the program. It should be noted, however, that one care provider mentioned that residents sometimes do not attend the care conference if they are too frail, and instead the conference is only attended by their family member.

3.4. Aspects of the Goal-Oriented Approach Perceived to be Influencing Continuity

Results of the semi-structured interview analysis showed that the *SeeMe* program was perceived to both positively and negatively influence continuity of care for residents at the Perley & Rideau Veterans Health Centre. The following table provides an overview of the aspects of *SeeMe's* goal-oriented care approach perceived to be facilitating and inhibiting continuity of care, organized by type of continuity. Each of these factors is described in detail below.

Table 5. Aspects of the Goal-Oriented Approach perceived to be Influencing Continuity

	Facilitators	**Inhibitors**
Informational Continuity	• Goals of care discussions ensured resident, care team and family were on the same page • Care conferences created awareness for residents of their care options • Consistency in where *SeeMe* assessment information is stored	• Residents lacked awareness of *SeeMe* program • Care conference agenda caused confusion
Relational Continuity	• Incorporating a resident’s values and preferences to form holistic understanding of a resident • Staff increasing awareness of the program for families • Integrating the family’s perspective into a resident’s care	• Relying on family involvement when family was not always available
Management Continuity	• *SeeMe* program discussions facilitated informed decisions • *SeeMe* assessments acted as reference tool in case of acute health event • Goals of care discussions empowered residents and family members to talk to external healthcare providers • Structure of the *SeeMe* program facilitated consistency in care being provided	• Wait time until residents attended their first care conference was too long • Family members faced difficulties making decisions

Informational Continuity

Facilitators

The results are organized into three categories of facilitators which participants expressed as influencing informational continuity. These factors all relate to care provided through the

SeeMe program: goals of care discussions ensured resident, care team and family were on the same page; care conferences created awareness for residents of their care options; and, the program created consistency in where *SeeMe* assessment information is stored.

Goals of care discussions ensured resident, care team and family were on the same page. Administrators and care providers felt that the *SeeMe* program goals of care discussions helped put the resident, care team and family on the same page about a resident's goals, values and care preferences. Participants felt that if a family member and a resident did not initially agree on what goals were most important, the goals of care discussion helped form a mutual understanding of what is really important to the resident. Specifically, by understanding the context around why certain goals are important to a resident, everyone involved in a resident's care had a foundation on which to base their decisions.

> *Because if your mindset is 'if I keep that going as much as possible [father's physiotherapy] then dad will keep going as much as possible'. But in the big scheme of the day and 7 days a week, what does dad want to do? What does dad like to do? And how much is too much? Being able to have those discussions with your dad at the table. And being able to say, "while I'd really rather go to Bingo". But having an understanding of the why piece and looking at it with that quality of life perspective and "what's the real goal".* - Administrator 3

Care conference created awareness for residents of their care options. Administrators and care providers felt that through the care conference discussion, care providers could educate residents and family members about the care options available to them. For example, if a resident had a certain health condition, during the care conference the care team had the opportunity to outline the options for care or treatment, the setting in which these would take place, and the potential impact and/or consequence of each option. From the administrators' perspective, residents and their families were often not aware of the services that can be offered within the long-term care facility, as opposed to service offered by external organizations. The intention of the care conference was to educate them on these potentially more comfortable and less invasive options that avoided transferring residents to different healthcare settings. This is captured by the following quote:

> *I think it's also highlighted what long-term care homes can support in our environment. So the perception of what we have the ability to do from a medical perspective, IV therapy and PICC lines, and we manage pain very nicely, and we can do these things on site, is not something that the general public knows. When you came to a long-term care home 10-15 years ago that wouldn't have been reality and understanding here's what we can do for you here. And having those conversation during the SeeMe discussion has been another very good educational component for families. Because they don't know what they don't know. And "wow I didn't realize, I don't want to go there then, because I can have that looked after by people I know in the comfort of their own home.*
> – Administrator 3

With an understanding of the care options available to them, administrators felt that residents and their family members had the knowledge to make more informed decisions.

Consistency in where SeeMe assessment information is stored. Administrators and care providers noted that, with the *SeeMe* approach to care, all important information about a resident was kept in one spot, i.e., in a resident's EMR. Information from the comprehensive frailty assessment and care preferences and goals from the care conference were recorded in a resident's EMR so all care providers could refer to this information at any time.

> *… all of the information is housed in one place and is actually pushed to various places. So people can at a glance access the most important information. So I think that in and of itself is an improvement to how we were documenting care conferences and health preferences*
> -Administrator 4

Care providers emphasized the importance of easily accessing resident information when they were covering shifts on units where they do not know the residents. Through the *SeeMe* program, care providers could quickly access resident information to provide person-centered care around a resident's specific needs and preferences. Specifically, care providers noted that when they are covering for other staff on a unit, the *SeeMe* assessments allowed them to quickly access information on residents who are considered “high risk.” With this information, care providers were aware of how they should react in the case of an acute health event. Having access to the same information in an easily accessible spot for all care providers ensures that residents are basing the care they are providing on a similar understanding of the resident, as demonstrated below:

> *So for example, I’m going down, I have a high risk guy to see after I talk to you today. And that goals of care and future healthcare tool will help inform me where we’re going to really…where I’m going to kind of centre my discussion. I’m not going to go down and have a discussion about like transferring to acute care. I’m going to go down, read their notes, understand their values, understand their understanding of illness and trajectory, and then help support them in that conversation. So it helps me to kind of also have that continuity of care. Which I think is also really important. I’m going to say the same thing as the physician, as the nurses. So that goals of care tool will help inform me. Which is awesome* – Care provider 1

Inhibitors

Inhibitors to influencing informational continuity were categorized into two themes, the first being residents lacked awareness of the *SeeMe* program, and the second is that the agenda of the care conference caused confusion for residents and their family members.

Residents lacked awareness of the program. Residents reported being unaware of the *SeeMe* program and only one resident was aware of the goal-setting component. All residents who participated were confused when asked about the *SeeMe* program and were unaware of the name or what it meant. Most residents felt they had not been asked about their goals of care or care preferences. Despite this, residents seemed satisfied with their care and felt they had no reason to raise any issues with their care providers.

> *Interviewer: And have you ever talked to any of your care providers or anyone here about your goals of care, what you want for your care?*
> *Participant: No, I’ve never raised any questions because the care I’m getting is quite satisfactory.* - Resident 1

However, when one resident described his experience with the care conferences, he recognized that he had the opportunity to discuss his care with his care providers and other staff in the organization.

> *Oh, yeah. We have a formal one every year – a care renewal assessment. And they also do it quarterly in-house here, within here. One's more formal and the other is just updating for anything that's required…I have lots of opportunities to discuss things with people by getting around. Like people in the foundation, people on staff levels, nurses and people like that.* – Resident 4

Care conference agenda caused confusion. Care providers expressed concern with the care conference agenda, noting that it often brought up conversations that would otherwise not be raised with the resident and their family. This often caused longer and more overwhelming conversations than were necessary according to care providers. Since the care conference agenda was standardized across the Centre, including checklists for goals of care preferences and future health and personal care preferences, it involved discussion on all aspects of care and all major care pathways.

> *…there's a template and you have to go through the questions in the template. And there's not much of leeway as professionals in terms of what to ask. You know, there's a sheet in front, there's a checkbox, and we go through it. Whether we want it or not, there's an assigned template to go through.* – Care provider 3

As outlined in the results of the documentary evidence review, the goals of care checklist includes various options and space for comments about specific goals. Options include: (1) focus on comfort/symptom management, quality of life; (2) focus on managing illness while maintaining current function/independence; (3) focus on treatment of illness; and, (4) focus on extending life. As well, the future health and personal care preferences checklist includes *Yes* or *No* options for: CPR and defibrillator; transfer to ED for advanced/urgent diagnostics and treatment; stay at Perley & Rideau for diagnostics and treatment; stay at Perley & Rideau for:

palliative/comfort care, chemotherapy, surgery, medications, dialysis, tube feeding, and ventilator. Care providers also noted that with very limited autonomy in what topics were discussed, residents and their family members were often left confused with the number of decisions that needed to be made.

> *What I'm saying is for very frail demented…a patient with dementia in her 90s, I would not broach the topic of chemotherapy or dialysis in my care conference, you know, anyway. So now, you know, because there's that questionnaire in the SeeMe program, I ask for it. But sometimes it opens or the potential to open some pandora's box with certain families that I wouldn't have necessarily opened before the SeeMe Program.*
> – Care provider 3

This specific care provider felt that the agenda was not always geared toward options that are available in the long-term care setting and expressed that they would like to be more involved in developing the care conference agenda.

> *…that checkbox list about future health and personal care preference, I find that it's geared more to acute care more than long-term care. I'll give you an example. So one of the questions that we are asked to inquire is about dialysis, chemotherapy, ventilators. All of those are not available in long-term care, and are more relevant in, you know, ICU setting, acute hospital setting, more than long-term care. At the Perley, we were not asked our input as [role] on the questionnaire or the checkboxes. We were kind of imposed that format.* – Care provider 3

Relational Continuity

Facilitators

The results are organized into three categories which participants identified as influencing relational continuity: incorporating a resident's values and preferences to form a holistic understanding of a resident, staff increasing awareness of program for families and integrating the family's perspective into a resident's care.

Incorporating a resident's values and preferences to form holistic understanding of a resident. Administrators and care providers felt that the *SeeMe* program put resident's and their family's needs first by incorporating a resident's values and preferences into their care plan through the care conference process. Health information, such as current medications, health and family history, as well as personal information such as family, previous career, interests, and hobbies, were shared during the care conference discussion so that care providers gained a holistic understanding of a resident.

> *We have just heard some really very heartwarming stories of staff who have really bonded with the residents and how they have really got to know them, know their past life stories. I know there are several PSWs who sing, they know all the residents' favorite songs, maybe they will sing to them in the shower to decrease their anxiety. There's just, you can see that there's this bond established between them…and I think that makes such a huge difference* -Administrator 2

Administrators and care providers felt this holistic understanding helped the care team and resident form a relationship that was more personal than caregiver-provider relationships in the past.

Staff increasing awareness of program for families. Families' awareness of the *SeeMe* program and how it influences care provided at the Perley & Rideau was identified by administrators and care providers as a facilitator of continuity. Administrators and care providers explained that staff meet with the family and resident before the resident moves into the Centre, describing the program and discussing how it influences the approach to care at the Centre. During this initial meeting, residents and their families also completed paperwork so that on their day of admission to the Centre the focus could be on building relationships with their care providers rather than administrative tasks.

> *It's part of our admission process … we discuss SeeMe on admission before the resident even comes to the facility. So we have those conversations with family members or the POA if it's the actual the resident, before they move in. We ask to see them the day before to do paperwork and all the things that stress you on the day you come with your luggage so it's more the relationship the day you come and not about the paperwork. So SeeMe is*

> *introduced there as a concept and how the philosophy of care is in the home.* - Administrator 3

Administrators and care providers felt these conversations between staff, family members and residents build trust as family members understand the approach that is guiding how their loved one will be cared for.

> *So now we're having these trusting, open, honest conversations. So we've got trust with residents, trust with families. When we say we're going to be there for their crisis, we are there for their crisis. We're stepping up to the plate to show them we heard you, we listened and we responded. And so being able to, I guess, facilitate those conversation.*
> - Care provider 1

While administrators and families noted that both residents and families are aware of the *SeeMe* program and how it influences care at the Centre, residents said that they were unaware of the *SeeMe* program, as described above. This finding, therefore, likely only applies to families of residents.

Integrating the family's perspective into a resident's care. Integrating the family's perspective into care for a resident through the *SeeMe* goals of care discussion was identified as a facilitator of relational continuity. Administrators and care providers found that through the care conference, family members provided information on what a "normal day" or "normal behaviours" for a resident looked like before they moved to the Centre. This unique and valuable information may only be provided by family members as residents are often frail and have difficulty remembering their normal life. Administrators and care providers explained that this information provided insight for the care team to try and make a resident's life at the Centre as 'normal' as possible, focusing on maintaining their quality of life.

> *To say to a family, "when things were good what did a normal day look like?" And let's try to make this as normal as we can. And if normal was always watching the midnight news then that's okay. And not to be structured by the clock and the task but to focus on the resident and the quality of life for him or her. That movement to the team approach and that everybody is*

> *here to support the resident. So there's not "not my job" and "the housekeeper only does". Everybody looks after the resident. From the commissioner at the front who helps the guy who helps find the transfer bus to the volunteer service department, everybody has a very cohesive role and knows what the plan is. So understanding people's care and what they want with their life that's very powerful stuff and having the good group of people who know that…good things happen.* – Administrator 3

Using the family's unique perspective and integrating this information into a resident's care brought the resident's care team together to focus on the specific needs of a resident and made their quality of life as high as possible.

Inhibitors

One aspect of the *SeeMe* program was identified as an inhibitor of relational continuity. Care providers expressed that family involvement created challenges when family members were not living near the Centre and had busy lives, as it was difficult to contact them when they needed to make decisions on the behalf of their loved one. Since the *SeeMe* program relied heavily on family members to make decisions and ensure care choices are aligned with resident preferences and goals, this challenge was magnified within this care approach.

> *So especially for residents who have dementia and cannot give consent about sharing information, so we rely on power of attorney or substitute decision-makers. Usually it's a family member. And one of the challenges is some families have different power of attorney at the same level but they don't have necessarily the same opinion on the care. So usually we have a point of contact person to call first. But if we cannot join that person, we'll call the next one in line, and so and so forth.* – Care provider 3

This challenge hindered the ongoing relationship between care providers and family members by creating an obstacle for effective collaboration.

Management Continuity

Facilitators

Four categories of facilitators were identified as influencing management continuity. These facilitators are all associated with the *SeeMe* program: *SeeMe* program discussions facilitated informed decisions, *SeeMe* assessments acted as a reference tool in case of an acute health event, goals of care discussions empowered residents and family members to talk to external healthcare providers, structure of *SeeMe* program facilitated consistency in care.

SeeMe program discussion facilitated informed decisions. The *SeeMe* program was perceived to have facilitated informed decisions by care providers, residents and their family members. Care providers and administrators felt the *SeeMe* program frailty assessment helped the care team and family understand a resident's level of frailty and make decisions based on this information.

> *We like to think of SeeMe as a set of tools and processes to really ensure that families and residents are able to make informed decisions about the next stage of care, with the context of understanding how frailty affects care decisions that are made.*
> – Administrator 3

The *SeeMe* frailty assessment reduced the confusion of the interacting factors that influence a resident's level of frailty by assigning a number that summarizes a resident's frailty status. This helps residents and family members understand the impact that frailty can have on their care. Understanding frailty can help care providers know how a resident will respond to an acute health event, informing decisions around how to react in such a case.

> *We put it all into an assessment and from that we can get a specific level of frailty. With that level of frailty, the doctor and the team can have a better idea of what to expect or how vulnerable that person is to healthcare changes. With that number and that understanding of their frailty, we bring it to the care conference and talk to the family about what that level of frailty means. We ask questions about what they want to see in their life here for quality and then together we can make healthcare decisions.*
> - Administrator 1

SeeMe assessments acted as a reference tool in case of acute health event. Administrators and care providers consistently mentioned the role of the *SeeMe* tools in the case of an acute health event. When an acute health event occurred, for example a resident fell and broke their hip, the family became involved in a discussion with care providers where they decided whether to change their goals of care decisions or keep them the same. Participants noted that many people find it difficult making decisions during a crisis and the goals of care provided a reference for family members to recall the choices they had made when things were good. By having goals of care discussions in advance, residents and family members were already informed of the risks and benefits of different care paths, and this simplified the decision-making process.

> *Because let's say an event were to happen, the intent is for the staff or physicians to touch base with the family and say "when we last discussed this you said this…now that this event happened is this still where you want to go?" and here is a review of the risks and benefits of each path. If you choose path B then here's the benefits…It is meant to inform discussion, but not have it be set in stone"* – Administrator 3

Goals of care discussions empowered residents and family members to talk to external healthcare providers. Administrators felt the *SeeMe* program empowered residents and their family members to talk to healthcare providers outside the Centre about their goals and care preferences. They felt that by establishing care preferences and goals through the *SeeMe* program, residents and their family members had a clear understanding of what they wanted from their care and were able to convey this information to their healthcare providers. Administrators perceived that residents and family members also recognized the impact that having a voice in their care has on the resident's quality of life.

> *How does it influence continuity of care? I'm going to come at it from the family and the resident's perspective. And I know two instances since the SeeMe program has come on board where this has happened. Where a family has felt empowered to talk to external healthcare providers, around the goals of care of their loved one. Because they felt informed, they understood the risks, they know frailty, and they understood frailty and its*

> *response to care delivery. And felt very supported in decisions that they were making because they knew that the home themselves, if there were questions, would be able to support that. I think it's very empowering.* – Administrator 3

Administrators perceived that empowering residents and their family members to discuss their care preferences and goals with external healthcare providers facilitated a more consistent care experience when a resident and their family have to navigate across healthcare settings.

Structure of the SeeMe program facilitated consistency in care. Administrators and care providers felt that the care conference structure ensured that all residents and their families set goals in the same way and had similar discussions about how they prefer to receive care.

> *Because this new care conference structure is structured around embedding the goals of care discussion within the care conference structure. Before we did not really have any type of care conference structure. So there was a lack of ensuring there was consistency across all care conferences. .... So all units are using the new care conference process with the goals of care tool.* – Administrator 3

As well, the understanding of frailty-informed care that staff gained from being trained on the *SeeMe* program was perceived to help everyone provide similar care and speak the same language. The training associated with the program was perceived to ensure that everyone in the Centre was aware of the philosophy of care at the Centre, and this awareness was reflected in their day to day work. One care provider emphasized that the senior leadership team played a critical role in the cultural understanding of person-centered and frailty-informed care:

> *I think for us what has helped us to achieve where we are right now is that we've had such a supportive leadership team. Like you can't do this without a leadership team that believes and understands frailty…. You know, it just shows the importance that it's part of their vision, they're educated, they have a great understanding. So really it's from the leadership team, to the QI team, to the managers, to the RNs. Like everybody has this understanding of frailty and the impact of trajectory, the impact on quality of life.*
> – Care provider 1

As a result, it was perceived that care providers provided care in a similar manner across the Centre. This meant that a resident was experiencing more consistency in the care provided to them.

> *… we're all kind of on the same page. So we all understand frailty, we understand trajectory, we understand terminal illness, we understand those drivers of frailty. So for me not only is it continuity around language care, you know, professionals, but that like we're all speaking…we're all doing kind of the same thing.* - Care provider 1

Inhibitors

Two aspects of the *SeeMe* program were identified as inhibiting management continuity for residents: the wait time until residents attended their first care conference was too long, and family members faced difficulities making decisions about a resident's care.

Wait time until residents attend their first care conference was too long. One care provider noted that the first care conference occurs six weeks after admission. This six week wait is used to conduct the frailty assessment and for the care team to set a date for the care conference. One challenge mentioned was that some residents do not make it to the six week care conference before transfering to another care setting or passing away. As a result, these residents were not able to express their goals and care preferences to guide their care.

> *They're done within the first 6 weeks of the care conference. And then annually after that. I think one of the challenges we're facing is those residents who come in who are imminently dying. Like they don't make it to the 6-week care conference. Those guys, we've got to figure out a way to capture those guys a little bit sooner.* – Care provider 1

Decisions about goals and care preferences may be especially important for people near the end of their life, as they may choose very different care paths depending on their goals during this time. Since the *SeeMe* program approach to care relied heaviliy on residents' care plans, care providers did not have information to structure their care for residents who had not yet attended a care conference. This could have created inconsistencies in care as care providers did not all have the same information about a resident on which to base their care.

Family members faced difficulities making decisions. Care providers felt that the care conference process was often very difficult for family members. During the care conference, family members were asked to make important decisions about the care that they would like for the resident, and encouraged to consider how these decisions aligned with the resident's values, goals and preferences. This was very difficult for some family members, as these are decisions that could greatly impact their loved one's life. As well, since the standardized care conference agenda covered all aspects of a resident's care, including their end of life care, often families were not ready to make such difficult decisions about care that they did not see as imminent. In fact, it was noted that this requirement sometimes offended family members:

> *It's a hard topic for people. I've seen people come into the care conference—family and that—and they have a really difficult time talking about end of life for their parent. It's like something that they haven't faced yet. And you know, they themselves are middle-aged people, you know. So I find that some people get very… I've had experiences where the doctor's trying to explain, you know, the prognosis and the end of life part. When they come down to talking like that, it's like the doctor hasn't consulted the family. I've seen family get very upset about the questions. You know, "Do you think that you're just going to throw her in the garbage?" You know? When you talk about CPR and do you want to…and about dialysis, and, you know, all these interventions, I find people have a hard time with those questions.* – Care provider 4

3.5. Other Factors Perceived to be Influencing Continuity

Participants also shared factors that they felt facilitated and inhibited continuity of care for residents at the Perley & Rideau that were not directly associated with the *SeeMe* program. Table 6 provides an overview of these factors. Each of these factors is described in detail below.

Table 6. Other factors perceived to be influencing continuity in this setting

	Facilitators	**Inhibitors**
Informational Continuity	• Tools were leveraged to record resident information • Assessments were used to ensure information is recorded after acute health events	• Care provider time constraints
Relational Continuity	• Teamwork between Perley care providers and informal care providers • Partnering model of scheduling of care providers	• Inconsistencies in care providers
Management Continuity	• Coordination and communication between care providers and support staff	• Size of organization creating silos between professions

Informational Continuity

Facilitators

Two categories of facilitators to informational continuity emerged from the data that were external to the *SeeMe* program: tools were leveraged to record resident information, and assessments were used to ensure information was recorded during acute health events.

Tools were leveraged to record resident information. Administrators and care providers found that having tools in place, including shift reports and 24-hour report binders, ensured that all relevant information on a resident was recorded so that, when care providers rotated shifts, they had all the information required to effectively care for their residents. In the shift report, care providers recorded any events that occurred during their shift that may be relevant to the next shift In the 24-hour report binder, care providers flagged any concerns that they felt other care providers should know about certain residents, for example that a resident should be watched more closely because they were experiencing pain. Many care administrators and care providers noted how important these tools were for facilitating continuity of care within the Centre, describing that when care providers across shifts all had access to the same information, they were able to provide continuous care.

> *So having that structured shift report can help ensure that there is a consistent structure for ensuring relevant things about residents across different shifts. So if you look at it at a more micro level, you can even see continuity of care across shifts. The documents like the unit calendar, 24-hour report, and shift report can help bridge that gap between continuity from one shift to another, or even amongst the nursing team to the allied health.* – Administrator 2

One administrator noted that despite these tools being in place, they were not always leveraged to their full capacity. When care providers faced time constraints, recording information on a resident in reports and reading information from reports was sometimes skipped, as demonstrated below:

> *Well, I would say that it's always an area that we could do better. So what we do know is that across the team, whether it's the PSW that's learning something or an RPN, sometimes the information isn't shared in a timely manner or isn't documented appropriately. And there's always concerns about staff members accessing, reading the information that has been shared. So we have 24-hour report and different kind of methods in our electronic health record that aren't always leveraged by the team. And often it's because they feel that they don't have time to do it. So we have a lot of mechanisms that exist but they're not all leveraged to their full capacity.*
> – Administrator 4

Assessments were used to ensure information was recorded after acute health events. In the case of an acute health event, administrators and care providers felt that assessments were in place to ensure that care providers took the appropriate steps and recorded the necessary information required to treat the resident. Assessments for specific events, for example a fall assessment when a resident fell out of bed, ensured that the information being recorded was specific to the situation at hand.

> *And depending on the situation, we have some specific assessments that can be used, for example, if they have a fall, there is a post fall assessment. And then that would help communicate all the details surrounding the fall to the care team, because [the assessment] would be posted on their electronic medical record.* – Administrator 2

Participants noted that there were specific assessments for various members of a care team, and by having similar structures for every report, it standardized the information recording process and allowed all members of a resident's care team to know where to access important information.

> *And I would say profession specific assessment, like if an OT does an assessment they will have their own assessment. Rec has their own assessments. Also, there is some related to specific events, like falls and responsive behaviours. So those things also help ensure that if new things need to be added to the care plan then they are added to the care plan. Like everyone across different units and different shifts. I think a lot of our documentation tools, in our point-click-care EMR, are helping facilitate that.*
> - Administrator 2

Inhibitors

Only one factor was reported as inhibiting informational continuity: staff time constraints leading to poor information transfer. Participants shared that care providers were often faced with time constraints as they are assigned to so many residents who require care. Administrators noted that care providers often felt that there is not enough time do to all the tasks required of them. As a result, communication handoffs, such as shift reports, were not always fully completed. This meant that important information about a resident was not being transferred effectively between shifts, hindering informational continuity.

Relational Continuity

Facilitators

Two categories were identified as facilitating continuity of care in this setting. The first was teamwork between care providers at the Perley & Rideau and informal care providers, and the second was the partnering model of scheduling of care providers to reduce staff rotation.

Teamwork between Perley care providers and informal care providers. Care providers at the Perley & Rideau worked with residents' informal care providers to provide effective care to residents. One resident whose husband also lives at the Centre was still able to care for her husband who has dementia and prefers the familiarity of being cared for by a loved one; however, she also had the support of her husband's care team.

> *She also looks after my husband. So there's often exchanges because he's a veteran and he attends different functions where he needs to be dressed in his legion uniform. And we are like partners in that, in looking after him. Which is fine. I don't mind sharing that because it's a way of making my life a little easier. Because someone with dementia does rely on the caregiver that they've had all along.* – Resident 5

Partnering model of scheduling of care providers. Care providers are scheduled using a "partnering" model in order to reduce rotation and help ensure the same care providers are consistently working with the same residents. In this model, each role has two staff members assigned to it (i.e., partners) so when one staff member is not working the other one is. Administrators felt that this scheduling model was effective in facilitating a relationship between care providers, residents and their family members, as care providers have time to form a connection with their residents and their families and do not have to manage relationships with a large number of residents.

> *They have a strong relationship I think. One nursing team is around 24/7. Since we are big on continuity of care, the nurses don't rotate, so they stay with that same resident forever. So the family knows who the nurse is. I think, to some degree, we have short staff*

> *so the staff have to move around. I think that interferes with the continuity a bit. But the nurses know there staff well, as people.* – Administrator 1

Inhibitors

One factor was identified as inhibiting relational continuity in this setting: inconsistencies in care providers. Despite the scheduling model mentioned above, residents felt that there was inconsistency in their care providers. These inconsistencies made it difficult for residents to form relationships with their care providers as they saw so many new faces.

> *I've never seen such a revolving door. A rotation that is impossible to understand, and almost impossible to live with. Yesterday in the morning, out of 4 PSWs there were 3 that I'd never seen before.* -Resident 5

Residents explained that with so many different people providing care to them, their providers do not know them well enough to understand the way in which they would like their care. One resident felt that they were constantly "training" new care providers:

> *Well, for one thing, I find myself training them every time. Because I need to…I need different things. I have elastic stockings. Well, I have to show them how to put them on. I can't put them on myself. But I must show them. And what else do I need? Well, I need [shoes]. Okay, what kind of shoes? What this and that? They're new. They don't know. They don't even know which cupboard. They don't know which drawer. They don't know… It's more of a challenge than if it were the same person. Well, not the same. There's got to be some replacement during the week because everybody gets days off.*
> – Resident 5

Management Continuity

Facilitators

One category was identified as a facilitator influencing management continuity: care providers and support staff coordinating and communicating to provide effective care. Administrators and care providers felt that they work together through communication and coordination to provide care that meets the needs and preferences of resident. They noted that there was an organizational effort to break down communication barriers and facilitate teamwork around a resident and their family. These efforts facilitated consistency in care as all care providers were working together to ensure the resident and family were the focus of care.

> *The PSWs and the RPNs work really closely together. There is a lot of different aspects of care, and we are trying to really break down silos between different team members, to ensure there is communication across the board.* – Administrator 2

Inhibitors

Only one factor was reported as inhibiting management continuity: the size of the organization creating silos between professions. Participants felt that since the Perley & Rideau is an extremly large organization, with various units and multi-disiplinary care options, there were silos between care providers in different professions. Despite the recognition that care providers and administors were working together to break down organizational silos, as mentioned as a facilitator of management continuity, participants still highlighted the size of the organization as a barrier. Administrators explained that across units and professional specialities there was often much less interaction and communication.

> *I would say that it can be challenging between professions to have that care because they may be people that you don't see as often or interact with as frequently. Let's say the OTs are recovering lots of residents across the entire facility, so you're not actually seeing them that much because they are not on your unit so it can be harder to have the face-to-face interactions.* – Administrator 2

One administrator commented on the importance of face-to-face interactions, as they facilitated a back and forth dialogue necessary for collaborating and building trust, teamwork that is required to facilitate consistency in care for residents.They noted that this information exchange can be much more effective than simply receiving information about a resident through their EMR.

> *I find the face-to-face interactions are very helpful because you're able to connect with that person and it's more of a back and forth dialogue and you're building trust as you connect with them. It's a little bit more enhanced than just that exchange of information,*

> *and you're getting that immediate feedback. You're getting more information about how that person works and how they like to receive information. You're getting more information than just an EMR because it's just not physically possible, especially with an organization our size with 450 beds, it's one of the largest long-term care homes in Ontario.* – Administrator 2

Another administrator noted that face-to-face interactions can be extremly important for continuity of care:

> *And whether that be kind of like the formal shift report with the team in addition to the kind of direct handoff from registered staff to registered staff, I think those are kind of really, really key kind of verbal…like the warm handoffs that are really, really important for the continuity of care. Particularly when you're looking at risk for the resident.*
> - Administrator 4

CHAPTER 4: DISCUSSION

In this chapter, I present a discussion of my findings and explain how these findings align with the documentary evidence and with previous research in this field. I also outline the strengths and limitations of my study and its contributions.

4.1. Summary of Findings

In this thesis, I aimed to explore how a goal-oriented care approach influenced continuity of care in a long-term care setting. This exploratory case study included reviewing documentary evidence and conducting semi-structured interviews to determine the influence of the *SeeMe* program on continuity of care at the Perley & Rideau Veterans Health Centre. The semi-structured interviews captured the perceptions of continuity of care from administrators, care providers and residents. I aimed to determine aspects of the goal-oriented approach that were facilitating and inhibiting continuity of care in this setting, as well as other factors outside the *SeeMe* program that were influencing continuity.

My first research question was, “How do residents, providers, and administrators perceive continuity within the long-term care setting?” Similar views were shared by administrators and care providers on continuity and the extent to which continuity was experienced by residents. Overall, administrators and care providers felt that residents at the Perley & Rideau experienced continuity of care through the care provided in the *SeeMe* program. Residents also seemed to experience continuity. Since residents were unlikely to have knowledge of the concept of continuity of care, the interview questions aimed instead to get information about aspects of continuity by asking about their perceptions of the extent to which information is shared between their care providers, their knowledge and their care providers’ knowledge of their health status, their relationship with their care providers, the consistency of their care providers, the flexibility in their care, and the overall consistency in the care provided to them. These questions revealed that, for the most part, residents experienced continuity of care, according to the six indicators in Reid et al's framework (24). While residents seemed to experience continuity, some residents felt they had many different care providers rotating through their unit, meaning that they often found themselves repeating their care instructions, and found it difficult to form long-lasting relationships with care providers. This indicates that the extent to which relational continuity is experienced by residents is likely not as strong as it could be.

The care conference and the goal-setting components of the *SeeM*e program align with the basic principles of a goal-oriented care approach. To investigate how this goal-oriented approach may influence continuity in a long-term care setting, the second research question was, "From the perspectives of administrators, care providers, and residents, what aspects of the goal-oriented care approach facilitate or inhibit continuity of care in this setting?" The findings indicated that the care provided through the *SeeMe* program had elements that both facilitated and inhibited continuity of care. In terms of informational continuity, aspects of the goal-oriented approach perceived to facilitate continuity included: the goals of care discussions which ensured that the resident, care team and family were on the same page; the care conferences which created awareness for residents of their care options; and, consistency in where the *SeeMe* assessment information was stored. Perceived inhibitors of informational continuity included that residents lacked awareness of the *SeeMe* program, and the care conference agenda caused confusion. In terms of relational continuity, aspects of the goal-oriented approach perceived to facilitate continuity included: incorporating a resident's values and preferences to form a holistic understanding of the resident; staff increasing awareness of the program for families; and, integrating the family's perspective into a resident's care. The one inhibitor of relational continuity was relying on family involvement when family was not always available. Finally, in terms of management continuity, aspects of the goal-oriented approach perceived to facilitate continuity included: the *SeeMe* program discussions which facilitated informed decisions; the *SeeMe* assessments which acted as reference tool in case of acute health event; the goals of care discussions which empowered residents and family members to talk to external healthcare providers; and, the structure of the *SeeMe* program which facilitated consistency in care. Perceived inhibitors of management continuity included a long wait time until residents attended their first care conference, and family members having difficulties making decisions. Overall, participants felt that residents at the Perley & Rideau experienced continuity of care through the care provided in the *SeeMe* program, showing the positive impact of this program in this setting.

The third research question was to determine what other factors influenced continuity of care in this setting. These factors included elements outside of the *SeeMe* program that may be influencing the resident experience. Similar to the *SeeMe* program factors, there were factors identified as both facilitating and inhibiting continuity. Factors perceived to be facilitating informational continuity included that tools were leveraged to record resident information, and assessments were used to ensure information was recorded after acute health events. The one inhibitor of informational continuity identified was care provider time constraints. In terms of relational continuity, factors perceived to facilitate continuity included teamwork between Perley & Rideau care providers and informal care providers, and use of a partnering model to schedule care providers. The one inhibitor of relational continuity identified was inconsistencies in care providers. Finally, in terms of management continuity, the one facilitator identified was coordination and communication between care providers and support staff. The inhibitor identified as influencing management continuity was that the size of the large organization created silos between professions. Overall, the results indicated that the organizational processes outside the processes directly influenced by the *SeeMe* program supported continuity within this setting.

4.2. Comparison with Documentary Evidence

For the most part, the organization's description of the *SeeMe* program, based on the information collected in the documentary evidence review, aligns with administrators' and care providers' descriptions of the program; however, there was some contradictory information that is outlined below. The documentary evidence described the program as a true partnership between the healthcare team and resident/family, using a holistic approach to care that recognizes and assesses frailty as part of a resident's overall health, and that the program aligns provision of care with a resident's level of frailty and healthcare preferences. These were all key themes that were described by administrators and care providers as outcomes of the *SeeMe* program that facilitated continuity in this setting.

In terms of contradictory information, when asked about the *SeeMe* program, the five residents that I interviewed said they had not heard about the program and were unaware that it existed at the Centre. This finding perhaps contradicts one of the objectives of the program outlined in the evaluation framework: "educating residents and families about the *SeeMe* program." While the program is still in its initial stages of being operationalized, it seems that the organization has not adequately educated residents on the program and how it influences their care at the Centre. Since family members of residents were not included in this study, it cannot be determined to which degree family members were educated about the program.

The other objectives of the program including optimizing health outcomes for residents, delivering an effective frailty-informed care education program for staff, and implementing *SeeMe* tools and processes across the home, are apparently being achieved based on the perspectives of administrators and care providers. These participants felt that the *SeeMe* program facilitated effective health outcomes, especially in the case of an acute health event. Administrators and care providers noted that the *SeeMe* assessments acted as a tool to reference in case of an acute health event to help residents, families and care providers make decisions under these stressful conditions. As well, care providers and administrators seemed to have a very good understanding of the frailty-informed care approach, and all staff members included a description of this approach to care in how they described the *SeeMe* program. Finally, the tools and process associated with the program seemed to be progressing across the organization in alignment with the step-wise implementation program planned by the leadership team.

4.3. Alignment with Theoretical Framework

Reid et al's theoretical understanding of continuity was developed in a primary care setting and has since been empirically applied by others within a primary care setting. Although the literature review for this thesis was not systematic, it appears that this theoretical framework has been applied to the long-term care setting in only two studies, as discussed in Chapter 1.3. The thesis results are well aligned with the theoretical framework of Reid and colleagues (24), suggesting that it is appropriate for examining continuity of care in a long-term care setting. The factors facilitating and inhibiting continuity of care within this setting that were identified in my thesis fit within each of the three types of continuity outlined in the Reid model. Using the framework, the interviews were designed to gain insight into how residents experience each type of continuity. For example, questions were designed to start discussions about each of the indicators associated with information, relational and management continuity in Reid's model. Interestingly, there was no factor that stood out as more important or more emphasized in this setting, and the factors that were identified as facilitating and inhibiting continuity were fairly evenly distributed between each of the three types of continuity. Reid's model also included both a person-based focus and a disease-based focus as lenses on which to view each of the three types of continuity. Participants' overall perceptions of continuity aligned with the person-based focus in the model, as administrators' and care providers' conceptualization of continuity emphasized relational and management elements of continuity. Specifically, administrators defined continuity similarly as consistency in the care being provided to residents, an indicator of management continuity. Care providers defined continuity differently, some as consistency in care, some as consistency in care providers and some as the relationship between care providers, elements of both relational and management continuity. This research provides another example of the application of this conceptual model in the long-term care setting.

4.4.Comparison with Literature

Most empirical studies on goal-oriented care focus on the primary care setting. Two empircal studies were identified that evaluated a goal-oriented approach including Blom and colleagues' study on Integrated Systematic Care for Older People (18), and Steele Gray and colleagues' study on the usability and feasibility of an electronic tool designed to support goal-oriented primary care delivery (19). In both studies, goal-oriented care was conceptualized similarly to the goal-oriented components of the *SeeMe* program, with a consultation between healthcare providers and patients to determine a patient's goals and create a care plan. Specifically, in Blom et al.'s study on proactive, goal-oriented integrated care, the approach in practice included a disccusion between the GP or nurse and the older person and their informal caregiver (18). Steele Gray et al.'s study evaluated a goal-oriented approach where goals were also formulated as a collaboration between care providers and patients; however, this approach used an electronic tool, called the ePRO tool, to facilitate this process (19). Despite having very different study designs, these studies demonstrated similar outcomes to the results of this study. Specifically, in Blom et al.'s cluster randomised trial, GPs experienced a better overview of care needs and more stability using the care plans, a similar finding to the experiences of care providers in this research, as care providers perceived the goals of the care discussion to ensure that the resident, care team and family were on the same page, and care providers found the structure of the *SeeMe* program to facilitate consistency in the care being provided. Similarly, Steele Gray et al.'s pilot study found that providers felt the ePRO tool was helpful in focusing conversations on goal-setting. This result is also similar to my finding here that care providers perceived that the goals of the care discussion were to ensure the resident, care team and family were on the same page. While providers found the electronic tool helpful to focus conversations, Steele Gray et al., also reported that providers found the monitoring questions in the tool did not address individual patient needs, the tool did not fit well with provider workflow, and found the tool made daily reporting more time-consuming. This finding aligns with the perceptions of care providers in this study, specifically in terms of the perception that the care conference agenda can cause confusion as it was not personalized to a resident, and instead sometimes brought up conversations that would otherwise not be raised with the resident and their family. In terms of patient outcomes, Bloom's study found no direct outcomes related to changes in patient quality of life. In Steele Gray's study, some patients reported that the tool helped them self-manage, catalyzed a sense of responsibility of their care, and improved patient-centered care delivery. These findings are difficult to compare to results here since residents in this study were unaware of the *SeeMe* program, and therefore could not comment on its influence on their care. It is important to note that these studies focus on outcomes, whereas my thesis contributes to our understanding of the process of goal-oriented care and its impact on continuity.

While research on continuity of care primarily focuses on the primary care setting, there are some empirical studies that examine continuity in the long-term care setting. As mentioned in the literature review, one of the few studies focusing on continuity of care in the long-term care setting was conducted by Marshall et al. to assess the new "Care by Design" program implemented in long-term care facilities in Halifax, Nova Scotia (32). This study identified four key features of the program that facilitated continuity, and these factors were similar to many of the factors identified in this thesis. First, Marshall et al.'s study suggested that continuity of care is improved when there are standards of care in place (32). Similarly, administrators and care providers in this study identified that the structure of the *SeeMe* program facilitated consistency in care by providing structured care conferences, so that care is provided to all residents in a similar was across the Centre. Second, the Marshall et al. study identified that care teams prioritized patient needs in advance of physician visits as a facilitator of continuity in a long-term care setting. This thesis aligned with this finding, as care providers felt they incorporated a resident's values and preferences in the care conference, prioritizing patient needs and ultimatly facilitating continuity. Third, the Marshall et al. study identified that continuity of care was improved when there were tools in place to create consistencies in medical care (e.g., notes in charts and care directives). In line with this finding, a facilitator of continuity identified in this thesis was consistency in where *SeeMe* assessment information was stored so that all care providers had access to the information, and this finding was categorized into informational continuity. Fourth, the Marshall study identified that continuity was facilitated when physicians on site provided regular care at least one day a week. In contrast, this research did not reveal regular visits by physicians as a facilitator of continuity.

Another study, by Gjevjon et al., suggested that the number of care providers was not a barrier to continuity of care, according to patients; however, patients with trusting relationships with their current providers were more likely to be open to having more care providers (33). In contrast with Gjevjon et al's work (33), this research revealed that the number of care providers caring for a resident did inhibit perceptions of continuity. Residents in this thesis noted that inconsistencies in care providers meant they had to repeat care instructions and made it difficult for them to form relationships with their providers. This factor was categorized into relational continuity; however, it was a factor that was noted as not relating directly to the care provided through the *SeeMe* program, and instead noted as an "other" factor, meaning that it is not related to the goal-oriented care approach.

The results of this thesis indicate that the *SeeMe* program may facilitate continuity of care within the long-term care setting. A goal-oriented approach has the potential to positively influence continuity of care for residents. This finding adds to Miller et al.'s research that emphasized the importance of resident-centeredness in long-term care settings as a way of achieving better health outcomes for older adults (21), as my study identifies improved continuity as a possible outcome of the goal-oriented approach. This research also contributes additional features that may influence continuity of care, including a list of specific facilitators and inhibitors of each type of continuity.

4.5. Strengths and Limitations

The case study methodology facilitated an in-depth analysis of factors influencing continuity of care within this setting. A strength of this study was the use of various sources of evidence.

The documentary evidence provided the foundation for understanding the organization and the *SeeMe* program, increasing the contextual understanding of the study setting. This allowed me to build an interview guide that included in-depth questions about the program and its influence on care, as well as provided background program knowledge to design probing questions to further explore participants' responses. As well, by including multiple types of participants, including administrators, care providers and residents, varying perspectives were captured to gain a holistic picture of the case at hand.

Limitations of this research include the potential for selection bias. The in-depth nature of the information gained through this type of research relies on volunteers for participation. This means that it is posisble that the administrators, care providers and residents who agreed to participate had a vested interest in sharing their opinion and may not have represented the opinions of others in these groups. Another limitation is that the sample size was small. This relatively small sample could limit the insights that may have been gained from each group of participants. Specifcially, in terms of care providers, I only interviewed one or two of each type of provider. This meant that, for example, the perspective of only one physican was captured. As well, a resident's family members were not included in the thesis, and may have provided additional insight into the influence of the program and different perspectives. The decision to not include family members was made to simplify the study to fit within the feasibility of my thesis, and further research on this program could include family members to ensure their perspective is captured. Despite having a small sample size and not including family members, I feel my study reached thematic saturation with care providers' and administrators' perspectives, however, not with residents' perspectives. If I had interviewed more residents, I may have included residents who were aware of the program and able to provide their perceptions of how the program influenced their care. As well, by only including residents with a Cognitive Performance Score below one, I may have missed out on capturing the impact of the program on residents who were less cognitively intact. Also, this thesis focuses on a unique case which limits the transferability of the results. Since the Perley & Rideau is aiming to be a Centre for excellence in fraility-informed care, they may be performing better in terms of resident-centered care than other long-term care facilities. This means that these results may not be transferrable to other settings. Similarly, the *SeeMe* program is specific to the Perley & Rideau, and while it may be similar to other goal-oriented care approaches, it has other components that may differ. These components include, for example, the comphrehensive frailty assessment that occurs prior to the care conference, an aspect that does not exist in many other goal-oriented care approaches. This means that the results may not be transferable to other goal-oriented care programs in the long-term care setting.

Qualitative research quality is often dependent on the skills of the researcher, and can be easily influenced by the biases of the researcher (64). Various measures were taken to enhance the quality and credibility of this thesis including the use of triangulation, the use of a theoretical model, presenting a negative case analysis, and using a rich description to present the results; however, the results may still have been influenced by the skills and biases I have as a researcher. To understand the perspectives of administrators, care providers and residents on the care provided through the *SeeMe* program, a constructivist paradigm was used. My analysis focused on understanding the experiences of residents and discovering meaning through these experiences (49). It is important to note that how I understood and interpreted participants' experiences may differ from other researchers. Readers should use the rich description of the case provided in the results section to critically interpret participants’ perspectives and experiences.

CHAPTER 5: CONCLUSION

In this section, I present the practical implications of my study and recommendations for future research.

5.1. Practical Implications

From a practical standpoint, the findings suggest that a goal-oriented approach may positively influence continuity of care in a long-term care setting. A program like the *SeeMe* program that incorporates person-centered and goal-oriented care, may help facilitate continuity of care for older adults in a long-term care setting. Aspects of the *SeeMe* program that facilitate continuity can be targeted when designing goal-oriented care approaches. For example, to facilitate informational continuity, the program could consider: integrating a goals-of-care discussion that helps to ensure the resident, care team and family are on the same page; conducting a care conference that helps residents understand their care options; and, creating procedures that ensure consistency in where a resident's goal information is stored. To facilitate relational continuity, programs should consider: incorporating a resident's values and preferences to form a holistic understanding of a resident; ensuring staff have the tools to increase a family's awareness of the program; and, integrating a family's perspective into a resident's care. To facilitate management continuity, programs should consider including: discussions that facilitate informed decisions; assessments that can act as a reference tool in the case of an acute health event; discussions to empower residents to talk to external care providers; and, a structure that facilitates consistencies in care. The inhibitors of continuity identified in this research should be noted by others as practices that should potentially be avoided when designing care approaches to achieve continuity.

Aspects of the *SeeMe* program that inhibit continuity can also be targeted when designing goal-oriented care approaches, or to improve the *SeeMe* program itself. Specifically, these factors can be considered “areas of improvement” for future iterations of the program. For example, to improve informational continuity, the care conference agenda could be streamlined to avoid confusion. As well, to improve relational continuity there could be options in place for how to make decisions when the family is not available, such as having pre-determined decisions or adding other contact options. To improve management continuity, the program could shorten the time between when a resident moves into the Centre and when they attend their first care conference, as well as the family could be provided the care conference agenda in advance of the meeting to help prepare them for the questions that will be asked.

5.2. Recommendations for Future Inquiry

More research is needed on goal-oriented care approaches that have been implemented in other long-term care settings to determine if the factors identified here as influencing continuity are confirmed. Empirical research could validate the results of this study, or show that other factors influence continuity in different settings. Future longitudinal research could examine the specific outcomes of improved continuity of care for long-term care residents in facilities that have implemented a goal-oriented approach. This could also be done using a randomized controlled trial that compares the outcomes of residents who are randomized to a goal-oriented care approach to those randomized to receive normal care. In these times of witnessing the impact of the COVID-19 pandemic on older adults in long-term care, it is important to consider how we can improve the quality of life and care of these residents. Goal-oriented care and programs, such as the *SeeMe* program, have the potential to ensure that care is focused around the residents’ unqiue needs and wishes, offering a care approach that may improve lives and outcomes.

CHAPTER 6: REFERENCES

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APPENDICIES

APPENDIX I: Interview Protocol

INTERVIEW PROTOCOL FOR ADMINISTRATION & CARE PROVIDERS	
Time	**Instructions and Speaking Points**
0:00-0:05	**Welcome & Introductions** My name is Madeline and I will be interviewing you today.
	Purpose of Study The interview today is for a research project as part of my Masters thesis that aims to better understand continuity of care in a long-term care setting. Specifically, I am interested in understanding the *SeeMe* program and how this program influences care at the Perley & Rideau. I am interested in hearing about your experience with this program, as well as your perspectives on the care that your residents experience.
	Discuss Consent Process I provided you with a consent form prior to this interview. Have you had a chance to review it? (*if not, provide time for participant to carefully review*) Do you have any questions about the information provided on the consent form? (*Answer any questions*) Do you have any questions about the study? (*Answer any questions)* This interview will be audio recorded, do you have any questions about this? Ok, I will start the recording now. You may stop the interview at any time and withdraw from the study. You do not need to give a reason for your decision. You may skip any questions you prefer not to answer. By continuing with the interview, you are consenting to take part in the research study. Do you consent to take part in this study? Did you have any other questions before we begin?
0:05:0:20	**Part 1: General Experiences with *SeeMe* program** 1. Tell me about your role at the Perley & Rideau. *Prompts:* - How long have you worked with the Perley & Rideau? - What is your professional background? 2. Tell me about the *SeeMe* program. *Prompts:* - What is your involvement in this program? - What are your experiences with the program? - Have you been part of a care conference? What was this process like?

	- In what ways, if any, has the program changed care for patients? - What are some of the challenges or areas of improvement for the program? - How do you see the program evolving in the future?
0:20-0:40	**Part 2: General information about patient care in the *SeeMe* Program** 3. Tell me about the relationships between clients and their care team at the Perley & Rideau? *Prompts:* - How many care providers are part of a typical client's care team? - In a typical day, how many care providers would a client see? - Does this differ at all between clients in the *SeeMe* program and those that are not in the program? 4. Tell me about how patient information is shared between providers within the Perley & Rideau. *Prompts:* - What types of information about a patient is shared between Perley and Rideau care providers? - How is information shared? (i.e. in person, through EMR, on a report etc.) - In what ways, if any, does the information being shared facilitate care for patients? - What are some of the challenges with information sharing that you think could be improved? - In your opinion, how, if at all, does the *SeeMe* program affect information sharing? 5. Tell me about how members of a resident's care work together to provide care to clients? *Prompts:* - Is everyone in a client's care team aware of the client goals? - When a client's health status changes, for example they fall and hurt their hip, how do members of their care team react? - What if a resident decides to change their health & personal goals? How does a care team adapt to these changes? - Who is ultimately responsible for coordinating a patient's health care needs?

0:40-0:55	**Part 3: Factors affecting Continuity of Care** 6. What does the term continuity of care mean to you? [***NOTE****: If the term "continuity of care" doesn't resonate with the interviewee, explain what we consider continuity of care to be.*] Define as: "the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the clients' medical needs and personal context" (Haggerty, 2003) *Prompts* - What does continuity of care look like at the Perley & Rideau? 7. What helps achieve continuity of care for clients at Perley & Rideau? 8. What are some of the challenges in achieving continuity of care for clients at Perley & Rideau? 9. Do you think that the *SeeMe* program influences continuity of care for patients at the Perley & Rideau?
0:55-1:00	**Thank participant for his or her time and ask if they have anything else to add or any questions.**

INTERVIEW PROTOCOL FOR CLIENTS	
Time	**Instructions and Speaking Points**
0:00-0:010	**Welcome & Introductions** My name is Madeline and I will be interviewing you today.
	Purpose of Study The interview today is for a research project for my Masters' thesis on understanding patient's priorities and on continuity of care here at the Perley & Rideau. I am interested in hearing about your experiences with the *SeeMe* program that you are a part of here and how this program has influenced your time here. I am conducting this research as part of my graduate studies. I do not work at the Perley & Rideau. While the overall results of the study will be shared with the administration at the Perley & Rideau, the stories you share with me today will not be shared with your care providers or the administration directly. We will not share any data that will allow you to be identified.

	Discuss Consent Process I am going to start by reviewing the consent form for my study with you. (*read over consent form*) Do you have any questions about the information provided on the consent form? (*Answer any questions and have participant sign*) Do you have any questions about the study? (*Answer any questions)* This interview will be audio recorded, do you have any questions about this? I will start the recording now. You may stop the interview at any time and do not need to give a reason for your decision. You can choose not to answer any of the questions, for any reason. By continuing with the interview, you are consenting to take part in the research study. Do you consent to take part in this study? Did you have any other questions before we begin?
0:10:0:30	**Part 1: General Experiences with *SeeMe* program** 1. Tell me a little bit about yourself. 2. Tell me about your experiences here at the Perley & Rideau. *Prompts:* - How long have you lived here? - Do you have a spouse who lives here? - Do you enjoy living here? - Have you faced any challenges in your time here? 3. Have you heard about or been a part of the See Me program? *If response is yes,* tell me about the SeeMe program. *If not, skip to next section.* *Prompt:* - How has your experience been with the *SeeMe* program? 4. Have you talked to anyone about any goals or priorities you may have for your care or your time here? *Prompt:* - If you feel comfortable sharing, what were some of your goals or priorities for your care or your time here? 5. How did you feel about the opportunity to discuss goals with your care team? Prompt: Did you feel that your care team listened to you? Did you feel that what was important to you was taken into considering when planning your care? 6. Has being part of the *SeeMe* program changed your care or your experiences here at the Perley & Rideau? If yes, in what ways?

0:30-0:50	**Part 2: General information about patient care** 7. Tell me about some of your care providers, like your nurses, doctors, or other health staff, here at the Perley Rideau. *Prompts:* - Do you have a good relationship with them? - How many care providers do you have? - How often do you see your care providers? 8. Tell me about how well your care providers know you. *Prompts:* - Do they know your goals? - Do they know what you like and do not like, for example your favourite pass times? - Do they know your health conditions well? 9. In your opinion, do you feel your health care providers work as a team? *Prompts:* - Do you feel like your providers communicate well with each other about your health? - Do you feel you have to repeat your story often? - Do your care providers know when there has been a change in your health? 10. Is there anything you would like to share with me about your experience either with the *SeeMe* program or with your time here at the Perley and Rideau?
0:55-1:00	**Thank participant for his or her time and ask if they have anything else to add or any questions.**

APPENDIX II: CODE BOOK

GRANDPARENT CODE	PARENT CODE	CHILD CODE
Perley & Rideau: describes information regarding the Perley & Rideau at multiple levels including organizational, staff or resident	**Organizational information:** describes information regarding the Perley and Rideau in general	
	Staff Information: describes information on staff including care providers and administration	
	Resident information: describes information on residents living at the Perley & Rideau	**Resident experience:** describes the experiences of residents living at the Perley & Rideau
***SeeMe* Program:** Perley & Rideau's frailty-informed care model involving a frailty assessment followed by a care conference to determine a residents care goals	**Organizational Level:** describes how the *SeeMe* program influences elements of the Perley & Rideau's organizational structure, culture, and overall function	**Philosophy of Care:** values, beliefs and ethics regarding care and treatment of residents in the SeeMe program
		Implementation: describes how the program was implemented throughout the organization
		Organizational outcomes: describes outcomes of the SeeMe program that effect the organizations structure, culture and overall function
		Leadership Buy-in: support and agreement from senior leaders on the mission, vision and values of the *SeeMe* program
	Staff Level: describes how the *SeeMe* program influences staff and how staff influence the effectiveness of the *SeeMe* program	**Education & training:** Used to describe education and training efforts that are made to teach care providers about the *SeeMe* program and how they should be using it in their work.
		Roles: Describes what care provider's role in providing care through the SeeMe program is.
		Staff Buy-in: support and agreement from care providers on the mission, vision and values of the *SeeMe* program
		Staff level outcomes: describes outcomes of the *SeeMe* program that affect staff at the Perley & Rideau
	Resident & Family Level: describes how the *SeeMe* program influences residents and family members and how residents and family members influence the effectiveness of the *SeeMe* program	**Program awareness:** describes how aware patients and family members are of the SeeMe program and its care components (e.g. frailty assessment, care conferences, and resulting care as a result of these assessments)
		Autonomy: Freedom to make ones own choices. Use this code to describe information about patient having more or less control over their decisions.
		Patient level outcomes: describes outcomes of the *SeeMe* program that effect patients and families

	Approach to care: describes the care that is provided through the *SeeMe* program	**Holistic:** to describe care that is based on an understanding of the client as a whole person, not just a patient or diagnosis. Includes an understanding of their physical, psychological, emotional and spiritual dimensions.
		Structured approach: describes an approach to care that has clear procedures and protocols
		Person-centered: to describe care that is focused on the patient and their preferences, values and goals. Apply this code for any reference made to this type of care.
		Frailty informed care: looks at health decisions that would best suit a frail adult. Use this code for any action or decision that is frailty-informed.
		Goal-oriented care: approach to care that focuses on a client's individual goals
		Family involvement: Describes health events or decisions that involve the resident's family.
		Non-holistic/non-structured/non-person centered/ non-goal oriented care approach: describes care that does not follow the principles of either holistic, structured, person-centered or goal oriented care.
	Comprehensive Frailty Assessment: assessment conducted by a care provider on a resident that assigns a frailty score based on information on different drivers of frailty	**Frailty Score:** Clinical score assigned to a resident based on an assessment of a residents cognition, function and mobility. Scale ranges from 1 (very fit) to 9 (terminally ill).
		Frailty drivers: Major drivers including as cognition, function and mobility that effect a person's frailty
	Care Conference: meeting held with the client and their family to discuss the overall health picture and considerations for future decision making. During this meeting clients are asked to discuss their goals, values and preferences with the care team.	**Goal setting:** Creating goals after frailty-assessment to be used to treat health conditions. Describes choices that the resident gets to make about their health care plan and health outcomes.
		Care Plan: Describes the care plan that is a result of the goal-setting process. Includes information on how a resident would like to be cared for daily as well as in the case of an acute health event.
Informational Continuity: includes the use of information to make appropriate decisions for a client	**Information Transfer**: the transfer of documented or verbal information from one provider to another	**EMR:** Electronic Medical record. Apply code for any reference to processes or tools on this system.
		History: Information on a patient's past including personal and health information.
		Assessment & Report: Used to describe assessments conducted by care providers to record information about a patient and reports to inform

		care providers of important information (e.g. shift report)
		Discussion: Used to describe any face-to-face information sharing between staff or residents and staff.
	Provider knowledge: extent to which care provider is aware of information about a resident	**Provider knowledge of resident health:** the extent to which a provider is aware of health status information about a resident
		Provider knowledge/use of resident care plan: degree to which a provider is aware of a residents care plan and the extent to which they refer to the care plan to provide care
	Patient & family knowledge: extent to which a resident is aware of their health status and care plan. Use this code with health status and care plan information overlap.	**Patient & family knowledge of health status:** Describes the information that a patient knows about their health status including level of frailty, comorbidities, cognition, function and mobility.
		Patient & family knowledge of care plan: Describes the information that a patient knows about their *SeeMe* care plan and their associated goals of care
Relational Continuity: the relationship between the client and the care provider	**Client-provider relationship:** describes the relationship between clients and their care providers (PSWs, nurses, physicians, and any informal care providers). Use this code when care information and personal information overlap.	**Care relationship:** Used to describe relationships between care providers and residents. Refers to how well a care provider knows a resident's care preferences, frailty, and health status.
		Personal relationship: Used to describe relationships between care providers and residents. Refers to how well a care provider knows a resident's history, family, hobbies, interests etc.
	Consistency of care providers: describes the variability in care providers providing care to a client	**Short-staffed:** Indicates any reference to a shortage of staff in the organization, causing difficulties providing effective care.
		Staff rotation: When care providers have to rotate their shifts to be with different residents, meaning they are not always with the same resident.
Management Continuity: describes the overall management of care, including care planning and the coordination of care	**Consistency of care:** describes the variability in the experience of care for a client from shift to shift or day to day	**Process & procedure consistency:** Used to describe process and procedures that create a consistent resident experience across the organization.
		Teamwork & Coordination: Describes any activity that involves care providers working together to provide care to residents and/or family members working with care providers to provide care. Also use this code when multi-disciplinary teams are discussed.
		Transfer across care settings: the extent to which the care experience remains consistent across care settings (e.g. long-term care to hospital) and the

		extent to which care providers are aware of care needs and preferences across care settings.
	Flexibility of care: the extent to which care is individualized to a resident and the actions of adjusting care to meet the needs of a resident in a specific instance	**Dynamic:** Used to describe a process that involves constant change and adaptation as a residents care needs and preferences change
		Acute health event: Used to describe any sudden change in a patient's health conditions. Use this code when describing crises or reponse to acute events.