

Interprofessional Handover and Continuity of Care between Hospital and Community Palliative Services

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Abstract

Transitions from hospital to community palliative services expose patients and families to a distinctive continuity problem. Clinical information may be transferred while responsibility, follow-through, relational knowledge, and mechanisms for resolving uncertainty remain fragmented. This conceptual article develops a cross-setting continuity framework for examining that problem. It integrates informational, management, and relational continuity with clinical handover content, accountability transfer, interprofessional communication, patient and family participation, and feedback between hospital and community services. The central argument is that continuity after discharge depends on whether clinically relevant information becomes interpretable and actionable within a receiving system that has accepted responsibility and can respond when needs change. The framework therefore distinguishes transmission from receipt, receipt from enactment, and planned home care from the adaptive escalation that may become appropriate as illness, caregiver capacity, or preferences change. This approach provides a basis for analysing transition failures without treating every hospital return as evidence of failed care. It also identifies testable service-design and evaluation questions for cross-setting palliative practice.

Keywords: Palliative care, continuity of care, care transitions, clinical handover, interprofessional communication, family caregivers

Introduction

A systematic review of transitions from acute to community-based palliative care found heterogeneous interventions, outcomes, and methodological quality, leaving limited support for a single model of transitional care [1]. The problem is therefore broader than selecting a preferred discharge intervention.

Patients and family caregivers experience continuity through whether care remains coherent across a change in setting, personnel, routines, and access to expertise [2]. Their experience can diverge from the organizational view that a discharge has been completed successfully [3].

Recent co-design work on hospital-to-home palliative transitions reinforces the multiplicity of these needs. Patients, caregivers, and health professionals identify practical, communicative, clinical, and support requirements that cannot be reduced to the movement of a discharge document [4]. Some needs arise before departure, some

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become visible only after the patient reaches home, and others emerge when the initial plan encounters deterioration, uncertainty, or limitations in community capacity.

Particular attention is given to informational, management, and relational continuity; clinically actionable handover content; medication and symptom information; goals of care; responsibility transfer; patient and family participation; interprofessional communication; and the capacity to return questions or escalate care when the original plan no longer fits.

Conceptual approach

Multicountry qualitative research shows that patients and family caregivers experience continuity through several interrelated dimensions of integrated palliative care [5]. This perspective directs analysis toward what remains connected from the patient's viewpoint even when clinicians, organizations, and locations change.

A cross-setting account also requires attention to levels above the individual encounter. Work examining palliative-care integration at micro, meso, and macro levels demonstrates that coordination is shaped by organizational and system conditions as well as interpersonal practice [6, 7]. The analytical unit adopted here is therefore the handover–continuity configuration: the combination of information, ongoing management, relationships, responsibility, participation, and feedback that allows a plan initiated in one setting to remain clinically workable in another.

Hospital-to-community transition as a continuity problem

Qualitative investigation of successful palliative hospital-to-home transitions indicates that success depends on interacting clinical, practical, logistical, and relational conditions rather than on discharge completion alone [8]. The transition temporarily redistributes knowledge and responsibility: the hospital team relinquishes direct control, the community team must interpret and enact the plan, and patients and families frequently assume new work before the receiving system has fully stabilized.

Communication is especially vulnerable at this interface. Patients, carers, and primary-care professionals describe specialist palliative discharges in which inaccurate, incomplete, delayed, or insufficiently reinforced communication produces confusion and additional post-discharge work [9]. These observations identify information loss as one mechanism of discontinuity, but they also show why information cannot be the entire explanation. A complete message has limited protective value when responsibility remains ambiguous or the recipient lacks the capacity to act on it.

Continuity must also accommodate movement in the opposite direction. A 2026 qualitative synthesis of transitions from home to inpatient palliative care found that transfers may arise from changing symptoms, caregiver burden, service needs, or altered preferences about place of care [10]. Hospital return is therefore not intrinsically evidence of transition failure.

Table 1. Differentiating the continuity functions implicated in hospital-to-community palliative transition

Analytical unit	What must remain connected across the setting change	Diagnostic question	Characteristic discontinuity	What the construct is not equivalent to
Transition event	Timing, preparation, access, practical arrangements, and immediate post-discharge support	Can the move occur without creating a clinically unsafe gap?	Departure occurs before required people, services, medicines, or knowledge are available	Continuity itself
Informational continuity	Accurate, current, interpretable, accessible clinical information	Does the receiving side possess and understand what it needs to know?	Missing, delayed, contradictory, inaccessible, or poorly contextualized information	Mere transmission of a document
Management continuity	Coherent implementation and adaptation of the care plan over time	Can required actions actually continue after discharge?	Plan exists but is not enacted, reconciled, followed up, or adjusted	Information continuity
Relational continuity	Trust, shared understanding, and access to people who know the patient and plan	Can meaning and uncertainty be interpreted through dependable relationships?	Patient, family, or professionals cannot identify a reliable relational bridge	Permanence of one individual clinician
Responsibility continuity	Explicit understanding of who must act, monitor, decide, and respond	Has responsibility been received and made operational?	Tasks fall between services or are shifted implicitly to patients or families	Sending information
Feedback continuity	A route for questions, changing needs, correction, and escalation	Can the receiving setting reopen the plan when circumstances change?	New problems accumulate without an accessible response pathway	Failure-free home care

Note: The functions are analytically separable but potentially interdependent. The table does not assign numerical weights, imply a temporal sequence, or assume that every transition requires the same intensity of each function.

Dimensions of continuity of care

Empirical work following hospital-to-home palliative transitions demonstrates that transition quality contains multiple domains rather than a single measurable state [11]. The dimensions can move together, but they need not do so.

Setting itself should not be treated as a proxy for quality. In people with dementia receiving palliative care near the end of life, several symptom and functional trajectories were broadly similar across hospital and community settings, with differences in selected outcomes rather than a uniform advantage for one location [12]. The analytical question is consequently whether the necessary continuity functions are preserved in the setting that is being used.

Informational continuity

Informational continuity concerns more than whether data leave the hospital. Health professionals describe the hospital-primary-care transition in the palliative phase as vulnerable to incomplete handover and mismatched knowledge between services [13]. The clinically relevant sequence is transmission, receipt, interpretation, and usability. Failure at any of these points can leave the receiving team technically informed yet practically unable to act.

Information is also shaped by context. Communication experiences reported by patients, carers, and primary-care professionals similarly show the importance of accuracy, completeness, reinforcement, and accessible follow-up [9]. Informational continuity is therefore achieved when relevant knowledge becomes usable in the receiving setting, not merely when it can be shown to have been sent.

Management continuity

Management continuity begins where information becomes action. In a randomized trial of transitional palliative support for family caregivers, structured nurse-led follow-up produced improvement in selected patient and caregiver outcomes, although caregiver burden did not differ between groups [14]. The mixed pattern matters conceptually: active transition support can affect some outcomes without solving every problem generated by serious illness and caregiving.

Process evidence from transitional care for people with dementia likewise illustrates that continuity extends into the period after discharge through care plans, early contact, subsequent follow-up, and coordination with postacute services [15]. Management continuity therefore concerns whether the receiving configuration can enact, monitor, and modify the plan over time. It is especially important when symptoms, medications, equipment needs, or caregiver capacity change shortly after hospital departure.

Relational continuity

Relational continuity supplies interpretive connection across organizational boundaries. In a realist evaluation of end-of-life care, open communication among patients, families, and professionals functioned within particular contexts to support coordinated care and death in the usual place of residence [16]. The significance lies less in preserving contact with one named clinician than in maintaining relationships through which knowledge can be shared and uncertainty addressed.

Shared decision-making in home end-of-life care likewise depends on multidisciplinary relationships and negotiation among professionals, patients, and families [17]. Relational continuity can preserve tacit knowledge that is difficult to encode fully in written handover. It cannot compensate indefinitely for missing medicines, unavailable services, or unclear accountability, but it can determine whether ambiguity is recognized and resolved before it becomes a larger discontinuity.

Clinical handover content

Clinical handover content should be judged by the decisions and actions it enables after the patient leaves hospital. Patients and family caregivers describe going home with palliative care as requiring structured preparation and support rather than a reassuring intention to discharge home without an operational plan [18]. Clinically important handover content therefore includes both the patient's current state and the information needed to manage foreseeable change.

Contemporary co-design work has further refined hospital-to-home transition supports by incorporating the perspectives of patients, caregivers, and professionals [19]. This supports a functional approach to content selection: the handover should make the immediate care plan, anticipated problems, responsibilities, available supports, and routes for clarification sufficiently clear for the people expected to act on them. Excess material that obscures action may be as unhelpful as omission.

Medication and symptom information

Medication information illustrates why handover content cannot be separated from the capacity of those receiving it. A review of family caregivers managing medicines for people dying at home describes medication work as

involving administration, organization, knowledge, relationships with professionals, and responsibility for responding to changing symptoms [20]. A medication list alone does not address this work.

Qualitative evidence from family caregivers administering end-of-life medicines similarly identifies informational, practical, and relational support requirements [21]. Cross-setting handover should therefore make medication purpose, recent changes, symptom indications, relevant monitoring, foreseeable contingencies, and routes for help understandable to the people expected to use that information.

Goals of care and advance-care information

Goals-of-care information differs from medication data because its clinical significance depends on interpretation, currency, and applicability to the decision at hand. Communication about incurable illness and remaining life may remain incomplete even within specialized home care; a caregiver-targeted psychoeducational intervention did not produce a statistically significant change in such communication in one study [22]. The presence of specialist services therefore does not justify assuming that goals have already been fully discussed or shared.

Documentation also has to be visible and usable at the point of decision. Research examining advance care directives and goals-of-care processes in emergency care highlights the practical distinction between information existing somewhere in the record and being acknowledged and used by clinicians [23]. For hospital-community palliative handover, the analogous concern is whether the receiving team can identify what has been discussed, what has been decided, what remains uncertain, and who participated.

Advance-care communication remains modifiable rather than fixed. In a randomized trial among ambulatory palliative-care patients, motivational interviewing improved readiness for several advance-care-planning behaviours and increased completion of selected documentation outcomes [24]. These findings support treating goals-of-care information as part of an evolving clinical conversation. A cross-setting handover should preserve current preferences and prior discussions while allowing for revision as circumstances or patient wishes change.

Role and accountability transfer

Responsibility is not transferred automatically when information crosses an organizational boundary. Family-focused discharge work demonstrates that transition planning can explicitly surface family concerns and participation instead of treating relatives as peripheral to an otherwise professional process [25]. The same principle applies to professional accountability: tasks that will continue after discharge require an identifiable actor or team able to receive them.

For conceptual purposes, role transfer can be separated into an offer of responsibility, receipt, and operational acceptance or clarification. This is a proposed analytical distinction rather than a validated procedural sequence. The key continuity question is whether responsibility is sufficiently explicit that patients and families are not left to discover unresolved ownership only after a problem develops.

Hospital team responsibilities

The hospital team's continuity function extends beyond preparing a discharge document. Before transition, it must make the clinical plan sufficiently actionable for the next setting, address predictable practical gaps, and clarify which unresolved matters still require attention. Patient and caregiver accounts of home transition emphasize the consequences of leaving these issues under-specified [18].

Hospital responsibility also includes making family participation explicit rather than presumed. Family-focused discharge approaches show the value of directly addressing relatives' concerns, expected roles, and support requirements before the patient leaves institutional care [25]. When time, prognosis, or service constraints limit what can be completed, the remaining uncertainty itself becomes part of the handover rather than disappearing at discharge.

Table 2. Responsibility-bearing handover content across the hospital–community palliative interface

Handover element	Information that must become actionable	Hospital-side continuity work	Receiving-side continuity work	Patient/family participation	Warning sign of an unresolved interface
Medication and symptom plan	Current regimen, reasons for changes, symptom priorities, foreseeable contingencies	Reconcile and contextualize current treatment	Verify availability, feasibility, understanding, and response capacity	Report symptoms, preferences, practical concerns, and difficulties where desired	List is present but no one can explain what to do when symptoms change
Goals of care and prior discussions	Current preferences, documented decisions, unresolved questions, relevant participants	Distinguish completed decisions from continuing conversation	Reconfirm applicability and revisit when circumstances change	Express, revise, or clarify preferences	Documentation exists but cannot be confidently applied

Pending clinical actions	Tests, referrals, monitoring, procedures, equipment, or follow-up still outstanding	Identify what remains pending and expected next action	Confirm ownership and completion route	Know whom to contact where participation is appropriate	Each service assumes the other is following the issue
Responsibility for ongoing care	Who monitors, prescribes, reviews, coordinates, and responds	Make intended ownership explicit	Accept, renegotiate, or redirect responsibility	Understand primary contact routes without becoming the default coordinator	Patient or caregiver must determine who is responsible after a problem occurs
Caregiver-dependent tasks	Expected home-care activities and required knowledge/support	Assess whether assumptions about caregiver involvement are reasonable	Reassess capacity and provide continuing support	Choose level of involvement and identify limits	Family work expands without explicit agreement or support
Uncertainty and contingency	Questions not settled before discharge and conditions requiring reassessment	Transfer uncertainty rather than conceal it	Maintain a route for clarification and escalation	Report changes and concerns through an accessible route	No service can be reached when the original plan no longer fits

Note: Rows identify distinct responsibility-bearing elements rather than a mandatory checklist or chronological sequence. Responsibility may be shared, and the appropriate configuration depends on clinical complexity, patient preference, family capacity, service availability, and local organization.

Community team responsibilities

The receiving community team transforms a transferred plan into continuity by verifying what has been received, reconciling it with the home situation, and determining whether planned care is feasible. Systematic review evidence suggests that home-based palliative interventions can support quality of life, home care, and selected service outcomes, although findings and intervention designs are heterogeneous [26]. Community capability must therefore be treated as an active determinant of continuity rather than as a passive destination for hospital instructions.

Receiver responsibility includes identifying discrepancies early. If medicines are unavailable, equipment has not arrived, caregiver capacity differs from what was assumed, or the care plan no longer fits the patient's condition, management continuity requires adaptation and, where necessary, escalation rather than literal adherence to an obsolete plan.

Patient and family participation

Patients and families carry knowledge that professionals in either setting may not possess: preferences, tolerable burden, home routines, previous experiences, emerging symptoms, and the practical feasibility of proposed care. Family caregivers of patients with end-of-life cancer describe uncertainty, changing responsibilities, and continuing needs for guidance and communication during hospital-to-home transition [27]. Participation is therefore a substantive continuity function.

Participation should nevertheless be distinguished from substitution for professional coordination. Families may choose extensive involvement, but they should not become default couriers of missing clinical information or the only mechanism connecting services. Medication-management research reinforces this boundary because caregiving work can become technically and emotionally demanding even when family members are committed to home care [20].

Interprofessional communication

Cross-setting continuity depends on communication that permits response, clarification, and revision. A message that cannot be questioned is weaker than a channel through which receiving professionals can test interpretation and return unresolved issues. Communication capability is also amenable to improvement: structured serious-illness communication training has been associated with changes in clinician communication behaviours, although evidence from an intensive-care setting cannot be treated as direct validation of a hospital-to-community handover method [28].

For palliative transitions, the relevant interprofessional property is therefore closed-loop accessibility rather than use of one prescribed communication tool. Prior transition research shows why this matters when discharge communication is incomplete, [9] while professional accounts of the hospital-primary-care interface demonstrate the vulnerability created by gaps between settings [13]. Relational evidence further indicates that communication works through the connections among people as well as through the content exchanged [16].

These relationships are summarized in **Figure 1**. The central distinction is between information moving across the boundary and continuity becoming operational after receipt.

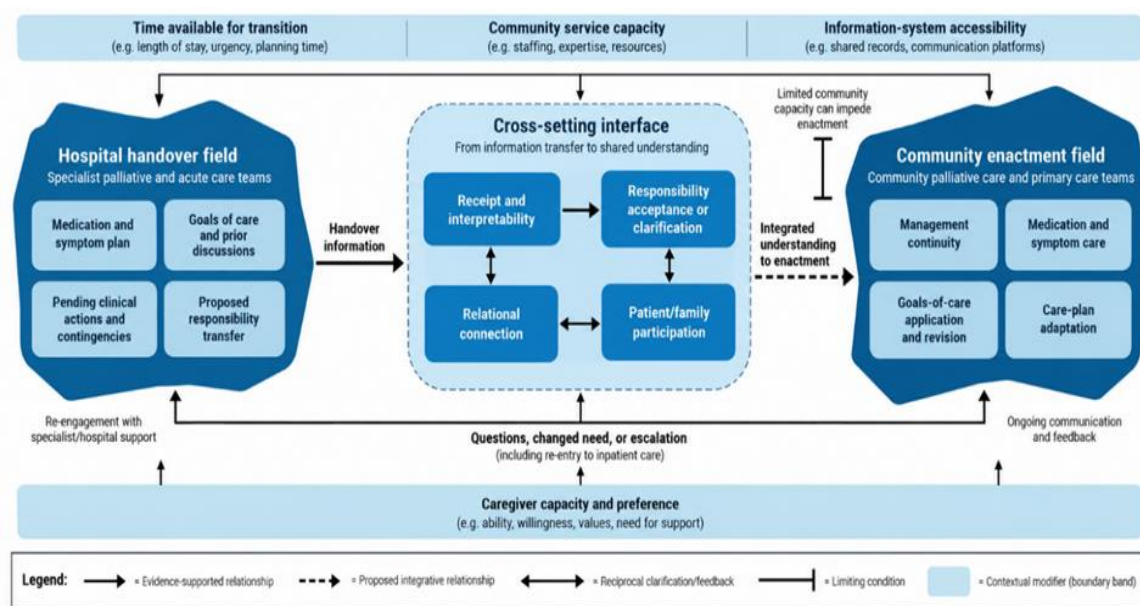


Figure 1. From transferred information to enacted continuity across the hospital–community palliative interface

Failure points and information loss

Discontinuity becomes visible when information, responsibility, capacity, or access fails to connect across settings. These failures should not be inferred automatically from utilization outcomes. In a retrospective cohort examining hospital admission during the last month of life, admission was associated with multiple clinical and service factors rather than a single transition mechanism [29]. Similarly, a national registry study found that some patients receiving specialist palliative home care were transferred to inpatient care near death and differed in symptom burden from those who remained in the community [30]. Neither observation establishes that transfer was preventable or inappropriate [31, 32].

A more useful failure analysis asks where the cross-setting configuration ceased to function. Community teams may receive an accurate plan but lack the medicines, staff, equipment, authority, or time required to enact it. These conditions produce different failure mechanisms and therefore require different corrective responses.

Feedback and escalation

Palliative trajectories can change faster than a discharge plan can anticipate. Qualitative research on crisis emergence in outpatient palliative care shows that crises can accumulate from interacting disease changes, care intensity, structural access problems, and caregiver burden rather than arising from one isolated event [33]. Escalation should consequently be understood as an adaptive continuity function. A community clinician may need specialist advice, the care plan may require rapid revision, or inpatient treatment may become the most appropriate option. Conversely, insisting on the original plan after its assumptions have failed can itself create discontinuity [34–38].

Proposed handover–continuity architecture

The synthesis developed here proposes that cross-setting continuity depends on five linked functions: actionable information, explicit responsibility, enactment capacity, relational connection, and feedback. A transition can be strong in one function and weak in another, and some deficiencies may be partly compensated for while others cannot [39–45].

The architecture begins with clinically meaningful handover content but treats transmission only as the opening condition. Information must be received and interpreted; responsibility for ongoing tasks must become explicit; the receiving service must be able to enact the plan; patients and families must be able to participate without becoming the default coordinating infrastructure; and changing circumstances must be able to return through a feedback route [39, 46–50].

Alternative service configurations reinforce the need for this flexibility. Systematic review evidence concerning home hospitalization in advanced cancer and dementia indicates that care may be organized through models that blur the conventional hospital-home distinction [51]. Cross-setting continuity should therefore be defined by preservation of clinically necessary functions rather than by loyalty to one organizational form.

Table 3. Decision and boundary conditions within the proposed handover–continuity architecture

Continuity state or decision problem	What is known at the interface	Key question for the receiving configuration	Appropriate response class	Boundary condition requiring caution	Interpretation
Information complete, responsibility clear, community capacity adequate	Plan and ownership are sufficiently interpretable	Can the plan be enacted as intended?	Proceed with community implementation and routine monitoring	Rapid clinical change may still invalidate the plan	High functional alignment, not guaranteed stability
Information complete, responsibility unclear	Clinical content is available but ownership is uncertain	Who is expected and authorized to act?	Clarify responsibility before reliance on the plan	Shared responsibility may be appropriate	Informational continuity without responsibility continuity
Information incomplete but relational access strong	Missing or ambiguous content can potentially be reconstructed	Can uncertainty be resolved rapidly through trusted professional contact?	Use direct clarification and update the record	Relational access cannot replace unavailable clinical capacity	Relational continuity may partially compensate for information gaps
Information adequate but community enactment capacity limited	Intended actions are understood	Can required care actually be delivered in the setting?	Modify the plan, mobilize additional support, or escalate	Workforce, medicines, equipment, authority, and timing may constrain action	Handover quality alone cannot overcome structural incapacity
Patient/family capacity differs from discharge assumptions	Formal plan depends on home participation that is not feasible or desired	Which tasks need redistribution?	Re-negotiate roles and professional support	Preference and caregiver capability may change	Participation must not become implicit substitution
Symptoms, goals, or practical circumstances change	Original plan was previously coherent	Does the existing configuration still fit current need?	Reassess, revise, seek specialist advice, or transfer setting	Hospital return may be appropriate	Escalation can preserve rather than negate continuity
Multiple functions remain unresolved	Information, ownership, capacity, or feedback pathways are simultaneously weak	Is community care currently sustainable?	Intensify coordination or adopt an alternative care configuration	Delay may increase burden or risk	Cross-setting continuity has become structurally fragile

Note: The table presents an original synthesis of evidence-supported continuity functions. It does not establish validated thresholds, rankings, mandatory sequences, or prediction rules.

Contextual and organizational conditions

The architecture operates within institutional conditions that determine what can realistically be transferred and enacted. Advance-care planning illustrates this dependency. Cross-jurisdictional mapping shows that legal recognition, institutional practices, terminology, and implementation arrangements vary substantially across health systems [52]. A goal-of-care document or advance directive may therefore carry different practical authority and accessibility across settings.

Implementation barriers also operate at several levels. A systematic review and meta-analysis of advance-care-planning readiness identified patient, family, professional, and system-level barriers, with substantial heterogeneity across studies and settings [52, 53]. Comparable multilevel variation is likely to affect other parts of palliative handover.

These conditions should be treated as modifiers rather than background details. The architecture therefore predicts no universally sufficient document, communication tool, staffing arrangement, or intensity of follow-up.

Indicators for future evaluation

Future evaluation should distinguish the functions that conventional discharge measures often collapse. Mixed-method transition research already demonstrates that patient and caregiver experiences change across several domains over the course of hospital-to-home palliative care [11]. Evaluation of the proposed architecture should therefore examine whether information was received and usable, whether responsibilities were understood, whether required actions occurred, whether patients and families knew how to obtain help, and whether unresolved problems were detected and addressed.

Outcome measures should also remain function-specific. Transitional support trials show that an intervention may improve selected outcomes while leaving others unchanged [14]. Candidate indicators should therefore include process measures—such as successful receipt, clarification, medication availability, timely follow-up, and

completed escalation—as well as patient-, family-, and service-level outcomes. These indicators require prospective validation; the present synthesis does not establish performance thresholds.

Practice and service-design implications

Service design should concentrate on the reliability of the interface between settings. Home-based palliative-care evidence suggests that community capability can support important patient and service outcomes, but models and effects remain heterogeneous [26].

A practical design response is therefore to match transition intensity to complexity. Patients with unstable symptoms, difficult medication regimens, unresolved goals-of-care questions, high caregiver burden, or uncertain service access may require direct professional contact, explicit ownership, early verification, and a more visible escalation route.

Patients and families should be included in this design without being turned into the mechanism that repairs professional fragmentation.

The relationship among these states, contextual constraints, evaluation targets, and adaptive responses is summarized in **Figure 2**.

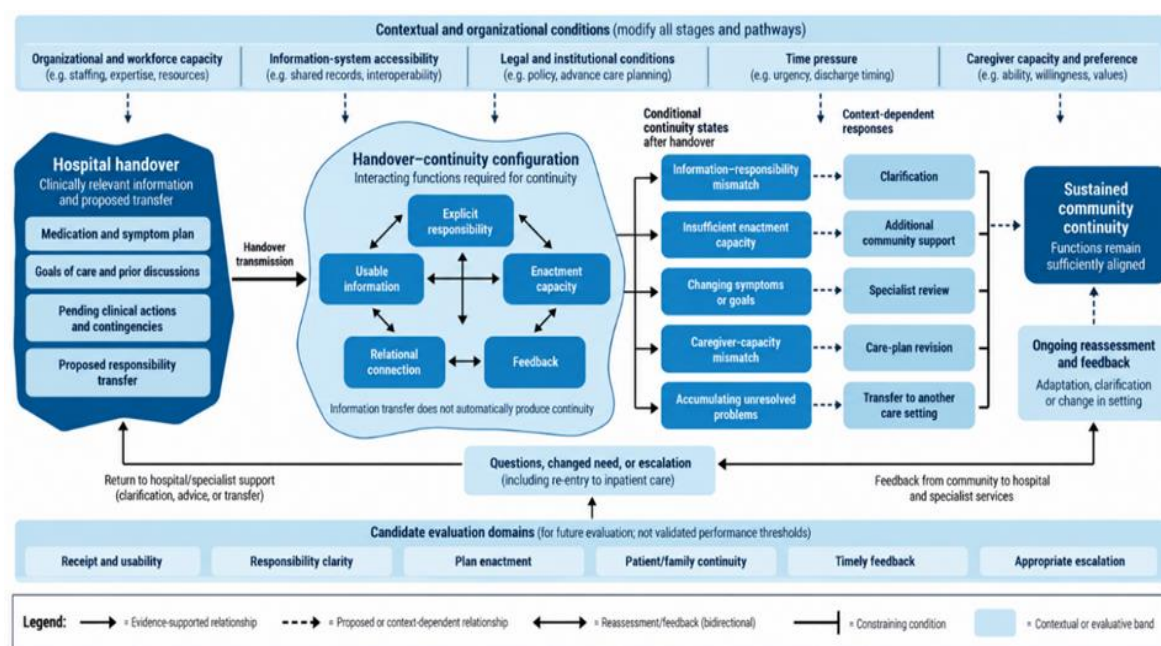


Figure 2. Conditional continuity states, escalation pathways, and service-design responses after palliative handover

Research agenda

The proposed account is useful only if its component relationships can be tested independently. Research should first determine whether information receipt, responsibility clarity, management enactment, relational access, and feedback predict distinct aspects of transition quality or merely restate one underlying construct. Longitudinal work is particularly important because place-of-care preferences and transfer needs can change as illness progresses [10].

Comparative studies should also examine rival explanations. Null findings deserve particular attention. The absence of improved communication after one caregiver-focused intervention [22] illustrates why mechanisms should be tested rather than assumed [54-56].

Results and Discussion

This article reframes hospital-to-community palliative handover as a problem of maintaining several continuity functions across an organizational boundary. Patient and caregiver research supports a multidimensional understanding of continuity, [5] while multilevel palliative-care research shows that integration depends on organizational and system conditions as well as individual clinical practice [6].

The synthesis extends these observations by separating information transfer from responsibility transfer and by placing both within a broader configuration that also includes enactment capacity, relationships, participation, and feedback.

The framework also avoids treating continued home care as the only successful endpoint. The evaluative question is whether the transition system recognized the change, preserved responsibility, and enabled an appropriate response [33].

Limitations

The evidence supporting the framework is heterogeneous. The transition literature includes substantial qualitative, observational, co-design, and review evidence, and earlier systematic work identified methodological limitations across studies [1]. Direct empirical tests of an integrated configuration combining all proposed continuity functions are lacking.

Some stronger designs address only parts of the model. Transitional-support trials demonstrate effects in particular populations and settings but do not validate the complete architecture [14]. Evidence on communication, advance-care planning, home medication work, and escalation likewise comes from differing countries and service arrangements [53].

The framework should therefore be treated as a testable conceptual synthesis rather than a validated care standard.

Conclusion

Hospital-to-community palliative handover achieves continuity only when the receiving configuration can make transferred knowledge clinically usable, assume or clarify responsibility, enact the care plan, sustain appropriate relationships, include patients and families without shifting professional coordination onto them, and respond when circumstances change. These functions may align or fail independently.

The resulting framework treats continuity as an adaptive cross-setting accomplishment rather than a completed discharge transaction. Its central implication is conditional: information transfer can support continuity, but continuity depends on whether information becomes connected to responsibility, action, relationships, and feedback within the context in which ongoing palliative care is actually delivered.

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