How to promote safety during transitions of care: A guide for CCGs and NHS Hospital Trusts

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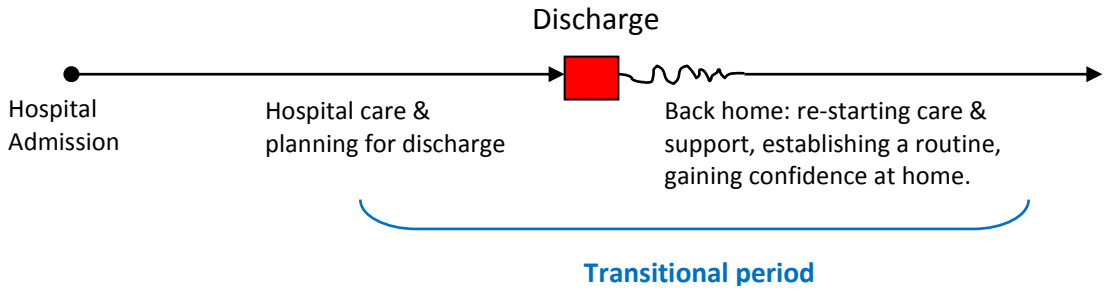
EXECUTIVE SUMMARY

For older people, the transitional period from preparing to leave hospital to the first few weeks at home (see Figure 1) can be risky and fraught. For some, there may be further and potentially avoidable readmissions. In this guide we report the findings from interviews with staff working in primary, secondary and community care teams specially selected for their good work on delivering safe transitional care. We go on to present recommendations for how teams can improve the safety and experience of transitional care for older people.

We describe three key factors that drive safe transitions: knowing the patient, knowing staff within and across teams, and bridging gaps in the system. Eight recommendations based on these factors are offered to system leaders, managers and teams working across the transitional boundary of hospital to home. These recommendations align with the recent NHS Hospital Discharge operating model guidance particularly relating to safety-netting[a] and will guide you in implementing systems that will support safer care transitions with reduced hospital readmissions for older people.

This work is part of a larger programme of research: the Partners at Care Transitions (PACT) funded by the National Institute for Health Research. More details about PACT are provided in the 'Further Information' section at the end of this guide.

Figure 1. The transitional period



[a] https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model

INTRODUCTION

Transitions of care span the time period from preparing for discharge to the first few weeks back at home. This period is risky. Shorter lengths of hospital stays mean that people are discharged home with on-going care needs (e.g. medication monitoring and wound care).[1,2] One in five patients experience an adverse event during this transition, 62% of which could be prevented or minimised.[3] Furthermore, 13.8% of patients are readmitted to hospital within 30 days of discharge.[4] Although not all readmissions represent poor quality care, around 30% are considered avoidable[5,6] and if we factor in the risks associated with being in hospital (e.g. post-hospital syndrome) this figure is likely to be much higher. Transitions are particularly risky for older adults who are more likely to have multiple comorbidities and complex health and/or social care needs.[7]

Previous research exploring how healthcare professionals perceive care transitions highlights fundamental and universal system flaws. These include communication breakdowns across professional groups and care settings, a lack of accountability, and poor communication with the patient.[8,9,10] Research typically focuses on understanding *what goes wrong* at transitions to provide guidance on potential solutions. Here we have taken a different approach, known as positive deviance.[11] We explored *what goes right* – i.e. what teams do differently to achieve safe transitions of care. By learning what is possible within existing resources we aim to develop realistic and sustainable intervention strategies.

Aim: to explore how 'high-performing' general practice and hospital teams successfully deliver safe care to older adults and overcome challenges during transitions from hospital to home.

METHODS

- We analysed 30-day emergency readmission rates for patients aged ≥75 years to identify general practices and hospital specialties in the north of England that demonstrated high performance, i.e. exceptionally low or improved readmission rates over time. High performing teams were purposively sampled to represent a range of healthcare contexts.

Overall population:
5 CCGs – 151 general practices
22 NHS Trusts – 85 hospital specialties (older people's medicine, cardiology, respiratory)

The high performing teams:
6 general practices
4 hospital specialties (2 older people's medicine, 1 cardiology, 1 respiratory)

- During 2017-2018, we recruited 157 multidisciplinary staff to participate in focus groups and interviews. Staff were recruited from the high performing general practices and hospital teams in addition to the community nursing teams that worked into or with them. In hospitals, we also observed meetings relating to discharge (e.g. board rounds, MDT meetings).

By setting: 68 hospital staff; 68 general practice staff; 21 community staff

By profession:
58 matrons / nurses / healthcare assistants
14 discharge coordinators
30 doctors
25 allied health professionals
30 administrators / others

FINDINGS

Across healthcare contexts, staff perceived three key factors to facilitate safe transitions of care: knowing the patient, knowing each other, and bridging gaps in the system. Figure 2 shows safer transitions are those that incorporate more factors. For example, staff felt it was easier to share knowledge about a patient's transitional care needs if good relationships existed within teams. The safest transitions of care were thought to occur when all three factors existed together.

However, each factor was challenging to achieve, particularly when crossing team or service boundaries. Exceptionally safe transitions of care were perceived to be relatively rare and typically they only happened when patients had particularly complex medical/social care needs.

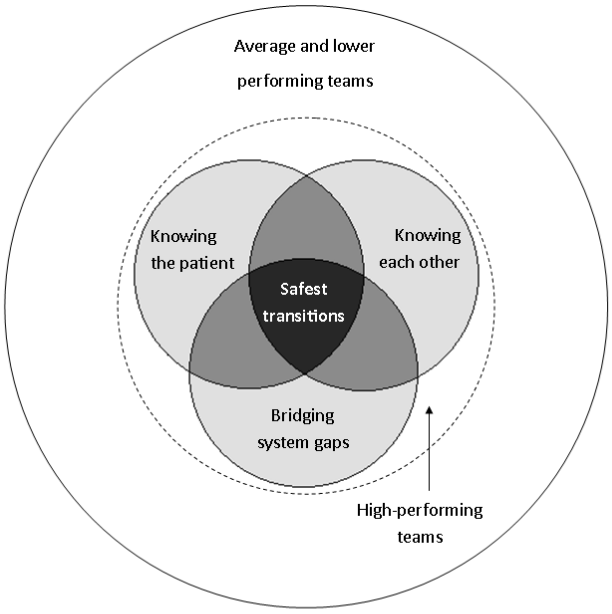


Figure 2. Key factors in delivering safe transitional care and hypothesised ways in which they interact.

NOTE: Scarce resources precluded this action for most non-complex patients.

The factors:

Factor 1 - Knowing the patient: Safe transitions of care were perceived to be supported when staff *understood patients' holistic needs*. Staff concertedly and repeatedly dug for information from patients and families by gathering collateral and corroborating accounts. *Trust and rapport* enabled patients and families to open-up about problems or concerns, discuss things they would otherwise consider irrelevant (e.g. a spouse who was struggling at home), and access the system when needed. Trust and rapport also made it easier for staff to have difficult conversations with patients. There was a *shared understanding* of patient needs among the multidisciplinary team including unqualified staff and those who were not regular team members. This enabled others to pick up care as needed.

Factor 2 - Knowing each other: Safe transitions of care were supported by relationships within and across teams. Positive relationships developed when staff *felt valued and listened to*. This was facilitated by integrated and non-hierarchical ways of working, open discussion, and respect for others' professional perspectives and experiences. Certain staff *proactively built relationships across teams and settings*. Relationships across teams were bolstered when staff were supportive, receptive and responsive to each other and they were often facilitated by proximity (e.g. meeting face to face). When relationships existed across teams, informal information flowed more easily. *Trust* (e.g. in others judgements or ownership of actions) facilitated collaborative and coordinated patient care. Disruption within teams degraded relationships (e.g. weekends and rotations in hospital, and service reorganisation in the community).

Factor 3 - Bridging gaps in the system: Staff attempted to bridge gaps within the system to improve transitions. They sought to *enhance communication*: hospital teams improved the quality of discharge letters or sent additional letters while GP and community teams relentlessly chased and clarified poorly communicated information. Some GPs reviewed discharge letters for patients they had seen most recently. Service level interventions (e.g. electronic discharge letters, centralised referral hubs) supported communication but were not always considered a sufficient alternative to verbal handovers, particularly when care was complex. Staff tried to *adjust patient and family expectations* by challenging perceptions about patient and staff roles, and what was and wasn't feasible under current system pressures and constraints. Staff also adapted to *evolving services and competing priorities.* They engaged with teams more appropriately and mitigated problems if they understood one another's roles – what other teams could offer and the pressures and constraints that they faced. However, staff had different, and often contradictory, perspectives about the problems faced across settings, and there were limited opportunities for feedback or learning.

KEY RECOMMENDATIONS

1. Knowing the patient - Consider organisational changes that enable staff to develop relationships and get to know the patients they care for. For example, ensuring staff rotas are planned to enhance continuity of patient care, and in turn, encourages the development of trust and rapport.

2. Knowing the patient - In hospital, encourage frequent and brief informal conversations between staff and patients so that they feel comfortable about providing relevant holistic information that will assist the delivery of safe transitions of care. In particular, understanding a patient's home circumstances and any worries will contribute to robust discharge planning.

3. Knowing the patient: Create mechanisms to ensure that informal and valuable information for ensuring safe transitions is shared within and across teams. Enhanced communication skills among, for example, reception staff in General Practice, will support them to sensitively enquire about patients that they know and be aware when things aren't right.

4. Knowing each other - Support staff to build relationships across different teams. Where staff are not co-located / or work across different settings bring staff together (even virtually) for short educational sessions to help them learn about gaps in the system by understanding each other's roles and the pressures and constraints faced in delivering patient care. This could include inter-professional simulation, job swaps / secondments, career development roles etc.

5. Knowing each other - Consider mechanisms to support informal communication within and across teams so that in-depth, nuanced knowledge about patients can be shared.

6. Bridging gaps in care - Recognise the impact on resources from team members temporarily plugging gaps in transitional care by for example verbally communicating risk or chasing missing discharge information and acknowledge this. Agree structural and systemic changes that could be implemented to create an efficient safety-net for patients.

7. Bridging gaps in care - Embed accessible and visible mechanisms for feedback and learning across settings so that frontline staff are empowered to influence and generate change.

8. Bridging gaps in care – Encouraging active patient and family involvement during hospital care so that they are better prepared for managing at home for example in taking medication, managing feeds and being physically active. Greater knowledge of other teams can be used to create realistic expectations in patients and families about what care is available.

FURTHER GUIDANCE

- In line with bridging the gaps in transitional care we signpost Trusts and local CCGs to the annual National Adult In-Patient survey data (https://nhssurveys.org/surveys/survey/02-adults-inpatients/year/2019/ See Analysis & reporting section) which reports the experiences of almost 80,000 hospitalised patients in England each year. Specifically we advise looking at survey items (34, 48, 54, 55, 56, 58 and 59) to guide you on where the opportunities for improvements in transitional care might lie.

- To understand how hospital processes can contribute to patient experiences during the transitional period please view this short educational film and share with your colleagues https://youtu.be/tovdiE8V4NY

This research has contributed to the development of an intervention specifically focused on Recommendations 2 and 8. The intervention specifically aims to increase the involvement of older patients and their families during hospital stay to help them prepare for going home and managing any gaps in care. The intervention called 'Your Care Needs You' will be tested in a multi-centred randomised controlled trial in hospital trusts across the north of England. See 'Further Information' section at the end of this guide.

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FURTHER INFORMATION

For Further information about this report or about the PACT programme of research and the trial of the **Your Care Needs You** intervention please visit **https://yqsr.org/pact/**

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