Partners at Care Transitions:

Exploring healthcare professionals' perspectives of excellence at care transitions for older people

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Background: As many as one in five patients experience an adverse event during transitions from hospital to home and this period is particularly risky for older people with complex needs. Research predominantly focuses on errors and harm and so little is known about factors that facilitate safe outcomes at transitions.

Aim: To explore how staff within high performing general practices and hospital specialties successfully deliver safe care to older people and demonstrate resilience during transitions from hospital to home.

Methods: 30-day emergency readmission data for patients aged 75yrs+ were analysed to identify 6 general practices and 4 hospital specialties demonstrating low or reducing readmission rates over time. 157 multidisciplinary staff participated in 20 focus groups, 12 interviews, and brief observations of 9 ward-based meetings. Pen portraits for each participating team were analysed thematically.

Findings: 8 themes were generated across primary and secondary care. Similarities and differences in how primary and secondary care teams ensured safe transitions are highlighted below.

Patient engagement and expectations

Staff **involved patients** and families in different ways.

Hospitals **gave and received information** to understand holistic situations and to prepare patients.

Primary care staff **educated patients** on self management and service navigation.

Staff overcame unrealistic patient expectations by having **honest conversations**, and involvement was facilitated by **relationships** between staff and patients.

Coping with an inadequate system

Hospital staff generally considered discharge to be effective but they **buffered** against inadequacies, for example, by signposting and getting collective responsibility.

Primary care staff responded to a wholly inadequate system by **chasing** information and using **intrinsic patient knowledge**.

For extremely complex patients, staff **bridge gaps** between teams.

Understanding others' roles and responsibilities facilitated team handovers.

Having a shared plan

Having a **shared plan** was important to all teams, but these plans were rarely shared across settings.

Hospital staff were all aware of discharge plans and priorities which included **multidisciplinary perspectives**.

Primary care staff valued **multidisciplinary discussion** to raise concerns, get advice, and agree actions.

In both settings, shared plans were facilitated by **relationships** and **proximity**.

Implications: It may be possible to use these study findings to help generate improvements at a service level, however, further research is required to explore whether these behaviours improve outcomes of care, and how they can be spread to other teams. Predominantly, staff demonstrated resilience to overcome system level problems, therefore, changes are also required at an organisation and policy level to support staff to deliver safe transitional care to older people.

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