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Stakeholder perspectives on transitions of nursing home residents to hospital emergency departments and back in two Canadian provinces

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ABSTRACT

Major gaps exist in our understanding of transitions in care for older persons living in nursing homes. The purpose of the study was to identify key elements, from multiple stakeholder perspectives, that influence the success of transitions experienced by nursing home residents when they required transfer to a hospital emergency department. This interpretive descriptive study was conducted in two cities in the Canadian provinces of British Columbia and Alberta. Data were collected from 71 participants via focus groups and individual interviews with nursing home residents, family members, and professional healthcare providers working in nursing homes, emergency departments, and emergency medical services. Transcripts were analyzed using constant comparison. The elements contributing to the success of transitions reflected a patient- and family-centered approach to care. Transitions were influenced by the complex interplay of multiple elements that included: knowing the resident; critical geriatric knowledge and skilled assessment; positive relationships; effective communication; and timeliness. When one or more of the elements was absent or compromised, the success of the transition was also compromised. There was consistency about the importance of all the identified elements across all stakeholder groups whether they are residents, family members, or health professionals in nursing homes, emergency departments or emergency medical services. Aspects of many of these elements are modifiable and suggest viable targets for interventions aimed at improving the success of transitions for this vulnerable population.

Introduction

As in many other member countries of the Organisation for Economic Co-operation and Development (OECD), almost half (43%) of Canadian seniors will be residents of nursing homes (NHs) during their lives and will spend 3 to 4 years there, with one in five staying more than 5 years (Council on Aging of Ottawa, 2008; OECD, 2005). Almost half (45%) of Canadians in NHs are frail elderly 80+ years of age (Statistics Canada, 2010). Three quarters are women (Statistics Canada, 2008); the majority (approximately 70%) suffer from age-related dementia (Doupe et al., 2011; Gruber-Baldini et al., 2010); and virtually all are highly dependent on others to meet their daily needs. The

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standards by which nursing home staff deliver such care, in Canada, are set by the respective provincial governments and no single standard exists (see Berta, Laporte, & Valdmanis, 2005; Harrington et al., 2012; McGregor et al., 2005). The quality of care received and health outcomes for NH residents has thus become an area of intense research interest (Berta, Laporte, Zarnett, Valdmanis, & Anderson, 2006; Boult et al., 2009; Kuske et al., 2007; Loganathan, Singh, Franklin, Bottle, & Majeed, 2011; Spilsbury, Hewitt, Stirk, & Bowman, 2011).

One area gaining prominence is the experiences of NH residents as they move between health services. Commonly occurring changes in health status – often triggered by events such as infections, falls, and geriatric syndromes – can result in frequent transfers from NHs to hospital emergency departments (EDs). Early research reported up to 1 in 4 NH residents experiencing a transfer to the ED each year (Bergman & Clarfield, 1991), and recent reports suggest that rates have not significantly changed: 19.0% (Gozalo et al., 2011) and 23% (Gruneir et al., 2010). We have defined the entire process of transferring a resident from their NH, to the ED (and inpatient care unit, if needed), and back to their NH as a transition in care. Transitions in care have been recognized as an important area for inquiry (Arendts, Reibel, Codde, & Frankel, 2010; Gozalo et al., 2011; McCloskey, Campo, Savage, & Mandville-Anstey, 2009; McCloskey & van den Hoonaard, 2007; Mitchell & Young, 2010) and have prompted the exploration of related health care needs (Coleman & Boult, 2003).

Transfers to ED among the NH population are: a) recognized to often place residents at significant risk for poor health outcomes and decline (Hustey, 2010); b) often prompted by weak evidence and poor decision making; c) plagued by operational inefficiencies that are reinforced by health system fragmentation (Terrell & Miller, 2006); and d) also extremely costly to the healthcare system (Boockvar, Gruber-Baldini, Stuart, Zimmerman, & Magaziner, 2008; Terrell & Miller, 2006). Residents can experience care that is delayed, not evidence-based, potentially unsafe and fragmented, and possibly unnecessary (Hustey, 2010; Saliba et al., 2000; Terrell et al., 2009). Few studies have reported on the entire process of transitions in care but instead have focused on discrete aspects of the process such as transfers of the elderly from hospital to NH (Newcomer, Kang, & Graham, 2006) or experiences in a single setting (e.g., the ED). Further, the multiple perspectives of all involved stakeholders, including residents and family caregivers, have not received systematic attention (McCloskey & van den Hoonaard, 2007). International and national reports describe sub-optimal quality of care in NH settings and in pre-hospital and ED settings (Keating, 2008; National Advisory Council on Aging, 2005; OECD, 2005), which may exacerbate the problems associated with transitions in care for NH residents. In summary, major gaps exist in our understanding of these complex transitions.

The objective of this qualitative study was to identify key elements influencing the success of transitions in care for residents moving between NHs and EDs from multiple perspectives (i.e., residents, family members, and professional healthcare providers) within the three settings of care (NH, Emergency Medical Services [EMS], and ED). For the purpose of this research, *elements influencing success* were defined as those aspects of the transition in care that were perceived to contribute to a transition 'going well.'

Design and methods

The interpretive descriptive study (Thorne, 2009) reported here is the first phase of a program of research: the Older Persons' Transitions in Care (OPTIC) project. The goal of this program of research is to identify modifiable factors to improve the care of residents experiencing transitions between NHs and acute care EDs. Two participating Canadian study sites – a large city in Alberta and a small city in British Columbia – are involved in this research. Thirty-seven NHs and multiple EDs exist in the larger city, and fewer than 15 NHs and a single ED in the smaller city. Participating EMS providers in each city are publicly operated. Ethical approvals were obtained in both provinces from the participating universities and health authorities.

Sample and data collection

Participants were recruited from three groups in each province: 1) NH residents who had experienced a recent transition in care to a hospital ED and a return back to the NH; (2) family members of those residents; and 3) professional healthcare providers (registered nurses, licensed practical nurses, paramedics, physicians, and administrators) involved in transitions from three settings—NHs, EMS, and EDs. The resident/family samples are described in Table 1 and the health provider sample in Table 2. Residents were eligible to participate if they were aged 60 or above, had an emergency transfer (911 calls only) to the ED within the last 12 months, and a Cognitive Performance Scale (Morris et al., 1994) score between 0 and 2. When compared to the Mini-mental State Examination, the Cognitive Performance Scale was found to be a valid measure of cognitive function in NH residents (Smart, Herrmann, & Lanctot, 2011). For ease of recall, we recruited residents and their involved family members in relation to their most recent transition. We did not attempt to match health professionals and residents/family members in relation to the same transition experience. Common reasons for NH transfers to the ED in the study sites included: fractures and lacerations related to falls, cerebrovascular events, cardiac problems, and infection (e.g., pneumonia and bladder).

Data were collected from residents (7 participants) and family members (20 participants) via 24 semi-structured interviews guided by open-ended questions focused on a recent transition to the ED and back to the NH. Residents and family members were given the option of individual or group interviews. Two families chose to be interviewed as a group (one family included 2 participants; the other family included 3 participants). Interview times for residents averaged 30 min while times for family members averaged 45 min. Participants were encouraged to describe what prompted the transition, the sequence of events (including family involvement) at each step of the transition, patient/family expectations regarding the transition, and perceived outcomes. Participants were asked to provide an overall assessment of the success of the transition they experienced as well as advice for responsible healthcare providers. Despite our best efforts to include the perspective of residents who met cognitive capacity criteria, we found that they struggled to recall transitions and provided extremely limited responses to open-ended questions. Family members, on the other hand, were able to provide detailed and reflective reports regarding their relatives' transitions.