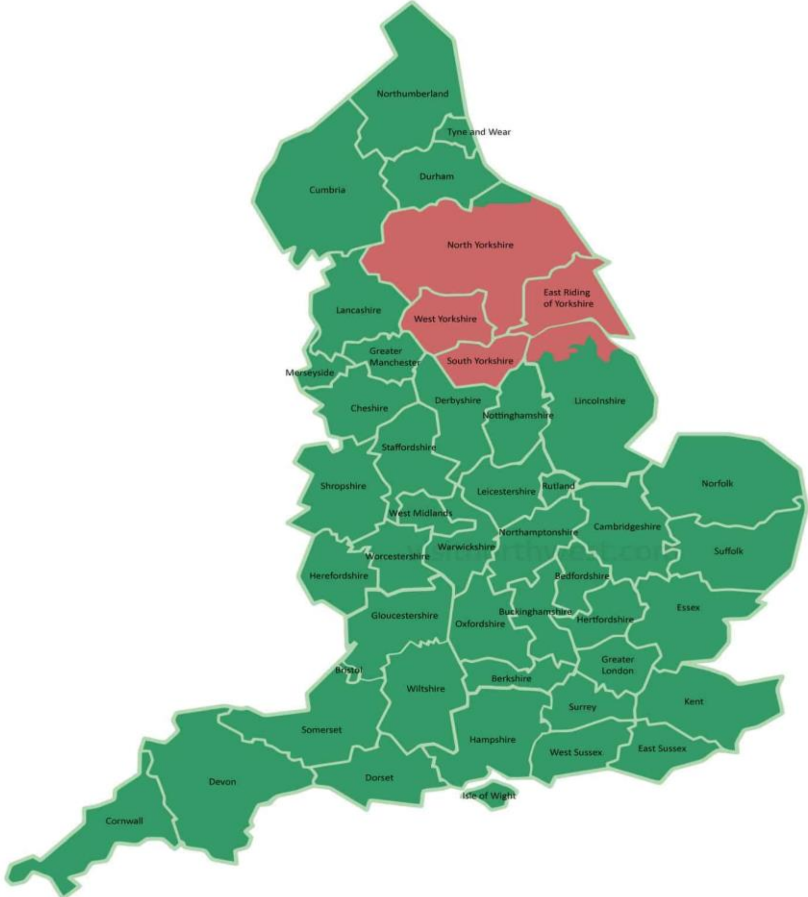
NIHR | Yorkshire and Humber Patient Safety Translational Research Centre

Cruise ship to rowing boat:

How can we improve safety for older people as they transition from hospital to home?

Rebecca Lawton
Director, NIHR Yorkshire and Humber Patient Safety Research Collaboration (PSRC)

NIHR Yorkshire and Humber PSRC



Acute care
Maternity
Transitions of care
Primary care
Mental health
Ambulance service

Outline for the talk

- Why transitions, why older people, why involvement?
- What we learnt about transitions of care for older people (WP1 and 2)
- Developing a measure of quality and safety of care at transitions (WP3)
- How we developed and pilot tested our Your Care Needs You intervention (WP4)
- Feasibility testing (trial methods) and developing our implementation package (WP5)
- The cRCT (WP6): A trial within a trial

Ethics – risk vs autonomy
Equity – and involvement
Experiences – of older people

Partners at Care Transitions

- An NIHR funded programme grant (five years)
- Understand experiences of older patients and their carers from admission to a few weeks post-discharge
- Understand how teams achieve success
- Develop a transitions measure (safety and experience)
- Develop an intervention to support involvement of patients and carers
- Pilot the intervention (Your Care Needs You) and refine
- Test the feasibility of the trial methodology and implementation
- Trial the intervention

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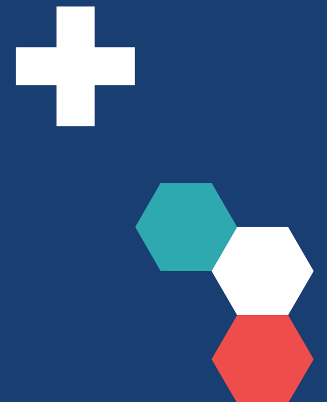
PACT Management Structure & timeline



Trial Steering Committee (TSC)

Programme Management Group (PMG)

Patient Advisory Panel

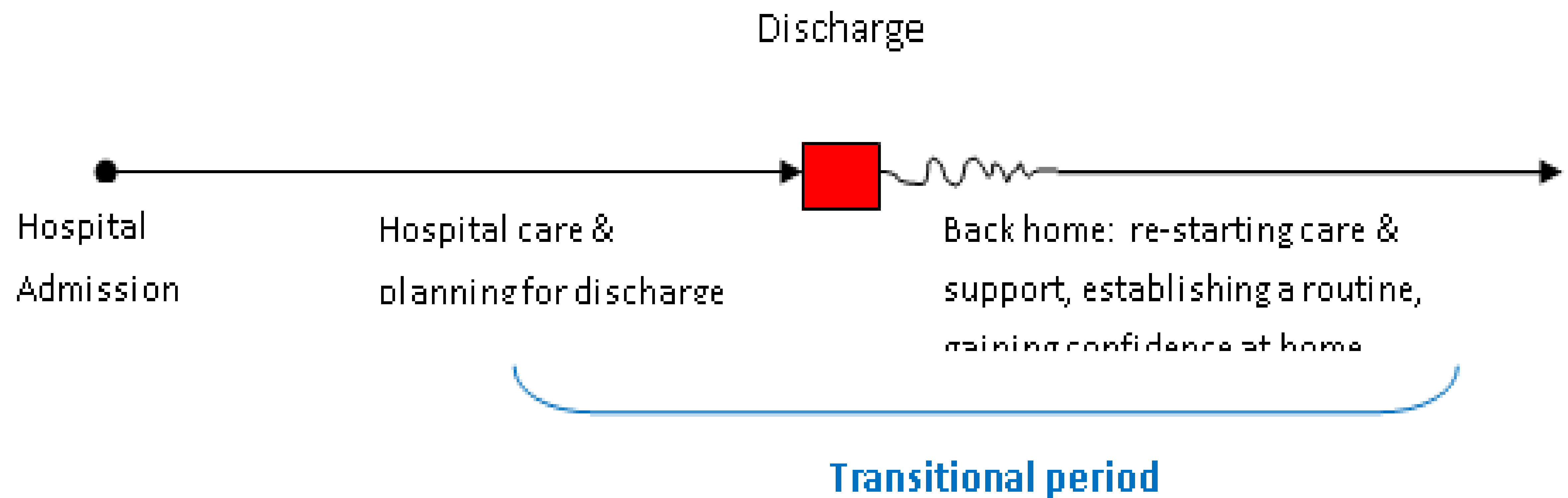
Trial Management Group

Operational Team

WP1	WP2	WP3	WP4	WP5	WP6
Patient experience	Understanding excellence	Measure development & testing	Intervention development & pilot (2 wards)	Trial feasibility study (10 wards)	cRCT & process evaluation (40 wards)

2017 — 2020 — 2023

What is a ‘transition’?



Why focus on safety at transitions of care for older people?

Unplanned

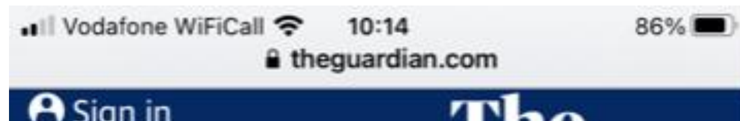
Readmissions

Avoidable

Readmissions

Safety events

at transitions



OPEN ACCESS | Research Publication

Earlier hospital discharge: a challenge for Norwegian municipalities

Heidi Gautun and Astri Syse

pp 1–17 • 7 July 2017 • https://doi.org/10.7577/njsr.2204

43 397

Abstract

Aim: In order to improve patient outcomes and minimize healt
attempting to reduce the length of stay in hospitals by transfer
primary care. In Norway, the Coordination Reform was implem
a result, the number of patients discharged to the municipal he
We investigate the extent to which nurses in nursing homes an
adequate care for patients discharged from hospitals after the r

Data: Altogether, 1,938 nurses representing around 80% of Nor
experiences of this reform.

Results: An increase in the number of poorly functioning patie
reported. Regardless of place of work, concerns were raised about limited resources in terms of personnel,

Hospital physicians' views on discharge and readmission processes: a qualitative study from Norway

Malin Knutsen Glette,[1,2] Tone Kringeland,[1] Olav Røise,[2,3,4] Siri Wiig[2]

ABSTRACT

Objectives To explore hospital physicians' views on readmission and discharge processes in the interface between hospitals and municipalities.
Design Qualitative case study.
Setting The Norwegian healthcare system.
Participants Fifteen hospital physicians (residents and consultants) from one hospital, involved in the treatment and discharge of patients.
Results The results of this study showed that patients were being discharged earlier, with more complex medical conditions, than they had been previously, and that discharges sometimes were perceived as premature. Insufficient capacity at the hospital resulted in pressure to discharge patients, but the primary healthcare service of the area was not always able to assume care of these patients. Communication between levels of the healthcare service was limited. The hospital stay

Strengths and limitations of this study

- This study, to our knowledge, is the first to explore hospital physicians' views on readmissions from the primary healthcare service to the hospitals.
- The sample consists of fellows and residents from several specialties within the surgical and medical fields, providing diverse perspectives on the addressed issues.
- The inclusion of a larger sample of physicians from additional medical specialties, as well as other healthcare personnel, patients and their next of kin, would have provided valuable insights into the issues identified in this study.

such as nursing home personnel, homecare

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Patients at the centre
of everything we do
NHS
Listening in
to improv
Patients at the centre
of everything we do
Caring ab
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Patients at
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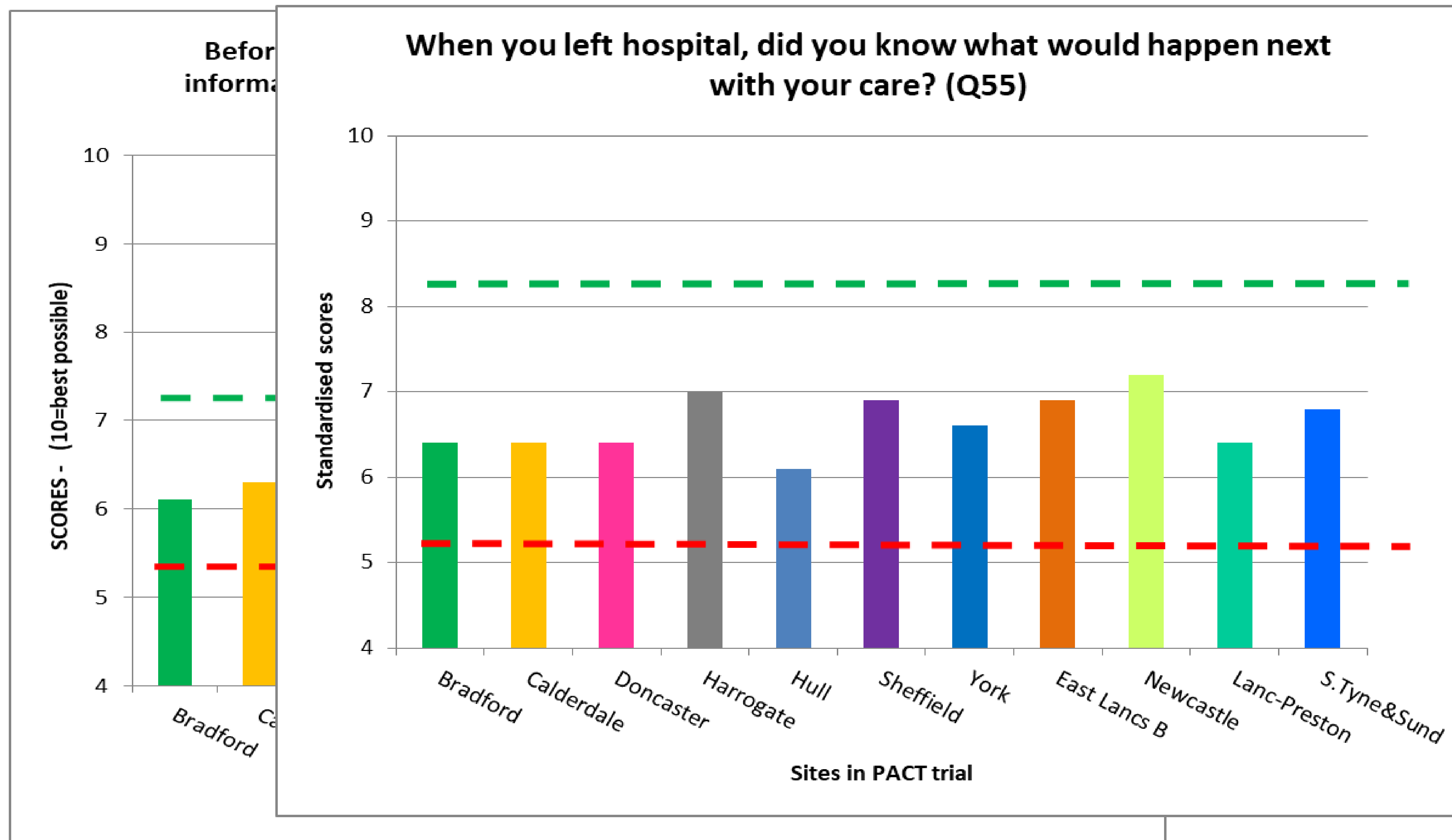
What about more locally? (2019 CQC NIPS data)



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Original Investigation

Preventing 30-Da

A Systematic Revi

Aaron L. Leppin, MD; Michael R. Gionfriddo
Frances S. Mair, MD; Katie Gallacher, MBCh
Kasey Boehmer, BA; Henry H. Ting, MD, MI
Victor M. Montori, MD

IMPORTANCE Reducing early (<30
improving health care quality. The
context. It predicts that highly sup
capacity to enact burdensome sel

OBJECTIVE To synthesize the evid
hospital readmissions and identify
burden and on patients' capacity t
varying effects.

DATA SOURCES We searched PubM
Scopus (1990 until April 1, 2013), c

STUDY SELECTION Randomized tri
unplanned readmissions within 30
medical or surgical cause for more

DATA EXTRACTION AND SYNTHESIS
activity-based coding strategy to c
authors. Blinded to trial outcomes
additional work on patients after c
accordance with the cumulative co

MAIN OUTCOMES AND MEASURES
without out-of-hospital deaths at

RESULTS In 42 trials, the tested int
random-effects relative risk, 0.82
consistent across patient subgrou
that were 1.6 times more effective
subgroup analyses, interventions
more individuals in care delivery (i
self-care (interaction $P = .04$) were
interventions, respectively. A post
providing comprehensive, postdis

CONCLUSIONS AND RELEVANCE Te
but more effective interventions a
Interventions tested more recentl

Burke *et al. BMC Health Services Research* 2014, **14**:423
http://www.biomedcentral.com/1472-6963/14/423

BMC
Health Services Research

RESEARCH ARTICLE **Open Access**

Identifying keys to success in reducing readmissions using the ideal transitions in care framework

Robert E Burke[1,2*], Ruixin Guo[3], Allan V Prochazka[1,2] and Gregory J Misky[2,4]

Abstract

Background: Systematic attempts to identify best practices for reducing hospital readmissions have been limited without a comprehensive framework for categorizing prior interventions. Our research aim was to categorize prior interventions to reduce hospital readmissions using the ten domains of the Ideal Transition of Care (ITC) framework, to evaluate which domains have been targeted in prior interventions and then examine the effect intervening on these domains had on reducing readmissions.

Methods: Review of literature and secondary analysis of outcomes based on categorization of English-language reports published between January 1975 and October 2013 into the ITC framework.

Results: 66 articles were included. Prior interventions addressed an average of 3.5 of 10 domains; 41% demonstrated statistically significant reductions in readmissions. The most common domains addressed focused on monitoring patients after discharge, patient education, and care coordination. Domains targeting improved communication with outpatient providers, provision of advanced care planning, and ensuring medication safety were rarely included. Increasing the number of domains included in a given intervention significantly increased success in reducing readmissions, even when adjusting for quality, duration, and size (OR per domain, 1.5, 95% CI 1.1 - 2.0). The individual domains most associated with reducing readmissions were Monitoring and Managing Symptoms after Discharge (OR 8.5, 1.8 - 41.1), Enlisting Help of Social and Community Supports (OR 4.0, 1.3 - 12.6), and Educating Patients to Promote Self-Management (OR 3.3, 1.1 - 10.0).

Conclusions: Interventions to reduce hospital readmissions are frequently unsuccessful; most target few domains within the ITC framework. The ITC may provide a useful framework to consider when developing readmission interventions.

Keywords: Readmissions, Framework, Interventions

Starting position: Existing evidence on readmissions interventions and gaps

- Many types of multi-component bridging interventions
- Many just not possible to implement in the current climate
- Patient education and/or patient involvement often cited as an important component
- Patient involvement rarely explored as the sole focus (except by a few including Karina Aase and team)
- Patients often feel excluded from their care
- How do patients experience the transition to and from hospital?
- How do staff and services deliver excellent care at transitions?

WP1

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DOI: 10.1111/hex.13327

ORIGINAL ARTICLE

WILEY

Doing involvement: A qualitative study exploring the 'work' of involvement enacted by older people and their carers during transition from hospital to home

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Dr. Jenni Murray PhD, Programme Manager[1] |
Rosie Shannon MA, Research Fellow[1] |

Dr. Laura Sheard PhD, Principal Research Fellow[1] |
Yvonne Birks PhD, Professor, Associate Dean (Research)[3] |
Dr. Lesley Hughes PhD, Senior Research Fellow[1] |
Dr. Alison Cracknell MBChB, FRCP, Consultant in Elderly Medicine[4] |
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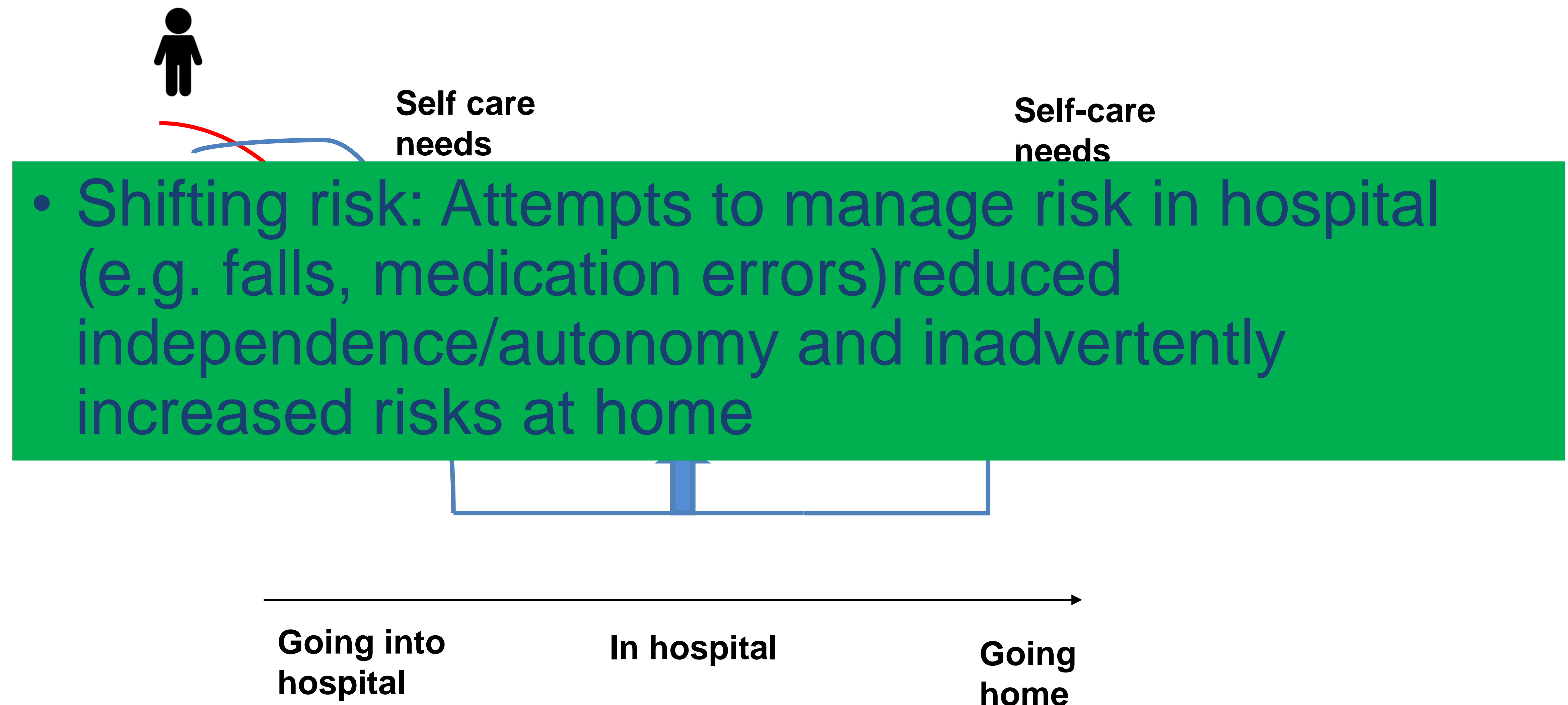
WP1:Patient experiences of the transition of care

- Analysis – thematic (2 levels)
- Key findings:
  - There isn't a transition, rather an exit
  - Patients experience a move from being cared for to caring for oneself with fewer skills to do so
  - Patients often wanted to be, or accepted being, passive or uninvolved.
    - Patients who wanted to be involved found it difficult a

Another way of looking at it



WP2: U... from the...

Qualitative... community... demonstra...

Pen portrai... and Marsh...

Key finding...

BMC Health Services Research

RESEARCH ARTICLE Open Access

Delivering exceptionally safe transitions of care to older people: a qualitative study of multidisciplinary staff perspectives

Ruth Baxter[1*], Rosemary Shannon[1], Jenni Murray[1], Jane K. O'Hara[2], Laura Sheard[3], Alison Cracknell[4] and Rebecca Lawton[1,5]

Abstract

Background: Transitions of care are often risky, particularly for older people, and shorter hospital stays mean that patients can go home with ongoing care needs. Most previous research has focused on fundamental system flaws, however, care generally goes right far more often than it goes wrong. We explored staff perceptions of how high performing general practice and hospital specialty teams deliver safe transitional care to older people as they transition from hospital to home.

Methods: We conducted a qualitative study in six general practices and four hospital specialties that demonstrated exceptionally low or reducing readmission rates over time. Data were also collected across four community teams that worked into or with these high-performing teams. In total, 157 multidisciplinary staff participated in semi-structured focus groups or interviews and 9 meetings relating to discharge were observed. A pen portrait approach was used to explore how teams across a variety of different contexts support successful transitions and overcome challenges faced in their daily roles.

Results: Across healthcare contexts, staff perceived three key themes to facilitate safe transitions of care: knowing the patient, knowing each other, and bridging gaps in the system. Transitions appeared to be safest when all three themes were in place. However, staff faced various challenges in doing these three things particularly when crossing boundaries between settings. Due to pressures and constraints, staff generally felt they were only able to attempt to overcome these challenges when delivering care to patients with particularly complex transitional care needs.

Conclusions: It is hypothesised that exceptionally safe transitions of care may be delivered to patients who have particularly complex health and/or social care needs. In these situations, staff attempt to know the patient, they exploit existing relationships across care settings, and act to bridge gaps in the system. Systematically reinforcing such enablers may improve the delivery of safe transitional care to a wider range of patients.

Trial registration: The study was registered on the UK Clinical Research Network Study Portfolio (references 35272 and 36174).

Keywords: Patient safety, Transitions of care, Hospital discharge, Elderly care, Health care professionals, Qualitative, Focus groups, Positive deviance

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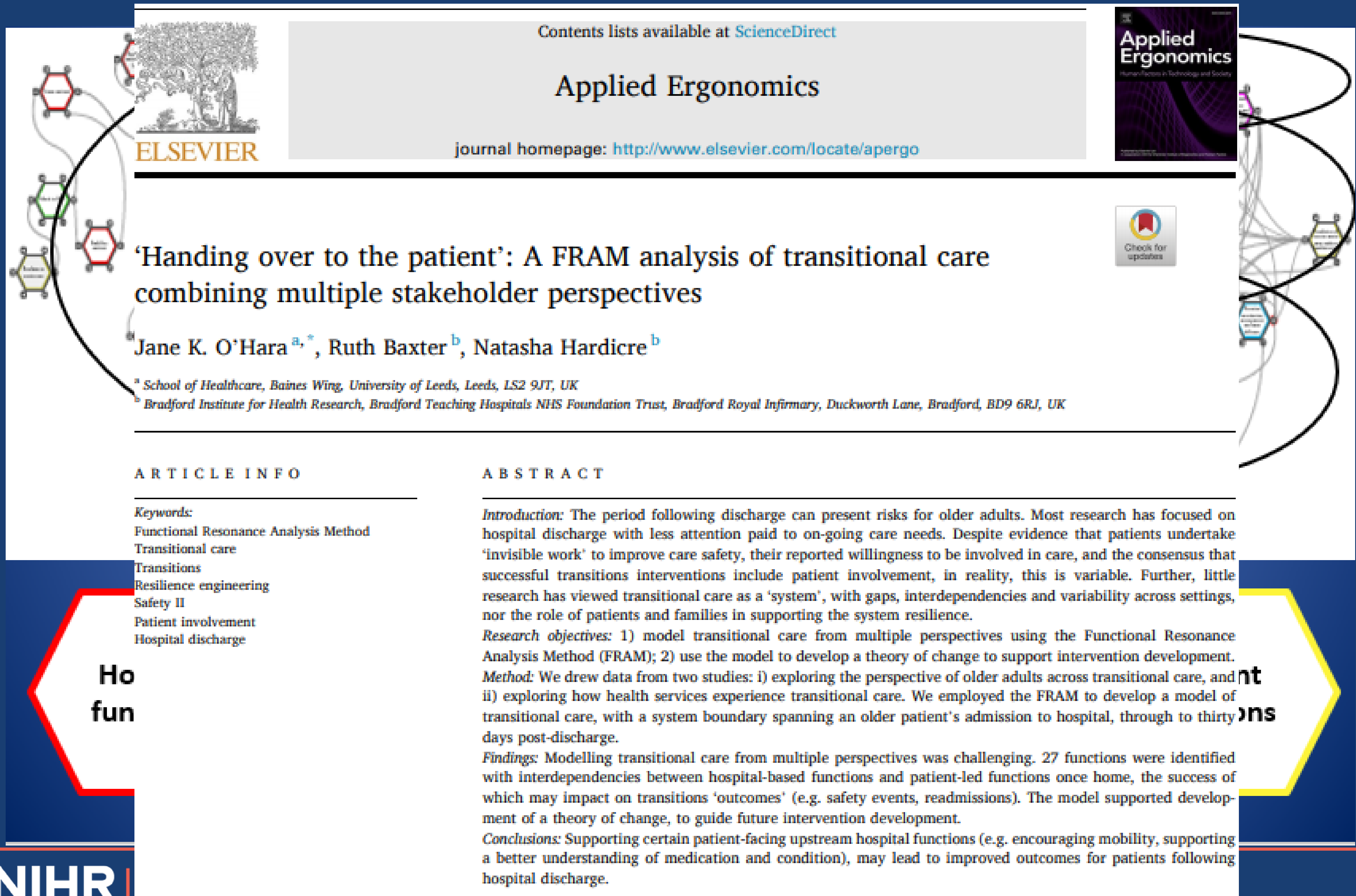
So, what do transitions look like?


Contents lists available at ScienceDirect

Applied Ergonomics

journal homepage: http://www.elsevier.com/locate/apergo

ELSEVIER

'Handing over to the patient': A FRAM analysis of transitional care combining multiple stakeholder perspectives

Jane K. O'Hara [a,*], Ruth Baxter [b], Natasha Hardicre [b]

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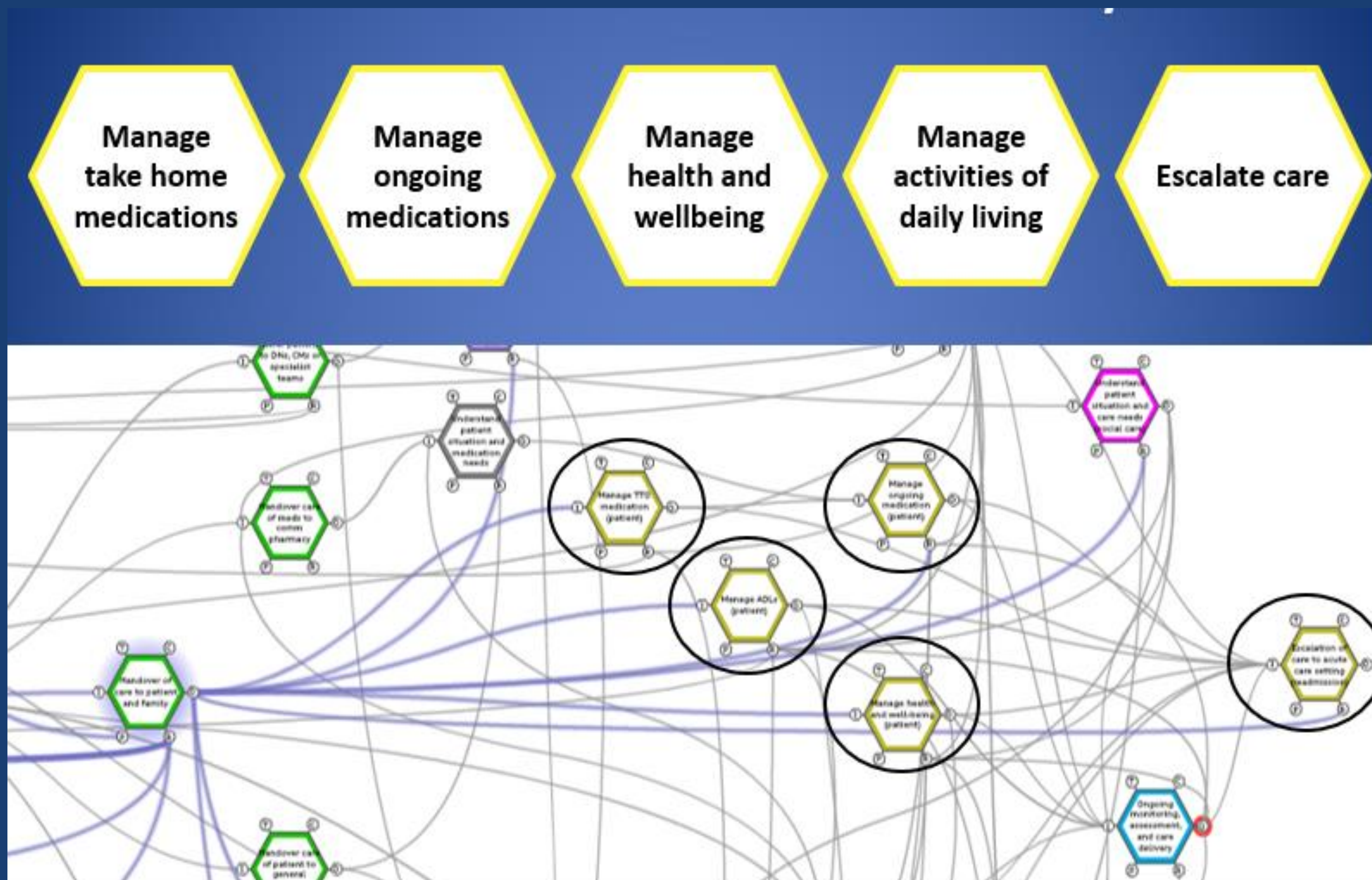
ARTICLE INFO

Keywords:
Functional Resonance Analysis Method
Transitional care
Transitions
Resilience engineering
Safety II
Patient involvement
Hospital discharge

ABSTRACT

Introduction: The period following discharge can present risks for older adults. Most research has focused on hospital discharge with less attention paid to on-going care needs. Despite evidence that patients undertake 'invisible work' to improve care safety, their reported willingness to be involved in care, and the consensus that successful transitions interventions include patient involvement, in reality, this is variable. Further, little research has viewed transitional care as a 'system', with gaps, interdependencies and variability across settings, nor the role of patients and families in supporting the system resilience.
Research objectives: 1) model transitional care from multiple perspectives using the Functional Resonance Analysis Method (FRAM); 2) use the model to develop a theory of change to support intervention development.
Method: We drew data from two studies: i) exploring the perspective of older adults across transitional care, and ii) exploring how health services experience transitional care. We employed the FRAM to develop a model of transitional care, with a system boundary spanning an older patient's admission to hospital, through to thirty days post-discharge.
Findings: Modelling transitional care from multiple perspectives was challenging. 27 functions were identified with interdependencies between hospital-based functions and patient-led functions once home, the success of which may impact on transitions 'outcomes' (e.g. safety events, readmissions). The model supported development of a theory of change, to guide future intervention development.
Conclusions: Supporting certain patient-facing upstream hospital functions (e.g. encouraging mobility, supporting a better understanding of medication and condition), may lead to improved outcomes for patients following hospital discharge.

Using FRAM to understand what the intervention needed to do?



The intervention target

Patients need to do four things at home:

Manage health

Manage medications

Manage daily activities

Escalate care

Supporting patients to **know more & do more by** 'reaching in'

Supporting staff to help patients to **know more & do more** by 'reaching out' so as to bridge gap

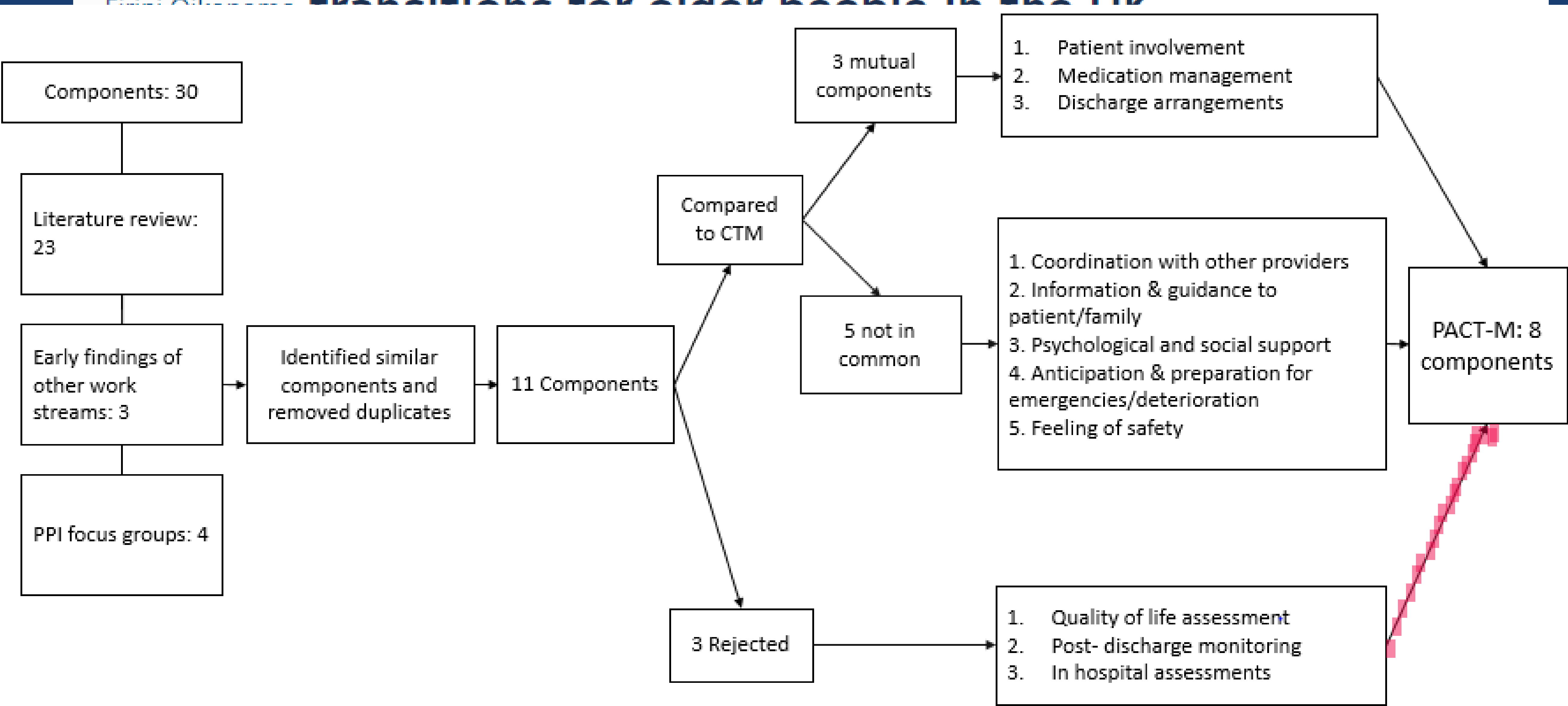
Measuring patient experience and safety at transitions (WP3)

Research article

Developi
transitio

Research article | Open Access | Published: 01 July 2020

Validation of the Partners at Care Transitions Measure (PACT-M): assessing the quality and safety of care transitions for older people in the UK



Methods

We used an es

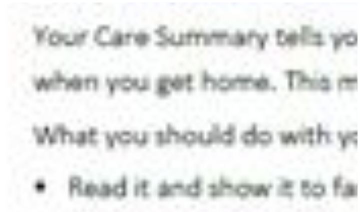
Methods

We administered the PACT-M over the phone and by mail, within one week post discharge

WP4: Piloting the intervention

Booklet to encourage patients to know and do more

No way of showing the film so staff rarely bothered



Staff felt uneasy about putting complex grey information into black and white

Doctors already completing discharge summary felt that this was an extra job they didn't have time for

Difficulty communicating information in a patient friendly way

Patients didn't always receive booklet

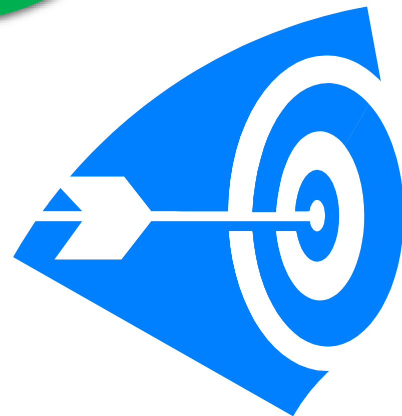
When they did they liked the content and found it useful staff didn't often refer to it and it got left on the side

Ward teams to encourage patients to know more and to practice in relation to four functions – left to vary

What we knew going into WP5 (the feasibility study)

- Co-design is not a neat linear process. A lot happens in between workshops and patients and staff involved outside of the co-design process (4 workshops)
- Some refinement of intervention components themselves necessary (going back to patients and carers)
- Staff are at capacity so intervention needs to align with goals and fit within current practice
- More work needed to raise awareness, generate motivation, remind and support staff to deliver intervention
- The PACT-M measure of experience and safety at transitions was reliable and had good construct validity

Trial feasibility study: ward level randomisation



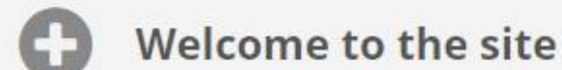
180/200 patients

- Can we recruit Trusts and wards & follow-up patients in timely way? ✓
- Can we collect data (primary outcome – unplanned hospital readmissions and patient level)? ✓
- What can we learn about trial set-up? – NEED LONGER
- What can we learn about the intervention & it's implementation? Move focus from delivering tangible components to addressing the functions

Contact us: PACT@bthft.nhs.uk

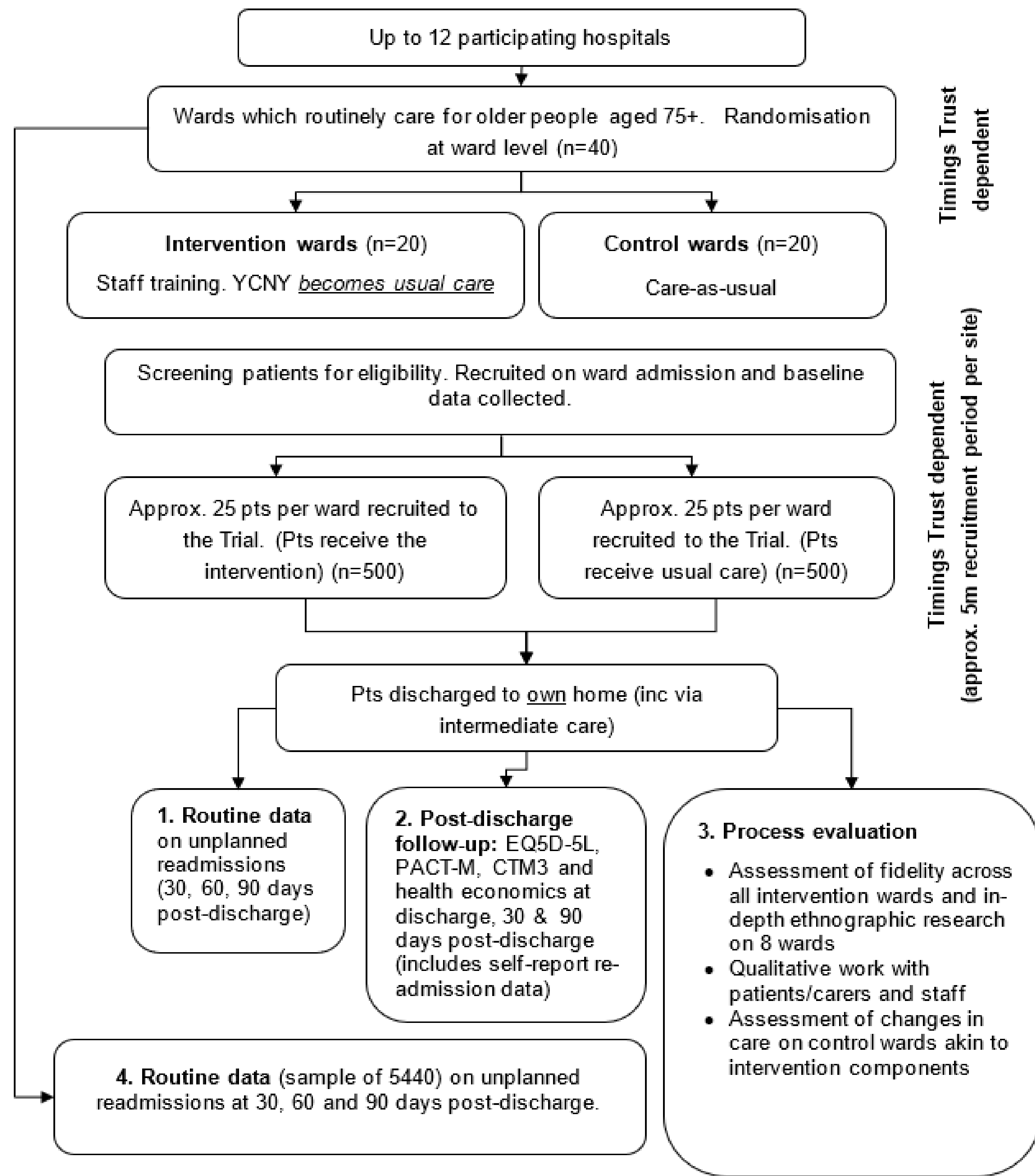
Preparing in hospital to manage at home

Helping you to help patients prepare for managing at home



Welcome to Your Care Needs You!

Our c-RCT



There are four resources

https://pact.yqsr.org/patient/

YCNY Training package

- Understanding what is meant by involvement
- Understanding what is looks like in hospital and what the staff role is in this
- Discussion of what staff can develop to support patient involvement in the four activities
- THEN…introduce the materials (avoid taskification)
- Ongoing support

cRCT (2021-2023)

11 NHS acute Hospital Trusts with 39 wards

613

4947

Follow-up, patient experience data

Routine readmission data

Findings

- Risk (odds) of readmission at 1, 2 & 3 months, not significantly different but all IN FAVOUR of intervention
- Total number of readmissions significantly lower in intervention group across 3 months (13% lower)
- Significant reduction in safety events at 1 month (not at other times)
- Intervention is cost effective
- Fidelity to intervention – low (pandemic)
- 77%-88% of patients found intervention useful / very useful

Learning

- Patient involvement can improve safety of transitions for older people
- It needs patients/families and staff
- We need a different way of thinking in which we plan for a safe return home
- **Experience** – patients experience an exit, not a transition
- **Ethics** - risk management in hospital (VISIBLE) vs risk management at home (INVISIBLE)
- **Equity** - not all patients want to or can be involved and capacity for involvement changes over time

Thanks for listening

on behalf of the PACT team – Jenni Murray, Laura Sheard, Catherine Hewitt, Jane O'Hara, Ruth Baxter, Robbie Foy……….

Contact me: r.j.Lawton@leeds.ac.uk

Find out more about our work at https://yqsr.org/