Concurrent session 6
Experiences and perceptions of patients, families and providers toward care transitions

This theme will feature oral presentations about research studies and innovative initiatives that explore the experiences and perceptions of patients, families and health care providers towards care transitions. Understanding the experiences and perceptions of those directly involved in care transitions is critical for informing the continuous improvement of transitions along the continuum of care. Examples of topics within this theme include:

- The lived experience of patients and families
- Patient engagement strategies
- Engaging frontline clinicians in care transitions
- Patient safety

Presentation 1
ID 52. Engaging Patients & Families Experience-Based Co-Design of the Admission Process
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Background: Bridgepoint Hospital - Sinai Health System is a 404 bed rehab/ccc hospital designed to enable patients to be active in their care. With government funding and clinical best practice requirements to shorten the length of stays, the first 48 hours from admission is a critical time for patients/families and the team. Patients arrive from acute care feeling overwhelmed with information, the new environment and the short length of stay. The interprofessional team has to quickly establish the patients goals, plans of care/treatment and set the discharge date.

Objective: This project aims to achieve exceptional patient experience with the admission process by capturing and understanding their experience, partnering with them to co-design the first 48 hours of hospital stay. This project received a grant from the Canadian Foundation for Healthcare Improvement.

Methods: Using Experience by Co-Design methodology, we captured the patient and staff experience with the current admission process on the orthopedic unit. Based on outcomes, patients together with staff co-designed priority areas in the first 48 hours of care. Patients and staff identified and implemented change ideas using quality improvement principles, tested and evaluated change. Process outcomes and balancing measures were put into place to determine whether the changes resulted in improvement.

Results: Patients informed us to shift the burden from the admitted to discharged patients, so new patients in pain are not waiting for a bed on admission. Together we revised a discharge slip providing patients with the date of discharge. We co-designed a discharge checklist “Ready to go”. Patients are given this tool 5 days before their discharge date to help them get ready to go home. We shifted the hospital discharge time of 10am to 09am to create bed capacity for new admissions. Since May 2015 patient satisfaction is very high 95-100%, more admissions have been arriving before 10am [43% (May-Sept 2015) vs. 35% in FY 14/15] our patients have been leaving earlier with 67% leaving before the discharge time of 10am compared to 49% in FY14/15. Only 1 patient has waited for a bed.

Conclusions: Engaging patients and capturing their experience and partnering with them to co-design processes benefits patients and staff to provide better, more efficient care

Presentation 2
ID. 111 Exploring the Self-Management Needs of Transitioning Young Adults with Osteogenesis
Alisha Michalovic, Charlotte E. Anderson, Argerie Tsimicalis, Kelly Thorstad, Sharon Brissette, Lucyna Lach, Frank Rauch
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**Background:** Youth with chronic conditions are at a heightened risk for various adverse health outcomes once transitioned from the pediatric to the adult healthcare system. The Shriners Hospitals for Children - Canada (SHC) is seeking to improve the transition services provided to the osteogenesis imperfecta (OI) population by (a) creating partnerships with the adult primary care settings, (b) providing OI training to the adult nurse practitioners, and (c) improving the self-management skills of our transitioning OI population.

**Objective:** To explore the future and current self-management needs of transitioning young adults with OI as they transition from pediatric to adult primary care.

**Methods:** A longitudinal qualitative descriptive study is currently in progress at SHC and CSSS de la Montagne (an adult primary care setting) with a convenient sample of up to 20 participants who agree to be seen by an adult nurse practitioner. Eligible participants consist of young adults with OI who were former SHC patients. Two semi-structured interviews are conducted with the participants, which focus on their self-management needs before and after they transition into an adult primary care setting. Genograms and eco-maps are also created with the participants to provide a graphical representation of their family structure, resources and support networks. Data are descriptively analyzed.

**Results:** To date, 4 participants have participated in 6 interviews (4 before and 2 after transition). Participants include those diagnosed with OI type III (n = 2) and OI type IV (n=2), and range in age from 23 to 34 years. Emerging themes suggest a desire for a home and work environment that promotes independence, knowledge and resources to help navigate the adult healthcare system, access to a primary healthcare provider knowledgeable about OI, a need for social support from the adult OI community, and a desire to maintain their longstanding relationship with SHC.

**Conclusions:** Findings generated from this study may inform our goals to provide a seamless transition into the adult system, ensure our patient population has the knowledge and skills to successfully navigate the system, and our adult practitioners have the knowledge to care for this rare genetic condition.

**Presentation 3**

**ID 125. A Major Healthcare Transition Milestone: Experiences and Needs of Parents of Preterm Infants Transitioning from Neonatal to Developmental/Rehabilitation Services**

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**Background:** Children with cerebral palsy (CP), who were born preterm (<37 weeks), have complex medical needs requiring transition to and from many healthcare institutions over their lifespan. While an abundance of research outlines the experiences and needs of patients and families during the transition to home, school, adult care, long-term care, and palliative care; very little is known about the transition from neonatal services to developmental/rehabilitation services. Researchers and practitioners have little knowledge of stressors encountered, and types of supports required to help patients and their families successfully cope with this healthcare milestone.

**Objective:** To identify and describe the experiences and needs of parents of children with CP, who were born preterm, as they transition from neonatal services to developmental/rehabilitation services.

**Methods:** Phase 1: Scoping review identifying experiences and needs of parents of infants/children (<13 years) as they transitioned within or between healthcare settings. Eight databases were reviewed by three researchers, eligible articles selected, and data were extracted for experiences and needs. Phase 2: Interviews with Holland Bloorview Kids Rehabilitation Hospital (HB) parents of children with CP, who were born preterm. Interviews were audio-recorded, transcribed verbatim, and underwent a thematic analysis.

**Results:** From 7,890 retrieved titles, 12 articles met eligibility criteria. No study focused on transition to developmental/rehabilitation services. Positive experiences were defined by: provision of information, feeling involved in care, and improved child health outcomes post-transition. Negative experiences were defined by: inadequate information or communication, fearing the unknown, feeling separated from their child, and unexpected differences within the new healthcare setting. Parent needs included: more information, emotional support, being part of the healthcare team, and instrumental assistance by families/friends. Themes were reiterated in HB parents’ interviews: feeling uncertain, receiving little information, and limited support to cope with changes.
Conclusions: Themes emerging from this research are not uncommon to the many types of healthcare transition experienced across the lifespan. There is an opportunity to support families’ resiliency and preparedness earlier in their journey of healthcare transitions, which will ultimately lower stress, embody family-centered care, and improve child health.