

A Co-Created Strategy to Improve Patient and Family Experience during a Hospital Discharge Delay in Ontario, Canada



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INTRODUCTION

- **Hospital discharge delay:** Hospital care is complete but the person is stuck in a hospital bed while waiting for their next point of care¹
- Discharge delays are associated with poor outcomes including: functional decline, falls, infections and other adverse outcomes^{2,3}
- There is currently a poor understanding of the user experience⁴
- To date, strategies to address delayed hospital discharge have had minimal success

OBJECTIVE

To **partner** with patients and caregivers (e.g. family) with hospital discharge delay experience and their healthcare providers to **co-design strategies** to improve the patient, caregiver and provider experience of hospital discharge delay

METHODS

Participants

- Providers (discharge planners, social workers, nurses, etc.), patients and caregivers who have experience with hospital discharge delay from Ontario, Canada

Study Design: 2-stage Qualitative Study

Stage 1:

- Focus groups with patients, caregivers and providers to identify key challenges experienced during hospital discharge delays

Stage 2:

- 3 co-design sessions with patients, caregivers and providers using deliberative dialogue techniques to explore ways to address key challenges identified in Stage 1

RESULTS

Table 1. Participants (N=61 unique participants)

Location	Toronto	Sudbury	Mississauga
Focus Group Participants (n=23)			
Patients/ Caregivers	11		
Providers	12		
Co-Design Session Participants (n=53)			
Patients/ Caregivers	7	10	10
Providers	10	9	7

Common Challenges with Delayed Discharge

- **Poor communication** (no standard conversation about delayed discharge, providers are on 'different pages')
- **Lack of services** (ambulation, recreation activities, meal support, foot care, specialized care for people with dementia or behaviours)

What do you talk about when there is discharge delay?

- Patient and caregiver goals, priorities and concerns
- Caregiver availability and capacity
- Managing expectations (uncertainty, reduction/ change in care)
- Access to care (barriers that limit discharge, available services & how to access them, medications needed & how to obtain them)

How do you talk about delayed discharge?

- **For providers to ask patients and families (examples):**
 - What is your understanding of how you are doing right now?
 - What concerns you most/ what are you most afraid of?
- **For patients and families to ask providers (example):**
 - What are the next steps before discharge and how do we best prepare?

Co-created care plan strategy

- **Check-in within first 24 hours, then weekly** with a designated 'point person' (e.g., social worker) to answer questions, assess needs, etc.
- **Activities that support mental & social wellness** (leverage what is currently available, align with patient & caregiver preferences)
- **Getting out of bed and dressed daily**
- **Daily mobility/ activation** (10+ minutes of mobility/ seated exercises)

DISCUSSION & CONCLUSIONS

- Partnering with patients, caregivers and providers helped us understand the issue at a deeper level and co-design a care plan that captured the needs of patients, caregivers and providers
- Acknowledging uncertainty and being willing to work together to determine next steps was essential
- Ongoing communication (regular check-ins to answer questions) and daily ambulation is required, at a minimum

PRACTICE IMPLICATIONS

- A practice guide organizing communication and service improvements are currently being developed for hospitals
- Engaging with patients, caregivers and providers in various contexts is a useful way to capture issues and design improvements

Future work:

- Testing the co-designed strategy on hospital units (assessing impact on patient, caregiver and provider experience, physical and psychosocial functioning and costs)

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ACKNOWLEDGEMENTS

This work was supported by the Ontario SPOR Support Unit, the Canadian Institutes of Health Research, Strategy for Patient-Oriented Research (Fund Number: 157054), Sinai Health System and the Toronto Central Local Health Integration Network

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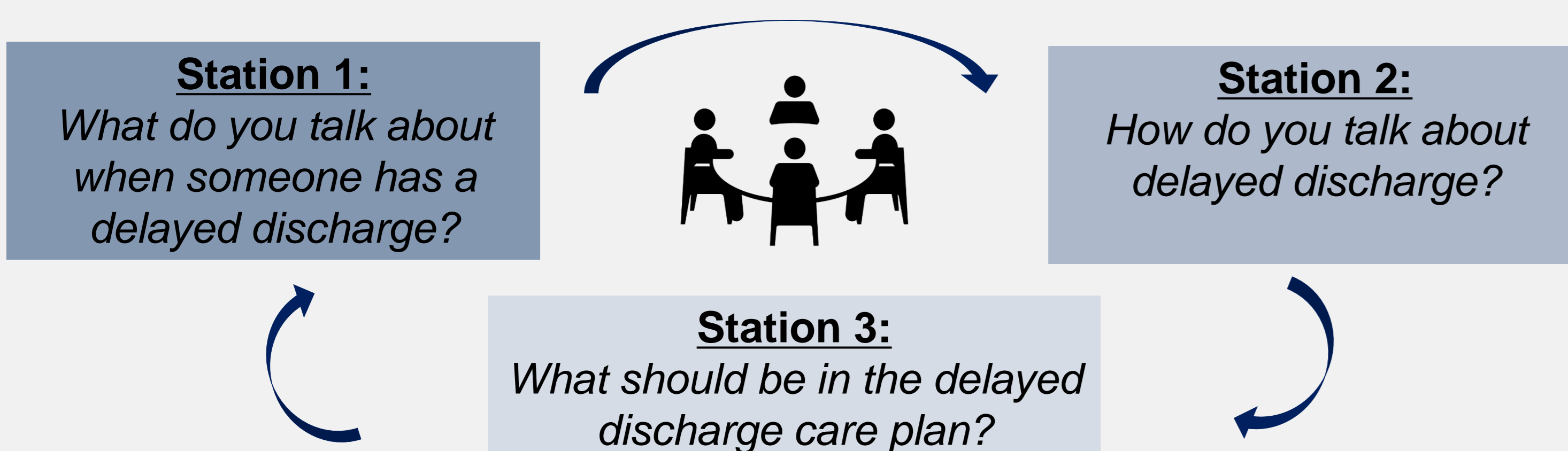


Figure 1. Co-Design Session Format and Guiding Questions