

Transitions Between Hospital and Home

Throughout the Hospital Stay and Transition Process: Enhance Patient and Caregiver Communication with the Use of Visual Tools

Released September 2016

Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, specialists etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices.

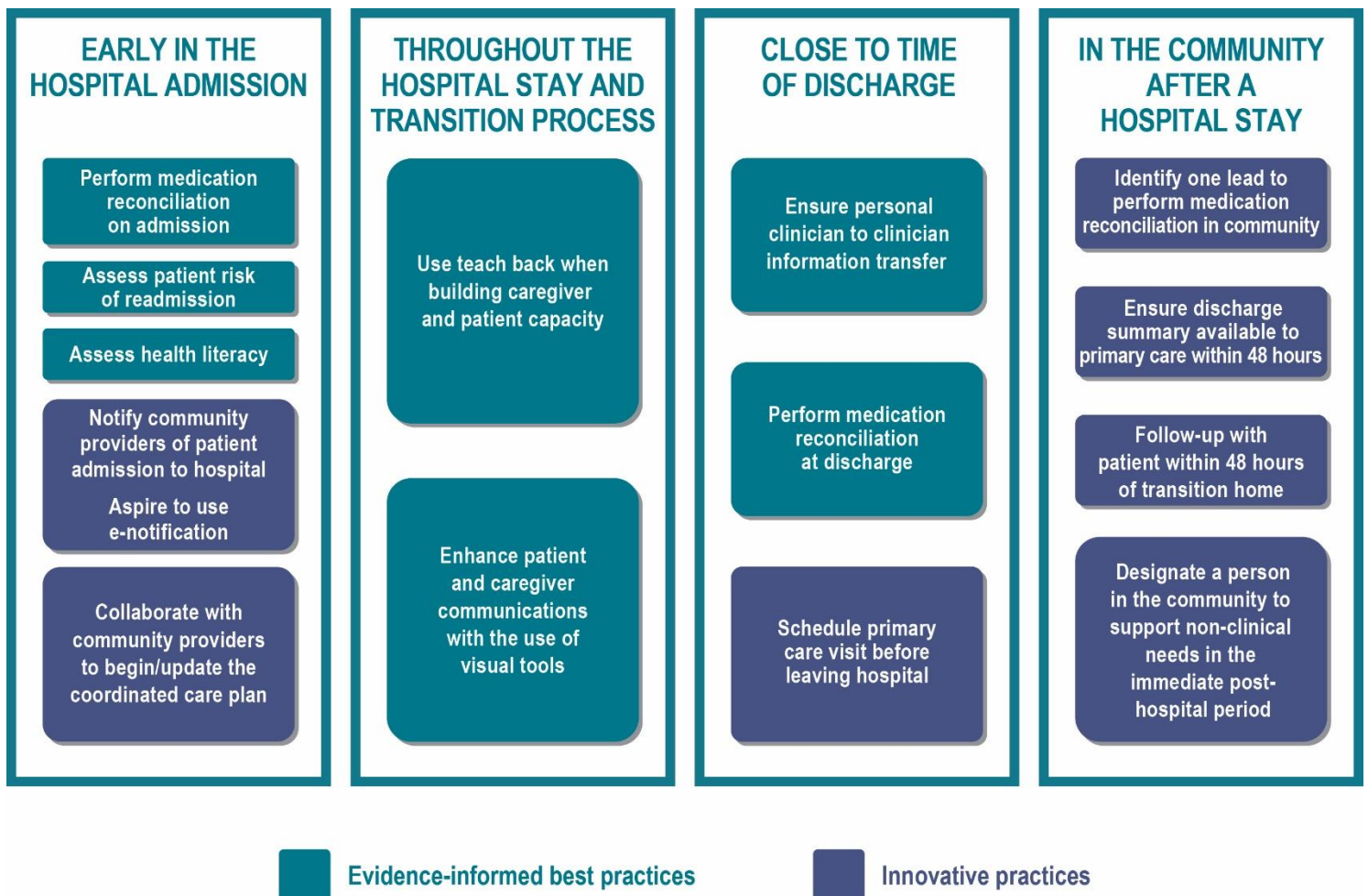


Figure 1: Practices to Improve Transitions Between Hospital and Home

Description of this Evidence-Informed Best Practice

“It has been shown that verbal communication alone is not as effective as when it is combined with other modes of communication. Visual aids have been shown to be particularly useful to non-English speakers and patients with low health literacy scores, who tend to have poorer recall of medications and instructions. It is also known that written materials are more effective when they are simple, use larger fonts, and focus on essential information. It also helpful to use short words and sentences, and write directly to the patient.”
(OpenLab, University Health Network, 2014)¹

Tools and Resources

In an environmental scan and literature review, the following tool was found to be highly effective and commonly used to enhance patient and caregiver communication. The decision to implement or administer one of these tools must be considered alongside other locally contextually relevant information.

Enhance Patient and Caregiver Communication with the use of Visual Tools		
Name of Tool	Overview	Considerations/Links
PODS (Patient Oriented Discharge Summary)	<p>PODS is a discharge template designed to better reflect the information patients want and need upon being discharged home. It includes five(5) key pieces of information:</p> <ol style="list-style-type: none"> 1. Medications I need to take 2. How I might feel and what to do 3. Changes to my routine 4. Appointments I need to go to 5. Where to go for more information 	<ul style="list-style-type: none"> • The expectations of transitions planning may be different for patients, families/caregivers and community partners and care team members. Real time transition conversations with the patient and their family/caregiver(s) and community partners should occur. • Commissioned by the Toronto Central Local Health Integration Network (TC LHIN), in 2014, OpenLab, University Health Network worked with patients and providers to co-design PODS. Resources on the OpenLab website are freely available to all organizations to adapt, based on their local circumstances. • PODS Toolkit is available at: http://pods-toolkit.uhnopenlab.ca/ • PODS implementation materials can be downloaded at: http://pods-toolkit.uhnopenlab.ca/implement/ • For history and background of PODS, see the following link: http://uhnopenlab.ca/project/pods/ • PODS template is available in multiple languages and can be accessed at: http://pods-toolkit.uhnopenlab.ca/form/

Additional Resources

For additional information on Quality Improvement, please visit: <http://qualitycompass.hqontario.ca/portal/getting-started>.

¹ Toronto Central LHIN. PODS Patient-Oriented Discharge Summary. Nov 2014. Available from: http://uhnopenlab.ca/wp-content/uploads/2014/11/PODS_report.pdf