Evidence-based review:

Care transitions in elderly patients to/from acute medicine

Commissioned by Executive Nurses, Derbyshire and Nottinghamshire CCGs

December 2013
## Contents page

1. Sparklers and Sparks – an introduction  
2. Background – care transitions in elderly patients to/from acute medicine  
3. Our approach  
4. Executive summary  
5. What we know  
5.1 Frail elderly  
5.2 Care transitions  
6. Treating and caring for people in a safe environment and protecting them from avoidable harm: what are the risks for elderly patients whilst in hospital?  
6.1 Medication errors  
6.2 Delirium  
6.3 Falls  
6.4 Pressure sores  
6.5 Infections  
6.6 Frailty  
7. Treating and caring for people in a safe environment and protecting them from avoidable harm: what assessments and interventions can reduce this risk for elderly patients whilst in hospital?  
8. Moving from information collection to communication  
9. What might be done?  
10. Can these models be implemented?  
11. Ensuring people have a positive experience of care  
12. Overall summary  
13. Suggested additional resources  
14. Reference list
1. Sparklers and Sparks – an introduction

‘Sparklers’ is a pioneering service that helps East Midlands health organisations synthesize research from multiple sources, providing the evidence on which to build rapid service improvements.

The project, which is funded by the East Midlands Academic Health Science Network (EMAHSN) and coordinated by Nottingham University Business School’s Centre for Health Innovation, Leadership and Learning (CHILL), provides support where member organisations need to compile evidence based reviews but don’t have capacity to pull together and summarise research from the many available sources.

In addition to the commissioning agency Sparklers are available to all our East Midlands member organisations – helping the EMAHSN in its key aim of translating proven research into practice, spreading innovation widely and quickly and underpinning rapid improvements in healthcare for the East Midlands’ 4.5m residents.

Sparklers – which stands for ‘Spreading Applied Research and Knowledge – Longer Evidence Reviews’ provide fuller reports on a particular and detailed element of healthcare. They are created using rigorous academic methodology and are written for practice audiences with the aim of synthesising key evidence for impact and decision making.

Sitting alongside Sparklers are ‘Sparks’ – shorter ‘at a glance’ digest summaries of research evidence intended to improve and enhance practice.

We are happy to take commissions from our partners for both formats. To find out more contact The EMAHSN Project Team at emahsn@nottingham.ac.uk

2. Background – care transitions in elderly patients to/from acute medicine

EMAHSN was engaged by the Executive Nurses from Nottinghamshire and Derbyshire CCGs to complete a literature review to inform proposed CQUIN measurements for 2014-2015.

The request was received on 30th October 2013, with the brief agreed on the 5th November 2013. This final report was issued on 19th December 2013. The total turnaround time (from agreement to delivery) was seven weeks.
As agreed between the Executive Nurses (Lynn Woods, Elaine Moss & Cheryl Crocker), East Midlands AHSN and the CHILL team, we have concentrated on:

- Quality and safety of care issues in relation to care transfers for the over 65s, with a focus on priority safety events.
- Internal and external acute care organisational transfers (into / across different sectors).
- No clinical/disease focus, but mental health has been excluded.

A series of search terms were identified and independently validated.

**Selection criteria**

- International (although mostly UK papers, given the need for transferability into the NHS and social care system in England).
- Empirical evidence (research papers only), not reviews, debates etc.
- English language only.
- Published since 2008 (unless it’s a key paper that is cited by many others).

**Search strategy**

- Search engine: CINAHL
- Search modes - Boolean/Phrase
- Primary search terms: TX transfer of care OR TX transfer discharge OR TX discharge planning OR TX hand-over OR TX hand-off OR TX transition AND TX elderly OR TX geriatric

**Search results**

The original ‘primary’ search terms were: transfer of care OR transfer discharge OR discharge planning OR hand-over OR hand-off OR transition AND elderly OR geriatric, for any date to present, produced 20,310 hits. However, when screening the references it became evident that a further search term was important – Transitions of care. The re-run search was then further narrowed by a ‘subject = major headings’ screen.


The search was further limited to Full Text papers; Published between 2008/01/01-2013/12/31; English Language; Research Article, Inpatient focus, Academic Journals – Peer reviewed.

This search led to the identification of 254 papers, which met the criteria and were reviewed.

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4. Executive summary

For the elderly patient, care transitions are risky episodes, when they are most likely to suffer adverse events. Locally adapted assessment tools result in better outcomes in terms of both patient safety and economic efficiency. However, these protocols should have good ‘fit’ with standard national reporting mechanisms and guidelines. In USA, patients receive only about 55% of guideline recommended care for their conditions. No comparable figures could be found for UK care; however UK guidelines impose no mandatory requirements for NHS providers.

However, risk assessment tools are only half the picture; ward level skills, knowledge of specific conditions, and if necessary, the development of further training opportunities are equally important. Taking responsibility for championing elderly patients’ needs requires people (groups or individuals) with the specialist knowledge and interpersonal skills to work collaboratively, to identify locally existing good practices and to look at what works well elsewhere. There are increasing calls for seamless care and of the need to improve inter-agency working.

Although new services are rarely commissioned unless they can demonstrate real benefits in terms of quality of care and cost reduction, three interventions offer promise:

1) Combined pre and post discharge interventions are most successful in reducing length of stay and increasing patient satisfaction. The more comprehensive the intervention, the greater the range of benefits, psychosocial and medical, in terms of increasing patient wellbeing and minimising incidence of adverse events AEs in hospital or post discharge medication errors.

2) The establishment of emergency frailty units in Emergency Departments are less costly and already established in NHS.

3) A lower cost intervention that has been shown to be effective is the Comprehensive Geriatric Assessment. This should be carried out soon after arrival in hospital ideally administered upon admission in order to determine which predetermined pathway might be of greatest benefit to the patient.

There is a gap in the existing evidence that relates to evaluations of system level interventions aimed specifically at improvements in transitions of care for the elderly.
Evidence-based review: 
Care transitions in elderly patients to/from acute medicine

5. What we know

The scale and breadth of the issues surrounding care transfers for the over 65s is huge. By default this review is wide, and is presented in note form for ease of reading.

- Transitional care is defined as a set of actions designated to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same locations.
- Globally the ageing population is putting a strain on acute care settings. Figures for 2010 show that in the UK, 10.3 million were aged 65+, representing 17% of total population.
- 60% of people in hospital are aged 65+ and account for 70% of bed days in NHS hospitals.
- Of those on acute wards, approximately 25% are estimated to have dementia.

5.1 Frail elderly

- Frailty is understood as comprising health, mobility and psychosocial factors and whilst psychosocial factors are often least attended to in acute settings, this aspect is of most concern to patients. For the confused frail elderly patient, admission to hospital poses a potential risk of harm as high as 10%.
- Adverse Events (AEs) are defined as ‘any unintended injury caused by medical management rather than by the disease process which is sufficiently serious to lead to prolongation of hospitalisation or to temporary or permanent impairment or disability to the patient at the time of discharge or death’.
- Risk of AEs increases with age; AE prevalence in patients younger than 65 is 5.3% of all admissions, compared with 11.7% for patients aged 65+.
- Risk avoidance would suggest it is better not to admit where possible (see below in relation to Frailty assessment units).
- Up to 90% of elderly people entering the Emergency Department (ED) are routinely admitted to wards as ED staff lack resources, experience or remit to deal with medication reviews or general assessments.
- There is a strong association between the numbers of AEs, transitions and length of stay (LOS), with current emphasis on LOS as quality indicator resulting in patients being discharged ‘sicker and quicker’.
- Data for 2002/2003 to 2012/2013 shows LOS for younger patients reduced by 34%, for ages 60-74 by 35% and for 75+ years by 38%. Given that older patients had a shorter LOS, this suggests the need for improvement in quality of discharge co-ordination.
- Breakdown in communication is responsible for 11% of AEs involving care transitions for elderly patients.

5.2 Care transitions

- Seamless care is proposed to be the goal, bringing multidisciplinary perspectives together in a holistic manner.
- The reality is that provider care remains segmented.
- The term ‘discharge’ implies ‘to be done with’, whereas the term ‘transition’ implies a more holistic concept. Transitional care is defined as ‘a set of actions designated to ensure the co-ordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same locations’.
- A delayed transfer of care is when a medically fit patient still occupies a bed.
- For all patient discharges, 65% of all delays are attributable to the NHS, 29% attributable to Social Care and 6% where both agencies were responsible. 32% of all NHS delays are due to patients awaiting further non-acute NHS care and 29% of all Social Care delays are due to patients awaiting a residential home placement. In the 6% of cases with joint responsibility the major reason for delay was patients awaiting completion of assessment.
- In light of the recently announced new target of paperless communications between primary and secondary care by 2015, The Royal College of Physicians guidelines relating to clinical handovers, may become standard practice by default visit http://www.rcplondon.ac.uk/ for more details and search for “standards for the clinical structure and content of patient records 2013”. Plans are well advanced to implement Electronic Summary Care Records (ESCR) across the NHS, through NHS England. ESCR are GP compiled records of patient data that will be accessible to ED, locum and out-of-hours staff. The speed at which this appears to be happening is of concern, as practically, the various groups involved in the planning and transition of patient care are neither ready nor equipped for this technological change. In relation to any future CQUIN development, we recommend that this guidance and NHS England policy is considered.
6. Treating and caring for people in a safe environment and protecting them from avoidable harm: what are the risks for elderly patients whilst in hospital?

6.1 Medication errors
- 66% of medication errors (MEs) are associated with transfer of care.
- Poor quality information at transition points accounted for 50% of MEs.
- MEs more critical in older patients due to physiological response to pharmacokinetics and pharmacodynamics.
- Older patients present with higher incidence of polypharmacy. The more medication a patient has the greater the chance of MEs. 45% of medication prescribed at discharge is new medication. 60% of patients have 3+ medications changed during hospital stay. Risk of adverse drug event post discharge increases by 4.4% for every drug alteration.
- Two indicators identified for CCG CQUINs are 1) the % of patients who have had their medication reconciled within 24 hours of admission, and 2) the % of discharge summaries with complete information.
- Summary care records (SCRs) will not remove the need for medication reconciliation, described as ‘the standardised process of obtaining a complete and accurate medication history in the context of the plan for care, comparing it to admission, transfer or discharge medication order’.
- Evidence supports the use of validated tools to reduce medication errors, but they cannot replace clinical judgement or context specific knowledge.
- Improvements to discharge summaries were found to reduce MEs by 45%, with joint responsibility being taken: pharmacists used structured checklists to review medication then return them to physicians to complete the discharge papers.
- There is evidence that 1-day training in clinical pharmacology enables nurses to identify drug related problems which could be missed using a computer based decision support system.

6.2 Delirium
- Delirium, as an indicator of further underlying illness, is often missed or assumed to be general confusion in the elderly.
- There is a need for greater awareness of pre-existing and predisposing risk factors (advanced age, dementia, depression, hearing or vision impairment, and impaired mobility), with little use of cognitive screening tools being used by health professionals.
- Risk of delirium can increase with changes in clinical status, condition, pharmacological changes and environmental factors, such as change of environment including both admission to hospital and transfer between wards.
- Nurses found a delirium check list useful to their practice, as cognitive assessment training is not routinely included as key component of nursing training.
- The link between delirium and dementia is not reviewed here (out of scope of this review). However there is a link between delirium and increased risk of falls.
6.3 Falls
- The cost of falls to the NHS is £15 million.\(^4\)
- Evidence shows a link between cognitive impairment and falls; 12.9% of cognitively impaired elderly inpatients fell whilst in hospital as opposed to 4.2% of patients who fell but were not identified as being cognitively impaired.\(^2\)
- Every year 35% of people aged 65+ fall at least once.\(^6\)
- Hip fracture is a serious consequence of falls; 20% of elderly patients die within 1 month, 30% die within one year.
- In the USA, falls risk/prevention programmes are driven by fear of financial penalty; Medicare hospitals are not reimbursed if falls within hospital increase the cost of the patient’s treatment episode.
- All UK Trusts have a falls prevention policy; the majority have fall assessments in place (11% use the MORSE scale, 14% STRATIFY and 19% locally developed assessment tools).
- However use of risk assessment tools alone is not as reliable as nurse screening, for nurses have access to information over and above that collected by assessment tools, such as history of falling, mobility, number of co-morbidities and medication taken at admission.\(^9\)
- Evidence cautions against relying solely on instruments. For example, STRATIFY’s diagnostic accuracy is limited in identifying high risk individuals; Hendrich II lacks clinical sensitivity, which is concerning as 44% of those who did actually fall whilst in hospital scored as low risk.\(^3\)
- 41% of UK in-patient AEs are due to slips trips and falls, yet 49% of Trusts fail to provide advice on clinical checks and bed-rail entrapment after a fall.\(^1\)

6.4 Pressure sores
- Hospital acquired pressure sores are under-diagnosed; only 49% of cases are reported in nursing notes and 2% in medical notes.\(^4\)
- Evidence for use of assessment scales is not strong.
- Individual units should put in place their own specific levels of risk cut-off points when using rating scales.
- Staff training in identifying patients at risk for pressure ulcers requires further development as insufficient use of preventive measures to relieve APUs remains a problem in acute care settings.\(^1\)
- For further best practice information visit http://www.nice.org.uk and search for “Pressure Ulcer NICE Guideline 29” (2005).

6.5 Infections
- Nosocomial Infections, risk of MRSA, and Clostridium Difficile are not solely related to elderly patient care. However, physiological decline means frail patients are less able to deal with infections and rate of decline is quicker.
- Older patients have a greater likelihood of urinary tract infections due to being catheterised for continence issues.
- Infections require speedy remedial action; there is no need for risk assessment but adherence to local protocols for infection prevention, control and treatment.

6.6 Frailty
- Frailty itself however poses the greatest risk for elderly patients during their hospital stay.
- The Identification of Seniors at Risk (ISAR) tool has for many years been considered reliable evidence in predicting mortality, readmission, resource use, decreased physical and cognitive function in elderly inpatients.
- However its ability to predict adverse outcomes has been questioned; therefore caution has been recommended against its use as a sole tool in clinical decision-making.\(^3\)

"Evidence-based review: Care transitions in elderly patients to/from acute medicine"
7. Treating and caring for people in a safe environment and protecting them from avoidable harm: what assessments and interventions can reduce this risk for elderly patients whilst in hospital?

- Keeping elderly patients safe whilst in hospital requires a multi-factorial, multilevel approach that recognises the (sometimes competing) needs of the patient, the task, the staff, the team, the environment, the organisation and the institution.
- Checklists are neither diagnostic tools nor intended to replace clinical judgements. They are a starting point in the process of documentation and communication.
- There is a need to eliminate wasteful processes in order to improve healthcare. Therefore, there is little point in conducting risk assessments if they are not acted upon.
- Risk assessment is only the first step; prevention is the main part.
- A simple check-list designed to identify risks for inpatient episodes of care, as opposed to measuring risks in the sense of long term adverse outcomes, may be effective. FrailSafe, described as a simple, low cost check-list to ensure clinicians are applying their knowledge and expertise consistently, is easily administered by non-geriatric specialist staff within the first few hours of a patient’s attendance in ED.
- Evidence suggests that single interventions, such as structured medication reports and checklists assessment tools achieve short term effects, such as fewer AEs and shorter LOS.
- However, multi-component interventions appear better at affecting long term outcomes.
- Successful care transitions rely on the key processes of information gathering and communication; but should also maintain a patient’s autonomy through existing care pathways.
- Outcomes indicators such as LOS and readmission rates are not unproblematic; they can lead healthcare practitioners to become preoccupied with the quantifiable measures at the detriment of patient centred, quality care. Documentation of care planning, implementation and outcomes assessment should all be considered indicators of quality of care delivered, yet there is recognition that with the mesh of interconnections surrounding discharge planning, the majority have a negative effect.

8. Moving from information collection to communication

- Poor communication between professional groups is known to lead to problems with transitions.
- Key workers have been found effective for transferring information.
- Nurses have the skills required to compile concise accurate information and then communicate this as appropriate.
- However, nursing records are found to be varied; more information is needed regarding what should be recorded and how it could be used.
- There is a need to establish common goals between settings/providers, so that all health and social care professionals involved in the care transition appreciate the limitations and pressures colleagues face in other settings.
- Practical solutions include the use of forums and questionnaires to set objectives, examine existing practices, and devise methods to manage the introduction of any new framework. This type of approach can start very simply by asking the key questions: Have there been any problems lately? What are they? What can we do?
9. What might be done?

- The Silver Book\(^4\) recommends a single point of access, with a multidisciplinary response within 2 hours of admission, and a preliminary discharge date set, with a coordinated plan for follow up after discharge.
- All services involved would have access to adequate, timely information in order that care can be coherent, connected and consistent across settings.
- In addition to the information given to clinical teams, appropriate information should be given to patients and carers, in a clear and digestible form.
- There is a growing body of evidence that handover improves after locally developed guidelines incorporating a structured tool or template is implemented\(^49\).
- However, no single model will be appropriate for all clinical areas, which perhaps explains only the presence of guidelines (see Resources below).
- It is generally accepted that the sooner discharge planning starts the better\(^50\).
- Reducing the numbers of transfers of care, in order to minimise loss of information and reduce risk of AEs is recommended\(^3\).
- However, reducing the number of transfers requires good forward, whole care planning.
- There is evidence that combined pre and post discharge models are effective\(^2\); those which contain elements of patient empowerment are the most likely to be effective\(^9\).
- Transitional models such as the Transitional Care Model (TCM\(^51\)), the Care Transition Intervention (CTI\(^14\)), and Better Outcomes for Older Adults through Safe Transitions (BOOST\(^52\)), are probably effective in reducing LOS and readmissions, but their impact on mortality remains uncertain\(^53\). Links to their websites are included in the resources section.
- Both BOOST and CTI are relatively short term interventions. They address the goal of ‘meeting the need to ensure that people have a positive experience of care’ through a heavy emphasis on patient coaching in what to expect and who to contact in order to better self-manage their discharge process.
- Both models employ similar ideas to Patient Passports currently employed in various NHS Trusts, where their use is recommended for vulnerable adults, or individuals who may have difficulty responding to queries about their condition or medications.
- However, TCM\(^51\) is a more comprehensive, holistic model with evidence of reduced hospital readmissions; of those patients readmitted, the time between their discharge and readmission is longer and the number of days spent in hospital is generally shorter than expected.
- Patients who received TCM\(^51\) have reported improvements in physical health, functional status and quality of life.
- The difference between TCM\(^51\) and other models is that, for BOOST\(^52\) and CTI\(^14\), the main emphasis is on the discharge process, yet whilst TCM does cover discharge planning, it is a whole care plan, designed and tested specifically for older patients which utilises the specialist skills of an Advanced Practitioner Nurse to navigate the patient’s care through the whole system.
- The TCM\(^51\) model is based around the role of a specialist Advance Practitioner Nurse, whose high level of training and expertise combined with agreed authority to span sector boundaries takes responsibility of the following:
  - Responsible for transition planning whilst patients in hospital and for subsequent home visits and follow up.
  - Ability and authority to co-ordinate care with community services.
  - Accessible to patients, care givers and healthcare providers.
  - Available for telephone support 7 days a week whilst person hospitalised thereafter for up to 4 weeks when back in community.
  - To initiate contact twice post discharge, the first time within 48 hours of going home and the second towards the end of the first two weeks.
- 6 months outcome figures for TCM\(^51\), for all patients except those with heart failure, were:
  - Intervention group had fewer re-admissions than control group: 20.3% v 37.1%. (p<0.001).
  - Intervention group had fewer multiple re-admissions than control group: 6.2% v 14.4%. (p<0.01).
  - Length of stay for any readmissions was significantly lower for the intervention group at 1.53 days as opposed to 4.09 days (significance not reported).
• The concept of a liaison nurse or navigator to support patients through healthcare transitions in attempts to integrate service provision is not new; however to offer a service specifically for older adults is new. It is important to note the distinction between the role of a bed manager or case manager, whose primary role is to free up bed space and reduce LOS figures, and the role of an Advanced Practitioner, as a liaison nurse who can not only navigate a patient's transitions but also act as an advocate for the patient, in order to ensure that information flow is bidirectional.

• Nurses with advanced levels of training in gerontological issues who adopt Navigator roles are of benefit to chronically ill elderly patients in their transition across care settings. The Navigator role in working on discharge planning has been shown to be multifaceted, with staff recognising the importance of developing good working relationships across sectors, in order to maintain communication and remove barriers to care.

• However, there is little standardisation of methods and systems to convey the information necessary to ensure smooth transitions, hence there is only limited evidence that Navigator roles are effective as a standalone intervention.

• A review on the effects of nurse led strategies to promote safe transitions of older people across settings found interventions that included patient assessments, medication follow ups, home visits, telephone follow up, liaison and communication with families and community services were effective at reducing older patients re-admissions to hospital at one to nine month follow ups; this led to a reduction in costs associated with readmissions.

• The chance of elderly patients being alive and well and in their own home one year after admission is significantly higher when patients receive specialist organised and coordinated geriatric care. One route is that patients stay on general wards and receive usual care, but are supported by visiting specialist multi-disciplinary teams.

• However the value of inpatient Geriatric Consultation teams is shown by other indicators; patient's felt that their quality of life, post discharge, was improved.

• The best outcomes are when patients are admitted to a dedicated ward area and receive care from a specialist multidisciplinary team. Acute Care for Elderly Units (ACE) as opposed to specialist geriatric care in general acute units, have been found to have positive benefits regarding, cost, LOS readmissions rates and overall satisfaction levels.

• Leicestershire Royal Infirmary set up an 8 bed Emergency Frailty Unit, located within the Emergency Decision Unit. Patients were transferred after ‘normal ED treatment’, multidisciplinary teams determined whether admission was necessary or initiated follow on care back in the community. Staff were trained in specialist areas - dementia, falls, nutrition and continence. The team included community matrons, who worked as the Primary Care Coordinators. Evaluation of the unit's attendance and discharge figures showed that although numbers attending ED had risen, admission rates onto hospital wards had fallen, as had readmission rates.

• Kings College London developed the Older Persons Assessment and Liaison (OPAL) intervention; this relies on early Comprehensive Geriatric Assessment by an OPAL team member who then either facilitates rapid transfer to a specialist geriatric unit or recommends case management by OPAL team on general ward or through cross sector links. This can eliminate the need for admission by facilitating discharge with appropriate referrals already in place. OPAL is currently used in several NHS Trusts, and has been shown to significantly reduce length of stay in hospital. Having team members with cross-sector / cross-organisational links can facilitate information and communication flow, as it bridges the pre - post discharge divide.
Evidence-based review: Care transitions in elderly patients to/from acute medicine

11. Ensuring that people have a positive experience of care

- Improving long term planning and a more refined use of risk assessment tools could potentially lead to reduction in unexpected readmissions and smoother care transitions.

- There are three main issues: 1) access to good clear information, 2) good communication - once information gathered, what to do with it, and 3) issues around people as barriers to implementation in and across settings, staff and patients and their perceptions which are briefly reviewed in the section that follows.

- In some areas of geriatric care, practitioner’s clinical skills are less likely to lead to adverse events than communication problems, not only between other HCPs but with patients.

- Patients find transfers to be unpredictable and stressful and prefer for planned rather than rushed or unclear transfers.

- Patient perception is that nurses play an important role in helping them to feel safe and secure, and to have confidence that care will be continued.

- When transferring between different wards, anxiety is reduced and satisfaction with care significantly improved by providing both verbal and written information, specifically tailored to the needs of the individual patient and their family.

- Looking at transfers of care from hospital, healthcare outcomes are shown to have improved when attention is paid to the specific needs as identified by elderly patients or their families.

- Listening to and involving elderly patients in decision making throughout their stay in hospital, improves their post discharge ability to cope. Increasing health literacy, by preparing patients for what to expect in the next stage of their recovery, reduces patient anxiety. This should be a two way process, for working with patients on self-management of their condition requires listening to patients views on information priorities post discharge.

- Patient satisfaction surveys have shown dissatisfaction regarding poor and varied communication, in relation to medications, patients report receiving different information from nurses and medics.

- The provision of clear, concise information regarding signs to look for to suggest a condition is worsening, has been shown to empower patients to feel more confident if problems arise later.

- Participation in a care transition programme not only enhances patients self-management skills and abilities post discharge, but also produces cost savings. US research shows every $1 spent on the programme saw a cost benefit of $1.9. However the evidence is equivocal, for whilst involving patients through feedback measures, or in planning and educational interventions may lead to short term improvements (and as such meet the goal of improving hospital’s responsiveness to inpatient needs), longer term impacts on patients remain uncertain, not least as these may rely on other non-acute care factors.

- However, within the acute care setting, elderly people may feel vulnerable, possibly confused and unable to communicate. In addition to medical complications, underlying factors that support and hinder their involvement may be related to power inequities and control. It is also important to acknowledge that not all patients wish to be involved in their care decisions.

- ESCRs (if/when they arrive) will be medically dominated records, intended to clarify information. Yet they will also have the potential to offer patient centred information, designed to minimise concerns and practical problems post discharge, for example, who to contact, what the next steps are etc. A Norwegian study of a hospitals medicines reconciliation procedure required pharmacists to complete a short check-list for quality assessment; in the process of doing so, the information collated, and at no extra cost, was available to use as a discharge summary to be given to patients. Hospitals have regularly provided GPs with a discharge letter, yet patient discharge letters are not routinely produced, despite evidence showing that increasing health literacy and keeping patients informed has positive psychosocial benefits for patients. The introduction of ESCRs offers an opportunity for those patients who wish to be kept informed, to do so.

Ensuring that people have a positive experience of care
12. Overall summary

- Highlight at risk patients.
- Use assessment tools most suited to local conditions.
- Audit staff knowledge levels regarding specific conditions/risks and prevention strategies.
- Reinforce the use of simple practices that can reduce or prevent potential risks.
- Consult patients, families and carers on their perceived needs for information on transfers.
- Identify critical points of the transfer process where communication is most likely to breakdown.
- Facilitate cross sector information exchange opportunities in order to better understand working practices and pressures in order to build better communications.
- Agree upon what information is critical for both sending and receiving teams.
- Ensure all information is kept as up to date as possible.
- Consider the use of individual APNs as champion/navigator liaison nurses or specialist teams.
- Consider specialist units and/or whole care transition models.
- Make a start; small positive steps are better than stagnation.

13. Suggested additional resources

- British Geriatric Society. The Silver Book (BGS) provides guidance on all aspects of acute care for older people during the initial 24 hours after an incident, accessible via, http://www.bgs.org.uk/campaigns/silverbook/executive_summary.pdf
- Royal College of Physicians. FallSafe resources for clinicians. http://www.rcplondon.ac.uk/resources/falls-prevention-resources
- Better Outcomes for Older Adults through Safe Transitions (BOOST). Accessible via http://www.hospitalmedicine.org/resourceroomredesign/rr_caretransitions/html_cc/project_boost_background.cfm
- Care Transitions Intervention (CTI) Accessible via http://www.caretransitions.org
- Transitional Care Model (TCM) Accessible via http://www.transitionalcare.info/home

The three care models are all available to be purchased with support and training.

- Better Outcomes for Older Adults through Safe Transitions (BOOST). Accessible via http://www.hospitalmedicine.org/resourceroomredesign/rr_caretransitions/html_cc/project_boost_background.cfm
- Care Transitions Intervention (CTI) Accessible via http://www.caretransitions.org
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Evidence-based review: Care transitions in elderly patients to/from acute medicine

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Evidence-based review: Care transitions in elderly patients to/from acute medicine


