

# Recommendations for Supporting Care Transitions for People with Hip Fractures

## A Concept Mapping Study

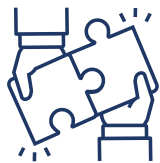
### What did we do?

We recruited 35 participants: people with lived experiences of hip fractures, care partners, healthcare providers and decision-makers. We used a method called concept mapping where participants responded to the question:

**What is needed to improve care transitions for hip fracture?**

### Identified areas of improvement

74 unique ideas, spanning 8 areas of improvement were identified:



**Informed and collaborative discharge planning**  
(e.g., including home and community care providers in discharge planning)



**Provider knowledge, skills, roles and behaviours**  
(e.g., ensuring providers use the proper transferring techniques)



**Support for care partners**  
(e.g., having more support for care partners to address caregiver burden)



**Person-centred care**  
(e.g., respecting patients' and care partners' preferences, knowledge and needs)



**Communication, education and knowledge acquisition**  
(e.g., having open conversations about what to expect about care and transitions)



**Access to inpatient services and supports across the care continuum**  
(e.g., reducing wait times for services or procedures)



**Access to transitional and outpatient services**  
(e.g., ensuring timely, consistent and sufficient homecare services)



**Physical, social, and cognitive activities and supports**  
(e.g., having individualized exercises that change over time to meet patient goals)

**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).

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