Homeward Bound - A Review of Transitional Care

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Aim

Our aim was to examine the process and outcomes in transitional care provision and highlight areas of interest for further evaluation

Context

Transitional Care Beds were introduced to facilitate the discharge from hospital of patients awaiting Long Term Care or Home Care Packages.

Different models of Transitional Care are in operation across the 3 CHO areas (CHO 1,8,9) with different definitions, processes and access criteria for each area.

Despite significant investment in Transitional Care there is an absence of data in relation to the use of and the effectiveness of Transitional Care.

What are we trying to accomplish?

- By end of May to review access criteria and processes across the 3 areas, and to agree data collection for measurement.
- By the end of July to review 100 client files across the 3 CHO areas and gather demographic data and patient flow data for each client.
- By the end of August to analyse data for trends to improve the organisations understanding of transitional care.
- By the end of August to make recommendations for the future delivery of Transitional Care.

Team

Paula Gallagher- Physiotherapy Mgr
Aoife Keegan – Snr Physiotherapist
Jack Koers – Services Manager
Fiacra McGuirk – Hospital Mgr
Michelle McManus – Clerical Officer

Acknowledgements

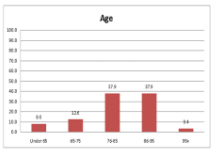
Gerry O'Neill, Nicola O'Grady, Staff and Management of Lisdarn Unit Cavan, Cottage Hospital Drogheda, St Mary's Hospital Phoenix Park and St Clare's Hospital Raheny.

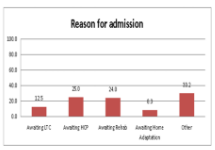
What We Did

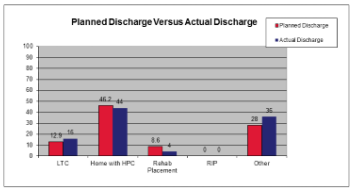
1. Identify and consult stakeholders
2. Research definitions and access criteria for Transitional Care
3. Agreed dataset for collection – gender, age, admission source, reason for admission, planned and actual discharge destination, length of stay, case manager.
4. Data collection – 100 client files across 4 locations
5. Reviewed data - generated demographic profile of clients accessing Transitional Care and identified markers for successful Transitional Care placement
6. Recommendations on future delivery of Transitional Care

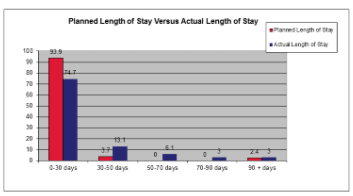
What We Achieved

1. Successful engagement with stakeholders at all levels to support the project.
2. Produced a demographic profile of clients accessing Transitional Care









What We Achieved Cont/d

3. Utilised data sets to make recommendations on the future delivery of Transitional Care.
4. Communicated findings and recommendations to key stakeholders.

Recommendations

1. Agree standardised definitions for Transitional Care, Convalescence and Step Down Care.
2. Agree standardised access criteria for Transitional Care, Convalescence and Step Down Care.
3. Appoint Case Managers for all clients in Transitional Care.
4. Ensure all clients in Transitional Care have access to therapy.
5. Develop a standardised template form for each Transitional Care client to include reason for admission, planned length of stay, planned discharge destination and named case manager.
6. Ensure healthcare record is completed in accordance with required standards.

Key Learning

1. Importance of engagement with stakeholders
2. Importance of utilising data to inform decision making.
3. Importance of critical thinking in decision making
4. Working as a team across a number of different sites is challenging but achievable.

References

1. Prioritising Measures of Quality of Care, HSE Quality Improvement Division 2016.