10. Minimising the risks of transitions

Best care for older people in hospital

What is it?

The complex needs of an older person, together with increasing age, means that the older person will often experience multiple transitions during their hospital admission.[1]

There may be a need to transfer the care of older people during a hospital admission for the following reasons:

- Planned and emergency transfers between the treating teams and specialities.
- Planned and emergency transfers between wards or units for the most appropriate or specialty care or completion of care (e.g. between emergency departments, short stay units, general medical, surgical departments, geriatric evaluation management units, ongoing rehabilitation or transition care programs).
- Transfers into ambulatory settings such as Hospital in the Home.

This factsheet will identify strategies you can use to minimise the risk of an older person experiencing an adverse event during a transition of care. This includes handover from shift to shift, between treating teams and transferring setting during the hospital admission.

Why is it important?

Older people are the major users of hospitals and often have longer stays. In 2011–2012, people aged 65 years and older accounted for almost half of patient days.[2] The importance of mitigating the risks associated with discharge planning are well known in the hospital setting. However, identifying and responding to the same risks when an older person transitions *within* the hospital need greater care and consideration

Each treating team of the hospital needs to consider strategic ways they can identify and respond to risks associated with these transitions. Implementing a person-centred approach is essential in minimising these risks.

The consequences of multiple transitions for older people include:

- Increased risk of adverse events.
- Increased risk of functional decline
- Increased risk of unnecessary tests and procedures.
- Poor, or no communication, between staff members, older people, their families and carers, which can contribute to the risk of conflict and formal complaints.
- Increased risk of loss of continuity of care.
- Increased risk of developing delirium.
- Potential delay in delivery of information held in medical records.
- Increased length of stay for the older person.
- Increased risk of premature readmission to hospital.
- Possible residential care placement.
- Practical concerns such as misplacement of hearing aids, glasses, teeth and walking aids – all of which play a large role in promoting a person's independence and participation in their own care.

How can you determine the risks associated with transitions for an older person?

Engage the older person

- Ascertain the needs and preferences of the older person on admission.
- Include the older person, carer, family members and general practitioner in all decision-making and keep them informed of any changes to the care plan.
- Use the following questions to guide conversation:

- Is the older person aware of the reason for transition?
- Is the family or carer aware of the reason for transition?
- Have you considered using written or audio-visual materials to communicate the reasons for transition?

- Ensure the older person and their family and carers have adequate opportunity to ask questions.
- Employ the 'teach-back method'.
- give the older person or their family and carers the information.
- ask them to use their own words to confirm their understanding
- re-phrase or use other strategies to ensure they understand and can repeat the information accurately (if necessary).[3]
- Bear in mind that you may need to repeat the conversation, or have the conversation at another time better suited to the older person.

Ensure team collaboration

- Identify and respond to risks of functional decline before, during and after the transition.
- Ensure that critical information, such as a medication list or falls history, is transferred, acted upon, and documented during clinical handover. Many health services use the framework ISBAR (identify, situation, background, assessment and recommendation) when transferring patient information during clinical handover.
- Advocate for the older person as part of the interdisciplinary team.
- Ensure vital tasks are delegated and followed up.

Consider practical issues

- Ensure the older person has their belongings (including glasses, hearing aids, dentures and walking aids) when they are transferred.
- Ensure that all medications, the patient summary and full medical history are transported with the older person.
- Ensure the older person's family or carer has the exact details of the impending destination.
- On arrival to the new ward welcome the patient and ensure they are orientated to the bathrooms and the ward routines.

Want to know more?

Older people in hospital
www.health.vic.gov.au/older-people-in-hospital

This video resource aims to complement 'Older people in hospital' highlighting the older persons' experience of hospitalisation and evidence-based strategies to optimise their care.
http://www.health.vic.gov.au/older/patient-experience.htm

National Safety and Quality Health Service Standards 2011, Australian Commission on Safety and Quality in Health Care. http://www.safetyandquality.gov.au/our-work/clinical-communications/

Transfer of care from acute inpatient services - Guidelines for managing the transfer of care of acute inpatients from Victoria's public health services 2014, Department of Health, Victoria.
http://www.health.vic.gov.au/acutemedicine/

Right Care, Right Time, Right Place
2008, Department of Health, Victoria.
http://health.vic.gov.au/subacute/right-care/

'Teach-back method'
http://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx

ISBAR (identify, situation, background, assessment and recommendation)
http://www.safetyandquality.gov.au/wp-content/uploads/2012/02/ISBAR-toolkit.pdf

See Factsheet 11. *References* for references cited in this factsheet.

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Available at www.health.vic.gov.au/older-people-in-hospital

Minimising the risks of hospital transitions

Reduce unnecessary transitions	**right** care **right** time **right** place
Engage the older person, their family or carer at the time of transition	**ascertain** individual needs and preferences **include** the older person in decision-making and inform of reasons for the transition **ensure** awareness of the need for transition **provide** opportunity for questions **ensure** understanding of the transition process **repeat** conversations as required
Engage your team at the time of transition	**encourage** all staff to identify and respond to risks of functional decline **advocate** for the older person's preferences **encourage** shared resources and responsibilities **inform** other specialists and services as required **provide** written and verbal handovers/referrals to the new treating team **use** ISBAR to assist this process **liaise** with community care providers
Consider the practical issues that need to be considered at the time of transition	**ensure** the older person has all their belongings **ensure** all medications and medical history are transported