Continuing Care Fall Forums 2019
Discussion RESULTS: Improving Care Transitions

Participants were invited to discuss information transfer needs and suggestions for improvement specific to different care transitions. Not all care transitions were discussed and in some cases only one or two groups talked about particular transitions. This summary report includes the most commonly discussed care transitions and highlights sample comments made within each that are reflective of the range of input provided.

The transitions and concepts included in this report are:

HOSPITAL to HOME CARE – Initial Client

1. What information is a must have for this transition?

- Any information that has been covered with client/family; lack of info causes nurses to ask redundant questions which is frustrating for clients.
- Correct/accurate information (i.e. name address, contact numbers); as much information as possible about patient, diagnosis, past medical history, treatment while in hospital, involvement with other teams (Social Worker, Dietitian, OT/PT) ; clear and concise physician orders.
- Same information acute care staff would share with one another should be provided to home care staff.
- Safety issues in home
- What supports are available to client; is clinic setting appropriate?

2. What can NSHA CONTINUING CARE do to facilitate improved information transfer and when should this happen in the process?

- Clear, complete, comprehensive orders; history of hospital admission summary report
- What needs are necessary for discharge and what services are able to start at a later date?
- Agency involved in care conferences/discharge planning
- Setting up the expectations with family as to what to expect. Consider literacy level of patient.
- Risk screening and challenging behaviours to be shared in care plan.
- Streamline a means of having discharge summaries sent to nursing/[home support] at time of new referral. Especially relevant if [home care staff] are in before [Care Coordinator].

3. What can SERVICE PROVIDERS (identify home care, long term care or others) do to facilitate improved information transfer earlier in the process?

- Request any missing information as soon as noted.
- Home care attend multi-disciplinary meetings, [patient] rounds, develop relationship with colleagues in acute care. Early conversations, understanding each other's roles is paramount – collaboration.
- Flagging to community Care Coordinator issues in home or other concerns.
- Call/follow-up with any contraindications. Make phone contact with referral source.

4. **What can OTHERS (e.g. other NSHA program areas) do to facilitate improved information transfer earlier in the process? (Please specify who.)**
   - Education within acute care system about community based care (ex: when VON chart goes to hospital with client, no one knows what becomes of the chart. It is a legal document.)
   - One patient, one record! Systems that speak to each other. Different levels of access.
   - Avoid giving client too much info at once as they are overwhelmed.
   - Allow professionals RN/LPN/OT/PT/RT to work to full scope of practice and give them access to the info they need to do it!

HOSPITAL to LONG-TERM CARE – Initial Resident

1. **What information is a must have for this transition?**
   - Appropriate financial information
   - Medical status report
   - 2 week resident review - progress notes, doctor's notes, Kardex, diagnostics - current care plan
   - OT/PT assessment if equipment needed
   - Appropriate reporting of behaviours and history of interventions trialed
   - [Medication reconciliation] updated
   - Power of Attorney/Substitute Decision Maker
   - Consistent information and level of detail (standardized package)
   - Removal of barriers related to privacy and sharing of information
   - Accurate, timely, history of person, culture, LGBTQI+
   - Medication accessibility/costs (reconciliation at least 24-48 hours prior to get authorization), wound care (current treatment, costs, discharges), clear understanding of "medically stable".

2. **What can NSHA CONTINUING CARE do to facilitate improved information transfer and when should this happen in the process?**
   - Transparency of information
   - Getting most information with the initial admission package
   - Earlier access to documents
   - Improved processes to access supplies, especially special products
   - LTC is in the circle of care, and all information needs to be provided.
   - Start educating families on LTC and expectations once they reach out to Continuing Care. CC LTC Liaison navigator (establish these).

3. **What can SERVICE PROVIDERS (identify home care, long term care or others) do to facilitate improved information transfer earlier in the process?**
   - LTC: clarification around what the LTC facility needs to accept new client - what supports may be required.
   - Ask questions. Review documentation.
   - Agreed upon standard and expectation regarding risk tolerance; hold accountable and work with outliers.
   - LTC facilities to provide a checklist of information required for admissions and why.

4. **What can OTHERS (e.g. other NSHA program areas) do to facilitate improved information transfer earlier in the process? (Please specify who.)**
   - Acute care: transparency of client needs, equipment needs
   - Different physician models and changing staff can create challenges in preparing information for transition.
   - Process based on people and relationships, not standardized tools.
   - Address equipment barriers, complex clients and develop enhanced care plans in hospital; equipment purchases in hospital and transition to facility.
   - Treatment or tests completed while in hospital. Do not wait until they are admitted to LTC. Share any info or consults of EACH.

HOSPITAL to LONG-TERM CARE – Existing Resident

1. **What information is a must have for this transition?**
   - Nurse to nurse communication
   - Discharge summary is complete and accurate
   - Would be helpful to actually be able to speak with nurse before an existing resident returns.
   - Starter doses of a new medication until next business day of rural pharmacy
   - More time or notice before discharge (i.e. meds, equipment needs, dietary requirements or accessibility)

2. **What can NSHA CONTINUING CARE do to facilitate improved information transfer and when should this happen in the process?**
   - Consider resources/financial of residents; there is a huge difference [in] medication costs coverage in LTC.
   - If nursing needs are required, the hospital doctor initiates that before patient transfer; referral to [nursing] services done and the facility gets the case, they will send someone the first day it is needed.

3. **What can SERVICE PROVIDERS (identify home care, long term care or others) do to facilitate improved information transfer earlier in the process?**
   - Clearly define what they need and when; express what resources have to be in place or access to (staff, equipment, etc.).
   - Standardized packages for sharing of information.

4. **What can OTHERS (e.g. other NSHA program areas) do to facilitate improved information transfer earlier in the process? (Please specify who.)**
   - More input from physio, OT, and other providers of care.
   - Hold people accountable for communication gaps.

COMMUNITY to LONG-TERM CARE

Summary Note: There were a number of references to the need for a provincial transfer tool to be used to support transitions from the community to long-term care facilities, similar to the one currently used for inter-facility transfers.

1. What information is a must have for this transition?

- Progress notes from the care plan
- Outside consults/references, collateral information from families
- Client needs vs. client wants
- Complete assessment on client, Medical Status Report (MSR), financial
- OT or any other services, equipment in place to follow client
- Form 1 - Personal Directive, med list from pharmacy signed by doctor
- Insurance/Pharmacare coverage, client home routine, emotional triggers
- Appropriate paperwork, decision making information, medication list, story of the person/social history, up to date and complete info, current home routines.

2. What can NSHA CONTINUING CARE do to facilitate improved information transfer and when should this happen in the process?

- Start well in advance; be proactive in planning for clients' needs, not crisis driven.
- Implement provincial transfer tool [for] community transfer.
- "So you have been accepted to LTC" with placement letter – information sheet and response times
- If information is mismatched (different info on MSR and service plan) - resolve discrepancies
- Better communication with clients/SDM/family. Share how the system works.

3. What can SERVICE PROVIDERS (identify home care, long term care or others) do to facilitate improved information transfer earlier in the process?

- Advance contact with home care provider, i.e. wound care.
- Clarify confidentiality issues to facilitate transitions between home care to LTC.
- Interprofessional communication between agencies, provide their own summary related to care of client.
- Share info about the client in the home environment.
- Transition of the transfer of information into a care plan, working collaboratively with NSHA and other care providers to develop standardized information sharing.

4. What can OTHERS (e.g. other NSHA program areas) do to facilitate improved information transfer earlier in the process? (Please specify who.)

- Electronic health records
- Equipment needs - coordinate community resources
- Reduce gaps for equipment (Red Cross, etc.)
- Sometimes issues with rates and documents can cause holdups.

SHARING INFORMATION IN ADVANCE OF A BED OFFER

Additional discussions also explored the concept of providing client information to long-term care service providers in advance of a bed becoming vacant. Specifically, for community clients with only 1-2 preferred facilities, NSHA would send service providers the information package for the next 2-4 individuals on their wait list in advance.

Should NSHA share information in advance if an individual has more than 1 preferred facility? Please explain why or why not.

Summary Note: Opinions were divided on this concept. Below are sample comments reflective of general input in each category: mostly supportive, mostly oppose, and neutral or general comment.

Yes/Mostly Supportive

- Yes, not all information needs to be shared. An opportunity to meet the staff, see the facility would be beneficial to families.
- Yes - electronic list. Further discussion on how much/what level of information.
- YES!! Helps to plan, meet families prior to placement, explain admission expectations.
- Some facilities are never preferred facilities but can still benefit from having the information if likely to end up there. Placement office knows this anecdotally.
- Behaviour information and functional assessment would be appreciated.
- Yes. It would save time; gives time to set up needed resources, equipment, answer questions and get questions.
- Yes, knowledge is beneficial. We could better prepare to accept the potential resident for admission. It would assist in providing person centered care.
- Yes better planning options - not always a scramble to accommodate.
- Expedite [placement] of person into appropriate bed if LTC facilities were knowledge about the potential people waiting on the list.
- Yes. This will help to get individuals to get a facility faster. Will also help with placement if for example person has dementia and the facility is not equipped to handle this.
- Yes - helps facility prepare and determine fit and appropriate placement.
- [Only if] preferred home, then send the info. Challenges if more than one, it would be time consuming. May not save time if status of resident changes.

No/Mostly Oppose

- NO - I do not feel there is efficiency to look prior. Clients change so quickly from week to week.
- From a privacy perspective, there would be significant concerns and ability to remove/discard client files.
- No. Waste of time, breach of confidentiality, too time consuming
- No - it would complicate the process. No staff resources for this; profiles would become [obsolete].
- No - concerns contacting families when a bed is not vacant, too many changes, can't do extensive history in that time, lots of extra work (labour intensive)
- No time to review all the packages when there is no bed, no advantage to it, discrimination, preference making by LTC home.

Neither Positive or Negative and General Comments

- Not sure how this could be done around Circle of Care
- Minimal amount, respect confidentiality
- AP and P2 clients would throw a wrench into plans
- Family need to give consent to send information to 2-3 facilities
- Knowledge is beneficial to provide the appropriate plan of care. Certain facilities may accommodate different clients.
- Consent from client - how much information needs to be shared
- Appreciate need but need a way to deal with privacy, availability, acceptance, results, expectation.
- Resource pressures, expectation of facility/family
- What does the information package consist of – would need a more condensed version that extracts pertinent information/data.

What information do LTC Service Providers need in advance to support their decision making processes and preparation work with individuals and families?

- Financial - issues
- Assessment of equipment (if needed)
- Current care information; normal placement package, financial information, POA/SDM to allow family finance meeting prior to [admission], helpful for families to process information, any specialized equipment, dietary needs.
- Behaviours are essential - we need to know how to support the resident
- Accommodation charges
- Pharmacare? Meds not covered
- Last ER, physician visits, consult reports, medication lists and med changes. Infection control information - flu vaccine, pneumonia vaccine, allergies, care needs, etc.
- Capacity - delegate/SDM, behaviours, mobility, mini mental, toileting, code status
- Up to date information (medications); full disclosure and only send updated forms not the whole package again.
- Care plan, consults, most recent info, disclosure of financial complications, 1 person/1 system to see all data, info, sharing.
- Safety issues, complex care management plan, special patient program, pediatrics, custody/child protection orders/DNR order, agencies/professionals involved, [Department of Community Services], home care.
- Accurate and timely history, longer time for transition, expectations of LTC for families (clothing, food, furniture, etc.), family info prior to move to LTC (habits, etc.)

If home care (home support and/or nursing) services are in place, would information from these agencies related to these services/experience be of value to LTC Service Providers? If yes, please identify what type of information would be most helpful.

- Risk assessment available
- Discharge tool from home care i.e. nursing, even home care
- YES!! Service plan; documentation on behaviours/challenges, strategies that work. Family dynamics.

- Absolutely - what is the day like for this individual? We have no idea what 'little' things may create a problem.
- YES!! Wound care, treatments; current assessments, care directives
- Yes, collateral information, care plan, routine
- Once accepted to facility, having a complete "care picture" including input from all members of the team would be advantageous and promote better outcomes (care and safety).
- Yes, if home care involved - what do they do, what does care look like? Care Coordinator may not know specifics (medication routine), people providing care in home.

How far in advance of a potential bed offer should NSHA share this information with LTC Service Providers?

Summary Note: A range of time frames were suggested, ranging from 2-3 days up to 4 weeks, as well as suggestions that it should be informed by the place on the list vs length of time.

- Not a function of time but a function of placement on the list. Could be on the facilities request, i.e. two residents are palliating…send me an idea of who the next few on the list are.
- Next person on the list so when I declare a bed, I already know what supports are required.
- NSHA should share their information of the next 2 clients to be placed.
- Variable - depends on the complexity of the resident
- At least one week to ensure medical orders are in place, getting meds ready, info to resident and family.
- If you can accommodate care needs 2-3 days; if more complicated 4-5 days (equipment, education needs)
- When the bed becomes available. No point in having it before.

Do you support this approach? Please explain why or why not. If you agree, what outcomes do you believe this approach will achieve?

Summary Note: Opinions varied; sample comments and suggested outcomes below.

Yes

- YES - better transition for resident, family, staff; more lean process; better prepared
- Yes. Better flow for patients and system.
- Smoother transitions. Families more comfortable with transition if client and family info shared earlier in process.

No

- Waste of time reviewing someone who may not come, confidentiality.
- No. Best and most accurate information is at the time of bed vacancy.

Other Comments

- Patient Flow is impacted by lack of information.
- May need to pilot this to see if it can work.
- Use respite beds (empty) for urgent AP clients?