Toronto abi Network

2020

Hospital to Community Transition Planning for Acquired Brain Injury (ABI): A Best Practice Guideline

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"The hospital to home transition heralds the commencement of the community re-integration process… during the transition phase many individuals with ABI begin to comprehend the impact of their injury and subsequent dependency." [1]

Poorly coordinated transitions back to the community following a hospital stay remain an ongoing issue within our health care system.[2,3,4,5] Patients and caregivers continue to face challenges with the transition from hospital to home,[3,4,5,6,7,8,9] and for individuals with brain injury, negative transition experiences are further complicated by the long term, multi-faceted nature of their deficits.[6,7,9]

The Toronto ABI Network's 2017-2020 strategic plan identified improving hospital to community transitions as a priority, and the Network convened a broad group of hospital and community stakeholders to work on solutions. Currently, every hospital supports transitions differently, and stakeholders identified the need for a clear guideline for transition planning specific to acquired brain injury.

To develop the guideline, the Network reviewed current evidence on best practices, particularly studies that focused on the experiences and perspectives of individuals with brain injury and their caregivers. Network members were surveyed about their current practices, and interviews with survivors and caregivers were conducted to gather the perspectives of people with acquired brain injury who had transitioned to the community in the past year and their families/caregivers.

Key elements for improved transitions

The literature and interviews identified the following elements as critical to better hospital to community transitions for individuals with ABI:

- Mobilize social supports for the individual with brain injury. Engage family members, caregiver(s) and friends. Also consider community supports, such as peer support groups. Don't forget the caregiver – consider caregiver support groups.
- Adjustment to life post-injury begins early in the recovery process and continues as the individual with brain injury transitions across the continuum of care. Education and psychological support or counselling are recommended while in hospital and after discharge.
- Prior to discharge, ensure continuity of care through community services to support the transition. In particular, service coordination in the community (e.g., case management). Provide information on wait times and service/program expectations. Do not forget the caregiver – consider services that may assist them in the future (e.g., respite care).
- Functional changes and a lack of activity can lead to increased stress and anxiety. Engagement in meaningful activities enables community integration. Provide education on the importance of a daily routine and/or assist with the development of a schedule to be used at home.
- Provide strategies to ease the return to daily life (e.g., BADLs and IADLs, equipment use), including how to address anticipated challenges.

- Provide tailored information and education on expectations post-discharge, community supports and services, symptom management (e.g., recommendations on sleep hygiene or screen time). Provide a contact (preference is for someone with ABI expertise) to reach out to and ensure "pathway" to access services (i.e., OHIP vs. WSIB) is understood from the start. Consider providing this through written materials.

About the guideline

The recommendations that follow apply to both acute care and rehabilitation hospitals and are intended for clinicians and others supporting transition planning. They support a patient-centred approach to hospital to community transition planning that takes into account the unique needs of individuals with brain injury. The recommendations also address the needs of caregivers, as they play an important role in the recovery and care of an individual with a brain injury.

Content is organized in four stages, adapted from Health Quality Ontario's work on *Transitions between Hospital and Home* model.[4] These stages are: Early in the Hospital Admission, During Inpatient Stay, Closer to Discharge and In the Community.

The Ontario Neurotrauma Foundation's *Clinical Practice Guideline for the Rehabilitation of Adults with Moderate to Severe TBI* [10] should be referred to for specific guidance on clinical and rehabilitative care.

Early in the Hospital Admission: Identify, Communicate, Appoint

Identify

- Identify social supports for the patient (e.g., friends, family, and caregiver). Early engagement of caregivers provides them with opportunities to ask questions and enhance understanding.[6,7,11]
- Assess health literacy (understanding of any written or verbal information relating to the patient's health and care, including transition planning).[3,5,10]
- Provide education and psychological support to facilitate individual and family adjustment. This should occur at multiple points in the transition planning process.[7,11]

Communicate

- Within 72 hours of admission, where appropriate, communicate 'estimated date of transition'.[13]
- Communicate with the patient and family member(s). Start early discussions on expectations while in hospital, transition planning, who will be involved and what is needed to return home safely.[10,12,13]

Appoint

- Perform medication review on admission.[3,5,10,14]
- A case or clinical coordinator with clinical experience and specialized training in a brain injury related field, should be appointed at each phase of the continuum of care. This coordinator should:[10]
    - Oversee the planning and be the key contact person
    - Coordinate the interdisciplinary team to avoid duplication of tasks or interventions
    - Advocate for the needs of the individual and their caregivers
    - Plan and coordinate the transition between phases in the continuum of care, providing continuity and communication

During Inpatient Stay: Communicate, Engage, Prepare

Communicate

- Notify community providers of patient admission (e.g., primary care provider; home & community care if individual is an existing patient).[14]

Engage

- Collaborate with community providers to begin/update the coordinated care plan and establish the single point of contact.[14]
- Transition planning should involve the patient, his/her family/caregivers (with consent) and, if available, the community case coordinator.[13]
- Meetings between the interdisciplinary team, the person with brain injury and family members should be offered regularly.[10] Utilize these meetings to review expected date of discharge.[13]
- Mobilize social supports for the patient and engage them early and frequently to address questions and enhance understanding of the transition process.[7,11]

Prepare

- The team should assess and document the family's capacity for and interest in being the caregiver for the person with brain injury.[2,13,15] Consider any reason(s) why the caregiver may not be able to take on the level of care being contemplated in the transition plan.[2,15]
- Individuals who assume a caregiver role to a person with brain injury should be provided with information relevant to their role and access to ongoing support.[10]
- For individuals in an inpatient rehab program, transition to home should be on a supported, gradual basis (e.g., through home visits, weekend/weekday passes and experiences in transitional living).[10]
- Provide family/caregiver training in the use of equipment and management of the individual to ensure his/her safety in the home environment, including how to address anticipated challenges.[7, 10, 11]
- Use teach back[16] when building caregiver and patient knowledge and skills; consider the use of visual tools.[3,10,14]
- Provide education and psychological support to facilitate individual and family adjustment. This should occur at multiple points in the transition planning process.[7, 11]
- Provide education on the importance of a daily routine and assist in the identification of meaningful activities to manage time after the individual with a brain injury returns home.[7, 10, 11]

Close to Discharge: Coordinate, Prepare, Communicate

Coordinate

- Transfer to the community should optimally occur when appropriate referrals have been made or when services can be continued in a timely manner.[10]
- If needed, coordinate telephone follow-up with a professional skilled in motivational interviewing,[17] goal setting, providing reassurance and problem-solving support.[10]
- If needed, long-term services (e.g., counselling) should be made available to enable and sustain societal participation.[10]
- If needed, collaboration and coordination should be established with mental health and/or addiction/substance use services and programs in order to develop management strategies for individuals with comorbid brain injury.[10]
- Identify a person in the community to support non-clinical needs in the immediate post-hospital period, particularly if gaps for required home supports are identified.[7, 10, 11] For example, if there is a diet restriction, will the patient be able to manage? Potential resources include family caregivers, community support agencies, etc.[5,10,14]
- Perform medication review at discharge. Identify one lead to perform medication review in the community.[3,10,14] The care plan is updated to reflect the identified the lead and the medication review at discharge.[14]

Prepare

- Transition plans should be developed using a standard approach.[3,5,10] Include the following:[18]
    - Assess discharge destination environment and support available
    - Provide any equipment and adaptations required
    - Train caregiver/family in equipment use and patient management to ensure safety in the home environment
    - Provide relevant formal and informal resources to patients and family/caregivers, including voluntary services and self-help groups.
- Inform patients and families about readiness (e.g., "you have achieved your goals and no longer require care in hospital"[13]); communicate how transition planning will be supported (i.e., service options and who will be involved).[7,10,11,12]
- Provide patients and families with information on timelines for services (i.e., wait times) and strategies for time management, activities and organization of the day activities.[6,7,9,11,19,21]
- Provide education and psychological support to facilitate individual and family adjustment. This should occur at multiple points in the transition planning process.[6,7,9,11,19,21]

Close to Discharge (*continued*)

Communicate

- Provide a copy of the discharge report and care to the person with brain injury, and with consent, to families/caregivers and professionals involved in the rehabilitation in the community. It should include: [10,13]
    - Electronic health records summary or report detailing the clinical history, examination, and any imaging
    - Results of all recent assessments
    - A summary of progress made and/or reasons for discharge/transfer
    - Recommendations for future interventions (e.g., appointments, services) and the contact information of a hospital staff should questions arise after discharge.
- Ideally a conversation between the most responsible physician (MRP) and the patient's primary care provider should take place just prior to discharge from hospital. The conversation should focus on the following goals: support a smooth transition in the transfer of care, clarify reason(s) for admission and provide advice on the recommended follow-up care.[10] In collaboration with the patient, schedule a follow-up primary care visit to occur within seven days of discharge.[10,14]
- Use documentation tools and communication strategies to standardize information that is shared at care transitions.[3,5]

In the Community: Communicate, Follow Up

Communicate

- Provide discharge summary to primary care within 48 hours of hospital discharge and notify primary care that the summary is available.[10,14] Information that is shared at care transitions is standardized using documentation tools and communication strategies.[3,5]

Follow Up with Patient and/or Caregiver

- A community and/or hospital care provider should connect with the patient and/or caregiver.[10] The objective is to monitor patient progress, enhance knowledge and self-management skills, establish networks to meet the patient's needs, provide follow up/reinforcement of care plan, and refer to services identified.[10,14]

CONCLUSION

The transition from hospital to community is a key milestone for patients and an important point of care, particularly for those who have just sustained a life altering injury that impacts their cognitive functioning.

It will take time for the person with the injury and their family to adjust to their new abilities and new reality, and providers play a critical role in helping individuals make that adjustment. A smooth transition from hospital to the community can ease their stress and set them up for success as they continue their recovery and move forward with their lives.

Thank you to members of the Hospital to Community Transitions Committee (in alphabetical order):

Pamela Madan-Sharma (West Park Healthcare Centre), Chair.

Bellwoods Centre, Bridgepoint Active Healthcare – Sinai Health System, Community Head Injury Resource Services (CHIRS), Cota, St. Michael's Hospital – Unity Health Toronto, Sunnybrook Health Sciences Centre, Toronto Rehabilitation Institute – University Health Network, Toronto Western Hospital – University Health Network, Trillium Health Partners, West Park Healthcare Centre.

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