

Social and healthcare professionals' experiences of end-of-life care planning and documentation in palliative care

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Abstract

Aim: To explore social and healthcare professionals' experiences of end-of-life (EOL) care planning and documentation in palliative care.

Design: A qualitative study with narrative methodology.

Methods: A narrative method with interviews was used. Data were collected from purposively selected registered nurses ($n=18$), practical nurses ($n=5$), social workers ($n=5$) and physicians ($n=5$) working in palliative care unit in five hospitals in three hospital districts. Content analysis within narrative methodologies was undertaken.

Results: Two main categories – patient-oriented EOL care planning and multi-professional EOL care planning documentation– were formed. Patient-oriented EOL care planning included treatment goals planning, disease treatment planning and EOL care setting planning. Multi-professional EOL care planning documentation included healthcare professionals' and social professionals' perspectives. Healthcare professionals' perspectives on EOL care planning documentation included benefits of structured documentation and poor support of electronic health record (EHR) for documentation. Social professionals' perspective on EOL care planning documentation included usefulness of multi-professional documentation and externality of social professionals in multi-professional documentation.

Conclusion: The results of this interdisciplinary study demonstrated a gap between what healthcare professionals consider important in Advance Care Planning (ACP), that is, proactive, patient-oriented and multi-professional EOL care planning and the ability to access and document this in a useful and accessible way in the EHR.

Relevance to Clinical Practice: Knowledge of the patient-centered EOL care planning and multi-professional documentation processes and their challenges are prerequisites for documentation to be supported by technology.

Reporting Method: The Consolidated Criteria for Reporting Qualitative Research checklist was followed.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS

care planning, clinical social work, death, documentation, electronic health records, end-of-life, healthcare professionals, palliative care

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1 | INTRODUCTION

Care planning and documentation with the goal of improved outcomes are central in palliative care (Burt et al., 2014; Norton et al., 2022). Confidentiality and respect for patients' autonomous decisions are important (International Council of Nurses, 2021; World Medical Association, 2022). Care planning means a process by which professionals, patients and their support network talk over, agree and assess an action plan to achieve the most statistically significant aims (Burt et al., 2014; Gonella et al., 2019; Haavisto et al., 2022; Ho et al., 2022). Advance care planning (ACP) is a special type of care planning (Crawford et al., 2021; Lakin et al., 2021; Wendrich-van Dael et al., 2021). It endeavours to align patients' end-of-life (EOL) care with their wishes and goals (Myers et al., 2018; Steel & Owen, 2020; Sudore et al., 2017). ACP gives people the possibility to define their priority for forthcoming care and medical treatment (Angheluta et al., 2020; NICE, 2022; Rietjens et al., 2017; Sudore et al., 2017).

Clinical documentation in palliative care includes medical and nursing care plans, ACPs and daily progress notes made especially by nurses (Stewart et al., 2017). Care plans, their content and recording are governed by Guidelines (American Medical Association, 2022; Care Act, 2014; Cerulus et al., 2021; Fereidouni et al., 2021; HIMSS, 2021; Hooper et al., 2020; Olsson et al., 2021; Saarto et al., 2022; Saranto et al., 2022; World Health Organization, 2007). They are recorded in the electronic health record (EHR) which is part of the hospital information system (HIS) (Langley et al., 2022).

ACP and EOL documents such as Advance Directives (AD) and living wills have different meanings and values in different jurisdictions (Bischoff et al., 2018; Rietjens et al., 2017). For example, in Finland, the AD, also known as a living will, is a repository of information that includes advance care plans and other documents, such as substitute decision-maker for health care (Finnish Institute for Health and Welfare, 2023). For handling financial matters, people can empower a power of attorney (POA), or a lasting power of attorney can be set up (Legal Aid and Public Guardianship Districts, 2023). In this study, the term "ACP" is used going forward because it has a consistent process and meaning across jurisdictions (Huber et al., 2018). ACP documents aim to ensure flow of information to patients and healthcare providers (Kanta, 2022; Khan et al., 2017; Langley et al., 2022). However, ACPs are rare (Bischoff et al., 2018). Their use is hindered by the healthcare system, which is not ready for every patient to have an ACP (Saarto et al., 2022; Tenzek et al., 2022). Thus, professionals have a key role in identifying and reporting the wishes of the patient and family members in an effective way in the EHR. However, patients' EOL preferences are not always accessible when needed, e.g., in the emergency department (Kuusisto et al., 2022; McQuown et al., 2017; Pyles et al., 2022; Sjöberg et al., 2021; Welsch & Gottschling, 2021).

Previous studies show that there are disease-specific treatment plans (Boekhout et al., 2015). However, the international trend is towards multi-professional care plans (Burt et al., 2014; Langley et al., 2022; Macías-Carrillo & Ortega-Ceballos, 2020; Norton et al., 2022; Sullivan et al., 2017). Care planning and documentation in EHR takes time and filling out forms requires resources

What does this paper contribute to the wider global clinical community?

- This study highlights the importance of proactive end-of-life (EOL) care planning and its documentation in the palliative patient care process from the point of view of professionals working in palliative care.
- The results of this study show that the usability of the electronic health record (EHR) is of great importance for how professionals are able to implement the EOL planning and documentation of care that aim to support the continuity of information in palliative care.
- The knowledge produced in this study can be used in the development and harmonization of the information content and structures of multi-professional EOL care plans.

(Haq et al., 2021). Care plan uptake can be facilitated by legislation (Lepore et al., 2018), structured documentation (Myers et al., 2018), integration into workflow (Haq et al., 2021; Weaver et al., 2020) and multi-professional teamwork (Haq et al., 2021; Khan et al., 2017; Langley et al., 2022). If care plans are comprehensive, multi-professional and used between organizations, patients can see their care planning from a holistic perspective and the burden of creating a plan is lessened (Langley et al., 2022). Besides physicians (Anderson et al., 2019; Mallidou et al., 2022) and nurses (Macías-Carrillo & Ortega-Ceballos, 2020; Mitchell et al., 2020), social workers can impact documentation (Dixon & Knapp, 2018; Fuentes & Pietrus, 2022; Walker et al., 2018; Wong et al., 2020). A HIS user interface should be easy to use; otherwise, it will not be used (Jarva et al., 2022). Thus, usability improvements (Kernebeck et al., 2022) with HIS support and guidance are important (Khan et al., 2017). Reviews show that the use of HIS interventions have increased ACP documentation (Bestvina & Polite, 2017; Huber et al., 2018).

Knowledge of the care planning and documentation processes and their challenges are prerequisites for documentation to be supported by technology. Studies on care planning and documentation vary by focus and are generally described from the perspective of a single professional group, often focusing on ACP. Studies concerning care planning and documentation broadly from a multi-professional perspective in palliative care are scarce. Thus, this study aims to explore social and healthcare professionals' experiences of EOL care planning and documentation in palliative care.

2 | METHODS

2.1 | Study design

A qualitative study used a narrative method with interviews, that is, healthcare professionals describing their experience (Holloway & Wheeler, 2015). Content analysis within narrative methodologies

was undertaken (Elo et al., 2014). The 32-item Consolidated Criteria Checklist for Reporting Qualitative Research (COREQ) (Supplementary File 1) was followed (Tong et al., 2007).

2.2 | Participants and setting

The participants of this study were social and healthcare professionals. Purposive sampling (Elo et al., 2014) was necessary to obtain an overall and representative sample of palliative care providers in Finland. The selection criteria were physician, social worker, registered nurse and practical nurse who were working in accordance with Finnish practice in direct patient care in a palliative care unit. The total of 33 interviewees consisted of 18 registered nurses, 5 practical nurses, 5 physicians and 5 clinical social workers employed in palliative care units of Finnish public healthcare. The study region covered five hospitals in three of the 20 hospital districts in the country. Each region had different EHRs, but a national Patient Data Repository collects all data produced in the patient's care.

2.3 | Data collection

The data were gathered from May to November 2019. Registered nurses and practical nurses participated in professional group-specific group interviews. Physicians and social workers took part in couple or individual interviews. Face-to-face interviews were held confidentially in a separate space in the workplace of the interviewees, excluding one that was conducted at a location away from the participant's work and one telephone interview (Table 1).

The interviews were performed by four researchers due to large geographical distances. The interviewers had a nursing science background and one also had a nursing informatics (first writer) background. All were non-clinical nurses but had previous experience in either clinical palliative care or clinical aspects of palliative care. They came from outside the clinics and had no relationship or other connection to the interviewees. Prior to the interviews, information about the research aims and the interviewer's status in the study were distributed to the contact persons, who were asked to distribute it further to the interviewees.

An interview guide which had been tested in one interview (data not included) was followed (Table 2). Besides interviews, a short questionnaire was used to gather the interviewee's socio-demographic information. The interviews took an average 58 min (29–173 min) and were audio-recorded with the approval of the participants.

2.4 | Ethical considerations

This study complied with the good scientific practice followed by the World Medical Association (2013). The Ethics committee approved the research protocol (15/2019). Before the interviews, contact

TABLE 1 Presentation of data gathering and the social and healthcare professionals included ($n = 33$).

| Professional category | Interview species (code) | Number of professionals |
|-----------------------|----------------------------------|-------------------------|
| Practical nurse | Group (GPN1) | 5 |
| Registered nurse | Group (GN1) | 6 |
| Registered nurse | Group (GN2) | 4 |
| Registered nurse | Group (GN3) | 3 |
| Registered nurse | Group (GN4) | 3 |
| Registered nurse | Couple (CIN1) | 2 |
| Physician | Couple (CIP1) | 2 |
| Social worker | Individual (S1–S5) | 5 |
| Physician | Individual (P1–P3 ^a) | 3 |
| Total | | 33 |

^aP3=Telephone interview.

TABLE 2 The topic of the interview, "Advance care planning", and the questions included in it.

| Questions |
|---|
| How End-of-Life care is planned in their unit |
| How the End-of-Life wishes of patients ¹ and family members are considered [e.g., treatment guideline (Z51.5), treatment limitations, living will, pain management, treatment setting, durable power of attorney] in relation to care planning |
| How Advance Care Planning is documented (e.g., care plan – page/ place for palliative care, structured documentation) |

persons supplied all interviewees with verbal and literary information about the study. A cover letter explained the study's purpose and invited the interviewees to participate. Professionals gave written consent to participate. The cover letter and interviewer's information made it clear that participation was optional and anonymous and participants could withdraw from the study if they wished. The data were treated confidentially. All identifiable characteristics were excluded from the report to confirm the anonymity of the interviewees.

2.5 | Data analysis

Inductive content analysis without an earlier framework was used to analyse the data. The inductive content analysis method is suitable for use when there is not enough previous research information on the matter under investigation (Kyngäs et al., 2020). First, data were transcribed word-for-word and then, a unit of analysis was defined as a set of words that characterized the social and healthcare professional's experience of EOL care planning and documentation. After that, the sets of words were simplified and encoded to enable the analysis. Next, the statements were simplified and categorized into subcategories and further, into categories and main categories (Tables 3 and 4). The categories were named according

TABLE 3 Social and healthcare professionals' experiences of end-of-life care planning in palliative care unit.

| Main category | Category | Sub-category |
|--|-----------------------------------|--|
| Patient-oriented end-of-life care planning | Treatment goals planning | Goals of care discussion <i>Well of course we interview the patients and their loved ones, and ask about the wishes, and we all discuss together what the objective of the treatment is, what we are aiming at here (P3)^a</i> Ensuring the existence and up-to-datedness of the living will and guardianship <i>Even though the patient's wish is partly known, there in the care plan, as long as the patient is able to communicate, we still try to make sure in some way if they have changed their mind. (CIP1)^a</i> |
| | Disease treatment planning | Determining treatment outlines and limitations <i>... sometimes, from our perspective, quite desperate final treatments are resorted to, so there hasn't been the courage to call it quits but just keep on going. So, in that sense, patients are listened to (GN1)^a</i> Symptom management planning <i>The aim is to draw up an ESAS for all as quickly as possible, preferably when the patient comes in, and use it in drawing up the care plan, so that it is based on what the symptoms are, what the patient remembers, and everything is based on that. (CIN1)^a</i> |
| | End-of-life care setting planning | Factors connected with the choice of end-of-life care setting <i>But very much things like what is the place of further care, which unit takes it from here and ... It's like a pretty crucial part of our work. (P2)^a</i> Organizing individual home services <i>...whether I should get something, or should I go and talk about it in advance, or whether it's quite clear that the nurse will call the discharge number and the physician will decide, that this patient can leave now and is in that kind of condition; so I sort of come in if needed. (S5)^a</i> |

^aOriginal expression.

| Main category | Category | Sub-category |
|--|--|---|
| Multi-professional end-of-life care planning documentation | Healthcare professionals perspectives of EOL care planning documentation | Benefits of structured documentation <i>Structured documentation. And the plan changes all the time according to the patient's situation and other things. It's updated. (GN4)^a</i> |
| | | Poor support of EHR for documentation <i>...well at the moment, we don't do anything because it's so complicated. We just enter daily monitoring data and nursing care data if there's something special...(GN3)^a</i> |
| | Social professionals' perspectives EOL care planning documentation | Usefulness of multi-professional documentation <i>Like the most important and acute things that you would wish that are noticed at once. But the summary is there, on the social work page. (S3)^a</i> Externality of social workers in multi-professional documentation <i>...practices really vary, so that in some wards it is allowed for the social worker to make a note on a topical issue on the nursing care page. (S1)^a</i> |

Abbreviations: EHR, electronic health records.

^aOriginal expression.

to their content. Relevant quotes were extracted to illustrate the main points within each category. One researcher (first writer) analysed the data step by step and meanwhile, a joint discussion took place in the research group. No conflict about categorization emerged.

2.6 | Rigour

The trustworthiness of this study was assessed throughout the research process using the criteria credibility, confirmability, reflectivity, and transferability. To increase the credibility of the study, the research

TABLE 4 Social and healthcare professionals' experiences of end-of-life care planning documentation in palliative care unit.

process was documented as clearly as possible. The quotations used to enrich the analysis can also be seen as a factor that increases credibility. In order to increase confirmability, the course of the research process was recorded so that it is possible for another researcher to follow the progress of the research. The analysis process was described as clearly as possible and the choices made were justified to increase confirmability. The researchers are familiar with the topic by nursing, nursing informatics, or medical profession. For this reason, considering prejudices and reflecting on their own roles were particularly important. To assess transferability, the researcher (first writer) described the number of interviewees in the study, their age, work experience in health care and palliative care, and information about possible palliative care continuing education. (Elo & Kyngäs, 2008.)

3 | RESULTS

The interviewees were on average 46 years old (range 19–62 years). They had been working in healthcare on average 17 years (<2–37) and in palliative care on average 6 years (<1–19). The majority (67%) of the participants had received additional palliative training.

3.1 | Social and healthcare professionals' experiences of end-of-life care planning

Patient-oriented EOL care planning includes three categories (Table 3).

3.1.1 | Treatment goals planning

Goals of care discussion was a starting point for EOL care planning in the palliative care unit. It meant that through discussions, current treatment goals emerged. Professionals, patients and family members, separately or all together, discussed treatment goals, that is, what to aim for. Family members were often present at the outpatient visit, but not necessarily in the ward. The patients were primarily asked about their wishes concerning, e.g., treatment line and resuscitation activity, but the role of family members was highlighted if the patient was no longer able to communicate. Then, family members could come in to explain the patient's wishes, or professionals called them about the patient's health. Professionals listened to the wishes of family members and got to know them, what kind of lives they had lived. Sometimes, conflicting wishes of patients and family members, for instance regarding treatment goals, gave rise to problems, such as ethical conflicts for nursing staff. In such cases, professionals gave in to the wishes of family members although their aim was to find out the patient's own will and to plan the treatment in accordance with the patient's wishes.

Ensuring the existence and up-to-datedness of the living will and guardianship meant a need for an up-to-date official document in which the patient could express what kind of care they wanted at the

EOL and defining their guardianship or continuing power of attorney for the future. In a palliative care unit, professionals always asked if the patient had a living will. If they did, it was easy to bring it up to help the EOL care planning. Sometimes, family members said that the patient had a living will from long ago at home. However, mere knowledge of the existence of a living will was not enough. Professionals wanted to ensure the correctness of the living will (as long as the patient was able to communicate). If not done previously, patients also had the opportunity to make a living will. For example, one social worker said that they could print out the information and form for the patient and their family members from the Internet. The goal was that the patient and their family members would take care of the documents in good time. It was considered important to know who to contact in the case of unexpected events. Guardianship or continuing power of attorney were closely related to social work and considered problematic issues. In particular, elderly patients did not always understand that official documents must be in order so that family members can take care of the patient's affairs, such as financial matter and banking. At times, against the organization's practice, patients might have wanted the social worker to act as their witness or proxy. In such cases, the patient could be directed to make a POA and guardianship could then be initiated. If social workers found that the patient's financial interests were not taken into account, they could make a notification to the magistrate about the need for guardianship. On the other hand, official processing took time and they were not necessarily able to promote the issue. Family members could be very distressed about unpaid invoices, for example. If there was not even a POA available it might be too late to draw it up if the patient was very weak or disoriented.

3.1.2 | Disease treatment planning

Determining treatment outlines and limitations were medical issues, but patient's wishes that emerged in the goals of care discussion were taken into account. ACP, as conceptualized by Myers et al. (2018), is planning in advance of the specific care or treatment decisions, taking into consideration values, goals and wishes. In terms of the quality of treatment, it was important to consider continuing active treatments or choosing a palliative care treatment line. When the patient arrived in the unit, a treatment line which defined the primary goal of treatment had often been defined in the previous treatment setting. If necessary, a specialized medical care team was consulted regarding the use of more active treatments. Usually, treatment was even more limited, depending on the condition of the patient. Treatment limitation issues were discussed and explained to the patient. For example, does the patient want antibiotic treatment for an infection? Accepting the disease treatment plan could sometimes take time for the patient and require consultations with several different professionals. Treatment limitations were made individually, and they were not necessarily made unless the patient was still in palliative care. The starting point was that the EOL care decision was written in agreement with the family members. If necessary, physicians could make do-not-resuscitate (DNR) decisions

and record them. Often it was concluded that the disease could not be cured but the symptoms could be alleviated. There was no particular effort to slow down the inevitably approaching death and the main focus was on quality of life instead of prolonging life.

Symptom management planning included monitoring patients' symptom and symptomatic medication. With the use of the Edmonton Symptom Assessment System (ESAS) questionnaire (Chang et al., 2000), patients monitored their symptoms upon entering the palliative care unit or when their symptoms worsened. Professionals used the results of symptom assessments as an aid in symptom management planning. Symptomatic medication meant medicines given for various symptoms of the disease, such as pain or nausea, if necessary. Specific treatments, for example currently prescribed medications for sedation or pain, required consent by the patient or substitute decision-maker and ought to be aligned with the ACP goals. The plan included what to do and how to take medication. For example, pain management and monitoring its efficiency were discussed individually. In some units, physicians made ACPs for sedation as well. The goal was to anticipate everything possible in advance.

3.1.3 | End-of-life care setting planning

Factors connected with the choice of end-of-life care setting were patients' desires, their ability to cope with home, family view, and a more permanent solution without back-and-forth transfers. Patients were assessed as having good opportunities to influence their EOL care setting selection although there were certain marginal conditions. If the patient did not live alone, efforts were made to ensure that they could be discharged despite their severe illness, and possibly go home for a while. For those who lived alone, returning home at the EOL was a different matter than for those who lived with someone. If it was thought that the patient could not cope at home even with services, they had to consider an appropriate EOL setting. When planning home care, the views of family members were felt to be essential. From them, professionals received confirmation that home care could be planned. Patients and family members should know, e.g., how to prepare for a possible rapid deterioration of the patient's condition in home care. The professionals emphasized that transferring a patient from one care facility to another should not happen at the EOL.

Organizing individual home services meant proactive multi-professional discharge planning according to patients' needs to support their coping at home. Support issues such as financial support or transport service were planned on a patient-by-patient basis. Together, physicians, nurses and social workers discussed the services needed at home. This was seen as extremely important especially when the patient was not sure how to manage at home. At times, from the perspective of EOL care, things seemed to proceed very quickly. The patient may already have been in the unit for a while when the idea about discharge emerged, and ultimately things could progress very quickly. Proactive planning of individual home

services as early as possible was seen as important for both the patient and the family member. All in all, sufficient time was needed for official processing.

3.2 | Social and healthcare professionals' experiences of end-of-life care planning documentation

Social and healthcare professionals' experiences of EOL care planning includes two categories (Table 4).

3.2.1 | Healthcare professionals' perspectives on EOL care planning documentation

Benefits of structured documentation meant that a common data structure organizes EOL planning documentation and promotes continuity of care. The physician recorded a structured extensive treatment plan and a proactive treatment plan (ACP). The "plan" was written down, that is, what to do and how to take medication, and usually there was quite a lot of text. On the other hand, ICD-10 codes, e.g., palliative care Z51.5 or certain cancer diagnoses codes were used. Assessment of records was important. At the outpatient repeat visit, the plan was reviewed and the text could be started with an assessment, e.g., if the pain medication has been increased, had it been beneficial etc. Treatment limitations such as DNR orders were recorded in the "Risk information" application of EHR. The physicians had drawn up their own guidelines for documenting them. Risk data were recorded so that the treatment limitation markings would "pop up" when the patient's patient records were opened. In the ward, the nursing care plan that had been initiated with the palliative care outpatient clinic was continued and updated according to the patient's condition, so it was not necessary to start preparing a nursing care plan from scratch. The information content of the nursing care plan arose from the patient's (EOL) wishes and symptoms. The aim was to prepare the nursing care plan from the patient's point of view, that is, how they wanted to be treated. When the terminology of Finnish Care Classification (FinCC) was used, the information could be easily found with the search functions of the nursing documentation system (NDS). According to nurses, documenting helped their own work and after the introduction of the Patient Classification System, documentation was written in more detail and more precisely.

Poor support of EHR for documentation hindered care planning documentation. It was especially manifested in the fact that according to Finnish national guidelines, there is no separate sheet for palliative care and ACP documentation, which made the operation difficult. In practice, the sheet of EHR in which physicians recorded their notes varied. For example, the notes of a patient with prostate cancer could either be under the care of a surgeon due to their disease or under the care of an oncologist. In these cases, the texts documented in palliative care could be found on either sheet. From the perspective of follow-up care, it was seen as a challenge that if the patient moved, for example, to the emergency

department, the texts might not be easily found there. A separate sheet for documenting palliative care was thus seen as necessary. Moreover, certain palliative care headings were not available for physician records. A new HIS was recently introduced in some palliative care units and it had dramatically changed nurses' documentation practices. The new HIS was seen to be totally different from their previous HIS. Nurses said that documentation was extremely structured in the new HIS and the care plan within it did not meet its purpose because it contained a lot of details and little things. Nurses considered it so complicated that they were not able to use it. However, previously, they had prepared nursing care plans and updated them according to the terminology (FinCC). Now, the nurses in those units documented only daily progress notes if there was something special.

3.2.2 | Social professionals' perspective on EOL care planning documentation

Usefulness of multi-professional documentation indicated that the records made by social workers were assessed to be useful for another professional group, such as nurses. The NDS was seen as a communication channel between different professional groups. For example, social workers recorded schedules or information transmission there so that nurses could read the records of the social workers if necessary. Nurses working in different shifts could then see that the social worker had visited the patient and knew how the treatment continued. Vice versa, social workers could read from the NDS what the nurses had documented. Documentation was considered to be in need of improvement because it was still such a new thing that practices had not been established.

Externality of social professionals in multi-professional documentation meant that social workers were not able to document in multi-professional NDS in all units. Social workers mainly documented interviews with patients and relatives and EOL wishes and social service discharge summaries in their own professional sheet. However, in some units social workers could ask nurses to make EOL care planning entries for them. In other units the most urgent matters that needed to be attended to immediately were recorded in the NDS. They saw recording as a professional duty, which is why each case had to be recorded. They did not mention the use of any terminology and there was no separate heading in the EHR for social work notes that would allow them to be seen and stand out.

4 | DISCUSSION

In this study, three categories – treatment goals planning, disease treatment planning, and EOL care setting planning – connected the professionals' experience with patient-oriented EOL care planning. Second, instead of a single discipline, healthcare and social professionals brought forwards a holistic, multi-professional perspective on EOL care planning documentation in palliative care.

According to this study *in patient-oriented EOL care planning treatment goals planning* means that the patient and family are seen as the starting point for EOL care planning. This complies with NICE (2022) guidelines that healthcare professionals in palliative care should familiarize themselves comprehensively with the patient's and family member's situation and use a proactive approach. In this study, patients' current and correct living will, including information of guardianship or continuing POA for the future, is seen to be of great significance for the EOL care. This finding is in line with earlier studies (Lepore et al., 2018; Sudore et al., 2017) showing that patients' EOL wishes may change and it is important to specify the most recent wish. In this study, especially social workers faced the burden of family members, e.g., unpaid bills, unless the matters had been agreed in advance. Previously, in their study Olsson et al. (2021) reported the important role of surrogate decision maker for patients with decreased ability. Patients should thus be enabled to select a person who is able to represent them. (Welsch & Gottschling, 2021). In this study, *disease treatment planning* includes preparation for a sudden worsening of the underlying disease. Patients are given information about different treatment options with focus on their right to their own decisions. Professionals pointed out that patient care had sometimes resulted in desperate treatments. This is a cause for concern – has it been recorded with a sufficient level of accuracy which treatment options have been decided upon and on what basis? If treatment lines and limitations are unclear for nurses, they are certainly unclear for the patient and family as well. Earlier integrative literature review investigated the integration of ACP in a hospital. The authors concluded that care plans with well-recorded patients' wishes can prevent unwanted treatments (Cerulus et al., 2021). This study shows the importance of proactive *EOL care setting planning* in consideration of patients' and family members' wishes and the patient's condition. Home care is seen for many patients as the primary option, taking into account the patient's ability to cope at home. Previously, Steel and Owen (2020) have shown that proactive care planning has been linked to the fact that the patients could have died in the EOL care setting of their selection. In this study, it is considered important that during the last days of life there should be no transfers from one treatment setting to another. That is why professionals should anticipate patients' individual care requirements and organize home services taking into account, for example, the expertise of social workers (Fuentes & Pietrus, 2022; Walker et al., 2018).

In this study, *multi-professional EOL care planning documentation* from the perspective of healthcare professionals, that is, physicians and nurses, seemed to be quite similar in terms of benefits and problems compared to the perspective of social professionals. *Healthcare professionals' perspectives on EOL care planning documentation* are related to the benefits of structured documentation and, on the other hand, to the weak ability of the EHR to support documenting. In terms of continuity of care, the physicians saw it as important to document so that EOL care plan information would be easy to find in the future. The importance of continuing nursing care plan adjustments according to the patient's health state raised in this study has been observed before by Angheluta et al. (2020). In their study, Bestvina and Polite (2017) recommended considering prompts in the EHR such as those used in this

study to increase the rates of physicians' documentation. In this study, similarly to a previous study (Pyles et al., 2022), physicians were worried that the palliative care notes they documented may not be found, e.g., in the emergency room due, to an unspecified place and lack of a separate sheet in the EHR. In this study, the EOL care plan was deemed important, but it was not implemented in an easy-to-use format in the new HIS. Nurses are thus not able to make a nursing care plan because of the poor usability of the HIS, even though a care plan is obligatory in Finland. Nursing documentation was perceived as "too" structured in some units. Similarly, the study of Wendrich-van Dael et al. (2021) showed that the recording should not be a "tick box" operation. Previously, Kernebeck et al. (2022) found in their study that usability changes, such as the use of familiar nursing terminology like FinCC used in this study (Saranto et al., 2022), are reasonable ways to increase HIS adoption. Similarly to the other study, the simplicity and ease of use of the HIS were related to its use (Jarva et al., 2022).

In this study, social workers saw documentation as a task belonging to their profession and through which multi-professional benefits were obtained. Previous studies show that multi-professional care plans can result in better outcomes (Burt et al., 2014) and facilitate patient coping (Norton et al., 2022). According to national guidelines in Finland, each professional group has their own professional documentation platform or sheet in the EHR. When documenting, social workers, unlike the physicians and nurses in this study, did not mention that they used any specific codes (e.g., ICD-10) or terminology (e.g., FinCC) of their own professional group. Maybe for this reason, social work notes are not distinguishable in the EHR because there is no separate title that would distinguish them from those of others.

4.1 | Strengths and limitations

The strength of the study is a multidisciplinary team of researchers who are well familiar with the phenomenon being studied and are able to assess whether the results correspond to reality. In accordance with ethical principles, only the members of the research group handled the research data, which will be destroyed in accordance with regulations. The results of qualitative research are context-bound. On the other hand, the description of the background of the research participants makes it possible to examine the results in other similar contexts. The small number of physicians ($n=5$) and social workers ($n=5$) who participated in the study can be seen as a factor that weakens transferability (Elo & Kyngäs, 2008).

5 | CONCLUSION

The results of this interdisciplinary study demonstrated a gap between what healthcare professionals consider important in ACP, that is, proactive, patient-oriented and multi-professional EOL care planning and the ability to access and document this in a useful and accessible way in the EHR. The findings can be utilized to improve

EOL care planning and documentation practices, such as developing a template for the EOL care plan in palliative care in the EHR. Although qualitative research does not aim for generalizability (Kyngäs et al., 2020), it is clear that more research is needed on the topic to deepen our understanding. Future research could focus on EOL care planning from the perspective of the patient and their family. Moreover, it would be interesting to assess how quickly the stress caused by the new HIS is resolved or whether it is resolved at all.

AUTHOR CONTRIBUTIONS

Study concept and design: AK, EH. Data collection: AK, EH. Data analysis and interpretation: AK (principal researcher), KS, PK, EH. Drafting of the article: AK. Critical revision of the article: AK, EH, KS, PK. All authors contributed to the final approval of the version to be submitted.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are not publicly available due to ethical restrictions.

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