

Care Coordination, *Samhandling* and Patient Safety

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Abstract: This chapter focus on Norwegian healthcare policies and regulations for care coordination and patient safety. The Norwegian Coordination Reform implemented in 2012 emphasizes patient engagement, care pathways, and competence development in municipal healthcare services. Moreover, protocols for division of work tasks and collaboration between specialist and municipal healthcare services are key aspects. The reform identifies fragmented health services and the lack of coordinated care as main challenges. The authors introduce the concepts of care coordination, continuity of care and patient handovers, and relate these to patient safety. Results from a Norwegian observational study, identifying factors affecting care coordination and patient safety in care transitions between hospital and municipal care, are presented. Finally, the authors introduce relevant measures to improve care coordination and patient safety, including the regulatory work and follow-up of health services through nationwide audits performed by the Norwegian Board of Health Supervision.

Keywords: *Samhandling*, interaction, healthcare services, patient safety, municipal care, coordination, risk, unforeseen.

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Introduction

The World Health Organisation (WHO, 2007) defines patient handover as a high-risk area in health care. In Norway, the Coordination Reform [*Samhandlingsreformen*] (White Paper No. 47, 2008–2009) points to fragmented and poorly-coordinated services as a key challenge in the health services. We use the term “coordination” in this field and chapter. The tasks related to treatment and care are carried out in separate units or ‘silos’ (Gloubermann & Mintzberg, 2001), although the municipality and specialist healthcare services have complementary roles and functions (Kodner & Spreeuwenberg, 2002). The hospital focuses on treatment and the municipal healthcare services focus on patient care, function and coping with daily life. Communication between involved healthcare personnel, continuity of information and transfer of care responsibility are some key factors for patient safety in care coordination between hospital and municipal healthcare services.

Insufficient care coordination across hospital and municipal healthcare services may increase the risk of adverse events (Laugaland, Aase, & Barach, 2011). This can be due to unclear, delayed or insufficient information and communication between healthcare personnel about the patient’s medication and treatment, inadequate preparations for upcoming care transitions, and poor coordination of measures in the municipal healthcare services (Hellesø, Sørensen, & Lorensen, 2005; Hesselink, et al., 2013). Inadequate care coordination leads to problems maintaining continuity of care, and increases the risk of adverse events, patient re-admissions to hospitals and mortality (Stoyanov et al., 2012; Tsmilligras & Bates, 2008). The preparation of elderly patients and their next of kin for upcoming care transitions to municipal healthcare services may be one way of improving care coordination and patient safety (Bull, Hansen, & Gross, 2000; Foss & Hofoss, 2011).

This chapter will shed light on the issue of care coordination within the framework of patient safety, health policy directives and legislation. We use the term “care coordination” in order to be consistent with the Norwegian government’s use of the concept in the Coordination Reform (White Paper No. 47, 2008–2009). The Coordination Reform and related laws emphasize responsibilities; rights and duties for specialist health

services and municipalities to ensure care coordination and continuity in healthcare services (Municipal Health and Care Services Act, 2011; Specialist Health Services Act, 1999; White Paper No. 47, 2008–2009).

The concepts of “care coordination”, “continuity of care” and “patient handover” will be explored in relation to patient safety. We will present some results of a research study that examines care coordination between hospitals and the municipal healthcare services. We will also identify some factors that affect patient safety in care coordination. Finally, we will comment on the work and follow-up efforts by the authorities, seen in the form of country-wide audits, and we will present some measures to improve care coordination and patient safety.

Health policy

The Coordination Reform, came into force in Norway on January 1 2012. The reform emphasizes strengthening patient autonomy, establishing care pathways for specific patient groups, ensuring consistency in contact and follow-up from health services during periods of illness, improving staff clinical competence in the municipalities, and establishing binding agreements between municipalities and hospital trusts to ensure collaboration and shared-accountability for patient care and follow-up. In the National Health Plan for Norway (2011–2015), tasks related to the Coordination Reform occupy a central role. Its objective is to ensure the provision of high quality, comprehensive services, a high degree of patient safety and short waiting times. The White Paper, ‘High Quality – Safe Services – Quality and Patient Safety in the Health and Care Services’ (White Paper No. 10, 2012–2013) identifies three main goals for work, related to quality and safety:

- 1) Services need to become more user-oriented. The experiences of the individual patient/user need to be used in quality improvement, and service providers and patients need to engage in collaborative work, to ensure shared decisions about the individual’s treatment and care. The next of kin are a vital resource.
- 2) Clearer prioritization of tasks related to systematic quality improvement. Work related to healthcare quality needs to be integrated into

the service. Improving on the systems measuring quality, ensuring leadership support and expectations for results, including follow-up, with appropriate improvement measures when necessary.

- 3) Improved patient safety and a reduction in adverse events, through mechanisms and a culture for reporting, analysing, and learning from and preventing adverse events. Additionally, oversight over risk areas needs to be improved.

The White Paper assumes a broad approach to quality in the health services. It is based on the principle that the services are effective, safe and secure; involve users and give them influence; are coordinated and characterised by continuity; utilize resources effectively; are accessible and equitably distributed (Norwegian Directorate for Health and Social Affairs, 2005; White Paper no. 10, 2012–13, Institute of Medicine 2001). In the Paper, patient safety is one of the six dimensions of quality, or characteristics, of the services (Aase, 2015; White Paper No. 10, 2012–2013; Directorate of Health and Social Affairs, 2005). In this chapter, we will focus on patient safety as a central concept, even though it is often used in conjunction with quality.

Legislation related to care coordination and patient safety

Norwegian regional health authorities have a duty to facilitate necessary collaboration between health trusts within the regional health authority and other regional health authorities, counties, and local municipalities, or other providers delivering services prescribed by law (Specialist Health Services Act, 1999). The Coordination Reform (White Paper, No. 47, 2008–2009) and relevant legislation require hospital trusts in specialized health services and municipalities to establish binding agreements, in order to improve coordination and integration of healthcare services (Specialist Health Services Act, 1999; Municipal Health and Care Services Act, 2011). This is intended to ensure that patients and users experience continuity and coordination of services. The agreement includes, among other aspects, that the parties have to agree on which tasks the healthcare providers have

responsibility for. In addition, the agreement requires the specification of a common understanding of measures which the parties are responsible for implementing, if necessary. It also includes guidelines on collaboration, in relation to both admission to hospitals and the discharge of patients who require healthcare from providers in the municipality. A breach of the agreement may result in a written notification of irregularity and possible penalties. Individual plans, patient coordinators and coordinating bodies or offices are other instruments in the legislation, established to ensure continuity and coordination of care for patients with long-term needs.

There are several legal requirements for the purpose of promoting patient safety. There is no specific patient safety act in Norway. However, there are requirements specified in several laws and regulations. Herein, we will briefly mention the most important ones. The concept of sound professional practice is one of the most central requirements for health-care personnel and service providers. This requirement can be found in the Specialist Health Services Act (1999), the Municipal Health and Care Services Act (2011) and the Health Personnel Act (1999). The requirement of sound professional practice is not the only requirement in health legislation with implications for patient safety. The Regulations on Leading Quality Improvement in the Health and Care Services (2016) describe central parts of the legally-required safety management system, which the provider must have in place. The provider is responsible for having an oversight over risk areas, and establishing mechanisms for prevention and following-up of adverse events, in addition to other things. There is also a specific requirement in relation to assessment of risk in handovers, within providers and between providers. Moreover, there are requirements imposing a duty on health personnel to hand over any available information on conditions that may endanger patient safety to supervisory authorities. There is a requirement in the Specialist Health Services Act stating that healthcare providers have a mandatory duty to report adverse events to the Directorate of Health, and notify the Norwegian Board of Health Supervision about the most severe adverse events. The latter concerns deaths or significant injuries where the outcome is unexpected in terms of foreseeable risk. Figure 23.1 depicts the participants and their roles in care coordination and patient safety.

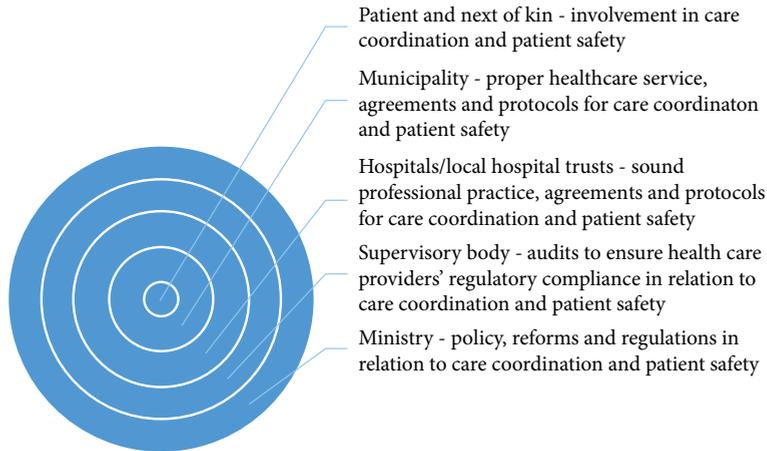


Figure 23.1 The participants and their roles in care coordination and patient safety.

Coordination and patient safety

Patient safety has become an established research area, both nationally and internationally (Aase, 2015). The development of the patient safety field in Norway has, to a large degree, been influenced by developments in other countries and international organizations, such as the World Health Organization (WHO) (NOU, 2015:11). WHO defines patient safety in the following terms:

“Patient safety is the absence of preventable harm to a patient during the process of health care. The discipline of patient safety is the coordinated efforts to prevent harm, caused by the process of health care itself, from occurring to patients.”

(WHO in NOU, 2015:11:26)

In 2010, the Norwegian Knowledge Centre for the Health Services explored taxonomies related to patient safety in the international literature. The following definition is currently used: *“Patients shall not be subject to unnecessary harm, or the risk of unnecessary harm, as a result of the health service’s efforts and performance or lack of the same.”* (Saunes, Svensby, Mølstad, & Thesen, 2010:6).

Research plays a central role in improving patient safety (Wiig & Manser, 2016). In a report on prioritized research themes in the field of patient safety, WHO has suggested that developed countries, such as

Norway, should prioritize research on the lack of communication and coordination in the health services, (including discontinuity and coordination across organizations/levels) as one of the top priorities (WHO, 2008; Bates, et al. 2009). This highlights the need for knowledge related to care coordination and the risk of adverse events, as a result of the rapid exchange of information between ever-more specialized health personnel at various levels. We will now present and explore the following concepts: care coordination, continuity of care and patient handover, after which they will be related to patient safety using results from current research.

Care coordination

According to Øgar and Hovland (2004:166), “care coordination” in the healthcare service concerns “... *information exchange, knowledge transfer, a division of responsibilities and tasks to properly safeguard the needs of the patient, and the overarching health policy goals and regulatory requirements which apply to the health service.*” The goal is the comprehensive provision of healthcare services centred on the patient’s needs. Øgar and Hovland identify a series of factors that affect care coordination. These are: familiarity with and respect for involved stakeholders (health personnel, patients and next of kin); positive attitudes towards collaboration; a common understanding of the division of work tasks and responsibilities; familiarity with each other’s organizational cultures and professional language; platforms for cross-level communication and collaboration; trust and continuity in relations; possession of necessary clinical skills; and legislation and financing arrangements. Similarly, Torgersen and Steiro (2009) emphasize that care coordination is a complementary process, including communication and the mutual exchange of information, and the use of involved stakeholder’s competence, experience and professional background.

Nedreskår and Storm (2016) conducted an interview study with administrative personnel and leaders in hospital and municipal health services, focusing on care coordination during the discharge of elderly patients from hospitals to short-term nursing-home wards in the municipality. According to the interviewees, there could be disagreement between the

municipalities and hospitals in relation to whether or not the patient had completed his/her treatment, and was ready to be discharged from the hospital. It could also be difficult for health personnel in the hospital to decide when the patient had completed his/her treatment, because the patient's health status can change fast. This requires regular communication between hospitals and the municipal health services. Municipal health services were under pressure to receive patients from hospital who had completed treatment, but had subsequent needs for follow-up care. This demands that the municipal health services have available beds in nursing homes, and that receiving healthcare personnel have the necessary resources and competence to take on full responsibility for the patient's care (Nedreskår & Storm, 2016).

Continuity of care

Continuity in patient information, efficient communication between the health personnel involved and the patient, flexibility and adaptability of care provision to the needs of the individual over time, are important preconditions for the patient to experience coordination and continuity in the health service (Freeman, Shepperd, Robinson, Enrich, & Richards, 2000). Haggerty et al. (2003) have identified three types of continuity:

1. Management and organizational continuity
2. Information continuity
3. Relational continuity

Continuity in information contributes to ensuring that the health services provided to a patient are consistent and continuous, in spite of different health personnel being involved. The information may be related to an illness or a person. *Management and organizational continuity* are important for patients with chronic or complex illnesses that require follow-up by health personnel in the municipal and specialist health services over time. An individual care plan is a mechanism for organizing and systematizing knowledge about the patient, creating a plan and setting goals for further following-up. It can also contribute to ensuring *information*

continuity and foreseeability in the provision of care (Wierdsma, Mulder, de Vries, & Sytema, 2009). *Relational continuity* can be ensured when the patient accesses services from a limited number of health personnel, and is able to establish meaningful and therapeutic relationships with them. In the field of mental health and municipal healthcare, relational continuity is particularly emphasized in the following-up of patients with long-term and chronic illnesses. However, it is also present in other situations (for instance, during a hospital stay), in which a core element of the staff provides the patient with an experience of foreseeability and continuity (Haggerty, et al. 2003).

Staffing levels, workload, time pressure, incompatible ICT systems and complex patient needs all affect the potential for continuity in the health services (Belling, et al. 2011). In the study by Nedreskår and Storm (2016), health personnel state that sufficient time, experience, competence and stability among nurses are important and contribute to coordinated care. Research in the field of mental health indicates that a lack of continuity in the provision of care may lead to re-admissions (Freeman, Weaver, Low, Crawford, & de Jong, 2002). Risk factors for suicide among users of mental health services include a reduction in the frequency and scope of contact between patients and health personnel, poorly-planned discharges from hospitals, changes in contact persons, and the absence of familiar health personnel (Freeman et al., 2002; Sweeney et al., 2012).

Patient handover

Patient handover is central in care coordination and for continuity in the health service. A distinction can be made between intra-hospital patient handover, for example, between hospital wards or across work shifts, and inter-organizational patient handover, for example, between hospitals and municipal health services, or between healthcare organizations in the municipality (Schibevåg, Laugaland, & Aase, 2015). The key components of patient handover are:

- The exchange of patient information (for example, current medications, ongoing treatment, changes in health status)

- Communication between involved health personnel (on different work shifts, in different hospital wards, in specialist and municipal health services)
- The transfer of responsibility for the patient's treatment and care (Jeffcott, Evans, Cameron, Chin, & Ibrahim, 2009; WHO, 2007).

Furthermore, the coordination of resources, staff training, involvement and training of the patient and family are important aspects (Hasting & Heflin, 2005; Wong, Yee & Turner, 2008; Laugaland, Aase, & Barach, 2012).

A review of the literature by Laugaland et al. (2011) identifies poor communication, improperly-written transfer notes, lack of medication lists, and failures in procedures and responsibility for follow-up care, as risk areas in patient handover. Failures in medication lists may be the omission of regular medications, the cessation of medication, changes in dosage as well as the use of generic drugs. Poorly-integrated ICT systems have been one reason for the discrepancies in patients' medication lists. When there is inadequate communication and information exchange about the patient, (for example, regarding diagnosis, test results, treatment and medication, and plans for following-up) receiving health-care personnel are not sufficiently prepared to safeguard the necessary treatment and provision of care for the patient (Laugaland, Schibevåg, & Aase, 2015). The consequences for the patient can be discomfort, a worsening of the health condition and possibly a hospital readmission (Boockvar, Fishman, Kyriacou, Monias, Gavi, & Cortes, 2004; Cornish, et al. 2005).

Patient experiences with care coordination

National surveys of patient experiences of hospital-based care are carried out regularly in Norway. They show a high degree of satisfaction, for example, with communication with health personnel, but there is need for improvement when it comes to engaging patients in participation in treatment decision-making, information and preparation for up-coming hospital discharge, coordination of care across hospital and municipal health services and the availability of services (Bjerkan, Skudal & Egge,

2014). A study by the Commonwealth Fund International Health Policy Survey of Adults, which incorporated data from Norway, also points to a lack of information given to patients during discharge from hospital (Schoen, Osborn, Squires, Doty, Pierson, & Applebaum, 2011). In Norway, over 60 % of those surveyed reported that they received inadequate information on how to manage symptoms and where to seek medical assistance, lacked a written care plan for the immediate period after discharge, had not made any agreement for follow-up visits and lacked clear instructions for prescribed medications. This is cause for concern, as a lack of preparedness and support for self-care after a hospital admission can increase the risk of medication errors and unwanted side effects of the medication. Inadequate following-up of a patient's medical treatment and care may also lead to unnecessary readmissions to hospitals and, at worst, death (Storm & Coulter, 2016).

Factors that affect coordination and patient safety in care coordination of the elderly

To provide an insight into patient safety and care coordination of the elderly, we will present the results of a Norwegian study from two Norwegian hospitals and their respective municipalities (Storm, Siemsen, Laugaland, Dyrstad, & Aase, 2014a). Forty-one patient observations were carried out in different hospital departments (the emergency, geriatric, general medical and surgical departments), in connection with hospital admission and discharge. The patients were over 75 years of age with a hip fracture or medical diagnosis, used more than five medications daily and required following-up from the municipal health services. The observations included conversations with the patient, next of kin and the involved health personnel. Two researchers carried out the observations over a period of eight months in 2012. One of the aims of the study was to identify factors which affected patient safety in care coordination. Table 23.1 based on Storm et al. (2014a) presents some factors that affect safety in care coordination, as well as the challenges associated with each of the factors, illustrated with statements and quotes from the data.

Table 23.1 Some factors that affect care coordination and patient safety based on Storm, Siemsen, Laugaland, Dyrstad, & Aase (2014).

| Factors for care coordination and patient safety | Description of the factor | Challenges | Quotes from the data |
|--|--|---|--|
| The Elderly Patient | The elderly patients may have complex clinical health conditions. They have varying levels of satisfaction with care coordination and report feeling unsafe during admission and discharge. | <p>During admission, the patient often presents vague and diffuse symptoms, which can lead to a lower prioritization for medical evaluation and longer waiting times in the emergency department.</p> <p>During discharge, the patients are often confused, tired, dizzy and afraid. They may have pain and problems with mobility.</p> <p>The patients are unprepared for discharge and can risk experiencing several care transitions between departments and care homes in the municipality.</p> <p>Multiple patient handovers can cause the patient's health condition to worsen.</p> | The elderly patients report that they are dissatisfied with long waiting times in the emergency department, and many would like to be transferred to a municipal healthcare provider after discharge. |
| Next of Kin | The presence of the next of kin contributes to patient safety and continuity by facilitating the communication of information about a patient's health condition (which is not necessarily documented in the medical records). They are the patient's spokespersons and provide support for self-care, both in hospital admission and discharge. | In spite of their important role, the next of kin are required to ask for information on the patient's health condition, treatment and planned follow-up in the municipality. | A son reported: "The discharge came up very fast...I was not involved...they called the same day to notify me that my mother was due to leave. They could have called the day before so I could have been prepared". |

| | | | |
|------------------------------------|--|---|--|
| <p>Information Exchange</p> | <p>Information exchange occurs orally, in written and electronic form when the patient is admitted and discharged from hospital to the municipal health services. Nurses play a key role in care coordination, in that they exchange and ensure continuity of information about the patient and by coordinating relevant measures.</p> | <p>Inadequate information (for example, the nursing report and the medication list), test results and results of examinations are not ready. A lack of integrated ICT systems between hospitals and municipalities, particularly in relation to discharges. This involves the patient carrying their discharge papers with them in an envelope to be delivered to the receiving health personnel in the municipality. The challenges of information exchange are frustrating for the health personnel involved. Extra time is spent gathering information about the patient's health condition, medical history and medication.</p> | <p>A nurse employed in a municipal nursing home: "The same medications as before! How should I know which medications the patient is currently taking? I had to call the hospital...they sent the medication list by fax".</p> |
| <p>Competence</p> | <p>The Coordination Reform in Norway has led to the introduction of formal protocols for care coordination between hospitals and municipalities. The protocols state that it is the hospital's chief physician who decides that patients are ready to be discharged.</p> | <p>Health personnel are not always acquainted with the protocols for handover of patients and care coordination. A patient can be considered 'ready for discharge' by a nurse, in spite of the fact that such an evaluation may only be made by a chief physician.</p> | <p>A district nurse in the municipality reported: "They did not call the telephone number they were given, nor did they call the district nurse directly... The hospital should call 24 hours before the patient is discharged".</p> |
| <p>Context</p> | <p>Staffing levels, protocols and the total number of times a patient is transferred between different organizations affect care coordination and patient safety. In hospital wards, there is pressure to discharge patients who have completed treatment in order to make more beds available.</p> | <p>Holidays, low staffing levels and overcrowded hospital wards reduce the time available for patient treatment, care planning and coordination during admission and discharge. During discharge, the patient may experience being transferred from the hospital to a care home for a short stay before they are transferred to a rehabilitation department, short-stay ward or home with a district nurse.</p> | <p>A nurse in a care home reported: "Several care transitions between different places following a hospital stay confuse the patient, even though they do not suffer from cognitive impairments".</p> |

Measures to improve care coordination and patient safety

The research literature identifies a series of targeted measures, often used in combination, to improve patient safety in care coordination of older patients (Laugaland, Aase, & Barach, 2012). We can differentiate between the following measures:

- 1) Measures targeted at patients and next of kin to improve coping and self-care (information and education to promote self-management of medications and how to manage symptoms, awareness of warning signs of worsening health conditions, engaging caregiver/next of kin, patient-centred health records) (Coleman & Berenson, 2004).
- 2) Organizational measures (discharge coordinator, systematic discharge planning, standardized discharge reports, including medication lists and electronic tools for exchange of information).
- 3) Profession-oriented measures (inter-organizational staff meetings, education and training of health personnel) (Gordon & Findley, 2011; Kirsebom, Wadesten, & Hedström, 2012).
- 4) Measures consisting of a follow-up audit of care coordination and patient safety.

Studies show that elderly patients benefit from different measures, and that the measures can promote better care coordination and patient safety through a reduction in adverse events related to medication, fewer re-admissions and increased patient satisfaction. We will further explore profession-oriented measures as well as measures in the form of audits and follow-up.

Profession-oriented measures

Inter-organizational staff meetings and discussion platforms have been suggested as strategies to stimulate inter-professional and inter-organizational collaboration, and for developing mutual understanding of the role and functions of health personnel in care coordination

(Kirsebom, Wadesten, & Hedström, 2012; Storm et al., 2014a). Gordon & Findley (2011) conducted a review of educational interventions to improve handover in health care. They report a paucity of research in the area, but there are some studies demonstrating improvements in health personnel's handover attitudes, knowledge, and skills, following participation in an educational program. In the research project, "Quality and Safety in Transitional Care of the Elderly", an educational intervention programme, "Meeting Point", was developed to increase healthcare personnel's competence with regard to quality and safety in care transitions. The program addresses the factors important for care coordination and patient safety presented in Table 23.1. "Meeting Point" is an inter-professional arena for knowledge exchange and education of healthcare personnel involved in care coordination in hospital and municipal health services (Storm, Groene, Testad, Dyrstad, Heskestad, & Aase, 2014b).

"Meeting Point" was organized as a series of three seminars, addressing the following themes: patient safety, patient involvement and system-level aspects of care coordination. The seminar focusing on patient safety included an educational component, with a teaching session addressing patient safety in care coordination, the review of a case report, both individually and in groups, and the identification of measures to improve patient safety and care coordination in own work unit. Approximately 100 participants (nurses, doctors, patient coordinators, physiotherapists, health care assistants and leaders) working in hospital wards, nursing-home wards and home healthcare services participated in "Meeting Point". The results show that "Meeting Point" can contribute to knowledge transfer between the participants and stronger awareness among health personnel of key factors related to patient safety and care coordination (Heskestad & Aase, 2015; Dyrstad & Storm, 2016).

Regulatory-oriented measures

The Norwegian Board of Health Supervision (NBHS) is a national public institution organized under the Ministry of Health and Care Services. The NBHS has responsibility for supervision of child welfare services, social services, and health and care services. It carries out its duties in

accordance with the relevant legislation and directives (Act on Government State Inspection of the Health and Care Services, 1984; Braut & Holmboe, 2015). Its duties as auditor are roughly divided into two groups: planned inspections and event-based inspections. Event-based inspections are instigated on the basis of an adverse event, situation or set of conditions which have arisen or become a matter of concern. The planned inspection is carried out in the form of system audits that aim to be risk-based and identify possible factors constituting a risk in care provision or where changes are needed (Braut & Holmboe, 2015). Certain tasks in the planned system audits are carried out as country-wide inspection activities. In such cases, the NBHS decides on the themes for the audit and which category of providers that will be included in the scope of the audit. The County Governors carry out the country-wide audits, according to a common template developed by the NBHS (NOU, 2015:11; Braut & Holmboe, 2015).

In 2015, one of the themes of the country-wide audit was care coordination during patient discharge from specialist health services to the municipality. The audit encompassed acute health care, except services related to addiction and the mental health service. The country-wide audits reviewed the activities involved in the care coordination process between the hospital and the municipality, when patients are admitted/discharged.

Audits were carried out in 19 hospital trusts and 37 municipalities. In 36 audits, the County Governors found noncompliance with the law. In 23 audits, clear areas for improvement were highlighted. According to the synoptic report, the investigation uncovered several areas in which care coordination had failed:

“The audit discovered that patients were not given enough information about their treatment at the hospital nor about what was to happen when they returned home. The audit also pointed to serious failures in care coordination between the hospitals and the municipalities. The transfer of information between the hospitals and municipalities was the area in which the County Governors found the highest degree of noncompliance and areas for improvement. This was partly related to the way in which information was communicated. However, it also owed to deficiencies in terms of the content; for instance, the patient’s condition, assessment of the

patient's functionality assessment, and information on medication. Where there are significant deficiencies in terms of patient information or where it is incomplete, serious consequences may arise for patient treatment in the municipality."

(Norwegian Board of Health Supervision, 2016:3).

The County Governors are following-up the hospital trusts and the municipalities where noncompliance with the law was found, until the conditions are carried out according to the law. The NBHS argues that it is fair to assume that the same conditions of noncompliance are present in other municipalities and hospital trusts, and therefore recommends others to review their own management system, to ensure that practices comply with the law (Norwegian Board of Health Supervision, 2016).

Conclusion

Care coordination and patient safety are high on the health policy agenda in Norway. Policies and legislation have been implemented to ensure that the patients receive timely and proper medical treatment and care in specialist and municipal health services. This chapter has presented key and overlapping features of the concepts of care coordination, continuity of care and patient handover, and related them to patient safety using results from current research. Important factors for care coordination and patient safety have been emphasized as: exchange of information and communication between involved health personnel; adequate staffing levels; protocols for care coordination; clinical competence about the patient's health situation; competence with regard to involved personnel's roles and responsibilities; as well as information to, and preparation of, patients and next of kin for upcoming care transitions. National and international studies of patient experiences with hospital discharge highlight challenges associated with the coordination of services, poor information and preparation of patients for upcoming discharge. In 2015, the Norwegian authorities carried out an audit of health providers' work related to care coordination and reported serious failures in information transfer between the hospitals and the municipalities, despite existing policies and legislation, and research which shows that measures exist to ensure care coordination and patient safety.

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