Optimising the transition from hospitals to nursing homes

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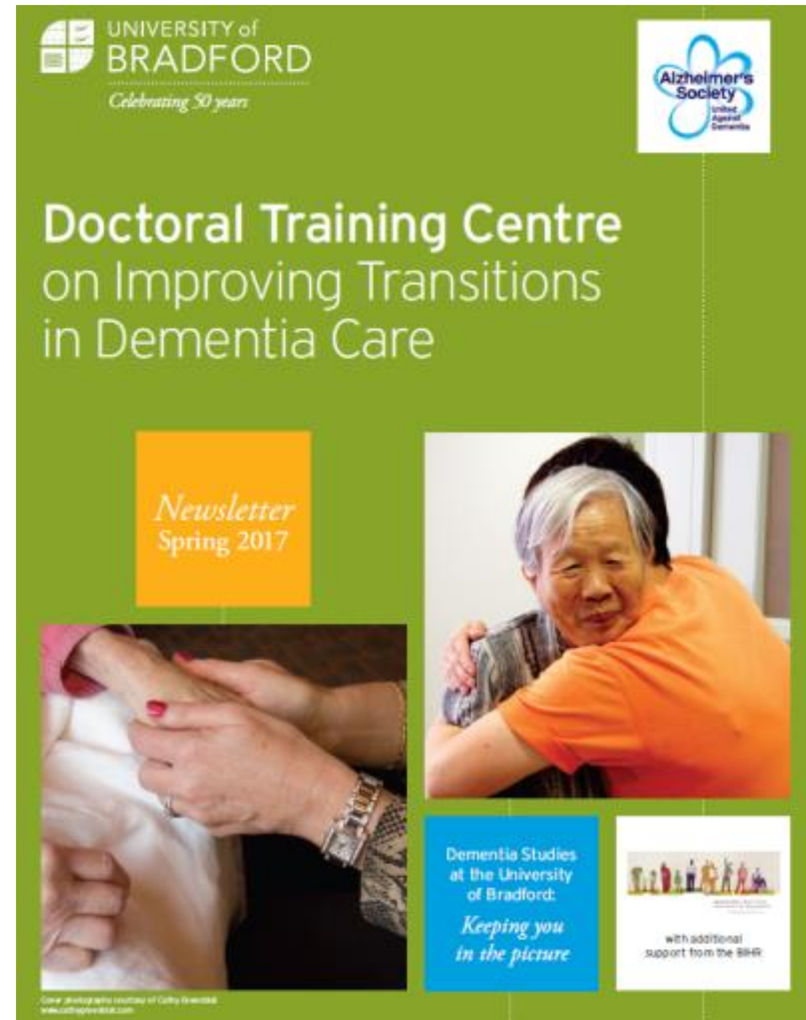

Acknowledgement

'This work was funded by Alzheimer's Society (UK) Doctoral Training Centre in Dementia Care grant 224, with support from Skipton Building Society and Malcolm Joyce in memory of his wife Jean'

My supervisory team

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Overview

- Problems in transitional care
- Research questions
- Method
- Findings
- Implications

What is transitional care

“a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location”

(Coleman et al. 2003:556)

This study is focused on transitional care for people living with dementia when they move between hospital and nursing home.

Problems in transitional care

What we already know

1. Poor transfers from hospital to care facilities

(*Digby et al; 2011; King et al, 2013; Caruso et al, 2014; Gilmore-Bykovskyi et al 2017, Kable et al 2017)*

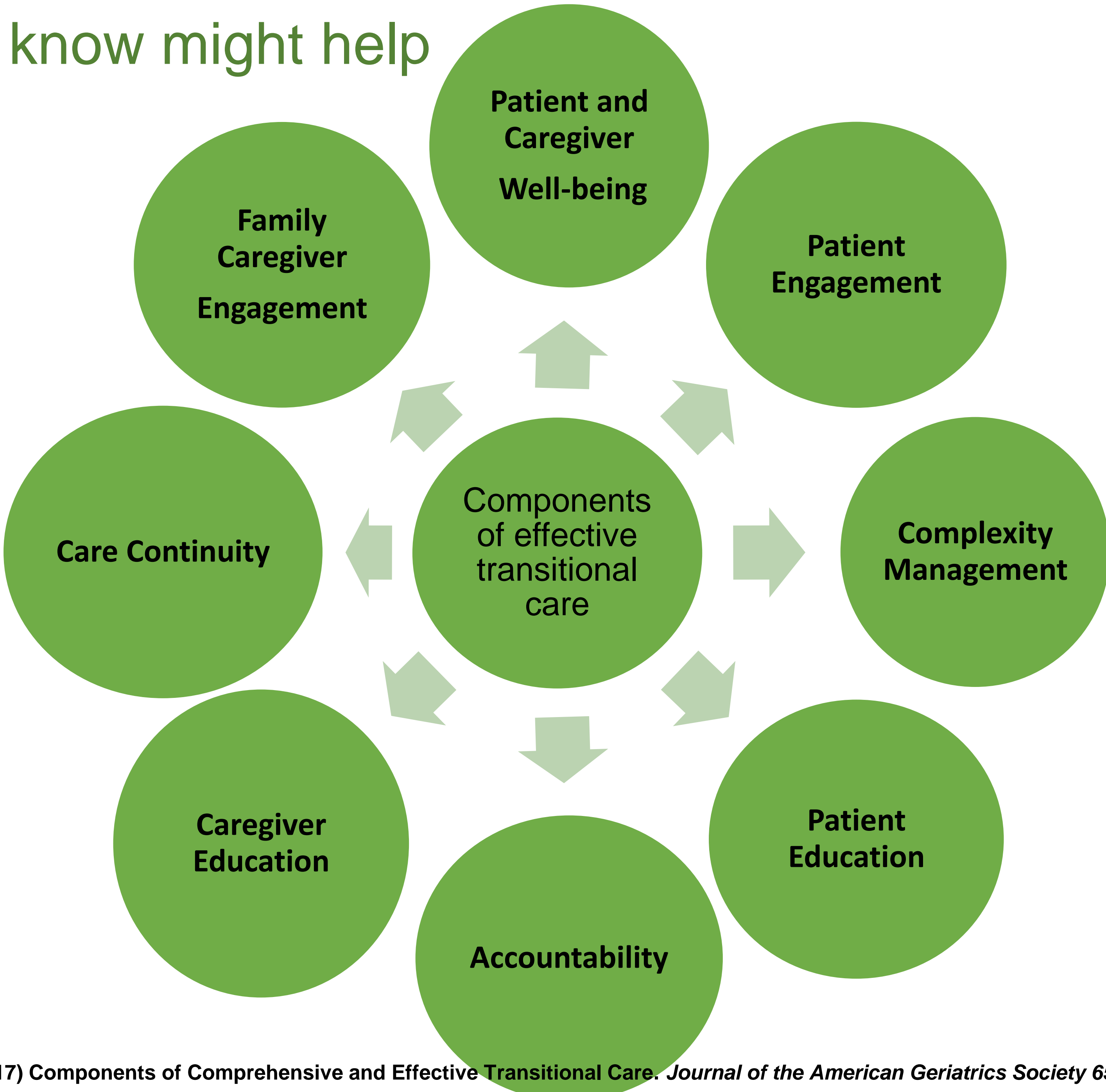
2. Negative outcomes for residents

- Lack of follow up tests and medicines review (*Caruso, et al 2014*)
- Delays in pain management, ambulatory care, re-hopsitalisation and individual and family dissatisfaction (*King et al 2013; Gilmore-Bykovskyi et al 2017*)
- High levels of resident distress, risk of falls, feeling unsettled and powerless (*Gilmore-Bykovskyi et al 2017; Digby et al 2017*)

3. Insufficient information – re resident's behavioural symptoms (*Gilmore-Bykovskyi et al 2017, Kable 2017)*

But this research comes mostly from US and Australia – limited research conducted in UK with a focus on people living with dementia in nursing homes

What we know might help



Naylor, M.D. et al. (2017) Components of Comprehensive and Effective Transitional Care. *Journal of the American Geriatrics Society 65 (6), 1119-1125.*

Research questions

1. How do hospital and care home nurses describe their role in providing transitional care for people living with dementia moving between hospitals and nursing homes?

2. To what extent do their perceived roles align with the components of effective transitional care (Naylor et al 2017)?

3. What do hospital and care home nurses describe as the facilitators and barriers for implementing their role to achieve quality care at transition?

Methods

Explorative qualitative study

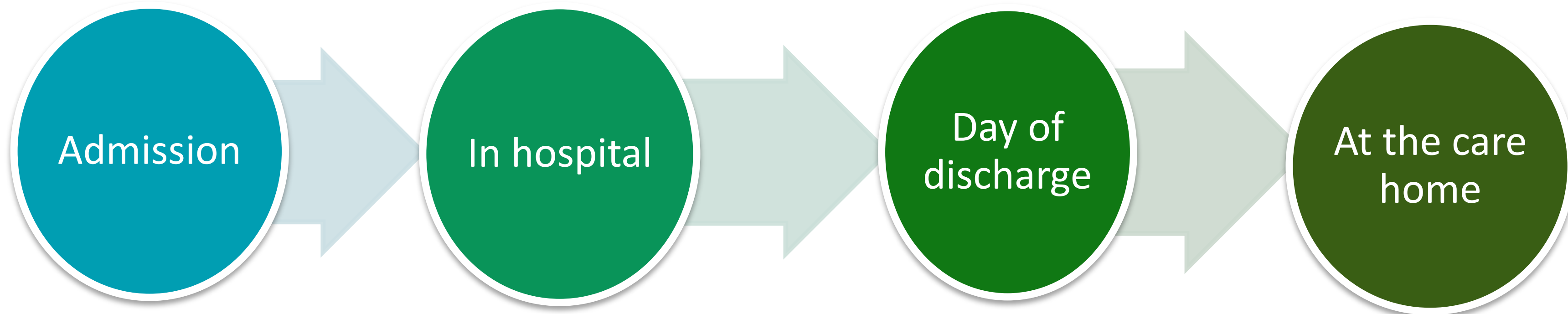
Sample
- 16 nurses from 2 Acute Hospital NHS Trusts
- 17 nurses from 4 nursing homes

Data collection
- Interviews
- Focus groups

Data analysis
- Deductive
- Inductive

Finding: Nurses' roles in transitional care

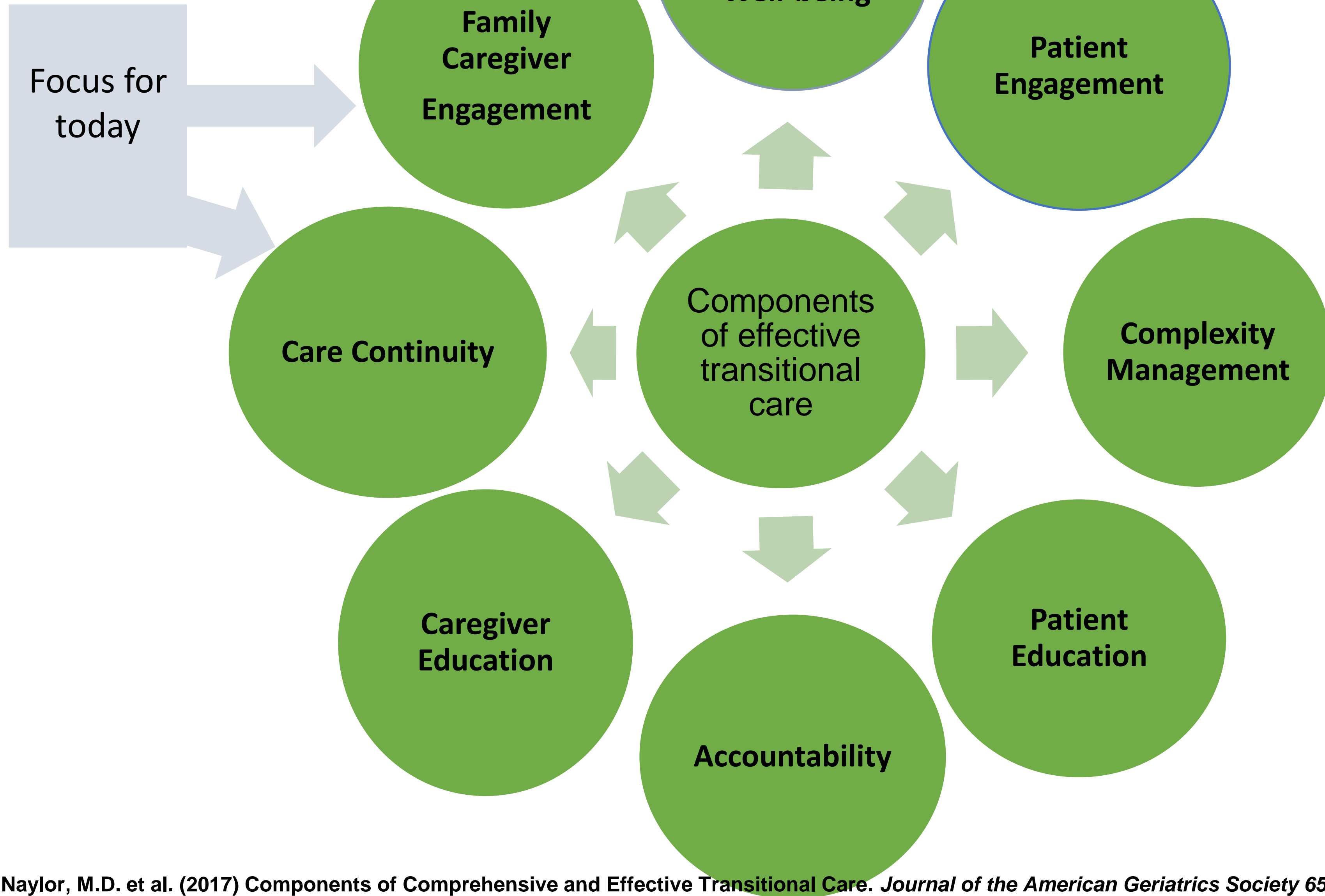
Start at admission and continues through resident being back in care home



"I think our main thing is that if you do the admission assessment correctly it always facilitates a smooth discharge…if you can identify what the person's needs are when they come in…you can anticipate any changes during the process while they are here…. The questions at discharge I think should come up early on in the admission"

(Hospital nurse)

Finding: Roles aligning to components



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Finding: Family carer engagement

Hospital and care home nurses agreed it was crucial to involve family throughout the transition

- in providing information
- physical presence on the day of discharge
- providing transport or acting as escort

"it's a stressful effect on them, it's change for them, hospital to nursing home, it's a big change.. so involving families can help in that condition… if they can bring them back, when they come back they can see a familiar face, it's home, the family giving them emotional support"

(care home nurse)

Finding: Nurses' roles in care continuity

Management Continuity	Information Continuity	Relational Continuity
Prepare comprehensive information which must include biographical and psycho-social information (Both nurses)	Coordinate the transfer of written communication (Both nurses)	Care home reassessment if required (Care home nurses)
Implement comprehensive care plans; (Both nurses) Coordinate follow-up referrals (Hospital nurses)	Pro-active nurse to nurse verbal handover (Both nurses)	Facilitating access to follow up care (Care home nurses)
Provide medication and any supplies (Hospital nurses)	Open lines of communication to clarify information after discharge/admission (Both nurses)	

Unclear information
"You may spend half an hour reading the paperwork but still doesn't tell you what you need to know, pilling through piles of discharge papers, charts at the end of it you still don't know what time someone's patch was changed, yesterday or the day before…."
(care home nurse)

Inaccurate and incomplete information
"We're finding that the information that's coming in is not very accurate and it's not always complete either. …the important stuff that we need to know, behaviour side of things…,"
(hospital nurse)

Insufficient care home education
"and they put a central line in, and sent him back with that. and, erm, you know, we, we weren't trained in that. So we would ask the district nurses to come in and do that, and then we had issues with the district nurses sort of moaning about having to come in and do this 'cause they were like 'well you've got registered nurses in the building' ".
(care home nurse)

Care home access to information
"the other thing I have noticed, there is usually a difficulty of releasing information. There's days like…… I've had trouble with, 'oh, we're not giving you that information, it's just next-of-kin to know this.' But I think we're just as equally important to know how our resident is…"
(care home nurse)

Care home excluded from discharge planning
"I think when they have these discharge meetings, we're not privy to when they are or not invited to them as part of that continuity…."
(care home nurse)

Care homes unable to make direct referrals
"..why can't we just ring them because for example they were seen by the SALT team in hospital and you may want to query something but you have to go through the GP again to get to the SALT team. Why? This resident is already on their list but no you have to go through the GP."
(care home nurse)

Summary

1. Hospital and care home nurses describe various roles in this transition, two have been described today relating to facilitating family carer engagement and providing continuity of care

2. Their perceived roles align with most of the components of effective transitional care (Naylor et al 2017)

3. Hospital and care home nurses describe the key facilitators to be good family engagement, good nurse to nurse communication, fostering working relationships and an understanding of settings. They cite key barriers to be the lack of integration between hospitals and nursing homes.

Implications

How can hospital and nursing homes share communication systems? (potential of red bag scheme)

How can relationships/understanding between nurses working in hospitals and nursing homes be better facilitated?

How can family carers be best supported in providing an active role in this transition?

thank you

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