Transitional care for older adults from hospital to home: a best practice implementation project

Supreeda Monkong, PhD., RN.

Ramathibodi School of Nursing,
Mahidol University

Introduction

- The transition following hospitalization is a critical period of health risk both the older adults and their family caregivers.
- The older adults need to learn how to take care themselves at home safely.
- Family caregivers play an important role in caring of older adults during hospitalization and home care.

Transition Care

- The transition care is defined as a set of intervention designed to ensure the coordination and continuity of care and to promote the safe and timely during the movement between health care settings.

Coleman & Boult, 2003; Naylor, 2006; Guerrero, Puls, & Andrew, 2014

Transitional care

- Transitional care facilitates safe and timely transfer of patients between levels of care and across care settings and includes communication between practitioners, assessment and planning, preparation, medication reconciliation, follow- up care and self-management education.

Best practice

- The best practice of transitional care for older adults from hospital to home was designed in response to the needs for older adults and their family caregivers.
- The goal is to improve the outcomes for older adults and family caregivers.

Best practice: outcomes

- To improve health outcomes for older adults and their family members
  - Older adults: prevent complications, rehabilitation, etc
  - Family caregivers: stress, health problems, etc
- To reduce the health care utilization:
  - rehospitalization, length of time to rehospitalization, emergency department usage, etc

Aims and Objectives

Aims: to promote the best practice of transitional care for older adults

- To identify and engage a team for promoting evidence-based practice in transitional care and assess compliance with best practice using a baseline audit
- To reflect on the results from the baseline audit and design and implement strategies to address areas of non-compliance with best practice

Aims and Objectives

Aims: to promote the best practice of transitional care for older adults

- To undertake a follow-up audit, assess the extent and nature of increased compliance with evidence-based best practice and identify areas and strategies to sustain and enhance care in delivery of transitional care

Audit Question

- Does the transitional care provided at the Ramathibodi Hospital to older people performed according to best practice?

Setting and Sample

- **Setting**
  - 1 Surgical unit and 1 Medical unit at Ramathibodi hospital, Bangkok, Thailand
- **Sample**
  - 1 Geriatric Physician
  - 2 Advanced Practice Nurses: 1 from Surgical unit and 1 from Medical unit
  - 6 Registered Nurses: 3 from Surgical unit and 3 from Medical unit
  - 20 Hospitalized older adults and their family caregivers

Methods

- A clinical audit was undertaken using evidence-based audit criteria regarding transitional care.
- Eight audit criteria that represented best practice recommendations of transitional care for older people from hospital to home were used. (JBI Database, 2018)

Audit Criteria

1. All staff involved in transitional care have received education regarding transitional care from hospital to home for older people.
2. Patients/caregivers have received education regarding self-management interventions.
3. An individualized discharge plan has been documented for all patients transitioning from hospital to home.

Audit Criteria

4. Patients/caregivers have been involved in the discharge planning process.

5. Transitional care services have been coordinated between the hospital and community setting.

6. Patient care needs have been communicated between the hospital and community healthcare providers.

Audit Criteria

7. Post discharge follow-up has occurred.

8. A multifaceted, approach is used for transitioning older people from hospital to home (e.g. may include telephone follow-up, home-based exercise programs, patient-centered discharge instruction)

- The implementation project used the JBI Practical Application of Clinical Evidence System (PACES) and Getting Research into Practice (GRIP) audit and feedback tool.
- A baseline audit was conducted followed by the implementation of transitional care strategies, and the project was finalized with a follow-up audit to determine the change in practice.

Methods

Phase 1: A baseline audit for transitional care

- Establishing a team for the project and undertaking a baseline audit based on criteria informed by the evidence

Project team

Team member	Position/Organization	Role
Supreeda Monkong	Lectuer/Ramathibodi School of Nursing	Project coordinator, protocol writing, project design, Education implementation, data analysis, and report writing
Orapitchaya Krairit	Physician/Ramathibodi Hospital	Supervision
Jirapee Soonthornkul Tipanatre Ngamkala	Advanced Practice Nurses/Nursing Department, Ramathibodi Hospital	Communication with other nurses and supervision
Wipawee Pussawiro Penny Ratchasan	Registered nurses/Nursing Department, Ramathibodi Hospital	Communication with other nurses, supervision, and data collection

Setting and Sample

- **Methods:**
  - Review of the discharge summary documents
  - Interviews with health care professionals, patients, and family caregivers

Audit criteria, sample and approach to measuring compliance

Audit criteria	Sample	Method used to measure % compliance with best practice
All staff involved in transitional care have received education regarding transitional care from hospital to home for older people	Baseline: 5 nurses, 1 physician Follow-up: 6 nurses	Interview
Patients/caregivers have received education regarding self-management interventions	Baseline: 20 older patients/family caregivers Follow up: 20 older patients/family caregivers	Interview
An individualized discharge plan has been documented for all patients transitioning from hospital to home.	Baseline: 20 older patients/family caregivers Follow up: 20 older patients/family caregivers	Interview Nursing Discharge Planning Record

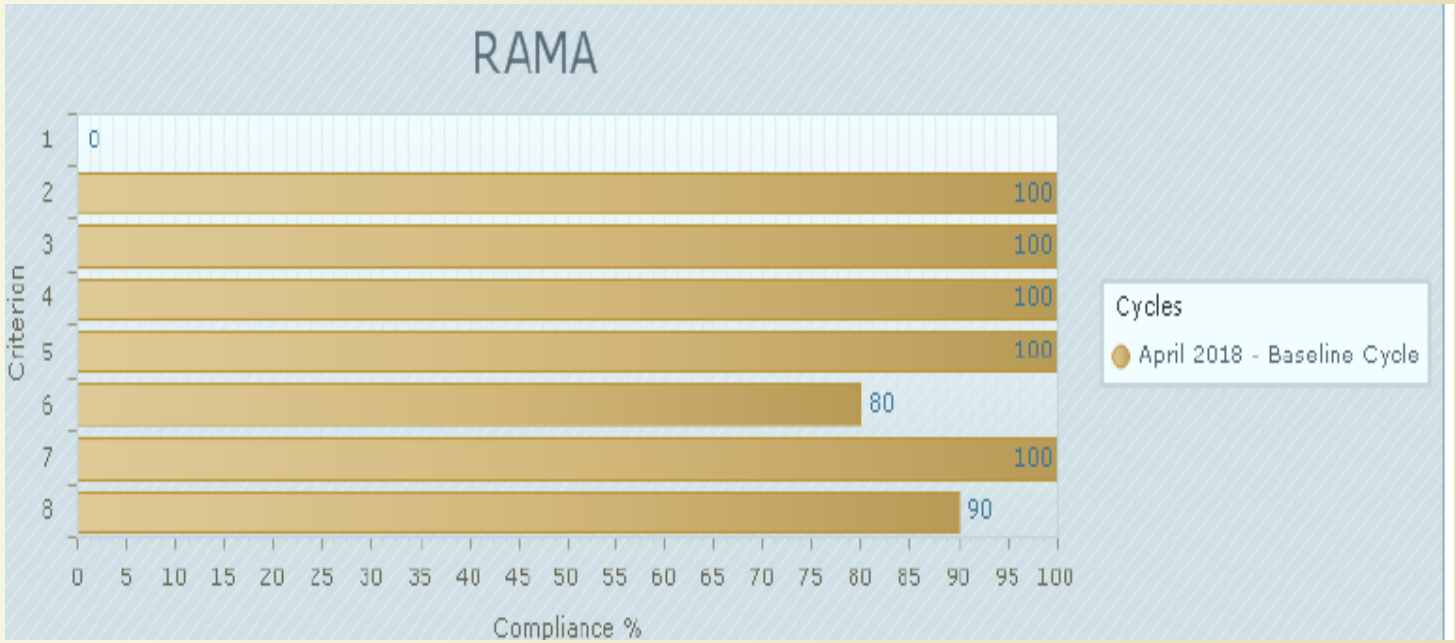
Audit criteria, sample and approach to measuring compliance

Audit criteria	Sample	Method used to measure % compliance with best practice
Patients/caregivers have been involved in the discharge planning process.	Baseline: 20 older patients/family caregivers Follow up: 20 older patients/family caregivers	Interview
Transitional care services have been coordinated between the hospital and community setting.	Baseline: 20 older patients/family caregivers Follow up: 20 older patients/family caregivers	Interview
Patient care needs have been communicated between the hospital and community healthcare providers.	Baseline: 20 older patients/family caregivers Follow up: 20 older patients/family caregivers	Interview

Audit criteria, sample and approach to measuring compliance

Audit criteria	Sample	Method used to measure % compliance with best practice
Post discharge follow-up has occurred.	Baseline: 20 older patients/family caregivers Follow up: 20 older patients/family caregivers	Interview Discharge Planning Nursing Record
A multifaceted, approach is used for transitioning older people from hospital to home (e.g. may include telephone follow-up, home-based exercise programs, patient-centered discharge instruction)	Baseline: 20 older patients/family caregivers Follow up: 20 older patients/family caregivers	Interview Discharge Planning Nursing Record

Results: Baseline audit



Methods

Phase 2: The implementation of the best practice for transitional care

- Reflecting on the results of the baseline audit and designing and implementing strategies to address non-compliance found in the baseline audit informed by the JBI GRIP framework

Results: Phase 2 - GRiP

- Three barriers to compliance with best practice were identified, and strategies to overcoming these barriers were then implemented.

GRIP matrix

Barrier	Strategy	Resources	Outcomes
Not all staff have knowledge on transitional care from hospital to home for older people	Educate staff	Monthly meeting Discharge planning information sheet Discharge summary record	All staff were qualified to conduct discharge planning
Incomplete discharge planning information, discharge teaching, and nursing discharge planning summary	Educate staff	Head nurses' monitoring Discharge planning summary record	All the staff were able to complete the discharge planning information.
Not all staff included family caregiver in discharge planning	Educate staff to emphasize the important of family caregivers	APN, senior nurse, and head nurses' monitoring	Patients/caregivers have been involved in the discharge planning process

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Meeting with Staff

Discharge Planning Record

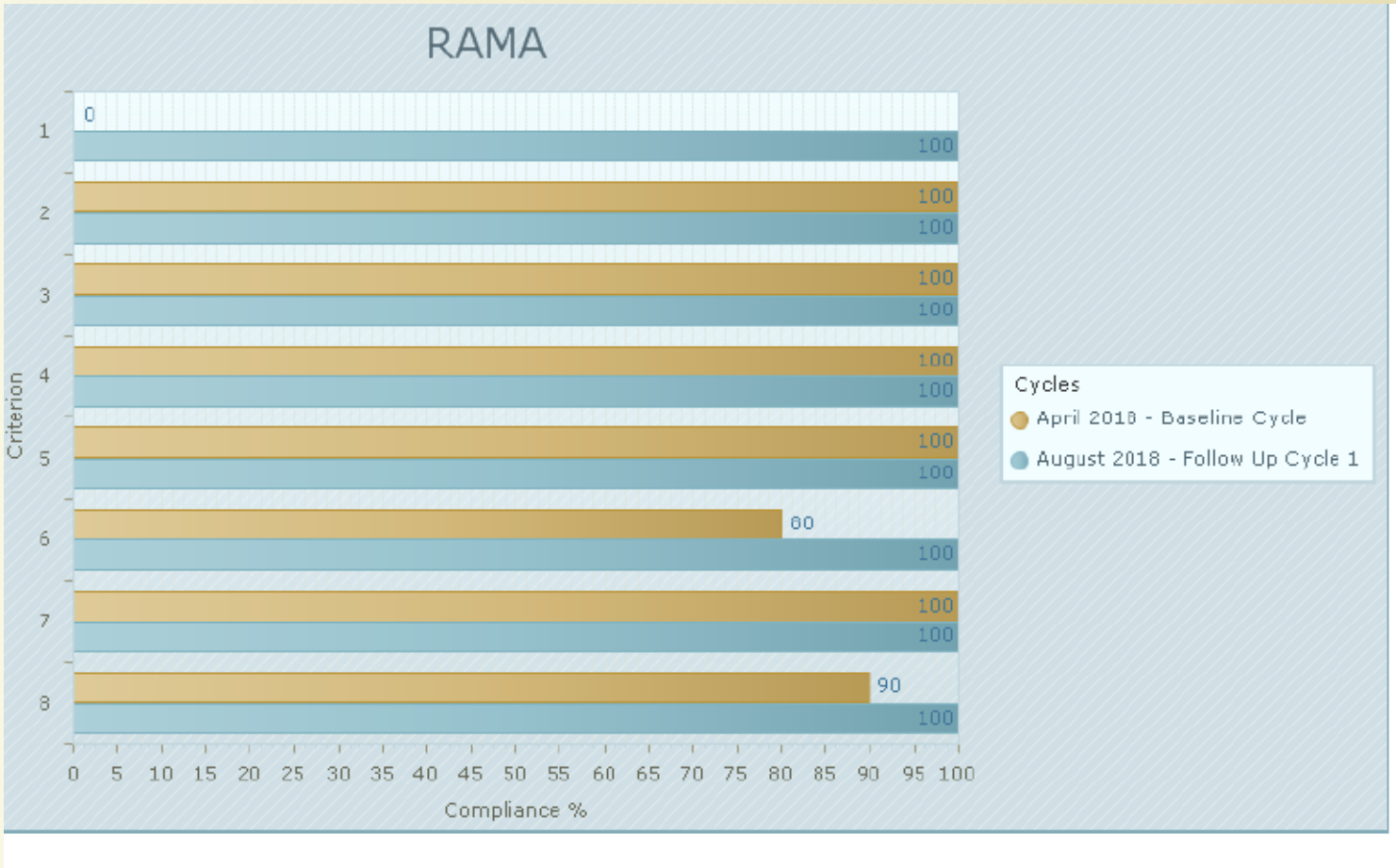
- Discharge Planning Information
  - Health Problems
  - Family, Social, and Environment Issues
  - Medical Payment Method
  - Family Caregiver
- Discharge Teaching
- Nursing Discharge Planning Summary
  - Continuing care, follow up, etc

Methods

Phase 3: A follow-up audit to determine change in practice

- Conducting a follow-up audit to assess the outcomes of the interventions implemented to improve practice, and identify future practice issues to be addressed in subsequent audits

Phase 3: Follow-up Audit



Results

- Improvements in clinical practice were identified in relation to
  - health care professional knowledge regarding transitional care
  - patient care needs during the transition
  - a multifaceted approach during the transition phase.

Discussion

- The transitional care provided at the Ramathibodi Hospital to older people is performed according to best practice.
- Recommendations:
  - A multifaceted approach:
    - Patient-centered discharge instruction/teaching
    - Family caregiver preparedness
    - Telephone follow-up by developing the outline of telephone follow up

Conclusion

- The implementation project achieved improvement in compliance with best practice recommendations.
- Further audits will need to be done to monitor practice and maintain the practice change.
- Future plans for continuous improvements in clinical practice is needed, especially for the high risk group.

Next Step

- Ongoing monitoring a best practice with high risk group
- Outcomes: Older adults and family caregivers (in process)
- Paper submitted for publication

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