Brazilian Journal of Physical Therapy 2017;21(2):85–91

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Associação Brasileira de Pesquisa e Pós-Graduação em Fisioterapia

Brazilian Journal of Physical Therapy

https://www.journals.elsevier.com/brazilian-journal-of-physical-therapy

ORIGINAL RESEARCH

Continuity of care in hospital rehabilitation services: a qualitative insight from inpatients' experience

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Received 1 September 2015; received in revised form 9 May 2016; accepted 12 May 2016
Available online 17 March 2017

KEYWORDS
Continuity of care;
Qualitative research;
Rehabilitation;
Physical therapy;
Quality of care

Abstract
Background: Few empirical studies have been conducted on the continuity of rehabilitation services, despite the fact that it may affect clinical outcomes, patient satisfaction, the perception of quality, and safety.
Objectives: The aim of this study was to explore experiences and perceptions of inpatients receiving physical rehabilitation in an acute care hospital and how these experiences may have led to perceived gaps in the continuity of rehabilitation care.
Method: Using qualitative research methods, fifteen semi-structured interviews were conducted with patients who received physical rehabilitation during hospital stay in an acute care hospital in Murcia, Spain. Interviews were transcribed verbatim, analyzed, and grouped into predetermined and emergent codes.
Results: Patients described three main themes in continuity of care: informational, management, and relational continuity. Several factors were described as influencing the perceived gaps in these three types of continuity. Informational continuity was influenced by the transfer of information among care providers. Relational continuity was influenced by patient–therapist relations and consistency on the part of the provider. Management continuity was influenced by consistency of care between providers and the involvement of patients in their own care.
Conclusion: The participants in this study identified several gaps in three types of continuity of care (informational, management, and relational). Inpatients often perceive their experiences of rehabilitation as being disconnected or incoherent over time.

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http://dx.doi.org/10.1016/j.bjpt.2017.03.002

Introduction

Physical rehabilitation plays an important role in the maintenance and restoration of function and the avoidance of complications in patients suffering from an injury or illness requiring acute hospitalization.[1] Due to the complexity and fragmented nature of modern hospitals, rehabilitation interventions in acute situations are usually provided individually by the separate disciplines (doctors, nurses, physical therapists, etc.) with no formal coordination or communication.[1,2] This absence of appropriate coordination and communication among different professionals can lead to gaps in patient care[3] and affect clinical outcomes, patient satisfaction, the perception of quality, and safety.[3,4] In fact, international research exploring the quality of hospital care has demonstrated a fairly high rate of problems related with the coordination of care and preparation for discharge.[5]

These findings have led to growing interest among rehabilitation providers concerning the development of policies that foster the continuity of rehabilitation care.[6,7] This interest is consistent with international efforts to maintain and enhance continuity of care within the health system and avoid its fragmentation.[6,8] However, despite increased interest, few empirical studies have been conducted into the continuity of rehabilitation care, particularly in acute-care services. In addition, most of these studies have focused on only one aspect of continuity, such as the time a patient sees the same provider over time (longitudinal continuity)[9,10] and have ignored the patient's point of view. Nevertheless, obtaining the perspective of patients is an important and valuable way of evaluating healthcare services.[11]

For patients, the experience of continuity is the perception that providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future.[12] Therefore, the continuity concept involves many aspects of care beyond simply measuring the time that the patient is in contact with a single therapist.

The investigation of continuity from the patients' perspective poses an opportunity to improve the quality and increase the number of studies on continuity of care. According to the model proposed by Reid et al.[13] in a systematic review and a subsequent workshop, this experience is dependent on patients' experiences in three types of continuity: informational, management, and relational continuity. Informational continuity refers to the use of information from previous events to provide the patient with adequate care. Management continuity is viewed as the provision of complementary services with shared management. Relational continuity is described as the ongoing relationship between a patient and one or more health providers.[13]

This qualitative study aimed to contribute to the knowledge base in rehabilitation about continuity from the patients' perspective. Therefore, two central questions were explored: (i) 'How do inpatients experience continuity of care in acute-care rehabilitation settings?' and (ii) 'Which aspects of care lead inpatients to perceive a break in continuity of rehabilitation care?'.

Method

Study design

A qualitative design using semi-structured in-depth interviews was used to allow a more detailed perspective of patients' experiences and gain an in-depth understanding of their experiences related to continuity of care.[14,15] The Research Ethics Board of the University of Murcia, as well as the Queen Sofia Hospital, in Murcia, Spain, approved this study (P1EMCA06/12).

Setting and participants

Participants were recruited from an acute care hospital in the Murcia Region of Spain. Rehabilitation services in this hospital are provided for both inpatients and outpatients by care-providers from a central rehabilitation department in the hospital.

Inpatients were included if they were adults (>18 years of age), currently in the hospital with musculoskeletal or neurologic clinical conditions and receiving physical rehabilitation. These clinical conditions were chosen for being the most frequently treated by rehabilitation services in Spanish hospitals. Patients were excluded if they unable to participate in interviews due to physical or mental disability (e.g., deafness or learning disability) or were non-Spanish speaking.

Recruitment

Potential participants were identified from medical records by a research assistant (non-hospital staff), who visited each potential participant in their hospital room to explain the objectives of the study and check the inclusion/exclusion criteria. Patients who met the criteria were invited to participate in the study.

We identified 25 potential participants and asked them for an interview at their home after discharge. A total of 15 patients agreed to be interviewed and provided informed consent. These patients were contacted again following their hospital discharge to confirm their willingness to proceed and to arrange a convenient time for the interview.

Data collection

Individual face-to-face interviews were conducted at the participants' own homes between ten and fifteen days after discharge. All the interviews were conducted by an experienced qualitative researcher (with a PhD degree) and lasted between 30 and 60 min. Participants were assured of confidentiality and each interview was recorded on audiotape with the participants' permission.

The interviews explored their experiences and perceptions regarding rehabilitation care during hospital stay. A topic guide was used containing predetermined open-ended questions. This guide was initially written based on the literature on the three types of continuity and it helped participants understand what we were investigating, particularly because 'continuity of care' is a technical term.

Table 1 Personal characteristics of participants.

Participants no.	Sex	Age	Diagnosis	Length-of-stay
1	Female	75	Knee replacement	5
2	Male	56	Stroke	11
3	Male	70	Stroke	15
4	Female	46	Hip replacement	14
5	Male	62	Knee replacement	6
6	Female	60	Hip replacement	8
7	Female	74	Stroke	20
8	Male	72	Knee replacement	6
9	Female	71	Hip replacement	11
10	Female	78	Hip replacement	8
11	Male	66	Stroke	13
12	Male	57	Hip replacement	7
13	Female	55	Hip replacement	9
14	Female	64	Knee replacement	8
15	Male	78	Hip replacement	10

The main topics covered by the guide were: the circumstances of hospitalization and type of care provided, communication with therapists, patient–therapist relationships, the experience of care among professionals, and their experience with the rehabilitation program.

Data analysis

All interviews were transcribed verbatim for independent analysis. Participants' names were changed using a pseudonym in the transcripts and quotations. Data were analyzed using a modified grounded theory approach that incorporates data collection, coding, and analysis using a process of constant comparison, without the theory development component.[16]

Three authors (FMM, SLOS, and MSF) independently reviewed the transcripts and coded sentences that contained meaningful incidents. Three authors independently coded segments of phrases and labeled them into categories, and combined the categories into key themes. They used a combination of predetermined and emergent codes. Predetermined codes were based on a literature review that classifies the continuity of care into three types.[13] The three authors reviewed and compared their findings to reach agreement on codes. Three rounds of coding and discussion took place with the intention of enhancing credibility of the coding process and to develop clear categories. This process was iterative, with data collected from subsequent transcripts. No new categories emerged at the end of the tenth interview, which implied that saturation had been reached. The next level of analysis involved identifying relationships between categories and the grouping of categories showing uniformity into themes from a higher conceptual level in order to identify factors associated with continuity of care.

Two researchers cross-checked their agreement through a blind review using codes for the same passages of two transcripts to check consistency of the final emergent themes and subthemes.[17] Any disagreements between the two researchers were resolved by discussion. At every step, an independent researcher (PER) reviewed decisions to verify whether the analysis was systematically supported by the data, thus enhancing dependability.[18]

Results

Fifteen participants (8 female) with a mean age of 65.6 years (SD 9.5) and a mean length-of-stay of 10.4 days (SD 4.5) were involved in this study. The individual characteristics of the fifteen participants are outlined in Table 1.

All subjects reported that they had at least one experience that led them to perceive gaps in their continuity of care. These experiences were related to one of the three types of continuity of care (relational, informational, and management). Thus, all experiences and perceptions are presented in the following themes: (i) relational continuity; (ii) informational continuity; and (iii) management continuity. These categories represented the general pattern of how a patient experiences rehabilitation care during a hospital stay, even though the process of rehabilitation was unique for each patient. These categories were not mutually exclusive; they were often parallel and closely related. The participants' experiences are described below by type of continuity and themes that emerged as factors affecting them. The emergent themes for each type of continuity experienced and their categories based on study data are summarized in Table 2. Themes are presented with example quotes (using a pseudonym for patients or physical therapists).

Informational continuity

An important feature of continuity of care identified by patients was the provider's ability to use information concerning prior events to adjust their intervention to the participant's condition. This was especially important for patients when events involved changes to the course of their rehabilitation. These experiences were influenced by the transfer of patient information from one provider to another in the same team at the hospital (therapists, nurses, or physicians).

Table 2 Summary of themes for each type of experienced continuity of care and their categories.

Themes	Categories of codes and statements
Informational continuity	
Transfer of information	Providers ask for information from patient regarding previous events
	Therapist unaware of what clinical complications occurred
	Therapist unaware of previous clinical decisions
	Physician unaware of what occurs with the physical therapy program
Relational continuity	
Established patient–therapist relationship	Consistency of therapist
	Therapist's interpersonal skills
	Therapist's attitude to establish personal relationship
	Ability to listen or give explanations
Consistency of provider	Changes of therapist
	Therapist aware of what patient is doing
	Therapist asking to patient about treatment
Management continuity	
Consistency of care	Contradictory recommendations
	Missed therapy sessions
	Simultaneous activities
	Therapy did not occur on schedule
	Consequences on rehabilitation program
Involvement of patient in their process of care	Information on daily routines during hospital stay
	Advice on precautions to take during hospital stay
	Instructions for self-management post-discharge
	Support to patients' families
	Information on follow-up visits

Transfer of information

The transfer of information among care providers was noticed when participants viewed the responses of providers to previous changes or complications in their health status. This transfer of information had a great influence on how participants felt about the coordination of their care. Participants who experienced a deficit in the transfer of information were confused but they always tried to communicate the right information to help the provider adjust the current intervention appropriately.

> ''*The doctor who operated on my hip told me that the sciatic nerve was damaged during surgery. During the first therapy session, the therapist asked me to move my knee and foot. I told him that I could not. He asked, 'Why can't you?' It sounded strange that he was asking me that, because I thought they all knew about the sciatic nerve injury*''. [Participant 4, female]

> ''*The doctor said to me: ''We're going to suspend physical therapy for a few days until your pain gets better''. However, on the following day they came to perform the treatment. Then I told them that the doctor had suspended the sessions*''. [Participant 6, female]

Relational continuity

Participants reported that sustained contact with providers was an important source of perceptions about how well their rehabilitation was connected over time and other benefits such as trust and comfort. Two themes emerged affecting these perceptions: an established patient–therapist relationship and consistency of the provider.

Established patient–therapist relationship

Having an established patient–therapist relationship increased the participants' sense of comfort and connection between past and current interventions. Participants felt that the provider knew them and were able to listen and answer their questions.

> ''*My physical therapist was Maria. I could ask anything about my illness every day she came to my room*''. [Participant 10, female]

The lack of an established relationship did not facilitate communication and sharing experiences about the patients' condition. Some participants mentioned that establishing a relationship was difficult if the therapist acted with little intention or had a low level of interpersonal skills. Such behavior led to participants feeling less satisfied.

> ''*The therapist only used to come for a moment to deliver the therapy and then she would be gone. We did not talk. We did not have any bond*''. [Participant 1, female]

All participants viewed the consistency of only one therapist as a necessary condition for establishing and maintaining a good relationship. However, some participants gave reasons to support the claim that having only one therapist was not a sufficient condition to ensure an established relationship.

Consistency of provider

Having a regular therapist was an important factor that gave participants a sense of coherence in their rehabilitation, even in the absence of an ongoing patient–therapist relationship. Most participants recalled that they had a regular therapist during their hospital stay. Participants valued a regular therapist because they would know what treatment they were having. Additionally, the sense that the therapist knew about their treatment made the participants feel confident concerning the quality of care.

> ''*The same therapist would come every day to give me exercises. As she was always the same she already knew which exercises I could do*''. [Participant 4, female]

Two participants whose therapist changed mentioned feelings of mistrust and the need to remain vigilant to avoid receiving conflicting treatments.

> ''*I had different physical therapists. They had to ask me what was being done for my treatment. I had to remind them and felt a little mistrust*''. [Participant 5, male]

Management continuity

Patients' accounts also focused on their perceptions of the relationships between different types of hospital healthcare and the consequences on rehabilitation. Patients' experiences and perceptions of complementary provision of separate types of hospital healthcare were affected by two factors: consistency of care and the involvement of the patients in their own care process.

Consistency of care

Patients' experiences with the consistency of rehabilitation content, as well as with the consistency of rehabilitation implementation, had a strong influence on how participants perceived the continuity of their care.

Participants who perceived an inconsistent content of care (conflicting recommendations, etc.) felt they were receiving incoherent care. Several participants mentioned contradictory recommendations for their rehabilitation, especially for the period after discharge.

> ''*The therapist had told me that I had to continue therapy after discharge. But later, the physician told me that walking should be the only exercise I should do and rehabilitation care would not be necessary. I did not understand...*'' [Participant 6, female]

The perception of inconsistent implementation of rehabilitation care was also an important aspect influencing perceptions of complementary and timely services. Participants reported this inconsistency because therapy sessions did not take place at the time scheduled by physicians or therapists.

> ''*The doctor told me that therapy would start two days after my surgery, but I remember that the therapists delayed the first session.*'' [Participant 15, male]

Participants often did not identify the reasons for the inconsistent implementation of their rehabilitation care. From the patients' point of view, the main reason for incomplete rehabilitation care was poor timing, i.e. different care activities were conducted at the same time as rehabilitation, resulting in missed therapy sessions.

> ''*One day I was in my room and the therapy assistant came to take me to the therapy room. However, I couldn't go, because at the same moment the nurse was taking me for an x-ray...*'' [Participant 1, female]

Involvement of patients in their care process

The absence of explicit requests to collaborate in their care plan affected how participants perceived their continuity of care. The patients reported a desire that providers include them as partners in their treatment plan by providing advice, self-management strategies, or information about daily routines of treatment.

Participants reported experiences related to their lack of knowledge of any precautions they should take during hospital stay and in scheduling therapy. The lack of this information was associated with adverse effects in their clinical status and missed therapy sessions. Most participants believed they could have avoided these consequences if they had received appropriate information.

> ''*I moved my leg the wrong way and dislocated my hip prosthesis. I did not know. The providers did not tell me which positions and movements I had to make to avoid the problem. They did not explain anything to me.*'' [Participant 12, male]

> ''*... I missed a few therapy sessions because the therapist came to my room to take me to the therapy room, but I was not ready. She said she could not wait. In the end, I only made it to two days of therapy.*'' [Participant 13, female]

Participants also reported a lack of appropriate advice and information for them or their families during their transition to the community after discharge. They valued information on exercises, adverse effects, the next post-acute rehabilitation setting in which to continue their rehabilitation after discharge, and the estimated time to initiate treatment in that setting.

> ''*Nobody, neither the physical therapist nor the doctor, told me or my family which exercises I should do at home to help my recovery. I do the exercises that I think will be beneficial, such as walking. They could have at least explained something...*'' [Participant 7, female]

> ''*On the day of discharge, my daughter asked hospital staff where I should go so that I could continue rehabilitation, but nobody told us. I left the hospital without knowing what was going to happen...*'' [Participant 2, male]

Discussion

We examined experiences and perceptions of inpatients receiving physical rehabilitation that may affect the continuity of their care. Our data suggest that three types of continuity of care are relevant for patients receiving rehabilitation in the hospital. These types are often parallel and assume a different degree of importance, depending on

the situation[13]; however, the factors influencing these three types of continuity differ.

The transfer of information among providers was seen to impact informational continuity, coinciding with previous studies that demonstrated that problems with this transfer were also perceived as incoherent care.[3] Some authors have reported that patients have difficulty in recognizing the problems that occur with informational continuity because they happen ''behind the scenes'',[2,15] e.g., the implementation of routines such as shift reports, written guidelines, and regular meetings that patients never see.[2] Nevertheless, our participants in a physical rehabilitation program were able to identify some problems with the transfer of information. For example, participants in our study understood when the therapist had little or no knowledge of their prior health problems. This has two significant implications: first, the absence of direct (face-to-face) and continuous communication between physical therapists and other professionals, especially doctors, is obvious to the patient; and second, it is clear when physical therapists make little use of the clinical records for information on previous interventions by other professionals, using the patient as a source of information.

A consistent provider and a good patient–therapist relationship affected the perceived relational continuity. Provider consistency was reported in other disciplines as an essential aspect of relational continuity,[2,14] and our study demonstrates its relevance in rehabilitation care; however, having a regular provider does not guarantee relational continuity. Unwillingness on the therapist's part or poor social skills seem to influence the development and maintenance of relationships with the patient. Some authors have also reported that hospital-based models of care traditionally give lower priority to interpersonal continuity.[19]

Management continuity was the component that contributed the most to negative experiences of continuity in our study, both in terms of consistency of care and involvement of patients in their own care process. This result is consistent with those of Cowie et al.,[19] who found that models of care that incorporate a high input from one or more specialists (i.e., hospital care) are more likely to lead to management concerns being of high importance to patients. In this context, the quality of teamwork and the degree of coordination between different specialties are relevant aspects for continuity of care.[19] We agree with Krogstad et al.[2] that modern hospitals are complex organizations that involve teamwork and that the concept of continuity must be related to these teams and their substructures and superstructures. Their complexity and constant running increase the likelihood that there will be gaps between different departments, professions, work shifts, and individuals.

This study supports the idea mentioned by some authors regarding the patients' desire to collaborate with the management of their own problem during their transition to the community after discharge.[19–21] Although there is a growing tendency for therapists to see patients as active collaborators in their own care, the idea of having the patient as a passive receiver of treatment may still prevail.[22] Reinforcement of self-management by providers to foster the continuation of activities would encourage patients to better manage their problem and contribute to their own maintenance of continuity.[20]

In general, the factors influencing each of the continuity types identified by our patients were similar to those reported in other studies[13,15,23]; however, we identified small differences in the aspects that affect the three types of continuity, which were essentially derived from their specific application in the rehabilitation and hospital context. For example, studies in primary health care[13,23] mention ''accumulated knowledge'' and ''flexibility'' as relevant factors in informational continuity and management continuity, respectively, but our participants did not report these aspects. This small difference might be related to the characteristics of the care offered. Hospital physical therapy is usually characterized by short sessions and follow-up, which does not facilitate communication or the sharing of patients' experiences of disability and treatment. In contrast, it may be that the functional changes experienced by hospitalized patients are minimal, and therefore, there is no need for flexibility on the therapist's part.

Conclusions

For patients, continuity of care may be the result of good interpersonal skills on the part of providers, information flow between providers, and/or their own involvement in the care process, and most of the problems mentioned can be modified by improving this continuity. Although our study provides a broad framework to study continuity of care in rehabilitation, the findings are specific to the participants of this study and therefore not generalizable to other settings. We also believe that patients' experiences and perceptions of care continuity could differ from other contexts outside hospital. For that reason, we suggest that further qualitative studies involving other types of services or contexts in rehabilitation (e.g., outpatient care, transition between hospital and community care) be conducted.

Conflicts of interest

The authors declare no conflicts of interest.

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