

# Recommendations for Supporting Care Transitions for People with Hip Fractures

## Background

- People who experience hip fractures can undergo many transitions between care settings, including hospitals, inpatient rehabilitation, outpatient clinics, homecare, assisted living, and long-term care homes.
- These changes can lead to hospital readmissions and emergency department visits.
- Previous work has often focused on the transition from hospital to home rather than across the wide range of care settings. A comprehensive look is needed.

## What We Did

- We brought together: **people with lived experiences of hip fractures, care partners (e.g., family or friends), healthcare providers, and decision-makers** to get their thoughts on improving care transitions for individuals following a hip fracture.
- We used a method called **Concept Mapping** where participants brainstormed ideas to answer the question: **‘What is needed to improve care transitions for hip fracture?’**
  - This created a list of 74 unique ideas that participants grouped based on commonalities to identify **areas of improvement**.
  - The ideas were then rated on how important each participant thought it was, and how much of a priority it should be, to improve care transitions, to identify **key action items**.

## Identified Areas of Improvement



Informed and collaborative discharge planning



Provider knowledge, skills, roles and behaviours



Support for care partners



Patient-centred care



Access to transitional and outpatient services



Physical, social, and cognitive activities and supports



Communication, education and knowledge acquisition



Access to inpatient services and supports across the care continuum

## Key Action Items for Improvement

The following statements were highly rated by participants for ‘importance’ and ‘priority’ for improving care transitions:



‘Ensuring patients and caregivers are included in the decisions’



‘Being compassionate while caring for patients’



‘Ensuring patients’ and care partners’ questions are answered’



‘Increasing staffing so providers can spend more time with patients’



‘Having a care team that works well together’



‘Having adequate pain management’



‘Having access to different healthcare providers (e.g., geriatricians, therapists)’



‘Using clear and simple language to improve patient and caregiver understanding’



‘Ensuring providers use the proper transferring techniques (e.g., sit to stand)’



‘Providing patients and care partners with ongoing communication throughout their care transitions’



‘Having established partnerships between hospitals, rehabilitation facilities, and homecare services for consistent transitions’

## Impact and Importance of Findings

The statements participants rated as high priority and high importance, provide ideas for improving transitions in care amongst people with hip fractures.

- Most of the ideas were related to person-centred care and continuity of care.
- The knowledge, skills, roles, and behaviours of healthcare providers, were considered amongst the most important and highest priority action items.

**Study results can be found:** Guilcher, S. J. T., et al., (2024). Identifying and prioritizing recommendations to optimize transitions across the care journey for hip fractures: Results from a mixed-methods concept mapping study. PLOS One, 19(8).

**Acknowledgement:** This study was funded by the Canadian Institutes for Health Research (grant #179845).

