

Information transfer and continuity of care for stroke patients with eating difficulties from the perspectives of nursing staff in Swedish elderly care

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Abstract

Continuity of care is a key issue in the care for elderly people, for example, those having experienced stroke, particularly with regards to informational and managerial continuity based on patient record data. The study aim was to explore municipal nursing staff's (n=30) perceptions of discharge information provided to them for stroke patients with eating difficulties.

Structured interviews were used and data were analysed by content analysis and descriptive statistics. Results showed that nursing staff perceived informational continuity and accuracy of information on patients' eating difficulties as poor and that little information on eating difficulties reached licensed practical nurses, who instead relied on their own assessments of patients' eating ability. Co-ordinated care planning and management continuity were largely lacking, increasing the risk for undernutrition and related complications for the patients.

Introduction

Continuity of care is a key issue in the care for elderly people with longstanding health problems, yet difficult to achieve across care settings. Theoretical models for defining continuity of care, as well as quality indicators, do exist, but there is lack of knowledge on how such continuity is perceived by nursing staff, particularly within elderly care.

Background

Integration across care settings and continuity of care for individuals in need of comprehensive and continuous nursing care is crucial to ensure a high quality of care.

Continuity of care applies to both informational continuity and management continuity. Informational continuity, defined as the use of information on past events and personal circumstances to make current care appropriate for each individual¹, depends mainly on the accuracy of the patient record. Accordingly, patient records and discharge summaries should provide essential information in the transfer of a patient from one care setting to another. However, studies on representation of care in patient records have revealed considerable deficiencies in terms of quality, comprehensiveness and accuracy^{2,3,4,5}. Management continuity, defined as a consistent and coherent approach to the management of a health condition in accordance with a patient's changing needs¹, is manifested in co-ordinated discharge planning involving the patient and his next of kin. To ensure continuity and safety in care for stroke patients with eating difficulties, information transfer between care settings has to be comprehensive and accurate. Despite discharge planning being an everyday activity for registered nurses (RNs), low quality in discharge planning for older patients has been reported^{6,7}. The discharge process for stroke patients has not been studied to much extent and knowledge is scarce on how nurses in elderly care perceive discharge information from hospital nurses; whether they receive the information needed and, if not, how they go about obtaining the lacking information.

Eating difficulties are prevalent and serious for people who have experienced a stroke, causing suffering for the individual as well as the risk of malnutrition and other well-known complications. Individuals with eating difficulties need comprehensive and continuous nursing care and for that, high quality discharge planning and information transfer across care settings are imperative.

Aims

To explore the perceptions of RNs and licensed practical nurses (LPNs) in elderly care of the accuracy and adequacy in web-based discharge information for stroke patients in the transfer from hospital to municipality care.

Material and methods

Findings reported are part of a larger study tracing 15 elderly patients with eating difficulties discharged from a stroke unit to municipality care⁸. Fifteen RNs and fifteen LPNs working in six nursing homes and rehabilitation units, and one home care team to which the patients were discharged, were interviewed via telephone, using a structured questionnaire. The discharge information was transferred via a web-based system. The system contained, among other functions, a discharge summary and a care plan. Study-specific questions were used, comprising twenty-three questions on demographic data, questions on the organisation and responsibilities of the nursing staff, on the information transfer process and on perceived quality of the information transferred from hospital at discharge. One question was open-ended and related to the specific patient, phrased: 'Please describe the patient's eating'. Answers were analysed and categorized using deductive content analysis and descriptive statistics⁹.

Findings

Data comprised the written, web-based information transfer, but the RNs reported that they, in addition, had received verbal discharge information via telephone for 14 patients. Ten of the fifteen written discharge summaries for patients with eating difficulties and risk for undernutrition contained information on those difficulties. After hospital discharge, patients' status as perceived by the municipal nursing staff differed for some of the patients in comparison with the information in the discharge summary; four patients were reported by the municipal nurses to have oral problems that were not recognised in the discharge information. Another four patients were reported as having visual impairment that made mealtime activities troublesome, which was not reported in the discharge summary. Four patients had better eating ability compared with what was described in the discharge information. The RNs' and LPNs' levels of satisfaction with the discharge information are presented in Table I.

Satisfaction with discharge information	Number of responses		
	RNs	LPNs	Total
Sufficient and accurate for further care planning	5	2	7
Fair, but some information missing	5	7	12
Insufficient information	3	1	4
No information	1	2	3
Inaccurate information	0	1	1
Don't know	1	2	3
Total	15	15	30

Table I. RNs' (n =15) and LPNs' (n =15) satisfaction with discharge information for 15 stroke patients transferred to municipal care.

For 10 of the 15 patients, discharge summaries were perceived by RNs to contain sufficient or fair information for further care planning. The LPNs perceived that they had received sufficient or fair information for nine patients. One RN and two LPNs reported that they had not received any information at all for three patients.

Both RNs and LPNs perceived that the discharge information was sometimes inaccurate and reported that they often had to rely completely on their own assessments of eating needs and the ability of the patient. Ten RNs reported that they did not routinely read patients' web-based discharge information. Fourteen RNs reported that

they had received verbal discharge information via telephone in addition to the written information. Nevertheless, sufficient information needed to care for the patients was not transferred, neither electronically nor by oral reports.

RNs and LPNs described patients' eating difficulties in lay language, focusing primarily on nursing interventions such as 'needs assisted eating' and 'needs modified food consistency'. In contrast to RNs, who did not take part in basic nursing care and therefore expressed incomplete knowledge on patients' eating ability and nutritional status, LPNs described eating in a comprehensive manner, often addressing patient participation, as exemplified by the following quote:

'He just doesn't want to eat. He doesn't say that the dishes taste bad, or that he cannot eat. He doesn't complain; he just doesn't want to eat. We have assessed his mouth and suggested that he would try to eat without his denture, but it's the same. He can eat rye bread and cookies, so he has no swallowing problems. We accompany him at meals to encourage him, but it makes no difference' (interview no 2).

Discussion

All 15 patients had multiple eating difficulties and were at risk of undernutrition and thus in need of care planning to prevent further deterioration. Yet only 2/3 of the discharge summaries included information on the patients' eating-related care needs, and not all nurses perceived this information as sufficient for further nursing care planning. Our findings indicate the lack of description of serious nursing problems in discharge information, which has been reported in studies in other contexts (patients with hip fracture and elderly patients discharged to home care) for example, the absence of reporting of pressure ulcers and communicative status in discharge summaries^{10,11}.

For several patients, discharge information on their eating difficulties was comprehensive and accurate for further care planning. However, all RNs in municipal care did not routinely read patients' information in the web-based system but relied instead on other sources of information, which may be explained by RNs' attitudes towards searching information in electronic systems¹². As suggested by our findings, electronic tools for information transfer need to be developed to support a structured discharge process in order to support reliable informational and management continuity for patients with stroke and eating difficulties. Such tools must also be part of an integrated patient record with relevant decision support for nursing staff. Scandurra¹³ proposes an electronic application for sharing information between health care professionals, the patient and his or her next of kin, based on point of care accessibility and integration of information from the patient's different care providers. For such devices to be successful, they have to be designed so that RNs and other health care professionals perceive them to be useful and easy to handle. So far, little is known on how transfer of information and responsibility for further care planning between care providers are processed⁷, as well as on the appropriate and relevant content of that information to accomplish information and managerial continuity.

Our study adds new knowledge by showing a discrepancy between how transferred information was described by RNs and LPNs; the LPNs, who work with the daily care of the patients, claimed sufficient information for planning further nursing care for only 2 out of 15 patients. Further, they often relied on their own assessments of the patients' needs rather than on the information obtained from other health care professionals. We suggest this to be an important aspect of continuity of care; inadequate information transfer and information gaps between hospital and municipal care, as well as within institutions, are potential threats to patient safety¹⁴. Safe and continuous care is hard to achieve if information sources integral to continuity of care are ambiguous, or lack standardised assessment and outcome indicators, or are not expressed in terminology that can be understood by all health care professionals. Thus, creating coherent information transfer processes should be an important area for improvement. In older patients with stroke, often aggravated by communication deficits, coherent care in the transfer from hospital to municipal care is imperative.

Study limitations

Information is the common thread linking care for the individual between care providers. This information may be contained in a health care professional's mind, on paper or in electronic media. When investigating information on the care that has been provided, this fact should be kept in mind; we studied information transfer and continuity of care by interviewing receiving RNs and LPNs in municipal care. All RNs expressed the view that the telephone report from the hospital nurse at discharge was an important source of information. However, as we did not target this dialogue in our study, the contents of the verbal information transfer is unknown.

Conclusions

According to nursing staff's perceptions, informational continuity and accuracy of information on patients' eating difficulties were poor. Despite their important role in caring for patients with eating difficulties, little information on eating difficulties seemed to reach LPNs in the municipalities when patients were transferred from hospital. Rather, the LPNs relied on their own assessments of patients' eating ability. Co-ordinated care planning and management continuity related to eating difficulties were largely lacking, increasing the risk of undernutrition and related complications for the patients. To improve continuity in stroke care there is a need not only to document eating difficulties in the patient record but also to transfer this information at discharge. The information content, as well as as the information transfer process must be adequate for the specific patient and cover all necessary nursing information, all the way to LPNs in municipal care.

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