

Safe Care Transitions

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Transitional Care

- High number of care transitions within and between settings
- Most transfers from acute care hospital
- Affect residents' health outcomes and quality of life
- Favorable transitions
 - Less restrictive level of care (assisted living, independent living, community)

Practice Gaps That Contribute to Poor Transitions

- Ineffective communication
- Missing or incomplete information
- Lack of follow-up
- Hospital providers unfamiliar with nursing home environment/regulations



Results of Poor Care Transitions



- Frequent emergency room visits
- Re-hospitalizations
 - 1 in 5 within 30 days
 - 1 in 3 within 90 days
- Higher healthcare costs

Results of Poor Care Transitions



- Medication errors
- Infections and complications
- Falls and injuries
- Fragmented care
- Longer recovery time

Strategies to Improve Care Transitions

- Facility policies that support successful transitions
- Structured communications
- Resident and family engagement
- Interdisciplinary team collaboration
- Education and clear instructions
- Medication reconciliation
- Follow-up appointments



Safe Transfers to Lower Level of Care

- Is transfer appropriate?
- Discharge planning
 - Instructions
 - F/U appointments
- Adequate support services
 - Home health/hospice
 - Medical equipment
- Support person/family member



Summary

- Care transitions are common
- Can result in poor outcomes
- Systematic approach
- Involve family/support person
- QAPI



Resources

INTERACT (free download)

- <http://www.interact2.net/tools.html>

QIN-QIO “Improving Care Transitions: A Guide to Tools & Resources for Providers and Patients”

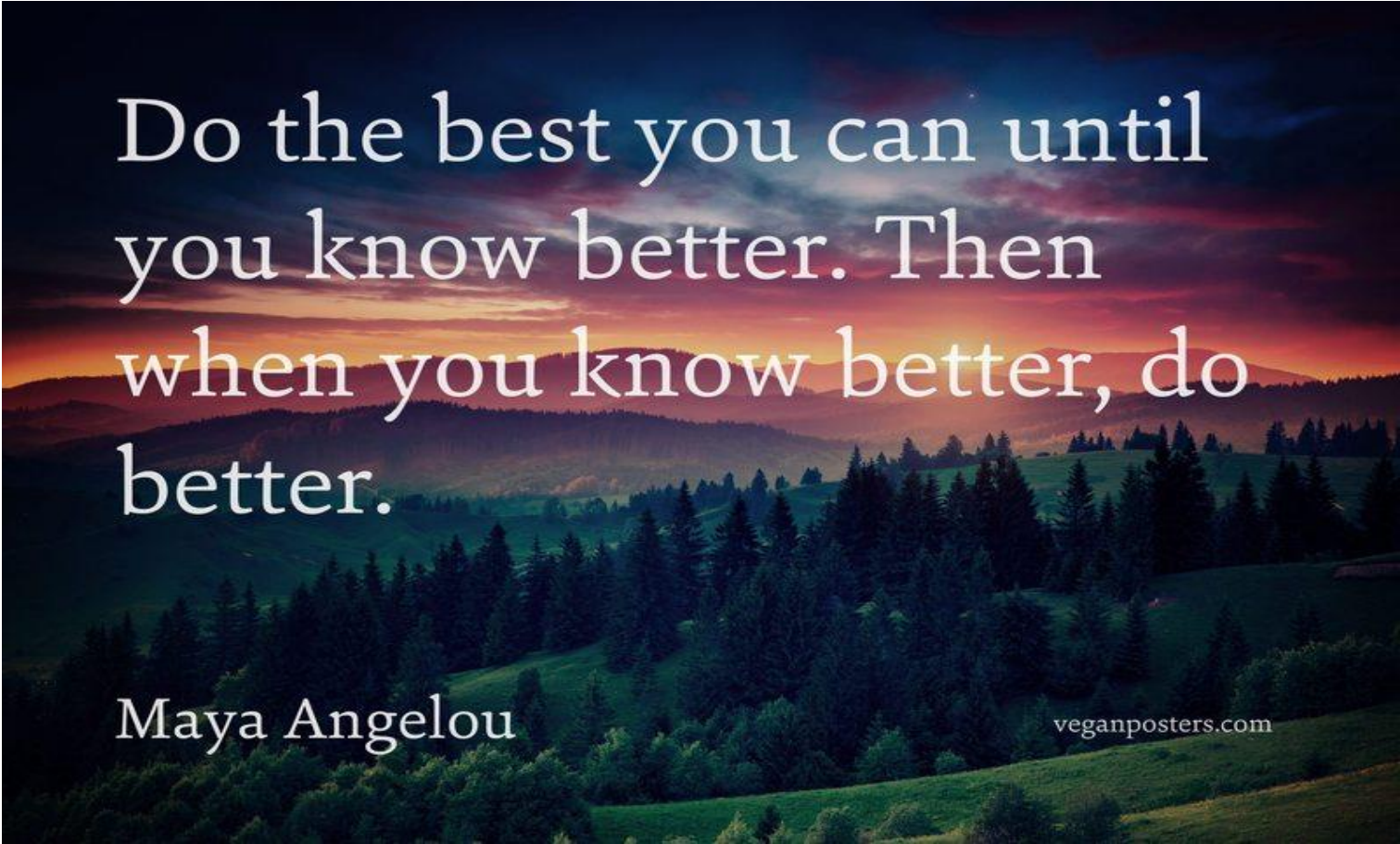
- [https://www.wellsense.org/hubfs/Provider/Quality/Care Transitions Guide.pdf?hsLang=en](https://www.wellsense.org/hubfs/Provider/Quality/Care_Transitions_Guide.pdf?hsLang=en)

Thank You!

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Questions?





Do the best you can until
you know better. Then
when you know better, do
better.

Maya Angelou

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