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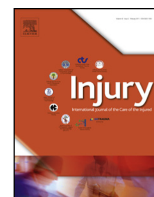

Full length article

Trauma patient discharge and care transition experiences: Identifying opportunities for quality improvement in trauma centres

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ABSTRACT

Background: Challenges delivering quality care are especially salient during hospital discharge and care transitions. Severely injured patients discharged from a trauma centre will go either home, to rehabilitation or another acute care hospital with complex management needs. This purpose of this study was to explore the experiences of trauma patients and families treated in a regional academic trauma centre to better understand and improve their discharge and care transition experiences.
Methods: A qualitative study using inductive thematic analysis was conducted between March and October 2016. Telephone interviews were conducted with trauma patients and/or a family member after discharge from the trauma centre. Data collection and analysis were completed inductively and iteratively consistent with a qualitative approach.
Results: Twenty-four interviews included 19 patients and 7 family members. Participants' experiences drew attention to discharge and transfer processes that either (1) Fostered quality discharge or (2) Impeded quality discharge. Fostering quality discharge was ward staff preparation efforts; establishing effective care continuity; and, adequate emotional support. Impeding discharge quality was perceived pressure to leave the hospital; imposed transfer decisions; and, sub-optimal communication and coordination around discharge. Patient-provider communication was viewed to be driven by system, rather than patient need. Inter-facility information gaps raised concern about receiving facilities' ability to care for injured patients.
Conclusions: The quality of trauma patient discharge and transition experiences is undermined by system- and ward-level processes that compete, rather than align, in producing high quality patient-centred discharge. Local improvement solutions focused on modifiable factors within the trauma centre include patient-oriented discharge education and patient navigation; however, these approaches alone may be insufficient to enhance patient experiences. Trauma patients encounter complex barriers to quality discharge that likely require a comprehensive, multimodal intervention.
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Background

Patient-centred care is a core dimension of healthcare quality and safety that prioritizes respect for patients' wishes and values in clinical decision-making [1]. While globally recognized, the increasing complexity of our health care needs and their coordination continually challenge local and system-wide efforts to deliver patient-centred care. The challenge is particularly salient during times when hospitalized patients move from one care context to another, for instance, leaving the hospital for home or another acute or long-term care facility. Care transitions are known to put hospitalized patients at increased risk for error as these are times when patients are between health care providers, teams and settings [2,3]. Incomplete documentation, medication discrepancies, sub-optimal information transfer between providers and inadequate provider-family communication are known problems [4–9]. Patients are also found to be poorly prepared to leave the hospital due to their physical, emotional and social status [10,11]. When transitions are poorly executed, patients may experience adverse events that require hospital re-admission. In light of this,

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improved hospital discharge and care transition processes and experiences are receiving considerable attention, as evidenced by recent studies on patient understanding at discharge [12–14], and the relationship between discharge processes and patient-reported [15–17] and clinical outcomes [18–20].

Severely injured patients have complex management needs and are under-studied with respect to the quality of their discharge and transition experiences. Though trauma patient and family views on the requirements for high-quality injury care are known [21], we are only beginning to understand patient experience of trauma centre discharge and transfer [22,23], and its relationship to quality care [24]. This knowledge gap is surprising given the prevalence of trauma worldwide and the estimated number of people living with ongoing injury-related disability [25,26]. For instance, 20 to 50 million people surviving road traffic injuries incur permanent disability [26]. A large proportion of the injured live with life-altering physical, cognitive and social impairments such as loss of limbs, spinal cord injury, and post-traumatic stress disorder [25,26]. This may result in prolonged hospital stays, require multiple surgical and medical services for multi-system injuries, and inability to advocate for resources. These factors, along with what is at times a fragmented social support network, put trauma patients at extremely high risk during transition from a trauma centre. At present, the best way to ensure the highest quality patient-centred discharge and transition for this patient population remains unknown.

The purpose of this study was to better understand the quality of trauma centre discharge and care transition experiences of severely injured patients. We aimed to explore how patients experience preparation to leave the trauma centre, their information and supportive care needs, and the perceived enablers and constraints to achieving these to identify modifiable factors for improvement.

Participants and methods

Study design and setting

We conducted a qualitative study using an interpretivist approach to capture the variation in patient and family experiences [27]. The study was carried out in a regional academic adult trauma centre in Toronto, Canada, where a publicly-funded healthcare system is in place. The trauma centre admits approximately 1000 injured patients annually, 90% of whom survive their injuries. In this centre, the most severely injured patients within the region will arrive direct from the scene of an injury or be transferred from one of over 80 referring non-trauma hospitals. Patients are cared for in a 35-bed trauma ward where they are visited daily by their primary surgical team (surgery trainees and staff from general surgery, orthopaedic surgery, or neurosurgery), and health care staff (nurses, therapists, etc) assigned to the ward.

Typical discharge and transfer procedures

Trauma patients discharged from our centre to home receive an information package including a discharge clinical summary listing their injuries, hospitalization course, interventions received, medications and follow-up procedures. Relevant written information about self-care, such as wound and collar care or social support is also provided. Discharge education is delivered by the patient's primary nurse, in conjunction with members of the health care team who review and teach the patient and/or family specific self-care needs such as weight bearing restrictions. A patient may receive in-home nursing care for wound dressing changes which would be reviewed at time of discharge.

Patients transferred to rehabilitation or another community hospital are notified by a social worker when a community bed becomes available and discharge is possible. Transportation is arranged by the clerical staff. Medical records, a discharge summary and follow-up appointment cards are packaged and taken in-hand to the receiving centre by the patient. Discharge teaching in instances of transfer is minimal with no standard process in place. When a patient is received by a community hospital, physician-to-physician handover and nurse-to-nurse transfer of accountability are completed by telephone. A patient with a neuro-trauma injury may have a consultation with a neurosurgical outreach nurse who will follow the case through to transition. Receiving providers within the surrounding region have access to a patient's electronic health record through a secured shared repository online. Patients and/or caregivers have access to an e-health service called MyChart in which all of their information from the hospital's electronic patient record is stored.

Recruitment and sampling

Purposive sampling was used to recruit trauma patients or, where appropriate, a family member involved in discharge procedures [28]. Given the heterogeneity of the trauma patient population, recruitment was driven by efforts to capture a varied sample based on patient characteristics (age and gender), type and mechanism of injury, and discharge disposition (home, rehabilitation, or another acute care hospital). Eligible participants included English-speaking patients or the family member of a patient who was admitted to the trauma ward between March and August 2016. Individuals were approached for participation prior to hospital discharge and presented with written consent forms approved by the hospital's research ethics board. Consented participants were contacted by telephone 30 days after discharge as this was determined to be sufficient time for the participant to experience and reflect upon the quality of the discharge or transition process. Three attempts were made to telephone consented participants who were purposively targeted to achieve a varied sample. If unreachable or unavailable after three attempts the researcher selected another consented individual for interview.

Data collection and analysis

Semi-structured interviews were conducted by telephone between April and October 2016 by the primary author, a medical anthropologist. The interview guide was informed by a literature review and research team expertise which included a senior trauma surgeon and systems researcher, an advanced practice nurse, a nurse-trained leader in interprofessional practice, and an organizational leader in quality improvement and patient safety (Appendix A). All interviews were audio-recorded and transcribed, each lasting approximately 20 min. Data were analyzed iteratively and inductively consistent with thematic analysis whereby themes were derived from ongoing data collection and analysis, i.e. coding [29]. Two stages of analysis involved initial data coding completed independently by two team members using open coding procedures and discussion to reach consensus on major themes identified. Second, using the constant comparison technique, similarities and differences across and within themes were analyzed refining the themes and their content. Data collection ceased when the authors determined there to be sufficient depth, breadth and redundancy in the themes that were derived from patient experiences to offer a complete and sensible understanding of quality trauma centre discharge and transition experiences [30].

Results

Twenty-four interviews were completed with trauma patients and/or a family member (spouse, child or parent of patient); patient

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