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Assessment of the Effectiveness of Transition of Care Process in Gaza Governmental Hospitals

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Assessment of the Effectiveness of Transition of Care Process in Gaza Governmental Hospitals

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Dedication

I dedicate this work to the sake of Allah my Creator and my master.

To my Father and my Mother whose affection, love, encouragement and prays day and night make me able to get such success and honor.

To my dear husband, for his support and love.

To my sons, Mohammed, Ahmed and Zain Al-Deen

To my daughters Ola and Tala.

To my brothers Saleem and Osama.

To my sisters Roba, Reem, Reham and Merhan.

To all my friends.

To all patients in Palestine ,who deseve the right of better care and life.

To everyone who contributed to getting this study a reality.

To all those beleived in me ,thank you.

Rola Sami Abu Dalfa

Declaration

I certify that this thesis submitted for the master's degree is the result of my own research, except where otherwise acknowledged, and that this thesis or any of its parts has not been submitted for a higher degree to any other university or institution.

Signed:

Rola S. Abu Dalfa

Date:/……/…….

Acknowledgment

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Abstract

Background: *Transitions of care is an essential part of a patient's journey through a health care system. It refers to the movement of a patient during an acute or chronic illness between different settings and health care providers., results in different challenges in providing ongoing care, and the movement of patient to home, which means the start of a new round of management activities and /or self-management, so health systems must focus on patient education and training about self-management and engage the patient as an active partner. Ineffective transition of care is recognized as a critical issue threatens patient safety, resulting in poor clinical outcomes, increased readmission rates in hospitals and financial burdens on the patient and healthcare system.*

Objectives: *This study aimed to explore the standing condition, strengths and weakness points of the current care transition processes, in addition to recognizing the patients', health care providers' and decision makers' impressions about it, in order to highlight it and make recommendations for improvement and development.*

Methodology*: the study is mixed one, the quantitative part is descriptive, analytical and cross sectional, was done through organizing interviews with patients discharged from the hospitals to fill in face-to-face questionnaires with 383 patients from four hospitals (2 general hospitals and 2 specialized hospitals) and the qualitative part included interviews with ten key informants and five focus groups. Quantitative data was analyzed using the Statistical Package for the Social Sciences software and the qualitative data was analyzed by open coding thematic analysis method.*

Results: *As for the eight study domains, the percentage of these domains ranged from (56.7%) to (69.05%) means. The overall patients' perspective was moderate, the lowest for the continuity of care and the highest for the care coordination. The discharge planning domain was 66.5%, the preparation domain was (63.4%), the information exchange was (69%), medication reconciliation domain was 59%, health education domain was 56.24% and follow up domain was (64.5%). Health providers and key informants revealed that there are gaps and barriers impeding the effective transition of care process, there are no systematic transition of care processes at hospitals and there is a lake of knowledge ,lack of understanding of discharge plans during hospitalization and lack of clarity in health care provider roles which tends to exacerbate already fragmented care responsibilities during transitions between settings and providers. And there is a serious lack of information addressing the problems the patient may face after discharge. The study showed poor provision of patient-centered care, patient and his family did not feel involved or informed about decisions in care, patient education is not a priority, it is about some instructions given before discharge. The study also revealed the fragmentation of the system in the provision of medicines to the patient, the medication reconciliation process is therefore not done. In addition to incomplete transfer of information, most patients receive oral instructions, patients don't understand written instructions and the discharge sheet is not informative for all information needed to the patient during care transition. There is a lack of teamwork, interdisciplinary work is dominated by individualism, and there is insufficient communication within a multidisciplinary team between the different specialties. There is poor coordination between hospitals and primary health care and community agencies which threaten continuity of care and results in readmission to hospitals.*

Recommendations: *The study recommended developing national transition of care policies to ensure continuity of care and integration of services, strengthening the role of primary care to reduce the burden on hospitals, working to develop a comprehensive health information system, encouragement of patient-centered services and developing medication reconciliation policy and procedures.*

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List of Abbreviations

ADL	Activities of Daily Living
AE	Adverse Event
AHRQ	Agency for Health Research and Quality
AMA	Against medical advice
ANOVA	One-way Analysis of Variance
BPMH	Best possible medication history
BSc	Bachelor of Science
ED	Emergency Department
EMRO	Regional Office for the Eastern Mediterranean
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GGs	Gaza Governorates
GP	General Practitioner
GS	Gaza Strip
IOM	Institute of Medicine
JCI	Joint commission International
KII	Key Informant Interviews
Km	Kilometer
LOS	Length of stay
M.P	Multiple professions
MANOVA	Multivariate analysis of variance
MD	Median
MOH	Ministry of Health
N	Number
NCDs	Non communicable diseases
NGOs	Non-governmental Organizations
OECD	Organization for Economic Co-operation and Development
PCBS	Palestinian Central Bureau of Statistics
PCC	Patient-centered care
PHC	Primary Health Care
SBAR	Situation, background assessment and recommendations
SPH	School of Public Health
SPSS	Statistical Package for Social Sciences
Sq	Square
Std	Standard Deviation
TOC	Transition of care
UK	United Kingdom
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USA	United States of America
USD	United State Dollars
WB	West Bank
WHO	World Health Organization
WM	Weighted mean

Chapter One

Introduction

1.1 Background

Transitions of Care (TOC) refers to the various points where a patient moves to, or returns from, a particular physical location or makes contact with a health care professional for the purposes of receiving health care, this includes transitions between home, hospital and consultations with different health care providers, it is an essential part of a patient's journey through a health care system at many different times and places (WHO, 2016).

Care transition necessarily involves several health care providers in and between settings, all contributing to one individual's responsibility for care. This, however, results in different challenges in providing ongoing care. Unfortunately, care transition is often discontinuous and poorly coordinated, leading to poor quality of care, compromised patient safety and adverse events (Naylor et al., 2017).

World Health Organization (WHO) Defines quality as "*the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered*."(WHO, 2006: 9) .Patient safety has long been seen as a key factor in improving the quality of care and safe care can be seen as a barometer of healthcare systems' success in improving quality (Syed et al., 2018). Therefore, care transition is a handover encircled by risk, dangers and hazards due to latent factors that are system failures, or active failures who are health care providers '. Such failures can threaten patient safety and lead to medical errors, rehospitalization and even death (Greenwald, Denham, & Jack, 2007). Risk can be caused by a number of factors, including fragmentation of the healthcare system, poor communication, lack of coordination among healthcare providers, lack of or inefficient discharge planning, inadequate monitoring and continuity of care and care transition gaps lead to unnecessary readmissions which increase health system costs and life-threatening to patients (Hesselink, et al., 2014)

Many readmissions are due to confusing discharge arrangements, unclear instructions from various providers, drug mistakes, including dangerous interactions between drugs