Transitions Between Hospital and Home

Summary of Evidence-Informed Best Practices

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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.

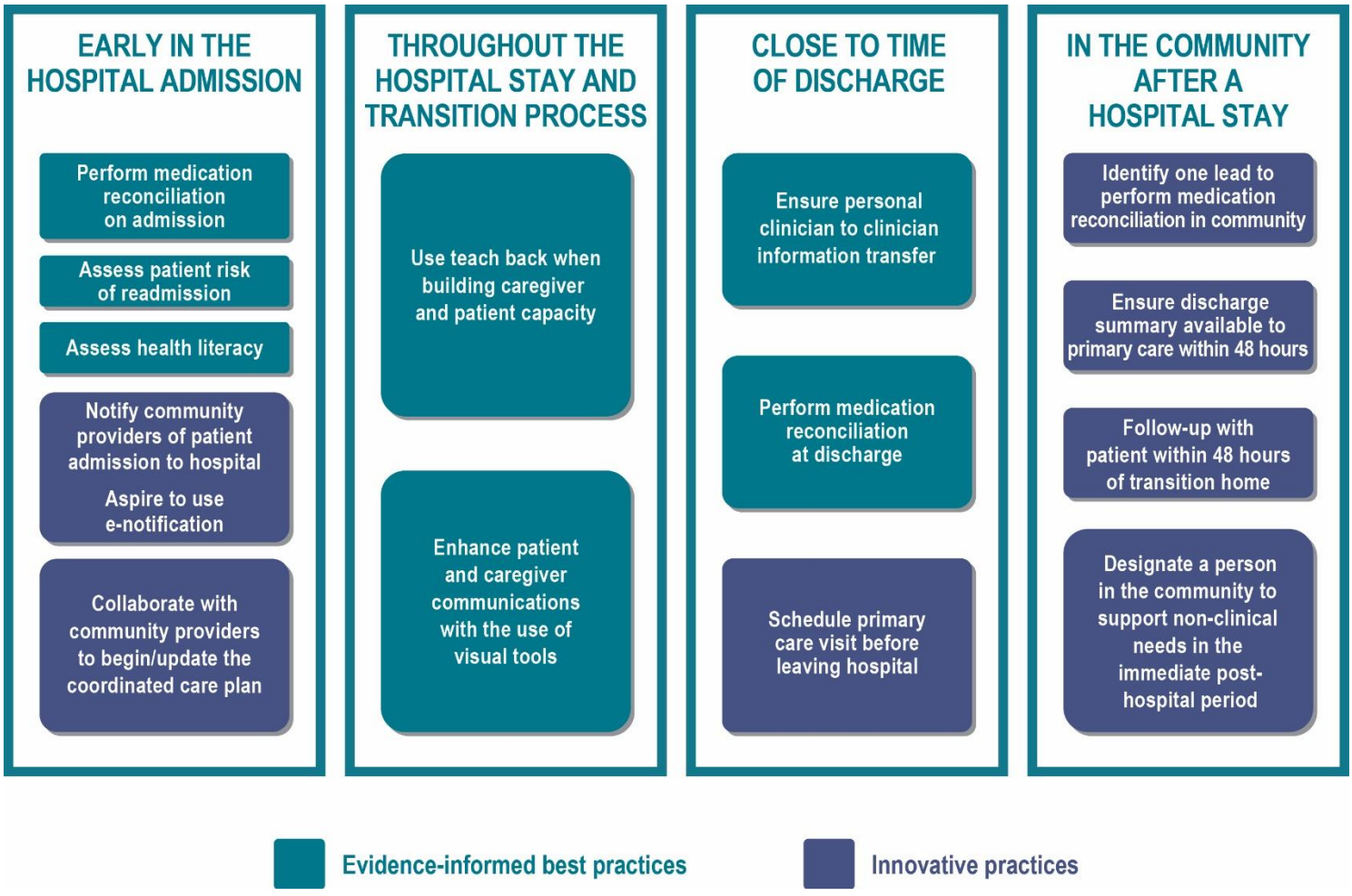

Figure 1: Practices to Improve Transitions Between Hospital and Home

The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.

Quality Improvement: Getting Started

Quality improvement (QI) offers a proven methodology for improving care for patients, residents and clients. QI refers to a team working **towards a defined aim**, gathering and reviewing data to inform their progress and implementing change strategies using rapid cycle improvements. QI science provides **tools and processes** to assess and accelerate efforts for testing, implementing and spreading QI practices. *For additional information on Quality Improvement, please visit:* http://qualitycompass.hqontario.ca/portal/getting-started#.V1rU7bsrK00 or *contact **QI@hqontario.ca** for access to e-learning modules.*

Evidence-Informed Best Practices

Evidence-informed best practices are based on quality evidence and should be implemented into practice to optimize outcomes.[1] Listed below you will find best practices graded according to the type of evidence. These **evidence-informed best practices** are believed to be highly effective and commonly used practices for transitions between hospital and home. It is suggested that Health Links draw upon this collection of evidence-informed practices to create the foundation for supporting their processes and improving transitions for patients within their Health Link. Throughout these toolkits you will notice that a particular clinical role is not identified to conduct activities associated with the practices. It is suggested that each Health Link identify the most appropriate person for the activities within their local context.

Steps for Transitions between Hospital and Home	Evidence-Informed Best Practice (cited in Quality Compass*)
Early in the Hospital Admission	Perform medication reconciliation on admission
	Assess patient risk of readmission
	Assess health literacy
Throughout the Hospital Stay and Transition Process	Use teach back when building caregiver and patient capacity
	Enhance patient and caregiver communications with the use of visual tools
Close to the Time of Discharge	Ensure personal clinician to clinician transfer
	Perform medication reconciliation at discharge

* To view a description of the types of evidence, please visit the Quality Compass at http://qualitycompass.hqontario.ca/Documents/EN/QualityCompassLevelsofEvidence.pdf

[1] Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. Lancet. 2003 Oct 11;362(9391):1225-30. Available from: http://www.ncbi.nlm.nih.gov/pubmed/14568747