



THE OLDER PERSONS' TRANSITIONS IN CARE (OPTIC) PROGRAM OF RESEARCH PARTICIPANTS' REPORT

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WORKING TOGETHER FOR

SUCCESSFUL TRANSITIONS



Dear OPTIC study participants,

The Older Persons' Transitions in Care (OPTIC) study would not have been possible without you – the front line staff at hospitals, long term care facilities, and emergency transport services. We are glad to be able to contribute to the success of care for the frail elderly by providing this booklet on the findings of the OPTIC study. We hope that you will find this booklet useful in your clinical practice.

One of the key findings of our study is a lack of communication and documentation across care settings. Our study shows that communication and successful care transitions are not disrupted by any one of the three care settings we examined (hospitals, emergency transport services, and long term care facilities). Instead, the “silo” effect within the health care system creates conditions for lapses in care even when each care provider competently adheres to best practices in their care setting. This is an important barrier to transition success that may be addressed by increasing avenues for communication between care providers in all facilities.

Guided by the findings of the OPTIC study and the Institute of Medicine Domains of Quality, we created a Quality Indicators for Older Persons' Transitions in Care tool (pages 7-8). This tool is meant to guide and inform clinical practice, communication, and documentation across the three care sites. We hope that you will find the Quality Indicators useful in your care of elderly long term care residents.

Greta Cummings

AT A GLANCE

The purpose of the Older Persons' Transitions in Care (OPTIC) study was to:

1. Identify successful transitions from multiple perspectives.
2. Identify organizational and individual factors that influence the success of transitions.
3. Ultimately, to improve quality of care for frail older adults who reside in LTC.

From 2009-2014, research was conducted in the Central Okanagan district of the Interior Health (IH) region in **British Columbia** and the Edmonton Zone of Alberta Health Services (AHS) in **Alberta**. We used a mixed methods approach to collect and analyze data from both secondary and primary sources.

Phase 1. In the first phase of the study, qualitative methods were used to investigate multiple perspectives on Long Term Care (LTC) to Emergency Department (ED) transitions. Semi-structured face-to-face interviews with more than 71 stakeholders (residents and families, healthcare practitioners, and managers/administrators) were used to identify key elements of transition success.

Phase 2. In the second phase, the study tracked 637 residents transferred from LTCs to one of two EDs in British Columbia and Alberta over a 12-month period. We collected more than 800 data elements on each of the 637 transitions in care we tracked.

The findings of this study have led to four main contributions. The large-scale data collected in this study provided in-depth **descriptions of transitions**, including the conditions of residents before, during, and after their transition to the hospital. These descriptions illustrated the **conditions that make for successful transitions** from long-term care facilities to the emergency department, and they also **indicated the current issues** that can impact transitions. These issues include gaps in communication, documentation, and dialogue between the long-term care facilities, emergency transportation services, and emergency departments. Our findings led to the creation of the **OPTIC Success Quality Indicators**.

The Older Persons' Transitions in Care (OPTIC) study was financially supported by:



TRANSITION STEPS

LONG TERM CARE FACILITY
CHANGE IN HEALTH STATUS
DIAGNOSIS AND TREATMENT
DECISION TO TRANSFER TO ED

EMERGENCY TRANSPORT SERVICES
ETS ASSESSMENT
TRANSFER TO HOSPITAL
TRIAGE SCORE (CTAS) APPLIED

EMERGENCY DEPARTMENT
ED ASSESSMENT
TREATMENT
DECISION TO ADMIT/RETURN

LONG TERM CARE FACILITY
POST-TRANSITION CARE



KEY FINDINGS

1. There were large gaps in documentation and communication between long term care facilities, emergency transport services, and emergency departments.
2. Successful transitions involved care that was resident-focused and family-focused.
3. Health outcomes were worse when family members decided the resident should be transferred to the ED (as happened in approximately 10% of cases).
4. Family members, caregivers and physicians were not well informed about the resident's location and disposition throughout the transition.
5. Care providers across sites believed that many transitions were avoidable but disagreed on which ones could have been avoided.

QUICK STATS (JULY 2011-JULY 2012)

Documents sent from LTC to ED	AB (%)	BC (%)
Patient summary leading to transfer	35	39
List of diagnoses	15	22
Record of allergies	90	65
Medication list	87	83
DNR order	68	72
Patient care plan	26	24

Documents sent from ED / Inpatient Unit to LTC	AB (%)	BC (%)
Record of allergy	54	7
Patient care plan	46	1
Medication list	46	47
Transfer record	45	32
ER records	30	4
Physician communication	23	18
No documents	0	15

The top 3 events leading to a decision to transfer from **Long Term Care facilities** are:

1. Falls
2. Sudden change in condition
3. Shortness of breath

No significant difference was found between the **number of transfers** made on different days of the week. Similarly, no significant difference was found between different times of the day.

The top 4 diagnoses in the **Emergency Department** were:

1. Pneumonia
2. Urinary Related Diseases
3. Sepsis
4. Heart Failure

Half of the residents transferred (56%) were **admitted to the inpatient unit at the hospital**. Nearly half (43%) of those who were admitted had no physical procedures performed (e.g. scopes, laceration repair, catheterization, thoracentesis, electrical cardioversion).

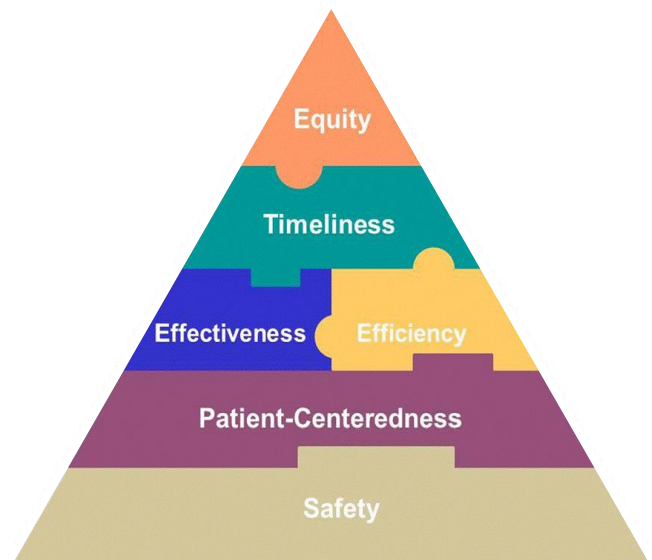
17% of residents returned to the LTC with new skin injuries. 26% of residents did not return to **pre-transfer level of function** within a week, in the view of the LTC nursing staff.

In 96% of cases, resident belongings and assistive devices – such as glasses, hearing aids, dentures and canes – were not documented or tracked across their care transitions.

INSTITUTE OF MEDICINE DEFINITIONS FOR DOMAINS OF CARE QUALITY, ADAPTED FOR OLDER PERSONS' TRANSITIONS IN CARE

Institute of Medicine Domains of Quality *

- **Safe:** Avoiding harm to patients from the care that is intended to help them.
- **Patient-Centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.



* Committee on Quality of Health Care in America: Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C; 2001.

Definitions of Domains of Quality for Older Persons' Transitions in Care

- **Safe:** Actions cause no unnecessary harm.
- **Resident-Centered:** Actions informed by knowledge of and respect for diversity, as well as the resident's values, choices and needs.
- **Effective:** Actions that align best available evidence with optimal outcome.
- **Efficient:** Actions which cause no overuse or underuse of resources.
- **Timely:** Actions resulting in no unnecessary or unwanted delay.
- **Equitable:** No bias associated with access to continuum of care.

The OPTIC definition of **successful transitions** - *A successful transition is a coordinated set of actions that optimize safety, resident centeredness, effectiveness, efficiency, timeliness and equity, across the entire transition.*

Cummings et al . BMC Ger, 2012, 12:75

STANDARDS FOR OLDER PERSONS' TRANSITIONS IN CARE



SAFE

- 1) Handover communications among healthcare providers allow for efficient transfer of care between and across healthcare settings.
- 2) Health care providers in each setting have access to essential information/documentation.
- 3) Health care providers in each setting complete medication reconciliation.



RESIDENT CENTERED

- 1) Health care providers are knowledgeable and respectful of resident needs, functional abilities and care preferences. Goals of care (advance directives, do not resuscitate orders) are sent across the transition and followed.
- 2) The resident's assistive devices (eyeglasses, dentures, hearing aids, etc.) are available to the resident at each stage of the transition. The resident's need for assistive devices is documented and the documentation is easily accessible.
- 3) Family/primary contact is meaningfully involved in the transition. Family/primary contact is notified of key points along the transition.



EFFECTIVE

Best practices are applied to meet the resident's care needs in each setting. Resident returns to their residential long term care centre in an improved state.



EFFICIENT

Resources (personnel, equipment) are used to minimize cost and maximize benefit to the resident.



TIMELY

No unnecessary delays in care (across entire transition).



EQUITABLE

Health services received by the resident are not affected by factors other than their medical need and care preferences. Sex, age and/or a dementia diagnosis have no effect on the timeliness of treatment.

QUALITY INDICATORS FOR OLDER PERSONS' TRANSITIONS IN CARE

LONG TERM CARE FACILITY

When an event necessitates transfer:



- Handover documentation on resident history, allergies, medication, and reason for transfer.



- Consult with family/primary contact to discuss need for transfer.
- Handover goals of care (e.g. advance directive, do-not-resuscitate order) and documentation of assistive devices accompanying the resident.



- Ensure the resident is assessed by a physician/nurse practitioner prior to transfer (assessment within at least 7 days prior to transfer).



- Time from trigger event to decision to transport does not exceed regional standard.



- Ensure that only the resident's medical needs and care preferences influence who makes the decision to transfer (e.g. physician, family member), and the timing of the transfer.

EMERGENCY TRANSPORT SERVICES



- Handover information on resident history, allergies, medication, and reason for transfer.



- Handover goals of care (e.g. advance directive, DNR order, Goals of Care Directive) and documentation of assistive devices accompanying the resident.



- Apply best practices to ensure the resident's condition does not deteriorate.
- Monitor and document cognitive status, assessing for onset of delirium.



- Transport the resident by emergency transport vehicle with two staff.



- Total transport time does not exceed regional standard.
- Time from initial call to departure from long term care facility (LTC) does not exceed regional standard.



- Ensure transport is based solely on resident's medical need and care preferences.

EMERGENCY DEPARTMENT



- Perform medication reconciliation to ensure emergency department (ED) list is the same as other documentation.
- Ensure you have received information on the resident's baseline cognitive status, history, allergy information, medication list, and reason for transfer.



- Consult with family/primary contact on resident's condition/disposition.
- Handover goals of care (e.g. advance directive, DNR order, Goals of Care Directive) and documentation of assistive devices accompanying resident.
- When the resident is returning to LTC, call the LTC to notify LTC staff.



- Monitor and document cognitive status, assessing onset of delirium.
- Ensure resident has no new wounds on discharge from hospital.



- Ensure that time from consultation request to time of consultation does not exceed the hospital standard.



- Assess and treat resident within CTAS score recommended times.



- Time between arrival at ED and being seen by physician is based solely on the resident's medical need and care preferences.
- Ensure that the resident's care is based solely on resident's medical need and care preferences.



- Collect all documentation needed to resume care for the resident (patient care plan, record of allergies, medication list, transfer and ED records, discharge instructions).
- Perform medication reconciliation within 12 hours of resident's return.



- Inform family/primary contact and physician of resident's return to LTC.
- Review/revise care plan based on assessment/acute care information.
- Collect goals of care and assistive devices accompanying the resident.



- Monitor and document cognitive status, assessing for onset of delirium.



- Note changes in clinical status and cognitive status from pre-transition.



- Perform clinical and cognitive assessments within 12 hours of resident's return.

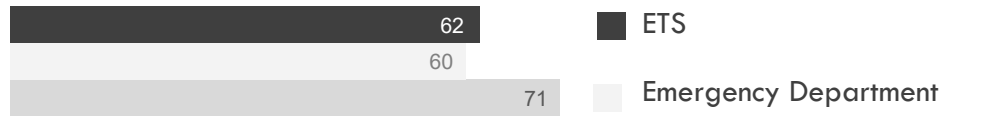


- Time to complete clinical assessment is based solely on resident's medical need and care preferences.

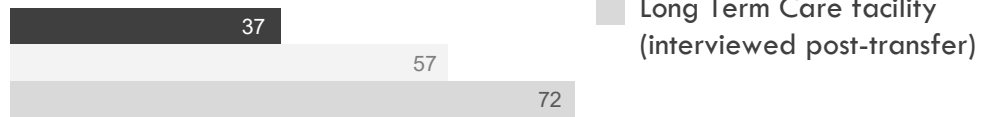
LONG TERM CARE FACILITY

INCONSISTENT COMMUNICATION

% of staff that agreed they received sufficient *written* information to care for the patient.



% of staff that agreed they received sufficient *verbal* information to care for the patient.



% of staff that were clear on the nature of the patient's condition based on all information provided.



There was high variation in the type of documentation sent with the resident from the LTC upon their departure and the documentation received by the LTC from the ED or inpatient unit upon the resident's return.

There are large differences between the documents sent by EDs back to the LTCs in Edmonton and Kelowna. In particular, LTCs in Edmonton were more likely to receive the ED records, patient care plan, and

the record of allergies when the resident returned from the ED.

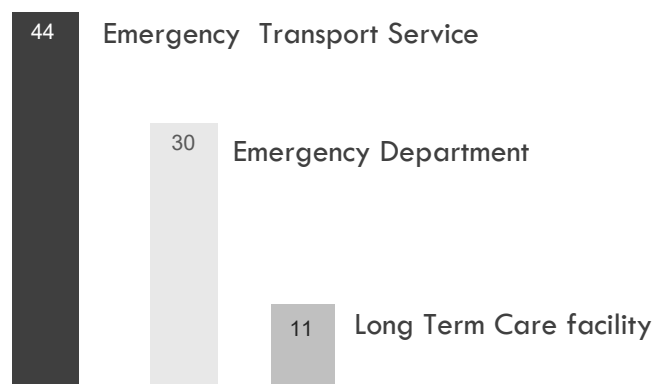
The discharge instructions received by LTCs in both cities contained details of the resident's diagnosis and management plan in 73% of cases. The discharge vital signs were provided in the discharge instructions in only 22% of cases.

AVOIDABLE TRANSFERS

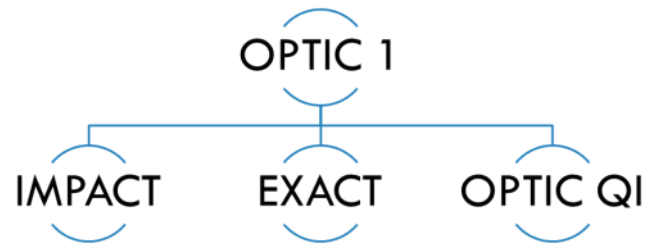
As we analyzed each of the 637 transitions in Edmonton and Kelowna, we asked 805 healthcare providers representing each care setting (436 in LTC, 149 in ETS, 220 in ED) if a particular transition could have been avoided. In 161 cases, at least one healthcare provider identified the transfer as avoidable.

However, there was little agreement among the providers, with only two transitions considered avoidable by providers from all three settings. It is clear that healthcare providers have varying understandings of what makes a transition avoidable or appropriate. ETS staff were the most likely to consider a transition to be avoidable and LTC staff were the least likely.

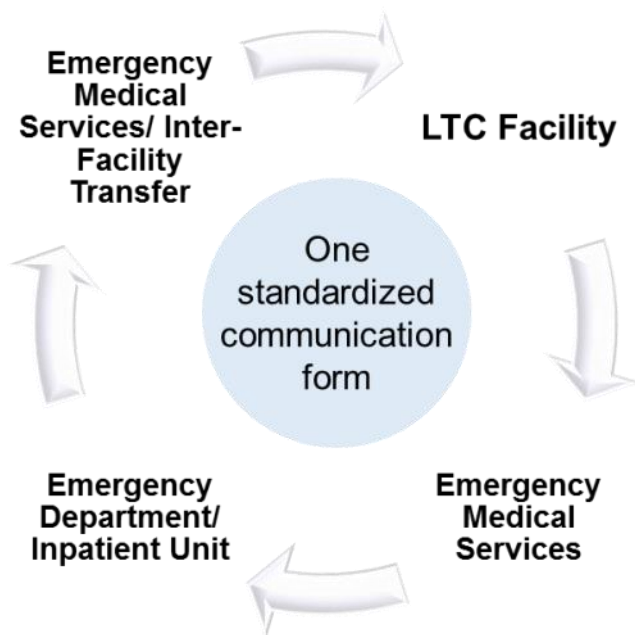
Percent (%) of staff, interviewed post-transfer, that believed the resident's transfer could have been avoided.



The OPTIC research team's findings have led to the development and funding of three more OPTIC studies: IMPACT and EXACT (below), and most recently OPTIC QI (a Systematic Review on Quality Indicators for Older Persons' Transitions in Care).



IMPACT: IMPROVING COMMUNICATION



A key finding of the OPTIC project is the need for standardized documentation across all settings. **OPTIC IMPACT** (IMProving communication during Aged Care Transitions) investigates the effectiveness of using a standardized two-page evidence-informed Inter-Facility Patient Transfer Form to improve communication of care information for long term care residents transferred to the emergency department by Emergency Transport Services and returned to their residence.

This project is funded by a CFN (Canadian Frailty Network) Catalyst Grant.



Canadian
Frailty
Network

Réseau canadien
des soins aux
personnes fragilisées

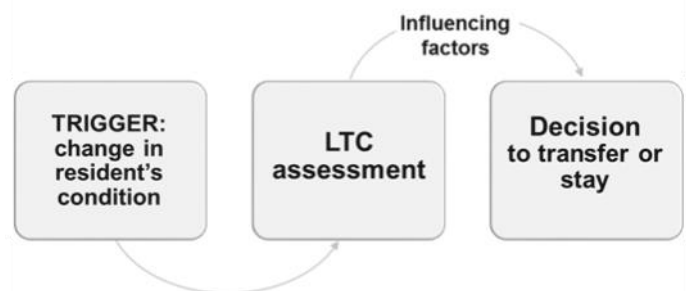
EXACT: EXAMINING TRANSITIONS

In the OPTIC program, we found that while healthcare providers agreed that many transfers were necessary, others could have been avoided. **OPTIC EXACT** (EXamining Aged Care Transitions decision making) explores attributes of avoidable transitions and factors influencing decisions to transfer LTC residents to emergency departments in ambiguous cases. The outcomes of this study will be decision-making guidelines for healthcare leaders and LTC staff.

This project is funded by:



Covenant Health
Network of Excellence in
Seniors' Health and Wellness



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