Knowing What's Going On:

Insights from Patients, Family Caregivers and Healthcare Providers around Care Transitions from Acute to Rehabilitation Settings

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Our Team

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Background

Why Care Transitions Matter – Improvement Opportunities

- Patients with complex needs associated with their multiple diseases and conditions, frequently require care in multiple settings and are particularly vulnerable to poorly executed transitions in care.

- Poor transitions often result in unnecessary adverse patient outcomes (e.g. increased LOS in hospital & unplanned readmissions, & medication errors) & additional health care spending.

- Emerging evidence that appropriate pre, post and bridging discharge interventions can enhance care transitions and reduce readmissions - ***however unclear around what components are most effective and under what conditions (context)***

Study Design

Realist Literature Review

Modified Delphi Panel

Embedded Case Design

Purpose of Embedded Case Study

- To identify the current state, organizational readiness, barriers and facilitators, components of the interventions and associated measures and outcomes of participating sites.
- To map out the local contextual data to the series of conclusive statements derived from the literature review and expert opinion derived from the first two components.

Methods

Embedded case study design

Study components:

1. **Observation/field notes** of (1) discharge from acute care; (2) admission to rehab; and (3) discharge from rehabilitation facility
2. **Semi structured interviews** of (1) involved healthcare providers; (2) patient post rehab admission; and (3) care provider post rehab admission
3. **Document analysis** of related clinical, policy, and patient targeted documents
4. **Alberta Context Tool** survey tool to evaluate context in the healthcare settings

Findings

Patients & Caregivers Demographics

Individual Patient Characteristics (N=13)

SEX	
F	9
M	4
AGE	
Average (Y)	82.9
Range	91-68
CO-MORBIDITIES	
Average	
Range	5.4
	2-16
LIVING ARRANGEMENT	
Lives alone	12
Lives with spouse/partner	1
MEDICATIONS	
Average	8.5
Range	17-5

Family Caregiver Characteristics (N=9)

SEX	
F	9
AGE	
Average	63.1
Range	51-89
RELATIONSHIP TO PATIENT	
Child	7
Spouse	1
Sibling	1
DURATION OF CAREGIVER ROLE IN YEARS	
Average	6.25
Range	1-20

Health Care Professionals Demographics

Sex	
F (%)	39 (78)
M	11 (22)
PROFESSIONAL BACKGROUND N, %	
Nursing	29 (58)
Pharmacy	6 (12)
Physical Therapy	8 (16)
Social Work	3 (6)
Occupational therapy	2 (4)
Medicine	1 (2)
Management	1 (2)
YEARS OF EXPERIENCE	
<1 Year (%)	3 (6)
2-5 years (%)	14 (28)
6-10 years (%)	6 (12)
11-15 years (%)	12 (24)
>16 years (%)	15 (30)
PLACE OF EMPLOYMENT N, %	
Acute Care	26 (52)
Rehabilitation	24 (48)
EMPLOYMENT STATUS N, %	
Full-time	39 (78)
Part-time	11 (12)

Overview of the Findings

Uncertainty and lack of involvement - Improvement Opportunities

- **1) Being uncertain around what's going on and where they are going**
- **2) Lacking involvement of patient and caregivers**

Quality Care Transitions

- **1) Communicating more effectively**
- **2) Being vigilant and knowing your patient**
- **3) Meeting patients' care transitions needs**
- **4) Engaging patients and family members in care transitions**
- **5) Enabling patients and caregivers to navigate and link with resources across the transition points**

Overview of the Findings

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1) Being uncertain around what's going on and where they are going

- *She couldn't take it all in and nor should she have been expected to. There are questions, little tidbits of information I have received, i.e. current drugs that she's taken so apparently that's being changed. I'm on side with that and I think I contributed to that feedback but I don't know what the outcome was. So I don't know the outcome of Mom seeing a geriatric psychiatrist, which I heard she saw. I don't know the outcome of her seeing a social worker. I don't know the outcome of anything so I don't know the plan. (Family Member)*

2) Lacking involvement of patients and caregivers

- *I didn't talk to the daughters at all. Typically I don't if the patients are … unless the patients ask me to. But for the most part, unless the family is there at the bedside when I have the discussion and the patient is cognitively intact, I just have it with them. (Social Worker)*

- *I thought there would have been a sit down meeting with one family member and my mom. So the family member could be the second sober thought, and my mom, and somebody, maybe the CCAC case manager, maybe Name-F-X, the manager, just somebody who knows all the stuff. (Caregiver)*

Overview of the Findings

Quality Care Transitions

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1) Communicating more effectively

Within the team

- *Our usual rounds, discussing what she is going to need at home, looking at her home situation and how much support she has, what she is going to need to be able to do in terms of OT, looking at supports that her family can provide and what she is going to need to be able to do. Nursing, just once again, coordinating the time of her pain medication to help facilitate her therapy … the physicians, in terms of adjusting her pain meds to help control her pain. (Physiotherapist)*

Exchanging relevant information

- *There needs to be a central communication information package based on her customized get-well plan so that we, as a family, understand and support you but also the patient has more control which is important to well-being. (Caregiver)*

2) Being vigilant and knowing your patient

- *When the family is there I explain the discharge prescriptions and the appointments because they're the ones who are going to be involved in the care after discharge. We just went through her medications to make sure she understands what she's taking and why she's taking it. If she can administer this medication to herself. Then we just told her about her two follow-up appointments, and then if there is any concern in regard to any aspect, like ADL safety or if there is any other problem as it pertains to nursing, then we usually go over it with the patient at that time.* (Rehab nurse RNCT)

3) Meeting patients' care transitions needs

- *Part of it is getting me more independent in washing and, obviously, moving is still a problem. But they're gradually getting me to do more in that area, for myself. They're doing less and encouraging me to do more. (Patient)*

- *We have to find out what the patient's goal is before we tell them what our goal is for them. If their goal is to be able to be more independent and walk out of here, this is what steps you have to do to encourage yourself. So at first we'll start off with commode at your bedside to take you to the washroom … and then one person will assist you to the washroom, and then slowly with therapy you will try to be more independent to go to the washroom on your own with a walker, and then eventually to the hallway. (Admitting Nurse)*

4) Engaging patients & family members in care transitions

- *Ensuring that they have the information that they need and identifying the patients and family that needs to be spoken to earlier rather than later. Not all the patients need to have a family meeting, but identifying the ones that we need to sit down with and have a conversation about the patient's progress, discharge date, and what other help or assistance do they need from us to move the patients forward.* (Unit Manager)

5) Enabling patients and caregivers to navigate and link with resources across the transition points

- *Making sure that they have the most available resources that they're willing to have setup for them. I don’t know how much information about their social history gets passed on from here to rehab, but just having the information that was already collected so that they're not starting from scratch to figure out what his socioeconomic status is. Setting up, marginal patients and trying to get them as much support in the community. (Physiotherapist)*

- *If the patient needs to have nursing at home, basically that’s done through CCAC. The patient will know well ahead of time that there is CCAC nursing coming in to either do your dressing, or to help you with your blood sugar, or whether PSW is going in to assist you with a bath, or whether physio is coming in to assess your environment and to see how you transfer from bed to chair at home. (Unit Manager)*

Next Steps

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