Perspectives of patients, caregivers, and healthcare providers on transitions from hospital to home in three rural communities in Eastern Ontario, Canada: a qualitative descriptive study

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BACKGROUND

- The successful transfer of patients between multiple providers across different settings is referred to as transition in care (TiC), with one of the most complex and sensitive transitions occurring during a patient's discharge from the hospital to the community
- TiCs present particular obstacles to patients living in rural communities due to multiple factors, including socioeconomic conditions, geographic isolation, a lack of evidence-based transition in care guidance, and a shortage of rural healthcare providers and services.
- However, there exists a gap in the current literature regarding these unique challenges faced by patients in rural communities.
- This study aimed to describe patients, caregivers, and healthcare providers' perspectives on the TiC from hospital to home.

METHODS

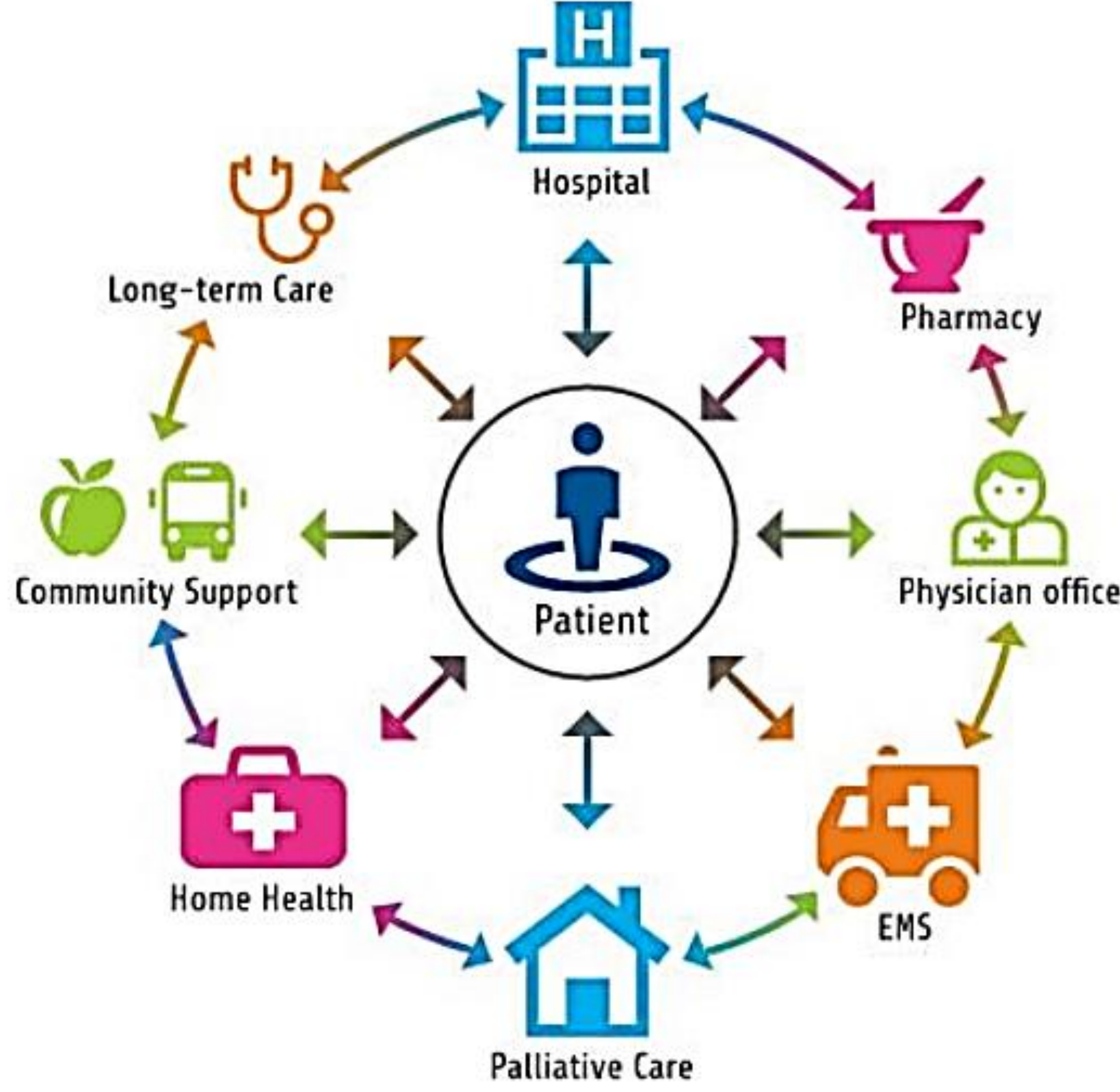
We conducted a qualitative descriptive study between January and March 2021. Semi-structured interviews in three rural communities in Eastern Ontario, Canada, were conducted with patients/caregivers (n=16), internal (n=16) and external providers (n=9).

Interviews were audio-recorded, transcribed, and thematically analyzed using the Ideal Transition in Care framework.

RESULTS

The main themes identified aligned with the ten domains of the Ideal Transition in Care framework, further supporting its relevance in TiC planning within a rural setting.

ITC Framework	Key Components Identified by Participants
Discharge planning	• Involving the caregiver/ family, and all community providers • Planning ahead for transportation
Complete communication of information	• Considering what information is important for community providers to receive
Availability, timeliness, clarity and organization of information	• Determining the most effective communication method between providers
Medication safety	• Completing a Best Possible Medication History upon admission • Medication reconciliation • Communicating discharge medications and needs
Educating patients to promote self-management	• Providing patient education
Enlisting help of social and community supports	• Setting up community supports • Having working relationships with community service providers • Availability of community services • Considering patient's home situation • Community providers knowledge of services
Advance care planning	• Considering patient goals
Coordinating care among team members	• Coordinating care within and across care settings • Addressing both medical and non-medical needs • Relationships with patients
Monitoring and managing symptoms after discharge	• Post-discharge follow-up
Outpatient follow-up	• Post-discharge follow-up with community physician and pharmacist



CONCLUSION

- Findings addressed the identified gap in the literature by generating knowledge that is specific and directly applicable to the unique rural context.
- In addition, decision-makers could use the knowledge base established in this study when designing future rural TiC guidelines and activities.
- Discharge planning within rural settings should look to directly address the unique challenges experienced by these patient populations.

REFERENCES

Please find full reference list on reverse side of poster.

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