TRANSITION OF CARE: BUILDING A SAFER SYSTEM

This PSHSA Fast Fact is intended to provide management, employers, JHSC members and workers with information that can help improve transition of care practices. Improving transitions in care results in improved employee and client safety.

WHAT IS TRANSITION OF CARE?

Transition of care occurs when clients move across the healthcare system such as between different health units, specialists, care settings or systems. As clients move from one healthcare setting to another or within units they will experience changes to physical setting, healthcare providers and to the care they require. The transition of care from one setting to another has been identified as a major contributor to employee exposure to hazards and can cultivate poor and unsafe client care. This is mainly attributed to a lack of a structured process to communicate risks to employee and client safety.

FACTS ABOUT TRANSITIONS OF CARE

- A higher number of obese and more acutely ill clients leads to increased physical demands that put employees at a greater risk of musculoskeletal disorder (MSD) injuries; early hazard identification can mitigate this risk.
- Early hazard identification also addresses the high incidence of workplace violence and aggression in health and community care organizations.
- US data shows that an alarming 20% of adverse drug events associated with medication errors occur during transitions of care between the inpatient and nursing home settings.
- A vast majority of employee incidents involving clients takes place shortly after admission.
- Evidence has shown that gaps in communication are a major concern in transitions of care between facilities.
- Accreditation Canada introduced a new Required Organizational Practice (ROP) in 2011 on transfer of information. Main components include introducing mechanisms for timely transfer of information at transition points, educating staff about the mechanisms, and documenting evidence of timely transfer of information.

KEY ISSUES AND CHALLENGES ARISING FROM COMMUNICATION GAPS DURING THE TRANSITION OF CARE PROCESS

Failure to communicate critical information about a transitioning client places not only employee safety but also client safety at risk and may lead to negative outcomes for both employees and clients.
Care providers indicate that they need more information to protect their own health and safety and to provide safer client care. Staff are most concerned during the transition of care process about:

- working alone
- inability to influence and control their work environment
- unclear communication and lack of clear guidelines
- inability to perform tasks as expected
- not providing care of sufficient quality, and
- Safety and security issues.

Collaboration and teamwork is the foundation for building safer client care, particularly where two or more individuals use shared resources and communicate to coordinate care. Communication gaps may lead to interruptions in continuity of care. Treatment provisions with minimal to no interruptions result in better client outcomes.

TRANSITION OF CARE POINTS WITHIN THE GREATER HEALTHCARE SYSTEM

The position where the client transitions from one caregiver to the next, moves from one facility to the next, or from one unit to another is known as the transition of care point. Clients may move in many ways throughout the healthcare system as they transition to and from various facilities, specialties and sectors.

Some examples include the transfer of clients between:

- Staff within the same organization
- Staff from two different facilities/organizations
- Staff from the Community Care Access Centre and service providers
- Service provider management and frontline staff
- Emergency medical services/police and Emergency Department staff
- Long term care and acute care
- Community care and long term care
- Mental health and other providers
- Family in the home and care-giving staff
- Primary care and other providers
- Private transport between facilities
- Community and Emergency Department
- Outpatient programs and Emergency Department or to a unit
- Correctional system and Forensic unit/Ontario Review Board
- Social services/group homes and healthcare

COMMUNICATION REQUIRED DURING TRANSITION OF CARE

Research and stakeholders indicate that the following Information should be provided when clients transition across the healthcare system:

- Client demographics
- Client medical information (diagnosis, allergies, adverse drug reactions, procedures, test results, Medications)
- Safety concerns:
  - History and risk of violence/aggression
  - Risk of musculoskeletal injury to employees while providing care and other assistance
  - Risk of exposure to infectious disease
  - Risk of slips, trips and falls
  - Additional physical hazards in the home care environment
- Responsible physician/health care provider
- Plan of care
- Strategies to prevent injuries and illness and control hazards (e.g. risk management, employee safety)

RECOMMENDATIONS TO IMPROVE INTERNAL AND EXTERNAL TRANSITION OF CARE PRACTICES

- Employer to identify all possible transition of care points
- Identify, assess and control employee and client hazards and risks and communicate information at each transition point
- Employer to raise staff awareness about transition of care points and the hazards involved

- Develop all measures, procedures and training In consultation with the Joint Health and Safety Committee/Health and Safety Representative
- Standardize the language and information exchange Process by developing a standard tool to share and Receive transition of care information
- Avoid relying solely on electronic communication tools
- Facilitate verbal communication between providers, in addition to written
- Integrate employee and client safety into existing communication tools
- ensure confidentiality and privacy of personal health Information when communicating hazards and risks To frontline staff in the transition of care process
- Use visuals to portray information, e.g., pictograms, color coding
- Include strategies for prevention and risk management

For more information and resources on protecting workers from workplace hazards, refer to PSHSA website or your local consultant: https://www.pshsa.ca/consulting/find-a-consultant