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# Patient-centered handovers between hospital and primary health care: An assessment of medical records

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ABSTRACT

*Background:* Handovers between hospital and primary healthcare possess a risk for patient care. It has been suggested that the exchange of a comprehensive medical record containing both medical and patient-centered aspects of information can support high quality handovers.
*Objective:* The objective of this study was to explore patient handovers between primary and secondary care by assessing the levels of patient-centeredness of medical records used for communication between care settings and by assessing continuity of patient care.
*Methods:* Quantitative content analysis was used to analyze the 76 medical records of 22 Swedish patients with chronic diseases and/or polypharmacy.
*Results:* The levels of patient-centeredness documented in handover records were assessed as poor, especially in regards to informing patients and achieving a shared understanding/agreement about their treatment plans. The follow up of patients' medical and care needs were remotely related to the discharge information sent from the hospital to the primary care providers, or to the hospital provider's request for patient follow-up in primary healthcare.

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*Conclusion:* The lack of patient-centered documentation either indicates poor patient-centeredness in the encounters or low priority given by the providers on documenting such information. Based on this small study, discharge information sent to primary healthcare cannot be considered as a means of securing continuity of patient care. Healthcare providers need to be aware that neither their discharge notes nor their referrals will guarantee continuity of patient care.

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## 1. Introduction

The Swedish healthcare system is non-integrated with different healthcare providers responsible for each step in the "chain of care"; that allows patients to seek care at any hospital, without referral from or prior consultation with their general practitioner. The system with a mix of public and private primary healthcare providers, differentiation and high level of specialization is considered as fragmented which may lead to gaps in patients' continuity of care [1,2]. Gaps in continuity of care represent one of the major obstacles in healthcare: one in five patients experience adverse events following discharge [3,4] and one in five is re-admitted to hospital within 30 days [5]. Continuity of patient care refers both to the management continuity – i.e. patient disease is managed in a coherent and consistent way across settings – and to information continuity, i.e. information about the patient is shared between those involved in the care [6].

One option for ensuring management continuity of care is to rely on patient information in the medical record; especially in the written discharge summary forms or letters which are the most common information source at discharge [7]. Such documentation influences the understanding and action at the next level of care [8]. In such one-direction information meta-communication – i.e. communication about the communication such as clarifying questions – is often lacking. The information must therefore contain all information that the other part may need, including both medical and patient-centered information [6,9–11]. It has been suggested, but to our knowledge yet not tested, that patient-centered documentation could facilitate continuity of patient care [10].

Patient-centered care has been described as a quality [12] that contributes to the overall improvement of healthcare [13,14] and that can reduce healthcare utilization [15–17]. Even though an agreed definition remains elusive and without consensus, Stewart et al. in one of the most cited definitions [18] defines patient-centered care as a set of components focusing on exploring both the disease and impact of the illness, acknowledging the patient with the goal of achieving common ground [19]. Other definitions range from focusing on the patient as a person, and on the patient–professional relation [10,20] to the healthcare systems' responsiveness to meet patient needs and ensure continuity of care [21,22]. In this study, patient-centeredness is defined following Stewart et al. [19]; exploring the patient's disease/illness, whole person and patient/professional shared understanding. Despite several attempts to improve patient handovers, the content of the discharge information has not been explored for the level of patient-centeredness.

The aim of this study was to explore patient handovers between primary and secondary care by assessing (1) the patient-centeredness in medical records used for communication between settings, and (2) management continuity of care as it can be traced in the medical record documents.

## 2. Material and methods

We used clinical data to assess the level of patient-centeredness in the medical record documents and the management continuity of care [23]. The medical record documents were obtained in regards to a specific index hospitalization that involved a patient handover (i.e., admission and discharge) between a university hospital emergency department and the patient's primary healthcare providers (PHC[1]) in Stockholm, Sweden. The PHC included general practitioner and community nurse offices, advanced home care services, nursing homes or occupational health services. The study was approved by the Regional Ethics Review Board in Stockholm, Sweden (No. 2008/1933-31/2), and patients were consented.

The study was part of the European Union HANDOVER-study described elsewhere [24–26] and the study inclusion criteria included adult patients with chronic diseases (diabetes mellitus, asthma, chronic obstructive pulmonary disease, heart failure) and/or polypharmacy—defined as being treated with six or more medications. Patients were included in the HANDOVER-study from the day of discharge from an unplanned hospitalization due to an acute exacerbation of the chronic disease or acute illness. Purposive sampling [27] was used to gather information from patients with different chronic diseases, at different ages and gender: altogether 25 patients were included in the HANDOVER-study.

For the present study, we collected data from the medical records of the included patients. We required records from both the hospital and PHC during either admission or discharge. For three patients, records could not be obtained from the primary health care. Therefore, 76 documents of 22 patient records (see Table 1) were obtained and analyzed using quantitative content analysis [28].

The paramedic notes during transport to hospital, discharge notes, and referrals from the hospital were collected from the index hospitalization episode. Medical record documents from the PHC, including referrals to the hospital, were obtained from two weeks prior to hospital admission, and, up to three months after the hospital discharge. The second

[1] PHC = primary healthcare provider.

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