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Preserving the Meaning of Symptoms across Nursing Handovers: A Conceptual Framework for Communicating Fluctuation, Patient Interpretation, and Unresolved Concerns in Palliative Care

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Abstract

To examine how symptom information can lose clinical and personal meaning during nursing handovers in palliative care and to develop a conceptual framework for preserving distinctions among symptom experience, observed change, contextual influences, uncertainty and unfinished follow-up. Original non-empirical discursive paper integrating nursing handover scholarship, palliative-care transition evidence, patient-reported symptom research, documentation studies and communication theory. A critically selected body of peer-reviewed literature published between 2017 and 2025 was used to examine structured handover, person-centred participation, palliative transitions, symptom assessment, documentation, patient-reported outcomes, communication uncertainty and ethical limits to information transfer. Symptom labels alone provide an unstable basis for continuity because the same label can refer to different experiences, trajectories and care implications. Meaning-preserving handover therefore requires information to remain distinguishable across five functions: patient-described meaning, observed symptom course, situational triggers or modifiers, unresolved uncertainty and pending follow-up obligations. These functions are proposed as an evidence-informed communication framework rather than a validated checklist or scoring system. Preserving symptom meaning requires more than transferring a symptom name or severity value. Nursing handovers should retain enough attribution, temporality, context and uncertainty for the receiving clinician to understand what is known, what the patient means by the symptom and what remains unfinished. Empirical validation is required before the framework can be treated as a standardized clinical tool.

Keywords: Palliative care, Nursing handover, Symptom assessment, Clinical communication, Continuity of care, Patient-reported outcomes

Introduction

Clinical handover is expected to transfer sufficient information for care to continue safely, yet structured communication does not remove the interpretive work required when symptoms fluctuate or when their significance depends on what a patient has said, what nurses have observed and what remains unresolved. Structured and locally adapted handover approaches can improve organization, completeness and consistency, but their effects remain dependent on implementation conditions and the clinical setting [1–3]. In palliative care, this distinction is particularly important because symptom descriptions frequently carry temporal, experiential and relational information that cannot be recovered from a diagnostic label alone.

Person-centred handover has consequently been defined in terms that extend beyond transfer of biomedical facts [4]. Direct observation of bedside handover shows that exchanges may be rapid, complex and substantially nurse-led [5]. Patients participate actively only in some encounters, with engagement shaped by both patient preference

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and nursing behaviour [6]. Systematic evidence similarly suggests that participation is valued but must remain flexible because confidentiality, conversational burden and differing preferences can make a uniformly participatory model inappropriate [7]. Even high adherence to a structured handover protocol does not guarantee equivalent attention to patient involvement or contextual detail [8].

These findings expose a specific problem for palliative nursing. A statement such as "pain worse today," "more breathless," or "nausea improved" may appear clinically intelligible while leaving several questions unanswered. Who judged that the symptom was worse? Was the change continuous, episodic or linked to movement, medication, conversation, eating or another circumstance? Did the patient regard the symptom as distressing, expected, tolerable or frightening? Was a possible explanation still uncertain? Had somebody undertaken to reassess the symptom or discuss it with another professional? Once these distinctions disappear, the receiving nurse inherits a label but may not inherit its meaning.

This paper therefore treats symptom handover as an interpretive continuity problem. Its purpose is not to replace structured communication formats or create another symptom score. It asks what kinds of meaning must remain available when symptom information crosses a nursing handover if the receiving clinician is to distinguish patient interpretation from professional observation, temporal change from isolated measurement, and completed care from unresolved responsibility.

Background

Palliative-care transitions illustrate why this problem matters. Moving between acute and community services requires assessment, preparation, coordination and communication across professional and organizational boundaries, while the evidence supporting individual transition interventions remains heterogeneous [9–11]. Patients and family caregivers may experience these transitions as periods of uncertainty in which continuity depends not only on whether information is sent but on whether the receiving service can understand what remains clinically and personally important.

Written transfer is vulnerable to similar problems. Examination of hospice discharge communication has shown that whether a need has been resolved and who is expected to follow it up may remain ambiguous [12]. Recent work on advanced-cancer transitions likewise identifies collaboration, coordination and communication as important facilitators without establishing a single transferable transition model [13]. Patients, carers and primary-care professionals describe accurate written information, verbal reinforcement and clarity about subsequent contact as important to continuity after specialist palliative discharge [14]. The communication problem is therefore not simply whether a record exists; it concerns whether the transferred record preserves enough context to support the next clinical interpretation.

Temporality further complicates handover. In specialist palliative home care, transfers to inpatient care still occur close to death, and symptom burden is one factor associated with such transfers [15]. The association does not establish that symptom deterioration itself causes transition, because service availability, caregiver circumstances, preferences and other factors can also influence place of care. It nevertheless demonstrates why the time-course attached to symptom information matters. "Pain present" carries less actionable meaning than a description that distinguishes a longstanding stable symptom from a new escalation, a brief episode, a symptom linked to movement or a concern whose response to intervention has not yet been observed.

The same difficulty applies when responsibility changes without a change of physical setting. Handover at shift change can separate the nurse who heard the patient's explanation from the nurse who later interprets the charted description. Discharge can separate the clinician who recognized a concern from the clinician expected to reassess it. A symptom may therefore lose meaning through several different processes: compression into a label, removal of temporal context, loss of patient attribution, disappearance of the conditions in which it occurs, or failure to carry forward an unfinished task.

A meaning-preserving account must consequently distinguish information completeness from interpretive continuity. Completeness concerns whether expected fields or topics appear. Interpretive continuity concerns whether the next clinician can reconstruct the clinically relevant relationship among the symptom, the patient's account, observed change, contextual modifiers and unfinished uncertainty. These are related but not identical goals.

The principal forms of information loss emerging from this background are summarized in **Table 1**.

Table 1. Distinct ways symptom meaning can be degraded during nursing handover

Form of information loss	What is retained	What is lost	Consequence for the receiving nurse	Meaning that requires preservation
Label compression	Symptom name	Patient-specific interpretation and qualitative character	A generic symptom category may be mistaken for the patient's actual concern	What the symptom means or feels like to this patient

Temporal flattening	Current symptom status	Pattern of fluctuation, onset, persistence or response over time	A transient episode and a sustained change may appear equivalent	Observed course and relevant change
Context stripping	Symptom statement	Circumstances in which it appears, worsens, improves or becomes tolerable	The receiving nurse may misread an environment- or activity-dependent symptom as constant	Situational trigger or modifier
Attribution loss	Recorded statement	Whether information came from the patient, family, nurse observation, measurement or inference	Differing evidence sources may be treated as interchangeable	Source and perspective of the information
Premature closure	Provisional explanation	Remaining doubt, disagreement or unanswered question	An uncertain interpretation may be inherited as established fact	Explicit unresolved uncertainty
Responsibility loss	Identified concern	Who intended to reassess, clarify or communicate it	An unfinished issue may disappear between shifts or services	Pending follow-up obligation

Data sources

The conceptual analysis draws on several evidence streams rather than treating any one source of symptom information as definitive. Patient-reported quality measures are important in palliative care precisely because they capture dimensions of experience that administrative or clinician-generated data may miss [16]. Their use, however, is conditional. Multicentre work in specialist palliative units shows that patient-reported outcome measures can be feasible and clinically useful while also becoming difficult to complete for some patients as illness severity, cognition or functional impairment changes [17]. Validation studies further show that patient-reported measures and clinician-defined palliative-care need overlap without becoming interchangeable [18]. Patient report should therefore be preserved as a distinct evidence source rather than absorbed into a supposedly neutral clinical summary.

The mode through which symptom information is collected also influences what becomes available for handover. Electronic patient-reported outcome collection can be implemented at substantial scale, but its practical value depends on workflow, interface design, integration into clinical encounters and the capacity of patients to complete the measures [19]. A digital entry, paper score and spontaneous bedside statement are therefore not equivalent merely because all refer to the same symptom. Each is produced under different conditions and may reveal different parts of the experience.

Symptom co-occurrence provides another reason to avoid interpreting isolated labels too confidently. Large oncology datasets show that pain, fatigue, mood, sleep disturbance and other symptoms frequently occur together [20]. Such patterns do not establish how an individual patient interprets a particular symptom, but they show why clinical meaning can depend on relationships among symptoms and on the circumstances under which they change. A handover that transmits each symptom as an independent static item may therefore preserve data while weakening the relationships needed for interpretation.

For this paper, three evidentiary distinctions are consequently maintained. First, patient-described information is retained as information attributed to the patient rather than translated automatically into clinician language. Second, clinician-observed information remains distinct from the patient's interpretation even where the two agree. Third, contextualized information records the circumstances and time-course that shape the significance of both reports and observations. None of these sources is assumed to be intrinsically superior. Their value depends on the question being asked and on the patient's ability and willingness to communicate.

These distinctions also establish a boundary around uncertainty. A receiving nurse may encounter a patient who reports severe distress while appearing outwardly settled, or a symptom measure may remain stable while the patient describes the symptom as newly frightening. Such discordance is not automatically an error to be corrected. It may indicate that different aspects of the symptom are being represented. Meaning-preserving handover therefore requires the transfer process to identify the source of information and retain clinically relevant disagreement when reconciliation has not yet occurred.

The same principle applies to incomplete information. When the patient cannot report directly, proxy, family or clinician observations may become necessary. Preserving meaning in that situation does not require pretending that the missing patient account has been recovered. It requires making the evidentiary position explicit enough that the receiving clinician knows what was observed, who observed it and what remains unknown.

These relationships are synthesized in **Figure 1**.

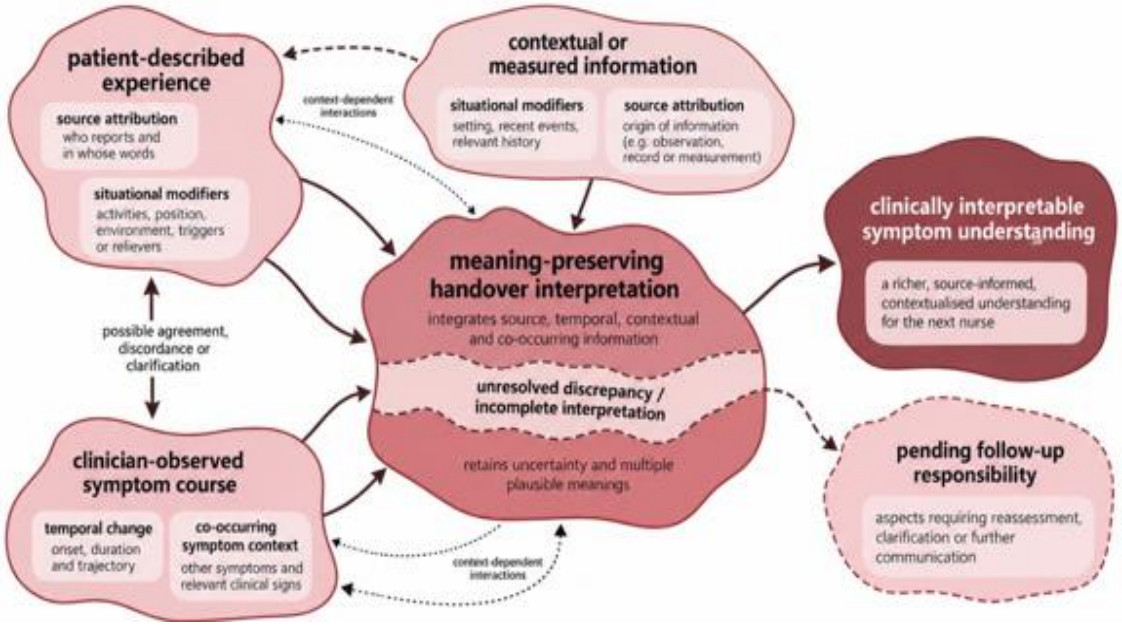


Figure 1. Preserving symptom meaning as information crosses a nursing handover

Overview of the issues

The first difficulty is that symptom configuration is not stable across patients or diagnoses. Specialist palliative home-care research demonstrates that symptom and problem clusters can differ between oncological and non-oncological groups [21]. Statistical clustering cannot determine what a symptom means to an individual patient, but it reinforces the danger of treating symptoms as context-free units. A receiving nurse may need to know whether breathlessness is part of a broader deterioration, whether fatigue has altered alongside medication or sleep, or whether pain is longstanding but newly interpreted by the patient as evidence of worsening illness.

Patient and caregiver perspectives can reveal dimensions that professional models underrepresent. When an established model of symptom management was reconsidered using patient and carer accounts, communication, medication-related experiences and caregiver burden emerged as important additions [22]. This finding supports a broader principle: information relevant to symptom management is not exhausted by what clinicians can observe or measure. The patient's interpretation may alter what matters about the symptom even when its measurable characteristics are unchanged.

Documentation creates a second source of distortion. Analysis of unstructured palliative-care notes in paediatric oncology showed inconsistent recording of symptom characteristics such as severity and distress [23]. The population limits direct generalization to adult palliative nursing, but the documentation problem is pertinent: written records can preserve the existence of a symptom while losing the properties necessary to understand it. Content-validation research also shows that the relevance of symptom-measure items can differ between patients and professionals and across cultural contexts [24]. A documentation system may therefore appear comprehensive while still organizing experience in categories that do not fully match what a patient regards as significant.

What is reported can additionally depend on what is asked. Comparison of versions of the Edmonton Symptom Assessment System demonstrated that explicitly including a symptom changes the likelihood that it is reported [25]. This does not mean that one format reveals an objective "true" prevalence. It demonstrates that elicitation conditions shape symptom visibility. A handover should consequently distinguish a patient's spontaneous concern from a symptom identified only after direct prompting where that distinction is clinically meaningful.

Documentation templates pose a related interpretive limit. Review of documented goals-of-care discussions found that templates can support recording of some recommended communication elements while failing to guarantee complete communication [26]. Documentation is therefore evidence that something was recorded, not proof that the full conversation occurred in the form implied by the record. For symptom handover, the same distinction matters whenever the receiving nurse sees a structured entry and assumes that a patient interpretation, uncertainty or follow-up plan has already been explored.

Taken together, these issues indicate that symptom meaning can be degraded without any obvious factual error. A symptom name may be correct; the recorded intensity may be accurate; the previous nurse may have complied with the expected handover structure. Yet clinically relevant meaning can still be lost if attribution, temporal pattern, situational conditions, uncertainty or unfinished responsibility disappears.

Table 2 converts these recurring problems into proposed information functions for handover. They are deliberately described as functions rather than mandatory fields because different settings and patients may require different levels of detail.

Table 2. Proposed information functions for meaning-preserving symptom handover

Information function	Core question for handover	Information to preserve	What should remain distinguishable	Boundary on use
Patient-described meaning	What does the symptom mean or feel like to the patient now?	Patient wording, concern, tolerability, interpretation or stated priority when available	Patient account versus professional interpretation	Do not compel disclosure or imply a patient account where one was unavailable
Observed course	What has changed over time?	Onset, fluctuation, persistence, pattern and observed response	Current status versus trajectory	Do not infer causation from temporal association alone
Situational trigger or modifier	Under what circumstances does the symptom change or become important?	Activity, timing, environment, intervention, interaction or other relevant context	Constant symptom versus context-dependent manifestation	Include only context that affects interpretation or follow-up
Unresolved uncertainty	What remains unclear, discordant or provisional?	Conflicting reports, incomplete explanation, unanswered question or pending clarification	Known fact versus interpretation versus unresolved issue	Do not create certainty merely to make the handover concise
Pending follow-up obligation	What still needs to happen after this handover?	Reassessment, clarification, communication or review that remains unfinished	Documented concern versus completed action	Name responsibility only when it is actually known; avoid inventing authority

Conceptual findings

The evidence supports a distinction between transferring symptom information and preserving symptom meaning. The proposed Meaning-Preserving Symptom Handover Framework therefore treats a handover as successful when the receiving nurse can reconstruct the clinically relevant relationship among the patient's account, observed change, context, uncertainty and unfinished responsibility without requiring every detail of the previous encounter.

The first function, patient-described meaning, preserves the patient's own interpretation as a separate information source. This matters because palliative conversations are often unplanned, relational and initiated on the patient's terms rather than generated by a standardized sequence of questions [27]. A phrase such as "the pain is worse" may refer to intensity, loss of function, fear of progression, treatment burden or a change the patient considers acceptable. Meaning preservation does not require lengthy verbatim transcription. It requires avoiding a handover in which professional shorthand erases the distinction that matters for subsequent care.

The second function, observed course, gives the symptom temporal shape. The receiving clinician needs to know whether the description concerns a persistent state, a new change, an intermittent episode or a response still being watched. This function is intentionally separate from patient meaning. A patient may regard a longstanding symptom as newly intolerable without an obvious clinical change, or nurses may observe increasing frequency while the patient describes little additional distress. The framework does not require these accounts to be reconciled before transfer.

The third function, situational trigger or modifier, retains the circumstances in which the symptom becomes clinically meaningful. Context can include activity, timing, position, treatment, interpersonal interaction or other factors already recognized during care. The purpose is not to document every circumstance. It is to prevent a symptom that is conditional from being handed over as though it were constant.

The fourth function is unresolved uncertainty. Nursing communication in life-limiting illness occurs within forms of uncertainty that can remain dynamic and interconnected across the illness trajectory [28]. A handover can therefore be more accurate when it communicates uncertainty explicitly than when it converts a provisional interpretation into a definitive statement. "Breathlessness increased overnight; cause unclear" and "patient reports more breathlessness although observed respiratory pattern appeared unchanged" preserve more usable meaning than a confident but unsupported explanation. Uncertainty becomes clinically relevant information when it affects what the next nurse should watch, clarify or avoid assuming.

The fifth function, pending follow-up obligation, prevents identified concerns from disappearing merely because responsibility changes. This does not mean every symptom must generate an action. It means that when reassessment, clarification or communication has already become necessary, the unfinished status should survive the handover. Evidence linking perceived communication efficacy with unmet symptom-management needs supports attention to this interface, although the association cannot establish that better handover alone will reduce unmet need [29].

These five functions interact but should not be collapsed. Patient meaning may influence what requires follow-up; observed course may change the interpretation of uncertainty; a situational trigger may explain apparent disagreement between patient report and observation. The framework preserves these relationships while resisting the assumption that one stream must dominate.

An important ethical limit follows. More information is not automatically more person centred. Palliative-care teams encounter situations in which patients do not want particular information, and ethical reasoning must accommodate changing preferences, autonomy and concerns about harm [30]. Meaning-preserving handover therefore includes the possibility that the patient has declined discussion, does not wish particular information to be foregrounded, or has communicated a preference about who should receive information. The framework is intended to preserve relevant meaning, not maximize disclosure regardless of preference.

The framework also resists equating silence with absence. A patient account may be unavailable because the patient is fatigued, cognitively impaired, unconscious, distressed, chooses not to discuss the symptom or communicates in ways that the available system does not capture. In such cases, the handover should distinguish what is unknown from what has been observed by others. A clinician-generated description may be necessary, but it should not be presented as though it reproduces a patient interpretation that was never obtained.

The conceptual contribution is therefore modest but consequential. Existing structured handovers primarily organize transfer; symptom measures quantify or categorize experience; documentation systems store representations of care. The Meaning-Preserving Symptom Handover Framework addresses a different task: preserving enough relational and temporal structure around symptom information that the next clinician knows whose interpretation is being transferred, what changed, under what circumstances, what remains uncertain and what remains to be done.

Its status remains explicitly provisional. The five functions have been derived from converging but heterogeneous evidence rather than validated as a single instrument. They should be tested for feasibility, burden, cultural appropriateness and clinical usefulness before being translated into mandatory documentation fields or performance standards.

Results and Discussion

The Meaning-Preserving Symptom Handover Framework reframes handover quality as an interpretive problem as well as an information-transfer problem. A technically complete handover can still leave the receiving nurse unable to determine whether a symptom reflects the patient's interpretation, a professional observation, a transient event, a continuing pattern or an unresolved concern. The framework therefore does not compete with structured formats. It specifies distinctions that may need to remain visible within whichever verbal or written format a service already uses.

Application across communication modalities requires caution. Telehealth research in palliative-care communication demonstrates that remote interaction can broaden access while introducing technical, privacy and observational limitations [31]. Similar considerations apply to handover. Spoken bedside exchange permits questions and immediate clarification but may be constrained by privacy, time and patient preference. Written transfer creates persistence and accessibility but can flatten uncertainty or separate a statement from the interaction in which its meaning emerged. Electronic systems can facilitate repeated symptom capture, yet their value depends on workflow and usability rather than the technology alone [19]. Meaning preservation should consequently be treated as a functional requirement that can be implemented differently across modalities.

Information burden and selective preservation

Preserving meaning does not require documenting everything that was said about every symptom. Nurses already experience handovers as information-dense encounters, and structured frameworks may create implementation challenges when added to existing workload [2]. Observational work likewise shows how rapidly bedside information exchange can become complex [5]. A framework that simply adds five mandatory narrative fields for every symptom would therefore risk solving information loss by creating information overload.

Selective preservation is more defensible. Detail becomes particularly important when a symptom has changed, when the patient's interpretation differs from professional observation, when context materially modifies the symptom, when an explanation remains uncertain, or when action is still pending. Conversely, a stable, familiar symptom may require little elaboration if its meaning and management are already shared across the team. Patient-reported measures can assist this process, although feasibility decreases for some seriously ill patients [17]. The framework should therefore support clinical discrimination rather than require uniform documentation intensity.

The responsibility function deserves similar restraint. It is intended to expose unfinished work, not to create artificial accountability. Discharge research shows that follow-up status and responsibility may be communicated ambiguously [12]. In practice, however, responsibility can genuinely be shared or temporarily uncertain. A handover should state that ambiguity when it exists instead of assigning an apparently precise owner unsupported by the care arrangement.

Translating the framework into communication

The proposed functions can alter interpretation even when the symptom label remains unchanged. Patient and caregiver research demonstrates that communication and lived context can add dimensions absent from professionally constructed symptom-management accounts [22]. Measurement research also shows that symptom visibility can depend on how directly a symptom is elicited [25]. These findings support communication that preserves the conditions under which the information was produced.

Table 3 illustrates this principle through conceptual scenarios. The scenarios are not empirical cases, prevalence estimates or prescribed scripts. Their purpose is to show how identical or similar symptom labels can imply different handover needs once meaning, trajectory, context, uncertainty and responsibility are made visible.

Table 3. Illustrative symptom-communication scenarios showing how the same symptom label can carry different handover meanings

Symptom statement available at handover	Meaning-bearing context	Uncertainty that should remain visible	Pending responsibility	Why the handover implication differs
"Pain worse today"	Patient says pain is physically similar but newly frightening because it is interpreted as disease progression	Clinical cause of increased concern has not been established	Reassess both symptom experience and concern; clarify explanation if appropriate	The principal change may be meaning rather than measurable intensity
"Pain worse today"	Nurse observed more pain during movement; patient reports acceptable comfort at rest	Extent to which movement-related change represents broader deterioration remains unclear	Continue observation during relevant activity and review response to current measures	Context prevents a movement-dependent symptom from being interpreted as continuously severe
"More breathless overnight"	Patient describes episodic breathlessness during toileting but recovery at rest	Reason for change remains uncertain	Reassess pattern and communicate if episodes persist or alter	Temporal and situational pattern matters more than the isolated label
"Nausea improved"	Patient reports less nausea but remains unable to tolerate usual intake	Symptom intensity and functional recovery are discordant	Reassess intake and whether further clinical review is required	Improvement in one dimension does not establish resolution of the broader problem
"No new concern reported"	Patient was too fatigued to discuss symptoms in detail	Absence of reported concern does not establish absence of concern	Offer reassessment when feasible and retain existing observations	Silence has a different evidentiary status from an explicit denial of symptoms
"Patient does not want further discussion"	Patient has expressed a current preference not to receive additional explanatory information	Whether the preference will remain stable is unknown	Respect present preference while allowing later reconsideration	Meaning preservation includes information preference and does not require maximal disclosure

Note: These scenarios are original conceptual illustrations derived from the evidence synthesis. They are not observed cases, clinical protocols or validated handover templates.

Ethical and interpretive limits

The scenarios demonstrate why meaning preservation cannot be reduced to maximal information transfer. Patients may decline information or prefer that particular concerns are not repeatedly explored, and palliative-care teams may need to balance autonomy, beneficence and changing preferences [30]. A patient's wish not to discuss an issue should therefore be represented as a preference, not reinterpreted as absence of concern.

Uncertainty also requires disciplined language. Theory synthesis suggests that uncertainty in life-limiting illness can remain dynamic rather than resolving in a linear fashion [28]. The framework therefore favours formulations that distinguish observation from inference. This does not mean that every handover should contain extensive epistemic commentary. It means that clinically consequential uncertainty should not disappear simply because a concise handover format encourages declarative statements.

A further limitation concerns evidence provenance. Much of the supporting handover literature comes from acute hospitals, while symptom and communication studies frequently involve oncology or specialist palliative services. The framework integrates these literatures conceptually, but their combination does not prove equivalent

performance across hospices, community nursing, long-term care or culturally different health systems. Likewise, evidence supporting individual framework functions does not validate the combined framework.

Implementation and research priorities

Implementation should therefore begin with feasibility rather than standardization. Palliative-care SBAR research demonstrates that structured approaches can improve aspects of handover quality [1], and ward-level intervention studies show that communication practices can change after context-sensitive implementation [3]. Neither evidence stream establishes that adding the proposed five functions will improve clinical outcomes. Transition reviews also caution against assuming a single intervention will transfer uniformly across settings [11].

Prospective evaluation should first examine whether nurses can use the framework without increasing handover burden or duplicating existing documentation. Testing should assess whether receiving clinicians can correctly distinguish patient-reported meaning from observation, recognize relevant trajectory and context, identify unresolved uncertainty and locate genuinely pending work. Measurement studies show that patient-reported and clinician-defined assessments need not coincide perfectly [18]; validation should therefore examine faithful preservation of differences rather than simple agreement.

Additional work is required for people who cannot communicate directly, for culturally and linguistically diverse populations, for family-mediated communication and for settings in which electronic systems constrain narrative transfer. Documentation studies caution that a recorded field cannot be assumed to represent the full communication event [26]. Evaluation should therefore include direct observation or qualitative assessment rather than relying solely on completion rates.

The framework should ultimately be retained, modified or rejected according to whether it improves interpretability and continuity without imposing disproportionate cognitive or documentation burden. Its present value is conceptual: it identifies what may disappear when symptom information is compressed during transfer and provides a structured basis for examining that loss empirically.

Conclusion

Preserving the meaning of symptoms across nursing handovers requires more than transmitting symptom names, scores or isolated observations. Continuity is strengthened when the receiving nurse can distinguish what the patient means by a symptom, how the symptom has changed, which circumstances modify it, what remains uncertain and what follow-up remains unfinished.

The Meaning-Preserving Symptom Handover Framework organizes these five functions without treating them as a validated checklist or requiring maximal documentation. Its central proposition is that clinically important meaning can be lost even when individual facts are recorded accurately. Future empirical work should determine whether preserving these distinctions is feasible, acceptable and useful across palliative-care settings before they are translated into standardized documentation or performance requirements.

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