Transfer of patient information in relation to person-centred care: A qualitative study from the perspective of nursing home staff

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ABSTRACT

Transfer of patient information in relation to person-centred care: A qualitative study from the perspective of nursing home staff.

Background: Person-centred care (PCC) is praised as an effective solution to current challenges like ageing populations, increasing prevalence of chronic diseases and the spread of unhealthy lifestyles. The transfer between health care providers is essential for its success. Because of the fact that PCC consists of a person related approach, lots of information concerning an individual patient has to be transferred. It is questionable if the daily practise of transfer of patient information fits with the complexity of PCC. Furthermore, little is known about the perspective of nursing home staff in relation to this crucial transfer of patient information towards PCC.

Aim: This study aims to investigate the transfer of patient information between completing and commencing shifts in relation to PCC from the perspective of nursing home staff.

Methods: A generic, qualitative study was conducted. An interview guide was used to structure the interviews. Data collection and thematic analysis took place iteratively.

Results: Nine providers were interviewed. Three main themes emerged from the analysis: knowing the patient, provider's present knowledge of the patient and transfer of patient information.

Conclusion and implications of key findings: Knowing the patient is a prerequisite to offer PCC. This extent in knowing depends on the providers' present knowledge about the patient and the content of the transfer of patient information. The needs of the nursing home staff concerning the transfer of patient information, and therewith the possibilities of executing PCC, is shaped by the differences in their present knowledge about the patient. To succeed in an effective transfer and meet the individual wishes from the staff, a clear guideline concerning the transfer and an enhanced usability of the electronic patient record is required.

Key words: Person-centred care, transfer of patient information, nursing home staff.

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SAMENVATTING

De overdracht van persoonsgerichte zorg in het verpleeghuis: een kwalitatieve studie vanuit het perspectief van de zorgverlener.

Achtergrond: Persoonsgerichte zorg wordt gezien als een effectieve oplossing voor de actuele uitdagingen binnen de gezondheidszorg, zoals de toenemende vergrijzing, chronische ziektes en ongezonde levensstijlen. De overdracht tussen zorgverleners is essentieel voor het laten slagen van persoonsgerichte zorg. Omdat persoonsgerichte zorg uit een persoonsgerichte benadering bestaat, dient er veel informatie over een patiënt overgedragen te worden. Het is twijfelachtig of de overdracht in de dagelijkse praktijk aansluit bij de complexiteit van deze benadering. Bovendien is er weinig bekend over de overdracht van persoonsgerichte zorg vanuit het perspectief van verpleeghuispersoneel.

Doelstelling: Het doel van dit onderzoek is om de overdracht rondom persoonsgerichte zorg tussen twee diensten te onderzoeken, vanuit het perspectief van de zorgverlener werkend in het verpleeghuis.

Methode: Er is een generieke, kwalitatieve studie uitgevoerd. De populatie bestaat uit zorgverleners werkzaam in het verpleeghuis. Om de interviews te structuren is gebruik gemaakt van een interviewguide. Dataverzameling en thematische analyse vonden plaats middels een iteratief proces.

Resultaten: Negen zorgverleners zijn geïnterviewd. Er zijn drie hoofdthema's gevonden: 1) het kennen van de patiënt 2) bestaande kennis van de zorgverlener over de patiënt 3) de overdracht.

Conclusie en aanbevelingen: Een voorwaarde voor de uitvoering van persoonsgerichte zorg is gelegen in het kennen van de patiënt. Dit kennen is afhankelijk van de aanwezige kennis over een patiënt en de inhoud van de overdracht. De behoeften van het verpleeghuispersoneel rondom de overdracht, en daarbij het kunnen uitvoeren van persoonsgerichte zorg, wordt gevormd door de verschillende aanwezige kennis over de patiënt. Om een succesvolle overdracht te laten plaats vinden, en te voldoen aan de verschillende behoeften van zorgverleners, is een duidelijke richtlijn en een hoge mate van gebruiksvriendelijkheid van het elektronisch cliëntendossier cruciaal.

Trefwoorden: Persoonsgerichte zorg, overdracht, verpleeghuispersoneel.

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INTRODUCTION

Over the past two decades, the call for a change in health care systems has increased(1). In particular, the World Health Organization (WHO) pleads for a renewing approach(2). This plea is driven by current challenges that we face, such as ageing populations, increasing prevalence of chronic diseases and the spread of unhealthy lifestyles. Literature states that a contribution for a solid health care system may be found in person-centred care (PCC)(3-5).

PCC is known as "treating the patient as a unique individual"(6). Multiple forms of PCC have been used for a long time. Indeed, many of the characteristics of PCC are already visible in Florence Nightingale's 'Notes on Nursing'(7). The main focus is located in considering the patients' point of view in the decision-making process as directive and thereby expanding the individual patients' role in their own health care (8). PCC assumes that patients are able to make substantive decisions and choices about what they need and want in their treatment(9). The task of healthcare providers is to give support to the patients' needs(5).

PCC is valuable for all layers of health care and can be applied in hospitals, home care and nursing homes(4). In the Netherlands, PCC is already included in the healthcare policy of nursing homes, known as 'kwaliteitskader verpleeghuiszorg'(10). This policy describes criteria for the execution of PCC by nursing home staff and it states PCC to comprise four themes(10). The first theme is known as uniqueness. The client is seen as an individual with a unique personal context whose own identity should be maintained. Secondly, compassion is important. The client has to experience proximity, trust, attention and understanding. The third theme is autonomy: for the client, the possibility of personal control over life and well-being is leading, also for the care in the final phase of life. The final theme refers to participation in established care goals. This means that the client has established agreements with the care providers regarding care, treatment and support(10).

In nursing homes, the patients' care is not restricted to one single care provider. Nursing home staff needs to exchange information with and about the patient. Communication is considered to be essential for executing PCC(3,11). In daily practise the transfer of patient (TPI) information is an accurate and much used manner for communication of patient related information between staff members(3,12).

TPI involves 'the exchange between health professionals of information about a patient accompanying either a transfer of control over, or responsibility for, the patient'(13). This exchange contains information about 'the patient's current condition and the possible changes or complications that might occur'(14). TPI takes place during the switch between the beginning and completion of two different nursing shifts. A care provider transfers information to another care provider, the receiver(15,16). The information can be exchanged via face-to-

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face communication or written forms, such as Electronic Patient Record (EPR)(17,18). In order to effectively implement PCC in nursing homes, communication between staff members during the transfer is essential(3).

In literature, PCC is praised as an effective solution to the challenges outlined by the WHO(2). However, it is doubtful whether PCC is achievable in daily practices, because the person-related approach requires a lot of information about the patient (3). The transfer occupies the discussion about the actual status of a patient, wherefore the transfer is crucial for PCC to be successful(3,18). It is questionable whether the daily practise of the TPI fits with the complexity of PCC.

To date, little is known about the perspective of nursing home staff towards this crucial transfer of patient information in relation to PCC. Therefore, the experiences and thoughts of nursing home staff on the TPI in relation to PCC need to be explored.

AIM

This study aims to investigate the transfer of patient information between completing and commencing shifts in relation to PCC from the perspective of nursing home staff.

METHOD

Design

A qualitative, descriptive, generic study was conducted using semi-structured interviews. This design was suitable since experiences, thoughts, and views of nursing home staff on the TPI in relation to PCC were explored(19, 20). The Consolidated criteria for Reporting Qualitative research (COREQ) checklist was used for reporting the study(21).

Population and setting

The population of interest consisted of nursing home staff. Nursing home staff members show much variation in terms of education and functions in practice. Nurse Assistant (in Dutch: 'helpende'), Certified nurse assistants (in Dutch: 'verzorgende'), Vocationally-trained registered nurses (in Dutch: 'MBO-verpleegkundige') and Baccalaureate-educated registered nurse (in Dutch: 'HBO-verpleegkundige') are all part of the nursing home staff(22). These staff-members are all key figures in the transfer of patient-related information.

To be able to achieve maximum variation, purposive sampling was used. Care providers from different departments, including somatic, psychogeriatric and the night department, were recruited(23). Moreover, snowball sampling was used when participants advised to include

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other relevant disciplines. Subsequently a supervisor of activities (in Dutch: 'actviteitenbegeleider') was included.

Data collection

For the semi-structured interview, the following topics as described in the Dutch national guideline 'kwaliteitskader verpleeghuiszorg' were discussed: 1) compassion; 2) uniqueness; 3) autonomy; 4) participation in established care goals(10). In addition, sex, age, work experience in years, function and department type were collected to get insight in the participants' characteristics.

Data were collected from February to May 2020. Interviews were tape-recorded and lasted between 45-65 minutes(23). If possible, interviews took place in a separate room at the work location of the participants, however, due the COVID-19 pandemic, six out of nine interviews were conducted by telephone after March 9, 2020.

We conducted a pilot interview to explore clarity of questions, resulting in minor adjustments. Data from the pilot interview were used in this study. Data collection took place simultaneously with data analysis(23). The interview guide was adapted several times due to new insights(23). During data collection the researcher reflected after each interview and took note of striking issues. Field notes were made to describe any conspicuousness in non-verbal communication and context(24,25). The recordings were numbered in line with the notes for an optimal analysis. To enhance the quality of data collection, the following decisions were made according to Lincoln and Guba(26). A member-check was conducted to find out if the reality of the participant is presented and to assess our interpretation of the data, to gain credibility(23,27). Transcripts were sent to all respondents. In this way the respondents were given the opportunity to respond to inaccuracies. Furthermore, prolonged engagement was used for building trust and rapport(27).

Procedures

Taking privacy in account, the recruitment started by requesting managers of the nursing home to distribute the announcement about this study. The announcement was designed to allow care providers with affinity regarding PCC, EPR and TPI to respond. The researcher was responsible for reaching the mentioned variation. When necessary, a respondent that would increase the maximum variation was sought with help from the manager. Each participant received an information letter explaining the goal of the study, the interview procedure, and confidentiality of data.

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Data analysis

The thematic analysis of this study was conducted by following the six steps of Braun & Clarke(28,29). During the iterative process, analysis took place after every two interviews, with the aim to examine whether more participants should be included and whether the interview guide needed adjustment. Analytical notes were written during this iterative process, to provide insight into the steps that were taken(30).

According to the first step, the data analysis started with transcribing interviews verbatim. These transcribed data have been read and re-read to get familiar with the data. Secondly, the relevant fragments were identified and assigned with a specific code. Subsequently, the codes were sorted into several potential themes, and in this manner all relevant data was assigned to each potential theme. This brought the analysis to the fourth step, in which the founded themes were refined. During this process, it became evident that some candidate themes were not really full-fledged themes (e.g., there was not enough data to support them, or the data were too diverse), while others might collapse into each other (e.g., two apparently separate themes might form one theme).

In the fifth step, the themes were checked and defined to create clear definitions and names for each specific theme(30). Finally, the themes were combined in order to answer the research questions. The process of data collection and analysis took place until code saturation was achieved. The process of analysing was supported by Atlas ti 8.4.24.

To enhance the quality of the study, two interviews were analysed by two researchers (APo and APe). These researchers compared and discussed findings until consensus was reached(23). APo and APe also discussed the emerging themes.

Ethical issues

The research ethics committee of the region Arnhem-Nijmegen concluded that this study did not fall within the scope of the Medical Research Involving Human Subjects Act. Written informed consent was acquired from all participants at the beginning of each interview after they received written and verbal information. The confidentiality and privacy of the participants and their responses were assured, since the policy concerning data management based on Radboud guidelines was followed(31).

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RESULTS

In total nine care providers, who worked for the same nursing home, were interviewed, namely: Nurse Assistant (n=1), Certified nurse assistants (n=3), Vocationally-trained registered nurse (n=3), Baccalaureate-educated registered nurse (n=1) and Supervisor of activities (n=1). They were located in somatic (n=4) and psychogeriatric (n=5) departments. All participants were female. The mean age was 45 years old (SD=11, with a range from 24 to 56) and the working experience in nursing homes was 15 years (SD=12, with a range from 3 to 38). Data saturation was reached in our sample, since no new information was gathered in the last two interviews.

Three main themes emerged from the analysis: a) knowing the patient; b) provider's existing knowledge of the patient; c) transfer of patient information. These themes are interrelated. The key for providing PCC is based in knowing the patient by care providers. The present knowledge about the patient and the content of the TPI determine to what extent this knowing exists. The main themes and their subthemes are described in Figure 1.

[Insert Figure 1: The perspective from nursing home staff concerning the transfer of patient information in relation to PCC represented in main and subthemes.]

A) <u>Knowing the patient</u>

All care providers mentioned knowing the patient is crucial for executing PCC. Knowledge about uniqueness, compassion, autonomy and the participation in care goals around a patient were important elements.

> "If you know the patient a little better, like, I know he or she can respond in this way because of this or that. Well, then it is easier to respond, than when you do not have that knowledge." (participant 1)

Uniqueness

Care providers mentioned uniqueness of the patient as significant in executing PCC. To connect to the individual patient, and meet their needs, care providers had to be familiar with their 'unique way of life', including culture, religion, personal character, habits, coping strategies, lifestyle, family traditions and medical backgrounds.

> "What they (the patients) experienced to be important in life, what they have always done, what their family was like, what they found important, are they religious. Or do they help other people, have they worked or taken care of family members at home?" (participant 5)

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Compassion

According to care providers, a compassionate approach had a great role complying PCC. Knowledge on the patient, such as background, wishes and needs were essential to achieve this pleasant approach. In additon, they stated that showing compassion is truly about the little things that matter.

> "When I am sad, I want somebody to put an arm around me or someone just sitting next to me. We try to record those things. Yes, we are working on it, but it is not automated yet, so to speak." (participant 2)

Autonomy and participation in established care goals

Autononomy was perceived as an important element of PCC, because it contained the patients' control over their current lifestyle. Bringing together the wishes of the patients aimed to enable a pleasant last phase of life. However, capturing wishes was complicated as a lifestyle could have changed during the stay in a nursing home. Therefore, consultation of patients and family was valuable to establish care goals. Care providers stated that consulting the patient and their loved ones is essential to guarantee participation of the patient.

> "If a person is used to wearing makeup, but can no longer express their wishes in wanting to verbally, the care plan will do it for them. This person will have their makeup put on in the morning and wear whatever clothing of preference they like, such as a favorite scarf." (participant 3)

B) Providers' present knowledge

The second main theme contained the present knowledge by care providers about a patient. This knowledge differed. To what extent care providers knew the patient depended on their relation with a patient and the interaction with colleagues.

Relation care provider and patient

Care providers stated the longer time was spend with the patient, the more information was received. *Permanent workers* who worked more hours than *flexible workers*, developed a bigger present knowledge. The context around care providers played a part in what was known about the patient, and thus how much extra information was needed. Flexible workers followed and used the knowledge of permanent workers.

> "When I worked with my colleague, she taught me the facets of the work. When you do this or that, you need to pay attention to this. It brought me a long way." (participant 1)

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Furthermore, whether and in which degree contact of the individual care provider with patients' relatives took place, influenced on how well a provider knew the patient. This personal relation between provider and relatives was partly accidental (being present when relatives visited) and partly by task as being the dedicated nurse of that patient.

> "Sometimes it takes longer to know someone inside and out, but really knowing someone so well might never happen. Also, with some people you immediately have a kind of connection, or you receive much more information from the family." (participant 5)

Interaction colleagues

According to care providers, they received and forwarded aware and unaware information about patients within the care team. This interaction was partly structural through reports but also random and informal by coincidentally encountering other disciplines. Care providers stated in particular client assistants, supervisors of activities, physiotherapists and housekeepers were seen as relevant disciplines for acquiring patient information. They all had a specific point of view and contributed to the present knowledge about patients.

> "Sometimes I noticed colleagues were standing in the hall, listening how I interacted with her *(the patient).* Because if you just directly watch me, it will not work. If you are in her room with two colleagues, it will already go wrong. But when the colleague says, well, I am in the hall for a while so I can still hear what you are doing, it works. In this way we learn a lot from each other." (participant 5)

C) <u>Transfer of patient information</u>

Care providers distinguished in the third main theme, three subthemes for the TPI: type of transfer, overview and procedure.

Type of transfer

Care providers used different types of TPI, mentioned as: EPR, email, verbal transfer and shadowlists. When the importance of the *EPR* was questioned, all care providers valued the reading in EPR*.* Reading the care goals, patient programs and daily records between the shifts, influenced on how well the patient was known. Some mentioned the use of so-called runninglists. Runninglists were based in EPR and contained printed patient programs and supported overview. However, modifications in care goals sometimes stayed unnoticed,

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because they did not change daily. Permanent workers did not felt feel the necessity to check this every day.

> "I do not know what is in her care plan, because I do not actually look at it. I do not look at the care plan, I know everything by heart." (participant 3)

> "A modification is not recognizable. You should have an alarm or something to notice that the data have changed. You just do not see it anymore." (participant 6)

Another written manner of TPI included *e-mail*. Care providers declared that e-mail was mainly used to discuss issues about patients with other colleagues. Moreover, relatives were not able to read along, while this was the case with reports in EPR.

> "Sometimes you still want to consult colleagues before you really want to propagate something. The point is that you basically work alone. You hardly ever see your entire team. And thus we often communicate by email: "I came across this or that".
> I responded as followed: "what is your opinion about this? What do you think of that?" (participant 9)

During the *verbal transfer* it was possible to check the comprehensibility of the EPR and e-mail just as tracingback missing information. The frequency was three times a day and lasted fifteen minutes. Care providers mentioned verbal transfer as important in the TPI and experienced it as pleasant. However, due to the fact that there was only fifteen minutes overlap between one workshift ending and another shift beginning, the verbal transfer is only possible within these minutes.

> "Reading is not always easy. Sometimes reports are picked up differently than intended, and it is just good to see someone's (colleague's) face or voice intonation." (participant 5)

Finally, some care providers mentioned the use of so-called shadowlists. Shadowlists were made with pen and paper by care providers themselves and not connected to EPR. The use of these shadowlists was not advised, since it yielded errors and double information. Nevertheless, flexible workers and care providers in nightshifts felt a need for shadowlists. They based the importance of these lists on the incompleteness of the EPR.

> "I think, shadow lists are more extensive than the EPR, in terms of different pieces of information which you should know about a client. What the person likes, is not always stated in QIC. But it is in the shadow lists. We actually work it out completely. Just like, whether the client likes to sleep with the door open or closed at night." (participant 7)

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Overview

Care providers considered the usability of EPR, up-to-date information and the amount of information as significant to reach overview in the TPI. They referred to the *usability of EPR* and experienced the easy backtracing of information in EPR as positive. The EPR 'QIC' was mentioned as a structured program where users could click through a specific section, for instance: care goals, client programs and work plans. All these sections were directly visible on the homescreen of EPR. However, care providers mentioned that staff should had carry the EPR by hand by care provision to check something in the moment with the patient himself. Immediately reporting in EPR during care provision prevented the risk of losing information.

> "But we are really reporting very goal-oriented, and I have to say, with the changed and updated QIC, including that page today, is really great. Because that is where the goals of that day are immediately stated. So you report on that."

According to care providers, it was crucial EPR contained *up-to-date information* concerning the patient so care providers can work fully focused and efficient with this current knowledge. Sometimes it occured that appointments were incomplete or not mentioned in EPR. This led to inconveniences between staff members in the care of a patient.

> "The more you record, the less you are solely responsible for it. It is then simply carried by the team. And that, of course, is the difficulty of all information coming in and not being registered." (participant 2)

At last, careproviders experienced a barrier during the transfer in the *amount of information*. If an overload was being channeled, it was hard to remember the information and resultedin a loss of overview. The number of patients in a department influenced this loss of overview.

> "That we work in units. So that we have two different units, so that two colleagues are responsible for the transfer of unit one and then two of unit two. So that we actually split it, so that we don't all care about twenty people, but we split it, so to speak. That is a stimulating factor." (participant 7)

Procedure

Care providers assigned reserved time, variable content and cooperation between care providers as important in the procedure of the TPI. .

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The *reserved time* for the verbal TPI between two shifts covered fifteen minutes. This timetable was too tight for reading the EPR before performing the verbal transfer. Some care providers mentioned they started reading the written transfer before their own shift to solve this problem.

> "Read back. I come to work earlier to read back, because I have not worked for three days, for example." (participant 3)

Next to this, care providers noticed that there is no specific guideline for the TPI and *the content was variable and random*. The transferror of information was in control and the content depended on what she considered as important. However, the content was meant for the collegue, the receiver, who might had other needs. For example, the present knowledge about a patient differed between flexible and permanent workers. They had different needs regarding the content of information.

> "Perhaps a limiting factor is that we do not really know what is important to pass on in a transfer. There are no manuals or guidelines for that." (participant 6)

Practice proved that not every detail of information was suited to be transferred verbally or written, while this was important for executing PCC. The following quotation illustrates this assumption:

> "But if you really have to know that one (the patient), I always tell a student or colleague. I know you know how to care, but this is specifically about the approach now. Just walk along with me, and notice what I do or do not say. Or what I only do non-verbally." (participant 3)

Finally, the *cooperation between the transferor and receiver of information* affected the TPI. For instance, the department of small scale living had no separate nightshift and they experienced a pleasant cooperation during the TPI. It led to informal interaction between care providers and faster exchange of knowledge. Meanwhile in other nursing homes with parted night- and dayshifts, this cooperation was not always considered as pleasant. This increased frustration and decreased interaction.

> "In the morning, there is not always so much attention for the transfer of information. And that is a major irritating factor. And for me, it is important that everyone listens to each other. Especially when you transfer information, faces are facing you and not to the computer. And that attention is paid to what has happened that night." (participant 7)

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DISCUSSION

This study focused on the perspective from nursing home staff on the TPI between completing and commencing shifts in relation to PCC. From the interviews, three main themes emerged: a) knowing the patient; b) providers' present knowledge of the patient; c) transfer of patient information.

The themes are related and support each other. According to care providers, knowing the patient is the key for executing PCC. This is achievable by knowing the background, wishes and needs of the patient. To what extent the care provider knows the patient depends on the providers' present knowledge of the patient and the additional TPI. The needs of care providers concerning the TPI, and thereby the possibilities of executing PCC, is shaped by the differences in their present knowledge of the patient.

In order to interpret the findings, some strengths and limitations need to be considered. The first strength included the repeated peer debriefing with independent researchers, which was used to detect bias or inappropriate subjectivity and led to higher quality of the study(23,27). Secondly, the first two interviews were double coded to positively affect the reliability. The current findings may be somewhat limited by the COVID-19 pandemic as the study took place in only one organisation, which may have affected the transferability. Furthermore, the last five interviews were conducted by telephone due to COVID-19. This may have influenced the credibility. However, we minimized the possible limitations of telephonic interviews by taking more time to get acquainted at the beginning of the conversation for building trust and rapport(32,33). Despite the limitations, we are convinced that the results are a good impression of the perspective from nursing home staff on the TPI concerning PCC, because code saturation was achieved and representative care providers were recruited.

Care providers claimed that to execute PCC, they have to know the patient. So, information about the patients' backgrounds, wishes and needs should be recorded in the EPR to comply with uniqueness, compassion, autonomy and established care goals. Reading EPR is essential for being aware of the actual information around a patient. The necessity of reading information differs for flexible and permanent care providers, as the latter knows the care plan by heart. Furthermore, the different present knowledge and needs of the transferor and receiver lead to a variable content of the transfer of patient information. Dutch research in 2017 has confirmed this finding and has stated that these variable content leads to different ways of transferring, which necessitates the establishment of adequate guidelines(34).

Next to this, care providers require the transferred information to be concise and clearly structured. Information needs to be up-to-date, easy to find in EPR and in proportion in order

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to reach an overview. These results are consistent with the results of a recent Dutch study, which has described that a lack of overview arises when information can be found in different places(34).

For staff who knows the patient well, it is important that they still transfer all information as it is helpful for colleagues to learn to know the patient and will thus to promote performing PCC. For care providers who do not know the patient yet, the information uptake is important. To facilitate the uptake, information has to be read and explained verbally. The time schedule is hereby important, as staff needs to have enough time to read the EPR before the verbal transfer. These results confirmed findings in other studies: the opportunity for feedback and asking questions during the transfer has been described as an effective transfer from the providers' perspective(18).

Based on this study several recommendations can be formulated. First, we recommend the development of a guideline, as such a guideline for the TPI in clinical practice is currently lacking, according care providers. This guideline should describe the content of transferring PCC, such as the backgrounds, wishes and needs of a patient to comply to the PCC themes of the Dutch guideline 'kwaliteitskader verpleeghuiszorg. In addition, the guideline must contain the essentials for achieving overview. The information needs to be in proportion, easy to find and clearly displayed.

Second, an effective TPI requires time. Care providers should get enough time to read and execute the (verbal) transfer. Another important recommendation relates to the usability of EPR, which affects the overview. In order to manage this overview, the usability of the EPR should be enhanced. We propose to build in an alarm for when changes in care goals are made. In this manner the choice to read the care goals lies with the reader. This would be a nice and appropriate solution, but as far as is known, this is yet not possible in current EPR's. Moreover, it is easier to evaluate the patients' care and care plan when the transfer is being adequately executed.

While this study highlights the need for a clear guideline and an enhanced usability of the EPR, further research is necessary to gather experience, thoughts and views from other organizations and disciplines regarding transfer of PCC. This study has given insight in three themes and contributes to the awareness around the TPI concerning PCC in nursing homes.

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TABLES AND FIGURES

THE TRANSFER OF PATIENT INFORMATION CONCERNING PCC
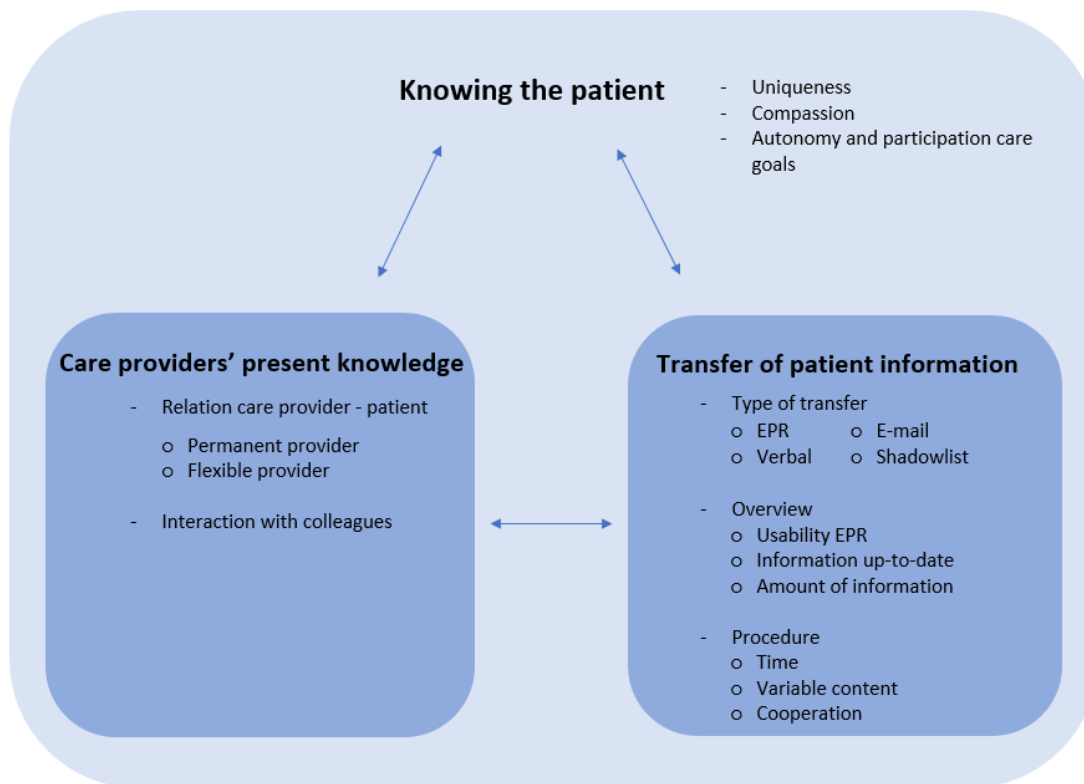

Figure 2: The perspective from nursing home staff concerning the transfer of patient information in relation to PCC represented in main and subthemes.

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