Impact of informational and relational continuity for people with palliative care needs: a mixed methods rapid review

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ABSTRACT

Objective To identify and synthesise existing literature exploring the impact of relational and informational continuity of care on preferred place of death, hospital admissions and satisfaction for palliative care patients in qualitative, quantitative and mixed methods literature.

Design A mixed methods rapid review.

Methods PUBMED, PsychINFO, CINAHL were searched from June 2008 to June 2018 in order to identify original peer reviewed, primary qualitative, quantitative or mixed methods research exploring the impact of continuity of care for people receiving palliative care. Synthesis methods as outlined by the Cochrane Qualitative and Implementation Methods Group were applied to qualitative studies while meta-analyses for quantitative data were planned.

Outcomes The impact of interventions designed to promote continuity of care for people receiving palliative care on the following outcomes was explored: achieving preferred place of death, satisfaction with care and avoidable hospital admissions.

Results 18 eligible papers were identified (11 qualitative, 6 quantitative and 1 mixed methods papers). In all, 1951 patients and 190 family caregivers were recruited across included studies. Meta-analyses were not possible due to heterogeneity in outcome measures and tools used. Two studies described positive impact on facilitating preferred place of death. Four described a reduction in avoidable hospital admissions. No negative impacts of interventions designed to promote continuity were reported. Patient satisfaction was not assessed in quantitative studies. Participants described a significant impact on their experiences as a result of the lack of informational and relational continuity.

Conclusions This rapid review highlights the impact that continuity of care can have on the experiences of patients receiving palliative care. The evidence for the impact of continuity on place of death and hospital admissions is limited. Methods for enhancing, and recording continuity should be considered in the design and development of future healthcare interventions to support people receiving palliative care.

INTRODUCTION

Continuity of care is an important aspect of healthcare, but is often lacking. Continuity of care can take a range of forms, from continuous relationships with clinicians (relational continuity) to coordinated, comprehensive information sharing (informational continuity) and shared management plans (management continuity) within a range of services or professionals.1 2

In a review of continuity across multidisciplinary contexts, Haggerty et al argue that continuity is experienced by patients as the ‘perception that providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future’.3

The generation of accumulated knowledge and trust between a health professional and patient achieved through relational continuity is valued by both patients4 and clinicians.5 High levels of management and informational continuity contribute to effective and efficient care. On the other hand, the same long term relationships between healthcare providers and patients may also open the door to collusion6 or prevent patients benefiting from the opinions of a fresh pair of eyes.7
On balance, evidence suggests continuity is beneficial for a range of populations across a range of outcomes. Lower levels of continuity have been associated with higher emergency department use throughout the life span.8,9 Continuity has also been associated with patient satisfaction,10 fewer hospital admissions11,12 and improved care for long term conditions such as diabetes.13 Compelling evidence for the promotion of relational continuity was provided in a recent systematic review which highlighted a relationship between increased continuity and lower mortality rates.14 In response, international policies and charters call for the promotion of continuity within healthcare services.15–17

However, the challenges to ensuring continuity are many and multifaceted. Within healthcare services that face growing demands and reducing resources, promoting and achieving continuity of care can be difficult.18 The size of medical organisations is growing19 and the number of physicians seeing patients on a part time basis is increasing.20 The demands for rapid access to care are hard to balance with the demands for continuity.

Continuity may become increasingly important or valued in a person’s care as they age, develop comorbid conditions or as their health deteriorates.21 It has been estimated that 69%–82% of persons who die in high-income countries would benefit from palliative care,22 a figure which is likely to increase. As the population of many western countries continues to age, the need for greater continuity in services may become more pressing as the impact of the presence or absence of continuity may be more keenly felt towards the end of life.

The number of different professionals and services involved in community palliative care can make continuity of care challenging,23 yet continuity was identified as one of the top 10 issues identified by the James Lind Alliance Palliative and end of life care Priority Setting Partnership.24

The literature exploring the impact of continuity in palliative care is relatively young, yet promising. Continuity has been reported to be independently associated with patient ratings of care during cancer treatment,25 while greater involvement of primary care physicians at the end of life is associated with deaths outside of hospital, and receiving home care or hospice support.26 A review of integrated palliative care models across Europe called for greater efforts to enhance continuity.27

In response, this rapid review aims to identify and synthesise the existing literature, exploring the impact of continuity of care (both relational and informational) on the experiences of palliative care patients and their families.

OBJECTIVES

1. To identify, from the perspectives of people receiving palliative care and their families, friends or carers the potential impact of continuity (or lack of continuity) on their experiences of care.

2. To explore the impact of interventions designed to promote continuity for people receiving palliative care on achieving preferred place of death, reducing avoidable hospital admissions and satisfaction with care.

METHODS

The guidelines put forward by the Palliative Care Evidence Review Service (PaCERS28) were used to shape this rapid review.

Inclusion criteria for studies

Types of participants

Interventions recruiting adults (aged over 18 years) receiving palliative care and/or their family, friends or carers. Participants at all stages of a terminal illness, including the dying phase were included, in line with previous systematic reviews in this area.29

Types of studies and outcomes

Original peer reviewed studies published in English within the last 10 years (June 2008–June 2018) presenting primary qualitative, quantitative or mixed methods interventions exploring the impact of continuity in palliative care were eligible for inclusion.

Specifically:

- Qualitative studies collecting information about the experience of continuity for palliative care patients or their families (including bereaved family members).
- Studies also including the views of healthcare providers were included if the voices of patients and carers could be separated.
- Prospective interventions designed to promote continuity and explore the impact of this on reducing avoidable hospital admissions, enabling preference for place of death, or patient or carer satisfaction with care. The following methodologies were included randomised controlled trials, non-randomised controlled trials/quasiexperimental trials and before–after studies.

Retrospective studies, grey literature, reviews, conference abstracts and qualitative studies exploring the perspectives of healthcare professionals were not eligible.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>PUBMED search strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative care</td>
<td>((terminal* OR (advanced disease) OR palliative* OR (palliative care) OR (palliative medicine) OR (end of life))</td>
</tr>
<tr>
<td>AND Continuity</td>
<td>((continuity) OR (partnership working) OR (collaborat*) OR (communication) OR (shared working) OR (joint working) OR (shared care) OR (extended team))</td>
</tr>
<tr>
<td>AND outcomes</td>
<td>((experience) OR (satisfaction) OR (place of death) OR (health care utilisation) OR (appointment*) OR (admission*) OR (hospital admission) OR (readmission) OR (emergency))</td>
</tr>
</tbody>
</table>

## Search method for identification of studies

### Electronic searches

The following databases were searched: PUBMED, PsychINFO, CINAHL. Reference lists and forward searches of relevant publications were also screened.

### Search terms

Based on previous reviews of the literature on palliative care and continuity, the free text and indexed terms listed in Table 1 were used to identify relevant articles.

## Data collection and analysis

### Data screening

Studies were screened by one researcher (BFH) and eligible studies were checked by a second (BN). Queries over the eligibility of studies were discussed with the research team (SB, BN and BFH).

### Data extraction

A unique form was developed to capture the following data from each eligible study. Figure 1 outlines the data that were extracted from each study.

### Data analysis

#### Quality assessment

To assess the methodological rigour of included studies, a tool developed by Hawker et al. was used. The results are presented in online appendix 1.

#### Quantitative data analysis

Due to the heterogeneity of outcomes, meta-analyses were not possible. A narrative summary of studies was provided.

#### Qualitative data analysis

Synthesis methods as outlined by the Cochrane Qualitative and Implementation Methods Group were applied and the review was reported according to Enhancing transparency in reporting the synthesis of qualitative research guidelines. Qualitative synthesis involves reinterpretation by considering the findings of multiple studies within an analysis, using a three-step process: coding, developing descriptive themes and generating analytical themes. All data titled findings or results were entered into NVivo for analysis, in line with previous reviews using qualitative synthesis.

#### Patient and public involvement

This review was motivated by the priorities identified in the James Lind Alliance Palliative and end of life care Priority Setting Partnership, which included the views of patients and the public. No further patient and public involvement was incorporated into this review.

## RESULTS

Figure 2 presents a flow diagram of the study selection process. The initial search yielded 339 citations and 18 articles met the inclusion criteria (11 qualitative, 6 quantitative and 1 mixed methods).

### Study characteristics

Half of included studies were conducted in the UK (50%, n=9), three were conducted in the USA or Canada, two in Australia and one each in Iceland, the Netherlands, Sweden and Denmark. Tables 2 and 3 outline the sample, methodology, components of intervention, types of continuity assessed, outcome measures included and whether the intervention was found to be effective.

### Study methodology

The majority of eligible quantitative and mixed methods studies used quasiexperimental methodologies (86%, n=6). One randomised controlled trial was included. Two interventional studies included a control group, and two used an interrupted time series design and three did not include a comparison group.

For qualitative studies, semi structured interviews with patients or their carers were the most common method of data collection. Of qualitative studies, three studies undertook multiple interviews with participants, while one utilised focus groups. Qualitative data were analysed using thematic

<table>
<thead>
<tr>
<th>All studies</th>
<th>Intervention studies</th>
<th>Qualitative studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Participant type (patient, carer, both)</td>
<td>• Components of interventions</td>
<td>• All text labeled as “results” or “findings” (both in the abstracts and texts of papers) were extracted.</td>
</tr>
<tr>
<td>• Diagnosis</td>
<td>• Impact of intervention on specified outcomes (patient/carer satisfaction with care, preferred place of death or reducing hospital admissions)</td>
<td></td>
</tr>
<tr>
<td>• Study design &amp; methodology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Type of continuity explored (relational/informational)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Main findings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1  Data extracted from identified studies.
analysis, framework analysis, a qualitative descriptive approach or content analysis.

Participants
In all, 1951 patients and 190 family caregivers were recruited across included studies. Most studies (n=10) recruited patients with a range of illnesses, identified as requiring palliative care, three studies recruited patients with cancer while three recruited patients with a different diagnosis (chronic obstructive pulmonary disease, Parkinson’s disease, advanced heart failure). Two studies recruited bereaved family members.

Quantitative studies
Components of interventions
To examine which types of continuity were implemented within each intervention, we considered the elements within each intervention separately. Each intervention was complex and included multiple components. In total, the interventions included 12 different components, used in a variety of combinations (table 4). All interventions included regular contact or follow-up appointments with the same healthcare professional (relational continuity) and the majority included liaison between medical teams (informational continuity) (86%, n=6).

Impact of interventions upon identified outcomes
Due to the heterogeneous nature of studies it was not possible to conduct a meta-analysis. A narrative summary of the findings of interventional studies, with regard to preferred place of death, hospital admissions and satisfaction with care is provided.

Place of death
Over half of interventions identified explored impact on place of death (n=4, 57% interventional studies). Two interventions reported a positive impact on facilitating preferred place of death while this was difficult to assess in two interventions due to a lack of comparator or limited information being reported. No studies described a negative impact, or a decrease in the number of deaths occurring in the preferred locations.

Preferred place of death was achieved for 91% of patients (92 of 101 participants for whom this was known) receiving care from the ‘Hospice Assist at Home’ intervention. Patients receiving care coordination from a GP registrar were more likely to die at home than control participants (OR 0.41 (95% CI 0.20 to 0.86); p=0.02) in van de Mortel et al’s intervention.

O’Connor et al report that preferred place of death was achieved for 59% of participants that died during the study period (20/34 participants). In the absence of a control group, the authors compare this to figures from the wider Australian population which state that 14% of those that wish to die at home, do so. Morris et al did not report preference for place of death.

Hospital admissions
Six studies explored the impact of intervention on hospital admission rates. The majority (n=4) described a reduction in avoidable hospital admissions for people enrolled in interventions. In two studies a lack of comparison information makes this difficult to assess, although no interventions describe increases in hospital admissions.

The four studies reporting a reduction in hospital admissions used the following types of intervention: care coordination by a GP registrar, a nurse practitioner, a specialist nurse and an intervention to improve care transitions including postsurgical follow-up calls and mandatory early follow-up appointments with oncology teams. A number of limitations were observed including differences between the control and intervention groups at baseline, small sample sizes and lack of preintervention data.

While Morris et al report that 90% (70 out of 78) of care home residents desiring a palliative course, enrolled in a model of palliative care consultation were never hospitalised, the lack of comparison data make conclusions difficult. Seven participants were hospitalised over the course of the intervention, despite orders for no hospitalisation, although this represents less than 10% of the sample.

Edwards et al relied on participant-reported healthcare utilisation to assess impact on hospital admissions. While participants were enrolled in a seamless care programme, other sources of medical care were still sought. Data from the control condition were not reported.

Patient satisfaction with care
No interventional studies measured the impact of the intervention on patient or carer satisfaction with care.
Table 2 Summary of reviewed quantitative and mixed methods studies

<table>
<thead>
<tr>
<th>Author</th>
<th>Country</th>
<th>Components of intervention</th>
<th>Continuity</th>
<th>Participants</th>
<th>Method</th>
<th>Outcomes relevant to review</th>
<th>Outcomes</th>
<th>Main findings</th>
<th>Intervention successful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>van de Mortel et al.</td>
<td>Australia</td>
<td>Care coordinated by GP registrar who conducted an initial patient assessment, and case conferenced with the medical and nursing teams and the family to develop the care plan; 3-month follow-up (for stable patients) or reassessed and updated the plan if the patient deteriorated. This service was initially available during business hours, but was extended to after hours as funding became available.</td>
<td>x x</td>
<td>191 (exp: n=99)</td>
<td>Adults ≥18 years with a terminal illness.</td>
<td>A quasieperimental design (no pretest measures).</td>
<td>x x</td>
<td>Hospital admissions per 100 patient-days, proportion of deaths at home.</td>
<td>Controls were more likely to have ≥2 admissions than the intervention group (OR 2.67 (95% CI 1.39 to 5.11); p=0.003) per 100 days. Controls were significantly less likely to die at home than intervention group (OR 0.41 (95% CI 0.20 to 0.86); p=0.02)</td>
</tr>
<tr>
<td>Ingadottir and Jonsdottir</td>
<td>Iceland</td>
<td>Specialist nurse acts as a coordinator of interdisciplinary collaboration. Visits patients at home for initial assessment. Regular telephone contact. Nurse coordinates multidisciplinary response to acute exacerbations.</td>
<td>x x</td>
<td>50</td>
<td>COPD patients</td>
<td>Interrupted time series study</td>
<td>x</td>
<td>BMI, capacity to use medications, length of hospitalisation, psychometrics (HRQL, HADS), smoking rate</td>
<td>Hospital admission rate and days spent in hospital because of COPD reduced by 79% and 78%, respectively. The number of days spent in the hospital because of other diseases was not significantly different in T1, T2 and T3</td>
</tr>
<tr>
<td>O’Conner</td>
<td>Australia</td>
<td>12-month evaluation of nurse practitioner role in palliative care. Aims of nurse practitioner were: To help patients achieve their preferred place of care. Enhance professional relationships between services. Facilitate timely discharges and admissions between services.</td>
<td>x x</td>
<td>683</td>
<td>Palliative care patients</td>
<td>Mixed methods—Qualitative evaluation of nurse led practitioner role And note review (no pretest data collected)</td>
<td>X x</td>
<td>How quickly patient seen by NP after referral Decreased unplanned/preventable hospital admissions Place of death Qualitative feedback</td>
<td>Place of death 34 clients died in the evaluation period. Twenty died in their place of choice (59%). Hospital admissions 53 potential presentations to A&amp;E had been averted, with only nine presentations in the 12-month period. Place of death 29%</td>
</tr>
</tbody>
</table>
### Table 2 Continued

#### Quantitative studies

<table>
<thead>
<tr>
<th>Author</th>
<th>Country</th>
<th>Components of intervention</th>
<th>Continuity*</th>
<th>N</th>
<th>Participants</th>
<th>Method</th>
<th>Outcomes relevant to review</th>
<th>Outcomes</th>
<th>Main findings</th>
<th>Intervention successful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montero et al. USA</td>
<td></td>
<td>Healthcare professional education</td>
<td>x</td>
<td>4551 admissions during study period</td>
<td>Patients referred to palliative and general medical oncology services.</td>
<td>Interrupted time series design</td>
<td>x</td>
<td>Readmission rates: During the 11-month post-intervention period there was a significant reduction in unplanned 30-day readmissions risk. Unplanned readmission rates declined by 4.5%–22.9% from baseline. Nurse call-backs improved a patient's capacity for self-care at home and compliance with medication.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Edwards et al. Canada</td>
<td></td>
<td>Generation of a seamless care report—shared with other professionals</td>
<td>x</td>
<td>200 (100 in intervention)</td>
<td>Patients receiving chemotherapy</td>
<td>RCT</td>
<td>x</td>
<td>Self-reported healthcare service use: Number and type of drug related problems: Patients in intervention sought additional healthcare support (hospital admission, A&amp;E). An average of 3.7 DRPs per patient in intervention arm. Not possible to tell from results provided—only gives % that accessed additional health support for example, hospital admission no comparator.</td>
<td>Not possible to tell from results provided—only gives % that accessed additional health support for example, hospital admission no comparator.</td>
<td></td>
</tr>
<tr>
<td>Morris and Galicia-Castillo USA (CARES): a collaborative consultative PC programme Two PC physicians under a medical director contract provided consultation A part-time facility-based chaplain provided spiritual and psychosocial support</td>
<td>x</td>
<td>170</td>
<td>Care home residents</td>
<td>Pilot intervention study No pretest data collected</td>
<td>Services provided Changes to care plans Hospitalisations Place of death Hospice sage</td>
<td>x</td>
<td>Seven residents were hospitalised, despite orders for no hospitalisation; five died in hospital. 96% (54 of 56) of LTC residents died with hospice services. Two LTC residents declined hospice services and died in the hospital, which was consistent with their families expressed goals. Among the SNF residents, 36 (43%) of 82 have died: nine transitioned to hospice services at home, an inpatient hospice unit, or LTC prior to death; 19 died under SNF care and were unable to access their hospice benefit; and eight others died in the hospital.</td>
<td>Not clear No comparison group and preference for place of death not reported.</td>
<td></td>
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</table>

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Continued
### Table 2 Continued

| Author          | Country       | Components of intervention                                                                 | Continuity | R | I | N | Participants                                                                                   | Method                                                                                     | Outcomes relevant to review                                                                 | Main findings                                                                 | Intervention successful? |
|-----------------|---------------|--------------------------------------------------------------------------------------------|------------|---|---|---|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------|
| De Graaf        | The Netherlands | The Hospice Assist at Home service consists of four components: (1) A GP requested home visit from the hospice nurse consultant | X          | X |   | 130| Patients living at home, with a life expectancy of less than 1 year | A cross-sectional evaluation study (no baseline data collected) | X                                                                                       | Expressed end-of-life preferences and the congruence between preferred and actual place of death | If preferred place of death was known, 92/101 (91%) patients died in their preferred place of death | Yes                      |

**Continuity.**

BMI, Body Mass Index; COPD, Chronic Obstructive Pulmonary Disease; DRP, Drug related problem; Ha, reducing hospital admissions; HADS, Hospital anxiety and depression scale; HCP, Health care professional; HNC, Hospice Nurse Consultant; HRQoL, Health related quality of life; I, informational; LTC, Long term condition; NP, Nurse Practitioner; pod, place of death; R, relational; S, satisfaction with care.

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**Impact of low continuity on patients and families**

**Impact on care**

**Difficulties and delays in accessing support**

- You're trying to navigate it and you're dealing with so many agencies and you don't know which to go to sometimes. They're very busy and they have to help you as much as possible, but it's just so simple, it's just too complicated. (Patient) (2)

- In addition, a lack of information and uncertainty about how and when to access support, such as uncertainty in navigating the numerous services and multiple professionals involved, made it difficult for some patients and families to access care. This appeared to be amplified outside normal working hours. (4)

**Qualitative synthesis—patient experience of continuity**

The impact of experiencing, or not experiencing continuity of care was explored via qualitative studies. The views of both patients and their informal carers are represented. Barriers to achieving continuity and continuity facilitators are presented in Table 5.
<table>
<thead>
<tr>
<th>Author</th>
<th>Country</th>
<th>n</th>
<th>Participants</th>
<th>Methodology</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leydon et al</td>
<td>UK</td>
<td>32</td>
<td>Patients receiving palliative care</td>
<td>Longitudinal prospective qualitative study using semi-structured interviews and telephone interviews over 6 months—qualitative descriptive approach to analysis</td>
<td>Interpersonal or relationship continuity and management continuity are vital to the process of optimising the patient experience of out of hours palliative care</td>
</tr>
<tr>
<td>Seamark et al</td>
<td>UK</td>
<td>54</td>
<td>Bereaved family members</td>
<td>Semistructured interviews, thematic analysis</td>
<td>Continuity of care that divided into personal, organisational and informational continuity. Large numbers and changes in care staff diluted personal continuity and failure of the GPs to visit was viewed negatively. Family carers had low expectations of informational continuity, finding information often did not transfer between secondary and primary care and other care agencies. Organisational continuity when present provided comfort and reassurance, and a sense of control.</td>
</tr>
<tr>
<td>Payne et al</td>
<td>UK</td>
<td></td>
<td>Patients (n=34), carers (n=13) and health professional (n=23)</td>
<td>Serial interviews with patients and family members (either together or apart) Focus groups with healthcare professionals (not included in analysis) Thematic analysis and cross case synthesis</td>
<td>While some care fell short of expectations, all patients reported high levels of satisfaction and valued continuity of care and efficient information sharing. All hospices supported and supplemented local providers, with three hospices also supplating local provision by providing in-patient facilities.</td>
</tr>
<tr>
<td>Richards et al</td>
<td>UK</td>
<td>28</td>
<td>Patients with advanced cancer and caregivers</td>
<td>Interviews with patients and caregivers, Thematic analysis</td>
<td>Participants reported a lack of relational and informational continuity of care. Consulting with an unfamiliar clinician out-of-hours raised doubts in some participants’ minds about the quality of care. While the themes suggest the delivery of out-of-hours care as a whole was not always perfect, around-the-clock access to professional sources of support and reassurance was highly valued. However, the transfer of information to out-of-hours providers remains a key challenge; participants did not understand why out-of-hours providers could not access more information on their medical histories given the level of computerisation within the National Health Service. The findings highlight the need to improve continuity between in-hours and out-of-hours services for patients with complex needs.</td>
</tr>
<tr>
<td>Klarare et al</td>
<td>Sweden</td>
<td>13</td>
<td>six patients and seven family members</td>
<td>Interviews Thematic analysis</td>
<td>Two themes were constructed through thematic analysis: (1) security and (2) continuity of care</td>
</tr>
<tr>
<td>Bailey et al</td>
<td>UK</td>
<td>109</td>
<td>39 patients (15 with COPD and 24 with lung cancer), 20 informal carers 50 healthcare professionals,</td>
<td>Semistructured interviews, after admission and following discharge Thematic analysis</td>
<td>Patients were satisfied with their ‘emergency’ care but not the care they received once their initial symptoms had been stabilised. The poorer quality care they experienced was characterised by a lack of attention to their fundamental needs, lack of involvement of the family, poor communication about care plans and a lack of continuity between primary and secondary care.</td>
</tr>
<tr>
<td>Mclaughlin et al</td>
<td>UK</td>
<td>26</td>
<td>Family caregivers of people with Parkinson’s disease</td>
<td>Semistructured interviews ‘a framework was used to guide analysis’</td>
<td>Lack of continuity between services means that carers were unaware of support until they reached a crisis and described difficulty accessing information. Carers called for a more integration between primary, secondary and tertiary care. Patients sought advice from neurologists over GPs who were not seen as having high levels of knowledge about PD. Palliative care was not accessed by any patients.</td>
</tr>
</tbody>
</table>
could speak to a professional who was familiar with them and their needs before seeking help. This resulted in many patients enduring unpleasant symptoms while they waited to contact their regular care providers, which was also disturbing for carers.44 45 48 50

…. Um … so, no, in the end I decided there wasn’t anybody, really, who could help me, (IV: Mmm), so I didn’t call anybody, I just sent my nurse a text and just hoped I’d survive the night. And I did [gentle laughter from P]. (Patient)50

**Care plan is poorly communicated**
The lack of consistent communication, and difficulty in accessing support meant that often, it was hard for patients to build up a clear picture of their current status.43 52 This ambiguity left patients feeling unsupported and unclear about what the future held for them. We’re waiting to hear from them, the [regional hospital], they said a week or two… it’s actually three weeks [now]… I know they say no news is probably good news, but waiting is the worst part. You just want to know how long you’ve got. (Patient)52

The inability of all services to access a patient’s medical records complicated care and was a source of much frustration and led to periods of unnecessary stress and discomfort. This again, was particularly pressing outside of normal working hours and necessitated much repetition of information and contributed to a reluctance to access out of hours support.44 45 48 50

Well by the time you phone one person and you try to explain to them that you’ve got a growth inside you and it’s bothering you and you’re in a lot of pain and stuff, then they have to go and get somebody else

**Table 3 Continued**

<table>
<thead>
<tr>
<th>Author</th>
<th>Country</th>
<th>n</th>
<th>Participants</th>
<th>Methodology</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neergaard et al</td>
<td>Denmark</td>
<td>14</td>
<td>Bereaved care givers (cancer patients)</td>
<td>Focus groups qualitative description approach</td>
<td>Relatives experience insufficient palliative care, mainly due to organisational and cultural problems among professionals. There is a lack of shared care. Mixed experiences regarding relationships with GPs, some good, some bad. Lack of care coordinator identified as barrier to shared care and high quality care.</td>
</tr>
<tr>
<td>Browne et al</td>
<td>UK</td>
<td>115 patients (n=30), carers (n=20), professionals (n=65).</td>
<td>Advanced heart failure patients (n=30), carers (n=20), and professionals (n=65).</td>
<td>Semistructured interviews (patients and carers) and focus groups (HCPs) content analysis</td>
<td>Four key problems: 1 Knowledge and understanding deficits. 2 Difficulties navigating and accessing health and social care support. 3 General challenges and barriers to optimal care. 4 Problems relating to emergency care. Fragmented care with lack of coordination and poor communication makes life difficult</td>
</tr>
<tr>
<td>Jack et al</td>
<td>UK</td>
<td>41 (16 patients and 25 family caregivers)</td>
<td>Eligible participants were in receipt of Hospice at Home service on at least three occasions and were deemed to have a life expectancy measured in weeks not days.</td>
<td>Interviews (individual or joint) Thematic analysis</td>
<td>Embracing holism, by bringing hospice care into the home and acting as a bridge from the Hospice, is clearly promoting patient choice in being able to be cared for and die in their own home. Hospice at home nurses helped patients to navigate services and different agencies Hospice at home helped avoid unwanted hospital admissions</td>
</tr>
<tr>
<td>Adam et al</td>
<td>UK</td>
<td>15</td>
<td>11 patients and 4 caregivers</td>
<td>Interviews Thematic analysis</td>
<td>The importance of continuity of care and communication between all involved. The continuity of care from a single GP was important within the patient’s registered practice. Continuity was not perceived to be as important in the OOH period when participants were happy to see any qualified practitioner. Prompt pain relief was their priority. The importance of good communication between the OOH service, their registered practice and in some cases palliative physicians and oncologists was emphasised. Those with palliative care summaries valued the informational continuity that they provided.</td>
</tr>
</tbody>
</table>

COPD, Chronic Obstructive Pulmonary Disease.
Open access

Table 4 Components of eligible interventions

<table>
<thead>
<tr>
<th>Type of continuity</th>
<th>De Graff et al</th>
<th>Edwards et al</th>
<th>Ingadottir and Jonsdottir et al</th>
<th>Montero et al</th>
<th>Morris and Galicia-Castillo et al</th>
<th>van de Mortel et al</th>
<th>O’Connor</th>
<th>Number of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordinator identified</td>
<td>R&amp;I</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>4</td>
</tr>
<tr>
<td>Sharing care plan with other professionals</td>
<td>R&amp;I</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Contact with same professionals out of hours</td>
<td>R&amp;I</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>Initial patient assessment conducted by coordinator</td>
<td>R&amp;I</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
<tr>
<td>Regular contact/follow-up appointments with the same healthcare professional</td>
<td>R&amp;I</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
<tr>
<td>Patient selects which professional acts as their coordinator</td>
<td>R</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
<tr>
<td>Regular telephone contact with coordinator/identified nurse</td>
<td>R</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
<tr>
<td>One point of contact identified for patients</td>
<td>R</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
<tr>
<td>Initial medication history interview and medical reconciliation conducted</td>
<td>R</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
<tr>
<td>Liaison between medical teams (MDTs, case conferences)</td>
<td>R</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
<tr>
<td>Education for healthcare professionals to promote buy into intervention/promote continuity</td>
<td>R</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
<tr>
<td>Creation of a (new) care Plan/database/report</td>
<td>R</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>7</td>
</tr>
</tbody>
</table>

MDTs, multidisciplinary team meetings; I, informational continuity; R, relational continuity.

Table 5 The barriers and facilitators to continuity in the provision of palliative care, and the impact of continuity on patient and carer experience

<table>
<thead>
<tr>
<th>Barriers and facilitators of continuity</th>
<th>Impact on patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers to continuity</td>
<td>Impact of poor continuity on patients and carers</td>
</tr>
<tr>
<td>Structure of systems</td>
<td>Impact on care</td>
</tr>
<tr>
<td>Multiple professionals involved</td>
<td>Difficulties and delays in accessing support.</td>
</tr>
<tr>
<td>Lack of information sharing</td>
<td>Care plan is not clearly communicated to patients.</td>
</tr>
<tr>
<td>Between primary and secondary services.</td>
<td>Impact on patient and carers</td>
</tr>
<tr>
<td>Limited access to medical records.</td>
<td>Emotional impact.</td>
</tr>
<tr>
<td>Continuity facilitators</td>
<td>Additional burdens.</td>
</tr>
<tr>
<td>One point of contact—care coordinator</td>
<td>Benefits of continuity for patients and carers</td>
</tr>
<tr>
<td>Multidisciplinary working.</td>
<td>Patient feels ‘known’</td>
</tr>
</tbody>
</table>

They took a lot of tablets off me [in the hospital], and my doctor [GP] went mad, because they shouldn’t have done… I’m back on all my old medication now… they shouldn’t have changed it. (Patient)

In addition, in the absence of a coordinated approach meant that the care patients received was often not streamlined with repetition and multiple appointments within the same location, within the same week often taking place.
Consuming. Each other. This was experienced as stressful and time
did not seem to be effectively sharing information with
having to take on the role of ‘coordinator’, as services
were often too tired and carers preferred to concentrate


Further consequences of this lack of continuity were
that some families described being unaware of sources of
support (for example additional financial support or
additional out of hours support), which could have been
beneficial for them.44 47 50 Patients felt that some profes-
sionals presumed that someone else had already provided
them with this information, a lack of continuity meant
that gaps in information provision were sometimes left
unfilled.47 50

I was surprised in retrospect that I hadn’t been told
that [about out-of-hours service]… perhaps they
thought I knew… [Would have been less worried over
the years if I’d known]. (Patient)50

The lack of informational and relational consistency
experienced by patients and families negatively impacted
their experiences of care, with patients enduring periods
of great discomfort in order to wait until they could seek
help from a professional that was familiar with their
needs, and with whom they felt confident and supported.

**Impact on patient and carer experience**

**Additional burdens**

**Taking on the role of coordinator**

Due to a lack of informational continuity between
services, patients and carers took on additional adminis-
trative burdens or duties to secure a coherent approach to
care management.44 47 50 Patients and carers described
having to take on the role of ‘coordinator’, as services
did not seem to be effectively sharing information with
each other. This was experienced as stressful and time
consuming.

It was up to me to contact her [the hospice nurse],
and this is what people say, if you need any help
ring, but it’s an extra thing to do, to organise your
own kind of help is an extra thing to do, and in the
24 hours you don’t have much time or energy for ex-
tra things. (Patient)44

Some carers described an ‘unspoken pressure’ from
healthcare professionals to become ‘semi-professionals’.53
This was also a role that many people did not want, patients
were often too tired and carers preferred to concentrate
on spending quality time with loved ones.45

I mean our own GP obviously knows Dad’s case inside
out, but there must be a way where the [out-of-hours]
doctor can access at least a recapped version of what’s
wrong with him you would think he had to tap into
his computer and access everything but, you know, he
went solely on what I told him when we went in. So
that to me was strange. (Carer)45

**Feeling vulnerable or out of control**

In addition to the more practical impacts of low continuity
(both relational and informational) significant emotional
impacts for patients and families were reported.45 50 Many
carers reported feeling vulnerable or out of control when
they could not access advice or support from a profes-
sional who was familiar with their history and needs.

And I remember thinking, I’m vulnerable, my wife is
in pain and we want a service and, and I have to ring
up this person—‘The doctor will contact you’! What,
tonight? Tomorrow? (Carer)45

For patients, a lack of relational continuity meant that
they could feel alone and unsupported.

All I wanted was a voice to recognize me, um, or, or
a voice to recognize what I was doing and say, there,
there, [name], that’s OK, I’ll speak to you tomorrow,
I’m aware of what’s wrong with you, um, and that’s
fine. And really, the only voice who could do that
would be [name], my, my nurse, um … but obviously
she switches her phone off, I think she [finishes her
shift] at 5 o’clock… (Patient)50

**Continuity facilitators**

In response to the fragmented nature of systems, patients
and carers agreed that it would be beneficial to have one
point of contact for their queries and concerns.44 48 51 53
Some participants suggested this role could be occupied
by a GP,48 53 while others felt that the qualifications of the
individual were less important than their ability to be a
consistent source of advice, signposting or support.49
Furthermore, to truly promote continuity the need for
multidisciplinary teams was highlighted.

**Benefits of continuity for patients and carers**

**Feeling known**

One of the most positive aspects of continuity from the
perspectives of participants was that of ‘feeling known’,
which was represented in a number of ways. ‘Feeling
known’ was related to recognition of who the patient was
as a person, being listened to and having the professional
demonstrate their ability to use their knowledge of the
individual to recognise and act on their suffering in a
person centred manner.44 46 48–50 Where this level of rela-
tional continuity was achieved, it was highly valued.

Yes, there was a nurse, a man, who came last week
and took some blood. And I think he has been here
once or maybe twice before. So, he asks me, how is
your eating? Because I’d had problems last autumn,
I lost a lot of weight… I think it is fantastic that he
remembers… They care about the little things, ask
how I’ve been over the holidays, what I’ve done, and
so on. (Patient)46
Another aspect of ‘feeling known’ that was appreciated by carers in particular was the ability to notice small but potentially significant changes in a patient that could only be achieved through consistent interactions.44 46 49 In addition, for patients being cared for at home, families felt more comfortable when they had developed a relationship with healthcare professionals.

But it would be wonderful if one nurse could concentrate on a case because you would have that continuity and they would notice changes and things and it would help them and probably help the family in that it isn’t a different person every night and you’re having to explain where the coffee is and what to do, but I know it isn’t practical because they have to have time off. But if it were one person, or even two, because we did have several different nurses. (Carer)44

Feeling confident in care
Continuity in all of its forms, bolstered a sense of confidence in both care providers and the care plans developed for them.46 49 50 53 Patients described feeling confident that their team could support them.

There’s nothing worse than feeling that you are on your own and there’s no support and like it’s the unknown. When you know that you can pick up the phone and at the other end are experienced professionals and they are like tuned in and that in a matter of minutes you can have assistance. That makes all the difference. (Patient)45

The ability to contact a team that could respond quickly and appropriately was greatly appreciated by patients and carers and went some way to alleviating some of the anxiety associated with supporting a loved one with palliative care needs.

…it happened in a few hours. He got a high temperature… but they came straight away and stood here with the doctor on the phone, and it felt like ‘Yes, they’ve got it covered.’ That felt like WOW! …They came for this and supported us, and that was great since… It almost caused anxiety before [enrollment in SPHC] to have to call the healthcare center… No one [there] has the complete picture, and no one knows us… No continuity. (Carer)46

Poor continuity was described as related to delays and difficulties in accessing care and increasing the burdens experienced by patients and carers. Patients were often left feeling vulnerable or unsupported without a clear understanding of their care plan and how to access support. In contrast, when patients experienced good continuity of care they felt confident, known and supported by care providers.

Comparison to other literature and the wider context
Many of the facilitators for continuity for palliative patients identified in this review (having one point of contact, and strong multidisciplinary working and information sharing), and the perceived benefits of continuity (accumulated knowledge) were identified in a review of the impact of continuity for patients with a range of conditions.21 Waibel et al note that continuity could be enhanced when patients take an active approach to the management of their own care. In the current review, in palliative care, participants and carers experienced the need to adopt the role of coordinator as burdensome and unwelcome. This may reflect both similarities and differences in how to promote continuity for patients with different conditions and at different stages of illness.

The impact of poor informational continuity for palliative patients was highlighted in this review. Retrospective studies highlight potential strategies for promoting continuity for this group, including electronic information sharing. Electronic palliative care coordination (EPaCC) systems54 have been suggested as useful in promoting information continuity for palliative care patients, although further work is needed to develop and test such strategies.

This review also highlights the importance of relational continuity for palliative care patients. Informational continuity is clearly important, but in isolation may be insufficient to achieve optimal patient outcomes or experiences. The importance of ‘feeling known’ by healthcare professionals was clear in this review, both for the emotional and physical well-being of patients (in terms of delaying access to out of hours services). These benefits have been described in previous research within palliative populations.55

Despite evidence of the beneficial impact of continuity of care on both patient outcomes and experiences, continuity is not ‘built in’ to interventions in the same way as other aspects of healthcare delivery.56 The number of retrospective studies in this area suggests that continuity is currently considered more of an outcome than an integral part of the healthcare process. This needs to be addressed. While there are undoubtedly methodological challenges in exploring the impact of interventions designed to promote continuity, this is an area in which future research is needed. It was also interesting to note that no quantitative studies included measures of patient satisfaction with care. Given the themes identified in the qualitative data, highlighting the positive impact that continuity had on their experiences of care and support,
this is perhaps something to be considered in future studies.

Continuity of care is difficult to deliver, and can be hard to measure, but is vitally important to patients. Relational continuity provides the context on which to build individualised care plans for patients, that in turn, requires informational and managerial continuity between services to be effective. Improving continuity in palliative care may not remove every negative experience for palliative care patients and their families. However, the contrasts in reports of patients who had, and had not, perceived continuity in their care in this review demonstrate the beneficial effects that continuity can have in terms of feeling safe, known and supported. While continuity may not be the panacea for all the challenges in providing high quality palliative care, we believe that good continuity, in a range of forms, can go a long way to improving a difficult time in a family or a person’s life. We acknowledge that where continuity is more integrated into care, or where elements of interventions are not identified as continuity facilitators, they may not have been included in this review.

Limitations
There are a number of limitations to this review that warrant consideration. This rapid review was completed within 12 weeks and only research published within the last 10 years was included, grey literature and the views of healthcare professionals were not included.

Half of included studies were conducted in the UK. We acknowledge that patient experiences are shaped by the healthcare services and structures of the country in which they are receiving care, however aspects of the experience of both good and poor continuity may transcend national borders.

Defining which interventions should be considered eligible for inclusion in this review was a challenge given the various definitions and approaches to continuity found in the literature. Consensus over whether an article was eligible for inclusion was assessed through consulting the full text articles, referring back to the definitions of continuity outlined in Haggerty et al’s review, and discussion among the research team.

Implications for future research and practice
The development of future interventions to improve care for palliative patients should consider how strategies for promoting both information and relational continuity can be embedded within interventions, and subsequently healthcare, alongside robust methods to measure the extent and impact of continuity achieved.

CONCLUSIONS
The impact of poor continuity and the potential benefits of improved continuity highlighted in this review add additional evidence to the body of literature calling for increased efforts to promote both informational and relational continuity for palliative care patients. Methods for enhancing, and recording continuity should be considered in the design and development of future healthcare interventions, across the lifespan.

REFERENCES
17. Hill A, Freeman GK. Promoting Continuity of Care in General Practice: Royal College of Physicians, 2011.


