International Journal of Integrated Care

Lindblom, S et al 2018 Perceived quality of care transitions between hospital and the home - a cross sectional study. *International Journal of Integrated Care*, 18(S2): A317, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.s2317

POSTER ABSTRACT

Perceived quality of care transitions between hospital and the home - a cross sectional study

18th International Conference on Integrated Care, Utrecht, 23-25 May 2018

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Introduction: Of the 25.000 persons suffering a stroke each year in Sweden, 90% are treated in stroke units at hospital. After the hospital, a period of rehabilitation is needed to regain functions that have been affected. However, there is a lack of knowledge on how patients in Sweden perceive the current care transitions. The aim of this study is to explore the perceived quality of care transitions between hospital and the home for patients with stroke.

Methods: A total of 200 patients with stroke referred from stroke unit to home rehabilitation will be included. To date, approximately 185 patients have been included from five wards stroke and geriatric at three different hospitals. One week after discharge, the perceived quality of care transitions are assessed with the Care Transitions Measure CTM. The CTM consists of 15 items covering different areas such as critical understanding, preferences important, management preparation, and care plan. Baseline data on age, sex and stroke severity are collected from the patients' hospital medical records.

Results: The preliminary results from 80 participants with a mild stroke 53 men, mean age 70 years, show that a majority perceived a high quality of care transitions. However, 26% did not perceive that they had clear health goals or knew how to reach them; 30% did not know what warning signs and symptoms to watch out; and 20% lacked a readable and understandable written healthcare plan. Further, 24% perceived they had a poor understanding about their health and 29% lacked written understandable information about plans after discharge. In addition, 46% had not clearly understood the possible side-effects of their medications.

Discussions: These preliminary findings have shown that there is room for improvement regarding the transition process. The participants had a mild stroke and where all discharged to their home for continued rehabilitation in the home environment. This meant that the patients would get home visits from rehabilitation staff but overall manage their rehabilitation training on their own. This stresses the importance of preparing the discharge from the stroke unit to the home. Extra attention should be made stating clear health goals and informing about how further health care needs can be met.

Conclusions: The preliminary conclusion is the staff at stroke units should acknowledge the importance of informing about subsequent care and rehabilitation after discharge. Specific

attention should also be drawn towards self-monitoring and increasing patient knowledge about potential side-effects of their medications.

Lessons learned: Even patients with a mild stroke experience problems in the discharge from hospital to home which emphasize further analysis on patients with more severe forms of stroke.

Limitations: A limitation of the study is that the questionnaire was only distributed in Swedish and that no aid was provided to help patients with affected cognitive functions. We hence lack information on how especially vulnerable groups perceive the quality of care transitions.

Suggestions for future research: Future research should focus on how the discharge could include patients and family care givers in the goal setting including self-monitoring and medication awareness.

Keywords: care transition; stroke; hospital discharge; rehabiliation