

# Continuity of Patient Information to Palliative Care

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**Abstract.** The purpose of this study was to describe the sharing of knowledge and information to palliative care in terms of information content, information structure and information quality by means of Advance Care Planning (ACP). This study used a descriptive qualitative study design. Purposively selected nurses, physicians and social workers working in palliative care in Finland took part in thematic interviews in five hospitals in three hospital districts in 2019. The data (n = 33) were analyzed by means of content analysis. The results demonstrate the evidence-based practices of ACP in terms of information content, structure and quality. The results of this study can be utilized in the development of sharing knowledge and information and as the basis in the development of an ACP instrument.

**Keywords.** Information dissemination, knowledge, continuity of patient care, health care professionals, hospital information systems, electronic health records

## 1. Introduction

The continuity of patient information refers to how well patients' health information accompanies them between different treatment settings and service providers [1,2]. Knowledge sharing is particularly important in palliative care, which refers to an approach that seeks to alleviate suffering in patients with a life-threatening illness [3]. Advance Care Planning (ACP) would constitute part of an individual care and support care planning. This kind of advance care plans can be recorded in a patient's electronic health record [4]. A scoping review shows deficiencies in the continuity of care in terms of transfer of information concerning patients who are in need of palliative care [5].

The purpose of this study is to describe the sharing of knowledge and information to palliative care in terms of information content, information structure and information quality by means of Advance Care Planning.

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## 2. Methods

This study used a descriptive qualitative study design. The study data were collected from purposively selected nurses (n = 18), practical nurses (n = 5), physicians (n = 5) and social workers (n = 5) who took part in thematic interviews in five hospitals in three hospital districts in Finland in 2019. Interviews with nurses were mainly conducted in focus groups, whereas physicians and social workers were mainly interviewed individually, one at a time, because there would not have been enough of them to form focus groups in individual organizations. The data (n = 33) were analyzed using content analysis. University Research Ethics Committee granted ethical approval (15/2019).

## 3. Results

All the interviewees were experts with long work experience in palliative care. They had an average of 17 years of work experience in health care and an average of six years' of work experience in palliative care. The results show the evidence-based practices of the ACP in terms of information content, information structure and information quality from the multi-professional perspective. According to this study, the quality of information is multi-dimensional and by using its different perspectives in other words availability, informativeness and usability, it is possible to evaluate the quality of patient information coming to palliative care.

## 4. Discussion

Further development of documenting ACP is needed, particularly when it comes to communication practices, as well as Hospital Information Systems in terms of interoperability.

## 5. Conclusion

The results of this study can be utilized in the development of sharing knowledge and information and as the basis in the development of an ACP instrument.

## References

- [1] Haggerty JI, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. *BMJ* 2003 Nov;327(7425):1219-21. doi: 10.1136/bmj.327.7425.1219.
- [2] Ohno-Machado L, Séroussi B, editors. Contents of informational and management continuity of care. Proceedings of the 17th World Congress of Medical and Health Informatics (Medinfo); Aug 25-Aug 30; Lyon France. Anne Kuusisto, Paula Asikainen, Kaija Saranto; 264:669-673. doi: 10.3233/SHTI190307.
- [3] Connor SR, editor. *Global Atlas of Palliative Care*. 2<sup>nd</sup> ed. London, UK: Worldwide Hospice Palliative Care Alliance; 2020.
- [4] NHS England. Advance care planning. What is advance care planning? <https://www.england.nhs.uk/>.
- [5] Kuusisto A, Santavirta J, Saranto K, Korhonen P, Haavisto E. Advance care planning for patients with cancer in palliative care: A scoping review from a professional perspective. *J Clin Nurs* 2020 Jul;29(13-14):2069-2082. doi: 10.1111/jocn.15216.