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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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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

and duplications. The consequences of ineffective transitions are far-reaching and can cause frustration among providers, add unnecessary costs to the health care system and cause confusion and stress for individuals and their family members (Naylor et al., 2017; Jencks, Williams & Coleman, 2009).

The concept of transition is derived from social science, Meleis ' theory of transition, which indicated that the transition reflects changes in health status, changes in relationships and responsibilities, aspirations and capacities, indicating changes in human needs (Meleis, 2011). He emphasized that such a change is taking place in the health situation, so we have to expect environmental factors that could threaten our patients during the care transition period, the transition itself produces a vulnerability status so this impression of Meleis makes us think of the fragility of our patients and the dimensions of this fragility that interfere with the major problems of the health system and its complex environment and the objective is to concentrate on identifying the points where fragility hits the peak while acknowledging the health needs of the individual and to take preventive steps before the transition takes place by assessing the information and education levels as well as communication at the time of transition (Meleis, 2011).

In the United States of America (USA), the United Kingdom (UK) , Australian Health System and many other countries, effective transition of care has been a priority for several years, such countries have developed numerous transitional care programs and policies for effective care transition with a multidisciplinary approach to reducing the number of hospital readmissions and reducing mortality and morbidity attributable to inadequate care transition, it has been a critical indicator of the quality of hospital care in recent years, and declining readmission rates are a major challenge for leaders of the health care system (Kommuri, Johnson, & Koelling, 2012).

Accordingly, the Palestinian healthcare system must be alert to those processes that a system of fragmented care and inconsistent performance in the transition of care could compromise the quality of care and patient safety, resulting in poor clinical outcomes, increased readmission rates in hospitals and financial burdens on the patient and healthcare system.

1.2 Problem statement

Ineffective transition of care is recognized as a critical issue threatens patient safety. According to the Joint Commission International (JCI), (80%) of hazardous medical errors are likely to include miscommunication among health care providers during patient transition. The transition process includes senders who transmit known patient information and move a patient's care to the next clinician, and recipients who embrace the patient's information and care. Besides causing patient harm, improper communication can lead to delays in treatment, inappropriate treatment and a longer stay in the hospital (Joint Commission, 2012). Upon hospital discharge, (49%) of hospitalized patients experience at least one medical error, diagnostic examination, or follow-up tests (Moore et. al., 2003). One study reported that one-quarter of patients had an adverse event post-discharge, and half of the Adverse Events (AEs) were preventable (Forster et al., 2004).

To the researcher's best knowledge, AL Massri (2009) conducted a study on the discharge process in the West Bank (WB). In addition, Al Ron (2009) conducted a study on the discharge process at the Al-Shifa Hospital in Gaza Surgical Departments and Abu Dagga (2014) conducted a study on the discharge process at government hospitals in Gaza Strip (GS). And the three studies found that there are a lot of gaps in the discharge process, but these studies focused on one part of the transition from hospital to home. However, there is an information gap on how all care transition processes works in Gaza Hospitals and there is a lack of reliable information and strategies related to care transition.

The ultimate goal of the researcher is to analyze the current system, deepen the patient journey of his disease to explore discrepancies, patients suffering, success and failure through this path. Thus, this study attempts to pay attention to this unclear area of care delivery process and to investigate current practices in governmental hospitals to promote the awareness of policy makers toward effective transition of care policy that improve quality and patient safety.

1.3 Justification

Many of us feel the anxiety and overwhelming of hospitalization whether on our own or with a loved one and the confusion that follows after discharge to home or transition from one health provider to another at the same hospital or another hospital, patients

discharged from hospital to home must get better and not have to worry from unclear instructions, medical errors or possible side effects of drugs.

Uncoordinated care and fragmentation that result from ineffective communication among health providers during transition of care processes can lead to misuse of resources, medication and medical errors ,patient frustration and rehospitalization which is stressful for team and dangerous for patients , as every hospitalization increases the risk of hospital acquired infections, medication errors, falls and other side effects which are costly to the health care system, on the order of $12–$44 billion annually in the USA (Alstveit, Aase, & Barach, 2011). Studies on chronic patients in USA hospitals propose that more than 75 percent of readmissions for chronically ill patients are potentially preventable with planned care transition after discharge (Medicare Payment Advisory Commission, 2007). Readmissions thus provide a critical indicator of quality and safety over an episode of care for policy and care system managers.

In Gaza governmental hospitals the total number of discharged patients according to MoH report (2018), 197,391 patients, and the number is increasing every year, thus the number of patients needing care after discharge increases. In addition, the number of injuries in the (GS) as a result of the wars 26,797, an average of 136.6 per 10,000 inhabitants, (54%) of them admitted to hospitals. And increasing life expectancy of old age lead to increase in chronic and complex diseases. According to Courbage, Abu Hamad, & Zagha, (2016) study about demographic changes next years, Palestinians aged 65 years and over will increase from (2.9%) to (7.7%). As a result of aging, there will be more chronic and degenerative diseases, and more multiple health problems that are common among elderly people. The population projection indicates that the proportion of the elderly population will triple over the coming 35 years, in addition Palestine is going through epidemiological transitions, non-communicable diseases (NCDs) are the major causes of morbidity and mortality. These factors enlarge the need for comprehensive and coherent follow up system and supportive transition of care processes.

Transition of care have been the subject of recent attention among health plans, researchers and policymakers in several countries to upgrade quality of care and health outcomes, cost saving and patient satisfaction. Efforts are done last several years and continue through transition of care programs tailor care transition programs to identify

patients' needs and engaging them early in the transition process safety (Naylor et al., 2017).

Moreover, this is considered as the first study in Gaza focus on the (TOC), according to the researcher's knowledge, which will contribute to creating awareness of this issue and contribute to encourage healthcare policy maker at different levels to apply intervention programs to improve transition of care at our hospitals and put this issue as a priority in health can plan.

1.4 Aim

To assess the effectiveness of transition of care process in Gaza governmental hospitals and associated factors, in order to highlight it and provide policy makers and health providers with recommendations for improvement and development.

1.5 Objectives

1- To examine current (TOC) practice in governmental hospitals in Gaza.
2- To explore areas of strengths and weaknesses in relation of (TOC) process.
3- To appraise effectiveness of care transitions from patients/ caregivers, health care providers and policy maker perspectives.
4- To determine differences in patient perspectives about the (TOC) processes in relation to patient characteristics.

1.6 Context

1.6.1 Demographic context

Palestine's total area is about 27000 square kilometers, (GS) and (WB), total population 4,915,943 million are in the state of Palestine, about 2,953,943 of population reside in WB which represents (60.1%) of total population, while 1,961,406 reside in GS with a percentage of (39.9%) (PCBS, 2018a)

According to PCBS (2018a), the total area of GS is 365 square kilometers on the east coast of the Mediterranean Sea, approximately (1.35%) of the Palestinian land; it is separated from WB because of Israel territory. It is divided into five governorates: North Gaza, Gaza City, Mid Zone, Khan Younis and Rafah. GS considered as one of the most density areas over the world that reach to 5,374 people by Km2. This high density of

population and a restricted area of land create high demands for health services and increase work loud on healthcare providers. Children under 5 years represents (14.9%) of population, children under (15) years represents (41.6%) of population, and elderly population who are more than 60 years represent (4.8%) from total population. The population is getting older, but the majority of them are young, with continually high fertility rates and increased life expectancies.

According to MoH (2018) the crude death rate reaches (2.76) deaths per 1000, cardiovascular disease is the leading cause of death (50.6%), cancer(10.6%) ,respiratory diseases (5.7%), perinatal diseases (5%), communicable diseases (2.4%) and diabetes (2.6%), shedding light the major health problems that the occupied Palestinian territory currently faces. The prevalence of non-communicable diseases and their risk factors are high, the reduction of communicable diseases incidence, in tandem with longer life expectancy and lifestyle changes, the population morbidity profile has changed, non-communicable diseases (NCDs) are emerging as todays leading health concerns and costly to treat and monitor, this epidemiological transition toward chronic diseases will increase the need for comprehensive follow up and effective (TOC) processes (Kyu et al., 2016) .

1.6.2 Socioeconomic characteristic

The (GS) suffers from hard economic condition because of Israel blockade. In 2018, the unemployment rate increased dramatically to (52%) compared to (44%) in 2017. The total Gross Domestic Product (GDP) in GS is 2,970.5 USD Million (PCBS, 2018a). Yet (80%) of the population depends on international humanitarian assistance, while the continuing intra-Palestinian divisions worsen the humanitarian and service crisis on the ground, the number of Palestinian refugees dependent on United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) for food aid grew from less than (80,000) in 2000 to nearly a million today (UNRWA,2018). The poverty rate was (38.8%) in (GS) in 2011 increased to (53%) by the end of 2017 one of the highest in the world (PCBS, 2018a), and the situation is complicated further by different political, economic and social factors, this economic downturn could have an effect on financial access to healthcare facilities, it may also increase the burden of poverty-related diseases like malnutrition, sanitary related diseases and anemia.

Access to clean water and electricity is still in crisis and affects almost every part of Gaza's life. Clean water is unavailable to (95%) of the population, and electricity supply has only recently increased to be 12 hours a day by the end of October 2018. Ongoing power shortages, however, have seriously impeded the provision of essential services, health, water and sanitation in general. And the fragile economy of Gaza continues to struggle, most of the sectors of manufacturing and agriculture.

1.6.3 Health care system

The health care system in Palestine is complicated and fragmented, facing continuous challenges due to political circumstances, siege, conflicts and wars, which causes continuous drainage of current limited resources. Moreover, internal Palestinian governmental fragmentation, cause poor coordination between stakeholders, which by common sense is, reflected on MOH's facilities in terms of lack of resources, poor resources allocation and low responsive governances.

Palestinian health sector includes three main levels of care of the primary, secondary and tertiary health care. It consists of four main providers; Ministry of Health (MOH), the (UNRWA), Non-Governmental Organizations (NGOs) and the private for-profit service. All providers share the delivery of health services at various levels with MOH, the main and largest provider of health services in the government health sector (MOH, 2018). MoH operates primary, secondary and tertiary health services and purchases from domestically and abroad the unavailable services. UNRWA provides primary health care services to refugees only and purchases some secondary care services. NGOs provide primary, secondary and other tertiary health services (MOH, 2018). The private- for-profit sector through some specialist hospitals offers the three levels (Regional Health Systems Obeservatory-EMRO-2016).

The shortage of electricity and the scarcity of drugs and medical equipments are life-threatening, particularly for patients with non-communicable diseases and emergencies. Electricity shortages affect the 12 government hospitals and more than 140 clinics for primary health care (PHC) clinics (49 MOH, 22 UNRWA and 66 NGO PHC facilities) and distracting essential services such as blood banks, laboratories, and storage of vaccines (OCHA, 2017).

MOH is the responsible body for the leadership and organization of the work of the Palestinian health sector, through well management of the health sector and ensure the necessary resources needed for sustainability and development. MoH is also responsible for policy development, the legislation, laws, plans, activation of partnerships between the various partners in the sector and with other sectors and optimal management and investment of available resources (MOH, 2018).

1.6.4 Hospitals in GS

The MoH is the key provider for secondary health services in GS. According to annual report of MOH (2018), number of hospitals in (GS) 32 hospitals in a rate of 1.63 hospital /100.000 of population with 2.943 beds in a rate of 15 bed/10.000 of population, while to cope with population growth hospital beds should be increased to 3,100 at the year 2020 (Courbage, Abu Hamad, & Zagha, 2016). Hospitals are distributed as the following; MoH operates 12 hospital in a rate of 0.66 hospital /100.00 of population, this rate is less than the reported rate in Jordan (1.9) and the average OECD country rate (4.9) with 2,240 beds which represents (76.1%) of total beds at GS by rate of 11.4 bed /10,000 of population. Number of inpatient beds at governmental hospitals 1,782 beds cover a variety of services (28.2%) for general surgery, (24.5%) internal and phycatric, (21%) pediatric, 11.9% gynecology and (13.6%) intensive care beds. Military medical services; includes 2 hospitals with 177 beds represented (6%) from total beds in GS. Occupancy rate was (52.9%) and LOS was 2.4 day. In addition, NGOs run 16 hospitals with 526 beds, represents (17.9%) from total beds

Admitted patients was of all hospitals was 243.333, (81.8%) admitted to governmental hospitals at the year of 2018 with increase of (1.9%). Occupancy rate at governmental hospitals was (95%) while occupancy rate at Non-governmental hospitals was (45%). Length of stay (LOS) average at governmental hospitals was 3.3 day during the year of 2018 while LOS average at Non- governmental hospitals was 2.2 day during the same year. Turnover rate at governmental hospitals 113.4 time by the year of 2018 which means that the bed is occupied 113 times during the same year and that explains high occupancy rate at the year 2018. Turn over interval rate at governmental hospitals 0.2 days equals 5 hours while it was 2.7 days at NGOs hospitals (MOH,2018).

No of patients at emergency departments of governmental hospitals was 1.402.222 patient with increase (4%) than the year 2017 represented (86.9%) of total emergency patients while NGOs hospitals emergency patients represents (5.9%) and Military medical services represented (7.2%). Moreover percentage of outpatient clinic patients was (54%) at MoH hospitals, (34.4%) at NGOs and (7.6%) at Military medical services (MOH, 2018).

All those numbers indicate high hospital utilization at MoH which need to reinforce transition of care processes as an essential part of care continuity.

1.7 Definition of terms

1.7.1 Transition of care

Is the movement of patient from the place of care to another one, inside settings from one department to another, between settings from hospital to another or from hospital to primary healthcare center or rehabilitation center, between providers, from generalist doctor to specialist doctor or between different health providers or the patient leaves to home.

1.7.2 Patient safety

Patient safety means that there is no preventable harm to the patient during the health care process and that the risk of unnecessary harm associated with health care is reduced to an acceptable minimum.

1.7.3 Medication error

Any preventable event that may cause or contribute to improper use of medication causing harm to the patient.

1.7.4 Adverse event

An unexpected medical problem that occurs during treatment or other therapy. Adverse events may be mild, moderate, or severe and may be caused by something other than a drug or therapy.

Chapter Two

Literature Review & Conceptual Frame Work

2.1 Conceptual Framework

As shown in figure (2.1) The conceptual framework illustrates the basic elements of the study, defines how these elements are linked together and describes the research variables and it is used as a guide for the researcher.

The researcher wants to explore the current transition of care processes that are implemented in governmental hospitals in GS. Following are the elements that have been recognized by the literature must be in place for effective transition of care:

2.1.1 Discharge planning

Discharge planning is a collaborative approach to healthcare continuity, coordination, and evaluation. Successful discharge planning maintains the continuity phase covering the identification, assessment, a set of goals, planning, execution, coordination, and evaluation of health care; it is defined as “the link between the patient's hospital care, and the treatment received in the community after discharge”(Shepperd et al., 2013)

2.1.2 Preparation for transition

It is the assessment of patient readiness for care transition taking in consideration physical and psychological condition to the patient and the capability of the patient to take care of their health after transition from hospital.

2.1.3 Information exchange

Timely and efficient exchange of important information on care between patients, families, and health care providers. Successful (TOC) requires timely, perfect and appropriate clinical information communication between health care providers throughout the entire care continuum. Information related to patient care must be transmitted to the patient in the form of a summary of information on patient care. Follow-up instructions and patient education should be given in a specific patient's language at a specific sheet.

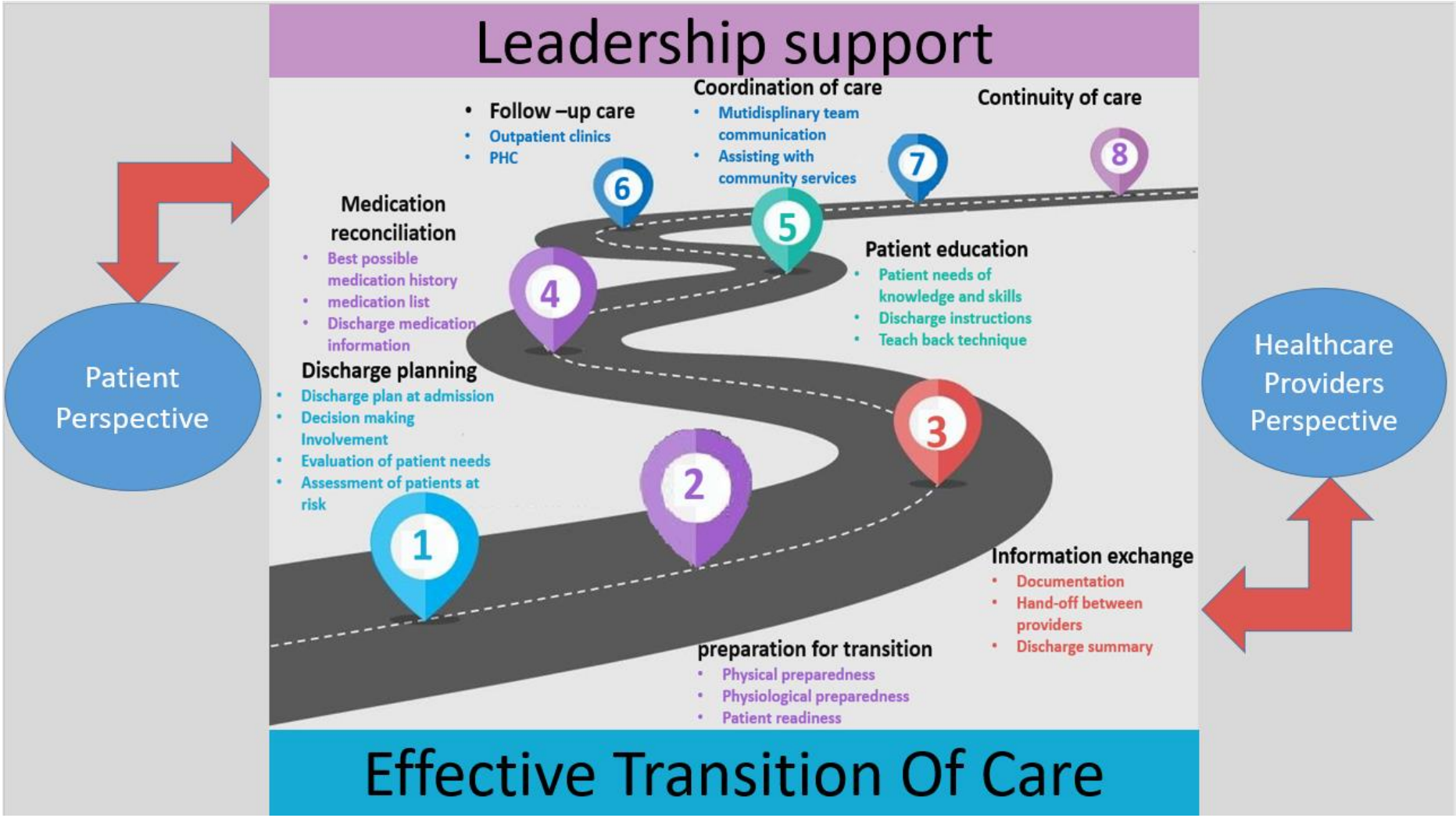

Figure (2.1): Study conceptual framework

2.1.4 Medication reconciliation

Ensuring that patients and their families use medications safely and on the basis of patient care plans, developing and implementing a drug management plan as part of the overall care plan of the patient, medication reconciliation with medicine lists for pre-hospitalization and post-hospitalization, clarifying which medications to take, highlight any changes in the regimen, explain the intent of each medication when to take each medication properly, and annoying side effects to look out for.

2.1.5 Patient education

Patient and family education and engagement to improve their active involvement in their own care, including informed decision-making. Patients and their families are familiar with the condition and care plan, upgrading patient and family learning activities to promote the use of teaching back to risk-specific problems, developing expertise in self-care performance and ascertain the degree of understanding of patients by asking them to explain in their own words the details of the plan.

2.1.6 Follow up care

Facilitate the successful transition of patients by appropriate follow-up care activities from one level of care or provider to another. Patients and families have prompt access to key health care providers after an episode of treatment, depending on the illness and needs of the patient. Making appointments before discharge for medical follow-up and post-discharge examinations, post-transition contact with patients and/or families and other healthcare provides.

2.1.7 Continuity of care

Continuity of care is all about quality of care over time. It is the communication, collaboration, and synchronization of medical information between different providers to facilitate patient care through multiple times and multiple care settings. To what degree the patient has an ongoing relationship with a medical team or clinical team member and organized clinical care that progresses seamlessly as the patient travels between various parts of the health service.

2.1.8 Coordination of care

Care coordination seamlessly integrates multiple providers and specialists delivering a patient's health care. Coordinated care aims at improving health outcomes by ensuring that treatment is not provided in silos by different providers through removing repetitive tests and procedures, and helping to reduce health care costs. It is regarded as a key element of the effective transition process. This makes the transition of patients easy and straightforward to move patients from one level to another.

2.1.9 Leadership support

Leadership support is one of the most important factors for success of (TOC). This means paying attention and reinforcing the regulations of the executive, policy making and strategies making for all participants in transition of care system. Senior management becomes mindful of the challenge of transitions and is dedicated to finding solutions. They find ways to reduce readmissions and produce other positive results.

Transition of care process effectiveness measure by: Perception of policy makers which means leadership support health care providers and patients.

2.1.10 Perception of patient and health care providers

This applies to the satisfaction of the patient's or not the with transition of care he experienced and the health care providers perspectives with the procedures they provided in reference to transition of care process.

2.1.11 Patient characteristic variables

There are several patient characteristics that might affect the transition of care processes which include; hospital department age, gender, patient educational level, and (LOS) at hospital and frequency of admissions.

2.2 Literature Review

2.2.1 Transition of care definition:

Care transition is an interdisciplinary approach involving assessment, setting goals, scheduling, preparation, and evaluation. Effective transition of care is a connection between the patient's hospitalized treatment and the community's post-discharge care. Health system integration is vital to ensuring the quality of health services, but this integration is met with many obstacles, specifically when the desired outcomes enhance healthcare quality, security and resource efficiency to ensure continuity of patient treatment and disease prevention, diagnosis, recovery, palliative care at various levels. (TOC) is one of the most important axes for the integration of the health system (Glenny, et al., 2013); (Lima et al., 2018).

It is defined as a set of actions designed to ensure the coordination and continuity of health care, as patients transfer between different locations or different levels of care within the same location (Coleman & Boult, 2003). Coleman & Boult (2003) hypothesized that improving quality and safety during the transition of care varies greatly between improving quality and safety in a single health institution because the goal of the transition of care is to facilitate the link between the needs of the patient and his care setting

In other words, care transition is an integrated treatment plan that covers a wide range of services based on the availability of well-trained and informed providers of patient goals, orientations and health status information. It also covers planning, collaboration, and interaction between service providers and addresses the change in patient health as it travels between different health centers. For example, moving to and from operating rooms or intensive care units, or from one health center to another. Studies have shown that there are very important problems in the quality of services for patients when care is transferred across multiple care bodies, especially when moving from one health care center to home or another health care center (Coleman et al., 2002)

Poor control of transition processes has been followed by negative effects on transition patients, their wellbeing, their expectations and care outcomes (Molter & Abrahamson, 2015). These negative effect trends include depression, immersion, stress, lack of medication compliance, increased complications, and preventable death, especially for

life-threatening diseases such as heart diseases(Ponikowski et al., 2014). On the other hand, evidence-based research has shown that good health management during care transition has a positive effect on the side of the patient and their families (Van et al., 2008).

2.3 Transition of care processes:

The researchers in the field of the effective transition of care have identified several interventions to improve the process ((Naylor et al., 2017; Jencks, Williams & Coleman, 2009; Hansen, et al., 2011). Such interventions can be defined as follows:

1- **Pre- transition interventions**

Discharge planning, patient education, medication reconciliation, patient preparation, booking for follow-up after discharge.

2- Post- transition interventions

Coordination with service providers, follow-up through telephone, home visits.

3- Interventions between and after transition

Transition training, patient instructions, continuity of care among providers.

2.3.1 Discharge planning

Discharge planning is to develop an individual plan for the patient prior to discharge in order to ensure that the patient is discharged at the right time with the necessary services after discharge (Shepperd et al., 2013).

Planning to discharge is a complicated process that should start from the beginning of the hospital admission of the patient and anticipated the length of his hospital stay, even if he needed services or equipment at home or had to be transferred to another health center or a different level of care (Meyer, Jekowsky, & Crane, 2007). Planning for the transition of care is a vital component of the quality of service provided to patients and of ensuring the continuity of the health care system. It is important to enable the patient to continue treatment and return to his performance before the disease (Halasyamani et al., 2006). The misconception of discharge planning is a set of measures taken at the end of a hospital stay. The quality of care at the discharge is therefore poor, as the planning for the transition of care consists of assessing the patient at the time of admission, training

and teaching the patient and his family, follow-up and assessment of his situation after transition. The plan should be adapted to the patient's needs and satisfy their expectations (Solomon, Damba, & Bryant, 2013).

This integrated procedure begins when admitted and continues through hospital treatment, interspersed with the risk assessment of the patient's functional and cognitive status. It also addresses the home environment in which the patient returns, the psychological and cultural factors affecting the patient, support systems and lack of information. Assessment of the patient's condition and health care needs should be initiated upon admission and repeated over the course of the illness and hospitalization, responding to changes in patient health as a new diagnosis or event that alters the patient's needs, when changing the shifts and before going out, make sure the patient is ready to transition (Laugaland, Aase, & Barach, 2012).

Structured discharge care planning is a proven method of reducing hospitalization and re-admission, reducing costs and ensuring continuity of care after discharge. It results in better mental health, increased patient satisfaction with services and improved patient outcomes. It not only improves the quality of care but also improves the quality of life of both the client and his family (Shepperd et al., 2013).

The discharge planning process includes the following: Effective recognition and assessment of patients who need assistance, support and identify their needs, to facilitate discharge planning, work with the patient, family and therapist team, develop recommendations and options for continuity of patient care and reference for changes and services that meet the needs of the patient, provide support and encouragement for the client and his family and include him in the decision-making process and provide him with a plan for the length of the stay and the change of patient situation.

In addition to paying attention to community services, an effective care transition plan depends on the involvement of the patient and their families and prepare them to discharge after taking into account the information and education that they need to make the patient and the family in the form of expectations and to avoid confusion during the transition of care. The involvement of the patient and his family is a key to a successful care transition plan and a multidisciplinary team that must be involved in its development. The data from the patient and his family helps staff develop meaningful plans before leaving the hospital. Studies have found that the role of the family in

planning care transition is positive, family involvement increases the effectiveness of care and increases in elderly cases, critical illnesses and hearing-impaired patients. The family of patients is an important source of information for health providers. It also plays an important role by sharing patient information with therapists and giving them feedback (Duguid, 2012).

Evaluation of patients at risk of readmission became part of the transition of care initiatives especially to identify high-risk patients and high-cost patients and who will benefit from coordination and follow-up after discharge using assessment tools to help identify patients at risk of adverse events following discharge in order to begin the follow-up of his condition and to initiate interventions that prevent re-admission to the hospital or to visit the emergency department. Risk factors include low education, hospitalization, several diseases or multiple medications. Patients who are discharged against medical advice (AMA) are at high risk, a retrospective cohort study was conducted at an urban academic medical center found that patients with AMA had a higher readmission rate and also a double increase in death risk compared to those with discharge planning. Those who leave AMA have to be advised regarding the illness-specific risks associated with premature discharge and the increased risk of death and readmission (Southern, Nahvi, & Arnsten, 2012).

Abu Dagga(2014) , conducted a study about discharge process at governmental hospitals in GS, the overall patient perspectives about the discharge process was low (33.6), the highest percentage was about receiving information about medications (42.9%) and the lowest percentage was about receiving information about referral (16.2%), over half (53.4%) of surveyed patients indicated that were not involved in their discharge process and three out of every patient showed that physical needs not assessed before discharge, the overall mean scores about health care providers perspectives and practices related to discharge process was 71% much higher than clients reported score, the highest percentage was about perception regarding the outcome of effective discharge planning (84.40%); mean while the lowest was in the availability of regulations (57.25%) and the study illustrated that more than two third of health care providers were not trained on discharge planning.

2.3.2 Preparations for Care Transition

Preparing the patient for transition is a major determinant of the patient's health outcomes and satisfaction. Preparing the patient for the care transition should take into consideration the patient assessment of his/her readiness for care transition in terms of physical and psychological condition and the patients' perceptions of taking care of themselves after transition from hospital.

The physical and psychological preparedness are both important for the efficiency of care transition. The health care providers should clarify the dangerous signs and symptoms that require the patient to consult the physician immediately, and those symptoms that do not need to consult the physician about, where the patient and his/her family could deal with at home. Therefore, the patient should realize clearly whom he/she will contact when these signs arise (Specialist doctor-PHC- GP doctor- or the ED department at the hospital), which requires providing the patient with a name and a telephone number to communicate in case of emergency (Coleman & Boult, 2003).

Involvement of the patients and their families in the daily morning round deem necessary as it helps the patients and their families to prepare for the care transition, it builds trust, it shows the patient's expectations and foster the physical and psychological assessment (McCarthy, Johnson, & Audet, 2013).

In a study conducted to find the relationship between the patient's readiness for discharge and preparations at hospital for discharge and patient-specific characteristics were conducted on 1755 patients the result was less than half of patients (47.8%) indicated their readiness to discharge, Only (58%) of patients indicated that they received interventions from service providers to prepare themselves for self- care, (30%) received interventions to prepare them for symptomatic management (Mabire, Bachnick, Ausserhofer, Simon, & Group, 2019).

The most important physical indicators which should be assessed such as; movement, pain, energy level, appetite, sleep, swallowing, and food taking, while the psychological indicators to be assessed like anxiety, fear, difficulty to sleep, hallucination, and depression. The knowledge indicators such as the skills required to treat their health like being familiar with the medicines and their side effects, and the ability to take a good care of themselves post transition (Commission, 2010).

Sneath (2009) has reviewed several studies about the patients 'families' opinion regarding the preparedness of their children's care transition from the hospital, where it was found that the patients have had many questions that were left without answer from the health service care team, and they felt that their children were not ready for care transition. In addition, he pointed that the health care providers should encourage their patients to express their opinion of their ability to encounter the care transition, and so are the patients, they need to be supported by their families during the care transition. That the patient and his/her family together will experience the status of care transition, as the anxiety, fear and stress negatively reflect on the patient and his/her family to figure out the required information (Sneath, 2009).

The psychological preparations have to be included within the patient care transition plan, in order to help the patient cope before, during, and after the care transition, in addition to the care transition timing, as it has to depend on the health care team knowledge of the patient's readiness, physically and psychologically (Ellis, 2010).

The successful preparation for the care transition may lead to a correct care transition and therefore, it may be resulted in the success of the patient and his/her family to complete the treatment of the patient and the good care of his/her health condition at home. On the contrary, the difficulty to face the health care transition and/or having complications or problems after the care transition may imply the lack of readiness and improper preparation of the patient for care transition, which would evidently bring about the patient readmissions or repeated visits to the ED department in the hospital. The lack of preparedness for the patient care transition and his/her return to the hospital course has been studied, in return, the patients discharged in an effective way and planned care transition proved to be more committed to the treatment plan and better adherent to attend to the consultation appointments, and less readmitted during 30 days (Jack et al., 2009)

2.3.3 Information Exchange

The care transition process is a complicated one and a high-risk process. And the ineffectiveness information exchange may lead to dangerous outcomes. Besides, poor communication of information exchange between the health care providers is related in about (80%) of medical errors which occur during the care transition. The care transition

safety and efficiency requires a clear communication and coordination in due time and documenting the patient's information (Solet, et al., 2005) .

The information exchange through the care providers deem necessary to inform about the patient, and it affects all the facts related to the patient, as it includes conveying the medical information about the patient, as well as the medical care responsibility whenever the patient moves between the different medical specialists and medical documentation or communication and/or both, and sometimes it needs interpretation as in the X -ray results.

2.3.3.1 Documentation

The medical documentation is any information about the patient available in the patient's file, which is kept as a patient's' record. All the employees within the health care team need to know their role in communicating and circulating the patient's precise information, in order to prevent repetition or loss of the patient's exact information during the process of exchanging the knowledge between the hospitals, health centers and health care providers. The discussion and circulation of the patient's information should be made according to specific criteria to ensure the clarity and accuracy of the information exchange (LaMantia, et al., 2010).

2.3.3.2 Hand off between providers

The gaps in exchanging the accurate and complete information, and the effective communication between the health care providers when changing the responsibilities upon hand off patients is a major problem, that negatively reflect on the health care quality and safety of the patient. Despite the fact of the primary objective of handing the patient off during the care transition is merely to provide the correct information about the patient, his/her current condition, and any changes recently happened or expected to take place, yet, each hand off is a strong opportunity for errors to occur.

The care transition of the patient between the hospital physicians and the primary health care physicians generates an inevitable requirement to improve the communication when exchanging the information between the admitted patients' physicians and the out patients' physicians upon the care transition process (Kripalani et al., 2007).

The proper exchange of the accurate related information about the diagnosis results, treatment complications, medical consultations, the crucial tests' results upon discharge, and the arrangements for follow-up may better the continuity of health care. In contrast, communicating at a later time, and the inaccurate information exchange between the health care providers, especially and directly after the care transition would bring about undesirable outcomes for continuity of care, patients' safety, satisfaction of patients and health care providers, as well as the resources' utilization (Coleman, Min, Chomiak, & Kramer, 2004).

For quite a long time, the health organizations and institutions suffer from the improper process of passing the important and correct information about the patient from one health care provider to the other, and/or from a health care team to another. Hand off the patient is a process that is shared between the sender, who is the health care provider that conveys the information about the patient, who has been care transited out of his responsibility, to another health care provider, who is the recipient that will receive the information about the patient and takes a good care of him/her

In a survey done by JCI, it has found that in the average, more that (37%) of the patient hand off was ineffective and did not allow the recipient to provide a safe care to the patient. It has also concluded that about (21%) of the senders are unsatisfied with the handing and receiving quality.

The certain root causes validated by JCI for communication failure during the patient's handing and receiving is the culture that does not give a room for handing and receiving such as; absence of team-work, respect, the expectations' difference between the sender and recipient, the ineffective communication techniques like verbal communication and/or bed-side communication, the insufficient time for the receipt and the disturbance which takes place upon the patient receipt and the lack of special criteria and procedures for receipt like (e.g. situation, background assessment and recommendations) (SBAR). Besides, the lack of sufficient staff to work at specific times of the day or week. Moreover, not involving the patient in hand off procedures (Commission, 2012).

Other definite reasons include the sender who provides inaccurate and incomplete information about the patient, as the sender himself does not know very much about the patient and hand that patient to the recipient. The sender also could not receive an updated information about the patient such as; the laboratory tests results and X-Ray

reports as they are not available during the hand off time, and at the same time, the sender is unable to communicate with the recipient who will receive the patient. Another problem is the inability of the sender to follow-up with the recipient when adding new information that should be informed, while the recipient may have other priorities and he is neither able to take care of the transited patient, nor have any information about him/her (Commission, 2012).

The information exchange should be done on time, which evolves that the patient when transited for care, there should be a time schedule that gives the chance for the recipient to receive the patient in due time, and effectively design the treatment plan or any required interventions and/or changes (Commission, 2012).

In the emergency departments, communication between the health care providers and patients is truly significant and indispensable, while the problematic environment at the emergency departments lead to losing this important part of communication. At one of the studies made in this regard, it was found that the patients leave the ED with incomplete information about their health condition and the required instructions of their treatment. Many factors bring in this status, one of which that the information available at the emergency departments are higher than the patient health education level. The study also found that the verbal communication between the patients and the health care providers is almost brief and incomplete (Engel et al., 2012).

2.3.3.3 Discharge Summary

The discharge summary and instructions is a collection of documents which include important information about the patient that is based on the patient's diagnosis and procedures made for him/her in the hospital. The discharge summary provides the information that is essential and related to the patient, the information includes vital parts such as; patient diagnosis, a brief about patient's disease history, general information about the physical tests, tests results, improvement in the patient condition, treatment, and plans and follow-up. The discharge summary is the primary documentation used by the physician to register and document the patient's details in the hospital, description of clinical incidents, medications, and follow-up instructions. The medications and diagnostic tests results are critical and central information within the discharge summary (Myers et al., 2006).

In the Kingdom of Saudi Arabia, Mahrous (2013) has made a questionnaire about the patients' opinion and level of satisfaction with the information given to them upon discharge and care transition, 167 patients have participated in the study. The researcher has found that (44.3%) of patients were unsatisfied with the information that should meet their needs upon care transition, (45%) of patients were not satisfied with the information that should make it clear to them what they have to do after discharged from the hospital, (60.46%) of patients have not received any information about expected complications, (46%) of patients have not received any information regarding the indicators of critical symptoms that may happen to them, (69.3%) of patients did not know to whom they should approach for help, (35.3%) of patients lack information about the medications, (53.3%) of patients did not know the reason for prescribing each medication, (69.3%) of patients do not the side effects of the medications, (46.6%) of patients have not received any information about the food, (52.3%) do not have information about the follow-up instruction upon care transition, (68.2%) of patients have not received a written document for care transition that explains the patient medical condition and shows the instructions upon care transition. As for the surgeries' patients, (41%) of patients do not have information about the way to take care of their wound, and (42%) of patients were unsatisfied with the clarity of instructions and information upon care transition (Mahrous, 2013).

The discharge summary could improve the health care services provided to the patient when it is sent to the physicians who follow-up the patient at the out-patient clinics and the primary health care physicians. The primary health care physician needs an information resource about the patient, in order to follow the patient up after care transition, as whenever the discharge summary has been clear and complete, it makes better communication with the patient, because the patient could not give the physician the full and accurate information about his/her stay in the hospital.

Generally, the patients are not a reliable alternate for the discharge summary, and it has been found that the discharge summary is a way to improve the patient's information, and his/her satisfaction. Circulating the discharge summary deem necessary, as the patient becomes responsible for giving this summary out to his/her physician upon follow-up after care transition, and as the communication between the inpatients care team and the outpatient care team upon care transition is vital for patient safety. The studies made in this regard proved that the patient follow up with a physician who has

access to the discharge summary has been related to decreasing the risk of readmission, while the lack of communication has serious consequences (Van Walraven, et al., 2002).

(Agency for Health Research and Quality, 2014) has stated that the discharge summary should be handed to the patient before care transition, the summary should be written at the primary level of health education for the patient. Also, these information should be written for each patient as an individual case, and be written at the level of third or fourth primary grade in the language that the patient prefers, and it should include the reason for hospital admission, the medications' list written in a simple language, with their doses and times for taking them, as well as the follow-up appointments. It should also include the symptoms that the patient should pay attention to, what he/she should do, and with whom he/she would communicate. Regarding the medications, the written information have to elucidate what the patient would take, when, why, and how, and be informed about the side effects that he/she should be careful about. It is similarly important to clarify whom the patient would approach if and when these symptoms appeared. In addition, the physicians should confer with their patients about the way to get the medications and clarify whether there will be any financial difficulties for the patients. Moreover, the discharge summary should be complete at the discharge time.

The discharge summary plays an essential role in helping the patient to deal with his/her illness, and protect the patient from any complications and/or disorder resulted out of ignorance, nevertheless, from the other hand, it helps protect the medical staff from being sued as a result of misbehavior. The completeful discharge summary spells out all the related health procedures and treatment which have been done in the hospital, it is necessary for the hospital to keep a copy of the patient's file, while the patient has to sign for receiving his/her information. All these procedures, if properly done, would help in protecting both the patient and medical staff to be sued.

2.3.4 Medication reconciliation

The medications errors are a common problem, particularly when the patients move between the health care service providers. The discrepancies usually take place upon hospital admission and discharge, wherever the patient moves between the different health care providers, when he/she moves between the departments in the hospital, when

sharing consultations between specialists and when moving from a hospital to another hospital medicines (Wheeler, et al., 2018).

Transition points within or across healthcare settings are often associated with changes in the medicines the patient prescribed, In addition, patients' medications may change as a result of , changing, starting or discontinuing over-the-counter medication purchased by the patient in pharmacies, herbal, traditional or complementary medicines without contact with their doctors, use drugs from friends or family members.

More than (40%) of the medications errors are resulted from the inadequate medication reconciliation at the care transition, out of which (20%) of medications errors cause harm for the patient, as the miscommunication of the medical file are so common and end with serious medication errors. These are truly problematic times for the patients who take several medications, (25–80%) of patients had at least one medication discrepancy or failure to communicate in-hospital medication changes at discharge (Lehnbom, et al., 2014) .

The studies made in this regard have proved that most patients are subject to at least one medication discrepancy upon hospital admission, which is a global issue (Pippins et al., 2008).

The Medications' discrepancies which occur with the care transition negatively reflect on the health system and the patient, they include an increase in using the resources in treating the patients, an increase in the medical staff work burden in tackling these discrepancies and treating them, which all negatively affect the health system's outcomes. It may be important to indicate that about (15%) of the OECD countries expenses is spent due to these risky incidents (Slawomirski, Auraaen, & Klazinga, 2017).

As internationally recognized, the total cost of medication errors has been estimated at US$ 42 billion annually (Aitken & Gorokhovich, 2012).

Most of the medication errors could be avoided by the medication reconciliation, which is making the comparison between the medications prescribed for the patient and all the medications that the patient takes. In addition to looking over the medications stopped, the medications the patient previously has taken with the medications added in the hospital, in order to medically decide for the new list of medications.

The medication reconciliation may help in identifying the medications problems such as; the medications interacting with each other's and the danger of the risky incidents. This reconciliation should properly occur at each treatment time and with the care transition from one health provider to another. Moreover, the patients and their families should be fully involved and be conferred about their medications changes, reasons for changes, purpose of prescribing each kind of medication, doses, how to take the medications, way to manage medications and keeping them at home (Duguid, 2012).

The patients would be eventually involved in the care transition process through providing them with the updated medications list and/or the same medications list. They need to be oriented with the information about the medications upon care transition and/or any time the medication changes.

Whereas the hospital pharmacist plays the leading role in the medicine's reconciliation, nevertheless, it is the responsibility of the whole medical care team. The whole health team members should be trained on this technique, not only that, but the team work culture should be reinforced as well as sharing the responsibility and effective monitoring. The specialties limitations and competition among the health care service providers from one hand and between the health providers and managers at work on the other hand should be molten and be gotten rid of, and work following the multidisciplinary team approach should be recommended and supported (Young, Barnason, Hays, & Do, 2015).

Zianeian et.al (2012) conducted a prospective cohort study to assess the frequency of medication reconciliation mistakes and patient uncertainty of their medications after discharge which enrolled 377 patients, the findings were (22.3%) of admission medications were represcibed or stopped at discharge wrongly (24.2%) of those medication were classified as suspected provider errors. Interview comparisons of the discharge lists of patients showed that 81.6 percent of patients did not know the names of their drugs stopped, (64%) unable to name drugs and doses for of their new drugs and (69.3%) could not name the changed the frequency of their re-dose medication (Ziaeian, et al., 2012).

In accordance with the World Health Organization (WHO) report in 2017 (WHO, 2018) regarding the medication's safety during the care transition, it would include applying structured formal procedures for medication at all the care transition steps, based on:

1.Taking the best possible medications history of the patient through interviewing the patient and making sure of the information through one reliable resource at least, updating the medications list of the patient, and communicating with the health care providers to which the patient will be transited, in order to know the changes on the medications list. Meanwhile, identifying roles and responsibilities, training, support, and making the tools and technology available.

2.The partnership between the patient and his/her family and the health care providers is required to agree on the treatment plan, and to ensure that the patient has received sufficient health education and training, in order to safely manage his/her medications. Making sure that the patient has the updated list of medications, as well as prioritizing the patient most vulnerable to the risk of using the medications through communicating with the patients before and after the care transition.

3. Application of a system to manage medications, that includes medical cooperation, nursing, and pharmaceutical, and working on improving the employees' capabilities and information about the medications and their risks.

4. Improving the quality and availability of health information upon the care transition, in order to facilitate getting the patient medications history through the patient electronic file and/or requesting the paper document file.

5. The medications history information should be verified and it should include reasons for changing the medications list during the time of admission in the hospital, which has to be realized by the health provider at the next stage of care. The studies therein have shown that this has reduced the medication errors and bettered the patient's outcomes.

2.3.5 Patient Education

2.3.5.1 Patient and family engagement

The patient and his/her family are considered as the most important partners for improving the health care quality and safety. Their participation as effective members with the health care team is a prime component for making the health service care safer. It also helps in reducing the percentage of readmission and visits numbers for patients attending to the emergency departments.

Patient-Centeredness is a key aspect for bettering the quality of health care services. It focuses on involving the patients and their families as real partners in the treatment process which could be met through educating and training the patient, creating mutual information and knowledge and respecting the patient's values, needs and expectations (Cliff, 2012). This objective could be achieved with the effective communication and coordination between the health service care providers from one hand and the patients and their families from the other hand. The health service care providers should pay a big attention and priority to educating the patient in order to be able to deal with his/her illness status and treatment options in a way to reinforce the patient's true engagement.

Educating the patient process is a collection of instructions that spotlights on the ability of the patient to care for his/her health condition. The quality education delivered for the patient and his/her family is the best technique to anticipate the patient readiness for care transition (Johnson, Sandford, & Tyndall, 2003; Weiss et al., 2007). It is the combination of educational programs that primarily take place during the patient's stay in the hospital, which paves the way for the patient and his/her family for the care transition from the hospital to home, as the patient's education tends to complete during the patient stay in the hospital and makes a priority with the discharge time. When the patient's education is left until the discharge time, the patient loses interest and attention and the short time available for the health care team brings ineffective patient education.

2.3.5.2 Discharge instructions

The patient discharge instructions are known as any kind of documentation the health service care provider may make to hand to the patient upon discharge from the hospital to home with the purpose of maintaining patient safety and continuity of receiving the treatment at home in order to foster the patient's interest and care about his/her health status. These instructions may be oral or written, while most patients prefer to speak to them, and enclose the dialogue with written instructions accordingly (Taylor & Cameron, 2000) .

The researches done in this respect proved that (40 – 80%) of the oral information given to the patients had been immediately forgotten, while half of these information were wrongly recalled. Many studies therein have shown that the weak level of health

education and health knowledge may lead to weak health outcomes especially for elderly patients with low education level (Solomon et, al., 2013).

Failure to comprehend the patient discharge instructions is one of the most important reasons for the patient's dissatisfaction with the health care provided. One of the studies has found that the patients do not get the details related to the medicines, food cautions, and changing the life style, which leads to an ineffective care transition as the discharge instructions should be taken as a complete process and not as an alternate for the oral instructions. The verbal instructions between the health care providers and the patient deem necessary and are considered as a crucial part that helps the staff to make sure that the patient has comprehended the instructions totally and they give the patient the opportunity to ask questions about his/her health condition (Mahrous, 2013).

The successful transition of health care requires providing the patient with suitable instructions and information that conforms with the patients' health needs which reassures the continuity of care at home. Communication and education include all what the patients' needs of knowledge and skills during his/her illness time in the hospital, as well as the knowledge and skills in various areas including: how to use medication and medical instruments and equipment, dietary instructions and nutritional education which he/she should master upon discharge from the hospital. As the patient should play a proactive role in taking care of his/her health condition, which evolves that he/she should do quite an effort to get a stable health condition and prevent or reduce the complications that may arise because of any chronic diseases. This role enables the patient to identify his/her health problems at an early stage. Moreover, engagement of the patient and his/her family in the treatment process is essential for the continuous health education and learning system (McGinnis, Saunders, & Olsen, 2011).

The factors that affect the patient's acceptance and readiness to learn about his/her health are many, as the health organizations and institutions' environment is a place that is difficult to train in, therefore, a suitable health learning environment should be created which would encourage and support the communication and coordination with the patients and their families, in order to meet their health education needs and recognize the difficulties encountered by the patient that hinders his/her care for his/her health condition (McBride & Andrews, 2013).

2.3.5.3 The Teach-Back technique

Is a tool used by healthcare providers to verify whether a patient (or caregiver) understands what is explained to them. When a patient understands, they will be able to "teach-back" the information correctly in the patient's own words. This technique allows the provider to identify and correct in real time any misunderstandings in order to prevent adverse events related to a lack of understanding of the information on discharge. Teaching back method has been validated to teach a patient new skills (e.g. insulin administration or dressing change). This method can be used sequentially, starting early in the hospital, to build knowledge, attitudes, and skills more effectively. It is a way to help the patient to be involved and in harmony with the health education and makes him/her able to ensure what he/she has learnt. In one study, teaching back was done to patients with heart failure over a three-day period. Day 1 focused on the aspects of knowledge (e.g., "What medications are you taking?" "What is your definition of heart problems?") Day 2 focused on the aspects of attitude (e.g., "Why is it important to keep an eye on your diet or to weigh yourself daily?") Day 3 concentrated on attitudes and abilities (Example: "How can you take your medicines every day or get to your follow-up appointments?") In this small study, the readmission rate and the duration of second hospital stays were decreased for patients who were readmitted(Peter et al., 2015).

Patient education is a nursing responsibility in the first place, yet, the rest of other health provider's members such as; physicians, pharmacists, physiotherapists, and others should play their roles in the health education process. The lack of a clear description of roles and responsibilities of the health education at the care transition time is practically resulted in repetitions, omissions, and unclear information that confuse the patient and so lead to lack of commitment and disobedience to the discharge instructions (Ashbrook, Mourad, & Sehgal, 2013).

2.3.6 Follow-up care

The healthcare provider should make follow-up appointments before discharge from the hospital and review all the details with patients that included the date of appointment, time and location. They should also discuss with the patient how to get to the appointment by providing maps and guidance. The main important thing is explaining to the patient the main purpose of that appointment. Also, to teach the patient to call the hospital if they need

to reschedule the appointment. Give the patient the contact information which includes the phone number of hospital. In addition, ask the patient to bring the discharge summary to all appointments (Agency of Healthcare Research and Quality, 2013).

Follow-Up upon care transition is essential for improving the patient's outcomes, and in order to meet the objective out of it, the health care providers are requested to guide the patients to better their health condition. They are also requested to involve the patient upon his/her return for follow-up after care transition from the hospital.

Follow-Up upon care transition may contain regular medical assessment of the patient's health condition, including clinical examinations, blood tests, and X-Ray tests.

According to the National Cancer Institute (2019), follow-up care checks for health problems that may occur months or years after treatment ends. The long-term relationship with the patient deems necessary for the individuals who have recovered from all types of treatment. For instance, Cancer patients could be subjected to follow-up either monthly or annually after recovery, while Orthopedic Surgery patients may need a continuous follow-up especially after having been operated. The nature and level of follow-up directly count on the type of disease and the health condition of the patient (National Cancer Institute, 2019).

The regular follow-up after care transition helps in disclosing any health complications early, relieves them, maintains the patient out of hospital, and decreases the patient's readmission in the hospital, which positively reflects on reducing the expenditures spent on the health system.

There is no ideal time for the first follow-up after care transition, either with a specialist or with a primary health care physician (GP). Many factors are related to the follow-up appointment such as; the severity of the disease, the patient's capability to continue taking care of his/herself at home, as well as the psychological and logistical factors. Several studies have proved that the patients who have been followed-up upon care transition were the least subjected to be readmitted in the hospital.

A study on Medicare patients for cardiac patients admitted in the hospital at 225 hospitals has concluded that the percentage of readmission during 30 days has been the highest for the patients discharged from the hospitals, who have been the least followed-up 7 days after patients' care transition (Hernandez et.al, 2010).

2.3.7 Continuity of Care

The continuity of care is the extent of health service care integration and consistency which conforms to the patient's needs and the surrounding environment, that's how a patient receives treatment as continuous and cohesive over time; this is the result of good information flow, strong interpersonal skills, and good care coordination (WHO, 2018). Continuity of care occurs when separate and discrete elements of care are connected and when those elements of care that endure over time are maintained and supported. Since the patient urgent needs to receive the health care from many specialists and many health centers. The need almost arises for the patient care transition from one hospital to another, or within the same hospital, or from a hospital to a primary health care center, therefore, the continuity of care is an indispensable requirement for the health system. It is a result of linking the patient proper access to the health care with the proper communication between individuals, and the easy flow of information between health service providers, in addition to the proper coordination between the health care service providers in order to keep the system consistency. As for the patient, the continuity of care means the availability of correlated and consistent health care service provided all the time through. For the health care service providers, the continuity of care means their experience to get sufficient information about the patient, in order to better apply their skills, and the trust that their health service care be recognized and followed-up by other health care providers (Haggerty et al., 2003).

Haggerty et al. (2003) Proposed there are three types of continuity of care; relational continuity characterized by ' the patient's continuing therapeutic relationship with one or more providers, management continuity, Described by a consistent approach to clinical health management that is responsive to changing needs of patients and informational continuity in which Clinical information is used to make each individual's current treatment appropriate.

Success of the continuity of care lies in improving the care transition between the hospitals and primary health care centers. The community mostly counts on the cooperation and proper communication between all the health system components, as the care transition out of a health center does not always mean the end of health care provision, but it may be a start of care provision at another health care center. Moreover, the most important

objective of planning for care transition is making sure of the continuity of care and linking the health services care with each other.

Planning for care transition is an essential component for improving the care of patients with chronic diseases, as the patient's needs do not stop with care transition, therefore, the care should continue between the hospitals with each other's, and between the primary health care centers and the community in order to make sure of the safety of health care service and best use of resources. Since the chronic diseases make a burden on the patient's family shoulder, this would require counting on the health care services upon care transition, which includes the supporting services from the community, home care, primary health care, and the visits to the emergency departments to meet the patient's needs upon care transition. The health services needed from a number of specialties and a group of health care providers, that creates challenges in coordinating the health care and so, keep the continuity of care (Coffey & McCarthy, 2013).

Based on the studies made on care transition from the hospital, the patient encounters failure in the continuity of care because of many reasons such as; loss of follow-up visits, untrained staff, health providers' team burn-out, the inability to meet the patient's needs and expectations, as well as the failure to implement the plan of care transition. All mentioned reasons are resulted in discontinuity of care, which brings partial care. The discontinuity of care and the weak health system applied make a difficult burden on the health care providers, which weakens the preparations for the patient and his/her family. Also, the lack of support for the patient, all these reasons may lead to patient's bad outcomes that include elongated time of recovery and risky incidents (Alstveit et al., 2011).

The fragmented health care system and the separation between the hospitals and the community bring in a complicated health care system, which increases the possibilities of communication failure and discontinuity of care and percentage of medical errors repeated with the progress of patient's age, with the lack of complete information conveyed to the primary health care providers upon care transition (MacAdam, 2008).

2.3.8 Coordination of Care

Coordination of care is the pre-arrangement of the patient health care to facilitate providing the health service care to the patients properly. This arrangement includes the list of activities that reinforce, improve, and assess the complementarity and harmony of health

care through different physicians, specialists and health care providers, between the primary health care and hospitals, between the health care providers and patients. Besides it includes the mechanisms and techniques used to manage the health service care during the time of illness and care transition.

Examples of health care coordination like the activities through which the patient is supported during the care transition, for instance; when the patient moves from one hospital to another and the arrangements of the health care services to be provided to the patient in due time. Furthermore, the care transition includes planning for care transition, arranging the appointments for follow-up after care transition at the outpatient clinics, follow-up in the primary health care or with specialists, coordinating the medications or any treatment services after care transition, in addition to helping in providing any equipment and/or instruments that the patient may need at home (Singer et al., 2011).

Coordination of care is critically important for assessing the patient's needs and objectives in a way to create bonds and connections between the patients and the resources available in the community. The coordination activities require sharing the patient's health information, to make sure of the continuity of care and health services needed for the patient, as well as the rehabilitation, in order to maintain the patient's health.

The Agency for Healthcare Research and Quality (2013), in its Care Coordination Measures Atlas has established an outline of its criteria related to the coordination of care, that is the comprehensive care is considered as a multi-dimensional structure, it is recognized as the health care coordinated through specialists, health centers and the continuous supporting systems during the whole treatment time and visits. This care fits in with the patient's needs and expectations, and it depends on sharing the responsibility between the patient and health care service providers to achieve a better health condition. Therefore, the coordination of care should be applied through the health care service providers, along with the different resources of the community, sharing the responsibility between the patient and health care service providers, and keeping the assessment of the patient's health condition all the time through (McDonald et al., 2010).

The lack of coordination during the care transition, especially from the hospitals is related to the readmission, the increase in attending several times to the emergency departments, the medications' errors, which all are several negative consequences that badly reflect on the health services expenditures.

In one of the studies made in this regard, about half of the medications' errors in the hospital, and (20%) of all the sentinel incidents have been related to the lack of communication and coordination during the care transition, which has eventually resulted in the readmission in the hospital (Barnsteiner, 2005). This has also been the basic reason of (80%) of sentinel incidents registered at JCI, as when the care transition is made through coordination, the patient' special health information flows fast, which would decrease using the health services repeatedly, resolve the contradictions between the health care service providers, and would prevent the medical errors. The best techniques to apply the coordination of care during the health care transition is through the inter-professional cooperation.

The weakness of communication's chains through the multi-disciplinary medical teams has been the key reason for the sentinel incidents registered at JCI in the USA between the years 1995 and 2006. It remains the basic reason which leads to file a lawsuit and complaints caused by the care transitions (Commission, 2006). Out of 25.000 to 30.000 preventable adverse incidents which brought permanent disability in Australia, (11%) has been due to lack of communication and coordination, while (6%) has been because of the health service care providers' incompetent skills and capabilities (Wacogne & Diwakar, 2010).

2.4 Leader ship support

Leadership means defining and strengthening executive regulations, policy making and creating strategies for all stakeholders in the discharge planning system, accepting high-level accountability and responsibility.

One study conducted in Iran to study the most important obstacles to effective discharge planning, the most significant was the lack of willingness of managers to execute successful discharge planning, lack of familiarity of the process by senior managers ,that the managers ' and politicians ' attitudes play a key role in the health system. They didn't give any priority to the discharge planning in health system. Lack of comprehensive plan to develop Discharge planning is not involved in the strategic plan in the ministry of health is not involved in training curriculum of medical and paramedical students which result in lack of a comprehensive system approach to patient care that leads to unified and consistent processes and avoids inconsistency between different levels and different providers. Systemic approach identifies care change as a priority in the healthcare system,

creates a roadmap for successful transformation of care systems and incorporates transfer of care in the curriculum for education, lack of integration and implementation of a coordinated system of referrals with definite standards and regulations for the transition of care and the definition of medical and administrative rules and responsibilities at various levels of health services. Managers in every levels of management should coordinate and interact with each other in the planning, performing and evaluation of (TOC) processes (Gholizadeh et al., 2016).

2.5 Perception of patients

Involvement of patients has a positive influence in their outcomes ,it is a vital factor for effective transition of care and their satisfaction on healthcare services in general, and their good rule in decreasing medical errors (Weingart et al., 2011).

When patients really understand their treatment, then the care they received will be better evaluated by them. That is why there is a growing interest internationally, in reforming health services not only to be more resource-efficient and effective, but also to be more patient-centered in further improving efficiency and effectiveness.

Patient-centered care (PCC) is viewed as a key element of safe, high-quality health care. It is defined as health care which respects and reacts to the interests, needs, and values of patients and customers. However, the achievement of this kind of care requires good communication between health professionals, patients, and families.

Principles of (PCC) by Picker Institute (2013) consist of integration of care, coordination, education, physical well-being, emotional support and relief of fear and anxiety; engagement of family, transition and continuity and access to care, in addition to the central basis of respect for patients' values, preferences and needs (Riechmann & Stahl, 2013).

2.6 Perception of healthcare providers

Healthcare providers perspective about discharge planning process was studied by Abu Dagga (2014) at Gaza governmental hospitals by five domains which illustrated that the domain of current practice related to discharge planning process scored (63.4%), giving instructions domain was (80.4%), information and about medication domain was (71.4%), availability of regulations and records was (57.25%) which is the lowest score

and finally their perception about discharge planning outcomes was (81.4%), this result indicates good perception of healthcare providers.at the same study health care providers responses about barriers that hinder effective discharge planning ,the majority of them agreed and strongly agreed that over work load (78.9%) and high demand for hospital bed (72.5%) and scarce social and health services after discharge (75%) was the main barriers for effective discharge planning.

Chapter Three

Methodology

This chapter outlines the methods used in this study. This explains the study's design, sampling, data collection methods and analysis of data, It describes the pilot sample, the study period and response rate. The information, reliability and suitability of the study instrument are preceded by the study limitations that appear at the end of this chapter.

3.1 Study design

The design of this study is mixed, descriptive, analytical and cross sectional one. Descriptive research is defined as a method of a study describing the features of the population or phenomenon being studied and description of the current situation. Analytical research is a specific type of research requiring critical thinking skills and the evaluation of facts and information relevant to the research being carried out. Cross sectional design reflects the existing facts at the same point of time of data collection, it is less expensive and it consumes less time than other longitudinal studies. In this study, methodological triangulation would provide combination between quantitative (interviewed questionnaire with patients) and qualitative paradigms (Focus group discussions (FGDs) with health providers) and (in depth interviews with key informants (KII) to validate findings from one method with another, or to enhance understanding of the facts on the ground (Donovan and Sanders, 2005).

After the quantitative, the qualitative component was carried out to examine the issues arising from the quantitative analysis.

3.2 Study Population

The study includes two populations.

3.2.1 Quantitative Part

The study population includes all patients discharged from all governmental hospitals. The number of patients discharged from 12 governmental hospitals in GS in 2017 was 197,391 patients (MOH,2018).

3.2.2 Qualitative part

The first population is health providers. As the researcher conducted 5 Focus Groups Discussions (FGDs) with the health providers. The second population were policy makers, ten key informants interviews (KII); five from hospitals and five from MoH.

3.3 Eligibility criteria

3.3.1 Inclusion criteria

Patients or caregivers transitioned from inpatient hospital departments at study settings hospitals and have given discharge sheet during the data collection period.

3.3.2 Exclusion criteria

1- Daily care patients
2- Patients (LOS) less than 24 hours
3- Obstetrics patients

3.4 Period of the study

The study began in June, 2018 and ended by November, 2019.

3.5 Sampling

3.5.1 Sample size

3.5.1.1 Quantitative Part

According to the annual report of the MoH about hospital statistics in 2017, the total number of admitted patients to governmental hospitals inpatient department was 198.684 patients. A proportional sampling approach, Raosoft software program was used to calculate the sample size with a (95%) confidence interval and (5%) acceptable marginal error (Annex 1). The calculated sample size equals 383 at (95%) confidence level. However, the sample was increased to 400 patients in order to cover for possible non respondents and the response rate was (95.7%).

The sample in this study is a multistage one. First hospitals divided to general hospitals and specialized hospitals. The researcher selected two general hospitals and two specialized hospitals randomly using simple random technique. Then, a systematic convenient selection for patients had been done depending on inpatient volume per each hospital.

Table (2.1): Population and sample size for each hospital

No	Hospital	Number of inpatients	% of sample	Sample size
1	Al-Shifa Medical center	57.388	74.1%	296
2	Andonisi Hospital	9.181	11.8%	47
3	Ophtalmic Hospital	4.790	6.1%	25
4	Al Dorra Pediatric Hospital	6.083	7.8%	32
Total		**77.442**	**100%**	**400**

3.5.1.2 Qualitative Part

1- Healthcare providers

A non-probability purposive sample of healthcare providers was selected at each hospital to conduct 5 focus group discussions. Participants in the focus groups were selected to ensure that they represent multiple professionals in health care.

2- Key informant interviews (KII)

A non-probability purposive sample of 10 key informants' for interviews were selected. The idea of including this sample is to dig deeply and understand in-depth their perspectives about transition of care success and challenges.

Table (2.2): explains qualitative part participants

Focus group	Participants
Focus group discussions with physicians	2 groups of 10 participants (one group for general hospitals and the other for specialized hospitals)
Focus group discussions with nurses	2 groups of 10 participants (one group for general hospitals and the other for specialized hospitals)
Focus discussions group with multiple professions (pharmacists, lab technicians, physiotherapists, radiology technicians, psychologist, local representative, rehapitalation center representative)	One group of 10 participants
KII	**Participants**
In depth interviews with 5 key health managers from general hospitals administration	General director of hospitals administration, medical department manager, pharmacy department manager, nurse department manager, operation rooms department manager
In depth interviews with 4 key health managers from hospitals	Hospital manager, medical managers, nurse manager, pharmacy manager
In depth interviews from PHC	One PHC manager

3.5.2 Study Instruments

3.5.2.1 Quantitative Part

A questionnaire used to collect data form patients discharged from hospitals. The tool was developed based on available literature and the objectives of the study. It consisted of 10 parts (Annex 2).

The main parts for the questionnaire are:

1- (15) items related to patient characteristics.

2- (7) items related to patient engagement with discharge planning.
3- (6) items related to patient preparation before transition.
4- (10) items related to information exchange.
5- (10) items related to medication reconciliation.
6- (12) items related to patient education and instruction they have been provided.
7- (8) items related to follow-up appointments.
8- (6) items related to continuity of care.
9- (6) items related to communication and coordination.
10- (3)open ended questions about patient opinions and suggestions for improvement.

3.5.2.2 Qualitative Part

The researcher collected the data with the help of a note-taker through open ended (semi-structured) questions. The researcher asked these questions within both the FGDs with health providers and in-depth key informants KII face to face interviews (Annex 4).

The main parts of FGDs and KIIs are:

1-Describtion of (TOC) processes

2-Describition of hand off process

3-Assessment of patients at risk of readmission

4-Barriers of effective (TOC)

5-The requirements for whole system approach to patient care

3.5.3 Pilot study

3.5.3.1 Quantitative

Pilot testing was done prior to the start of the main study. The aim of the pilot study was to check the reliability and validity of the questionnaire as well as to evaluate the possible outcome and to detect if there is a need for modification to the instruments. Piloting also aim to have an idea of the obstacles may face the researcher during the data collection, such as the accessibility to participants or records, in order to minimize the

non-response rate. The pilot study was done on 30 patient. Few questions have been modified that seemed nonsensical or confusing.

3.5.3.2 Qualitative part

A pilot focus group and a pilot interview was done for further improvement of the study validity and reliability. It was helpful to learn the management of time and discussion.

3.6 Ethical Considerations

The researcher was committed to all ethical consideration required to conduct the study. Ethical approval was obtained from the Palestinian health Research Council in Gaza (Annex 5 . In addition, an official approval was obtained from the MoH relevant authorities: General Directorate of Human Resource, General Directorates of Hospitals, and Hospitals managers (Annex 6). Every participant in the study received a complete explanation about the research purposes and confidentiality and about the optional participation in the study. All the ethical consideration observed, respect for people and human rights, respect for truth, and confidentiality was given and maintained.

3.7 Methods of data collection

3.7.1 Quantitative part

The researcher with four data collectors who obtained formal training collected the quantitative data through face to face questioner. The training was done to data collectors to understand study aim and objectives, the main components of the questionnaire, how to start interview, how to ask questions and how to ask open ended questions in order to standardize the data collection method and ensure the reliabity of the study.

After random selection of patients, face to face interview was done after the patient is discharged from inpatient department to another department, another hospital or home.

Data collection was done at time of patient discharge prior to leaving the hospital, after obtaining their verbal consent acceptance for participation and informing them to drop out when they want to.

Before starting the interview, data collectors explained the importance of the study, the main objectives, reflection express their opinion on detecting problems to find solutions. The data collector briefed the respondent during the interview on what they understand, to ensure that the respondent clearly expresses his/her opinion and verifying he or she understood the questions.

3.7.2 Qualitative part

Focus groups have been made using audio recording in order to help take notes, manage time and assist the researcher. Using the audio recording with the permission of the participants has been a good idea to recall the details of the meeting. Each session has taken 60 to 90 minutes with 8-10 participants attending. The structure of the group and the group discussion has been prepared carefully with the purpose of creating a non-threatening environment.

At first, the researcher has expressed gratitude for the attendees' participation and simply briefed about the study and its main objectives. The researcher indicated that the attendants' presence and participation has been of prime importance.

The researcher has therefore elucidated the general rules of the meeting that would facilitate the discussion and allow for an open dialogue with the participants, which would give every individual the chance to partake and express their view points.

Having initiated with brainstorming questions, the discussion has been planned to tackle all the details required. Finally, the researcher has prepared a brief report in this regard.

In depth interviews with ten key informant from MoH managers and policy makers was conducted. Each interview lasts about an hour. There has been a prolonged effort as the interviewer tried to probe answers and adequately cover all the interview dimensions.

3.8 Scientific Rigor

3.8.1 Quantitative part (questionnaire)

3.8.1.1 Reliability

The following steps have been taken to ensure reliability of the instruments:

- Training of data collectors on how to interview the patient and how to ask questions, it means to ensure that the questionnaire filling is uniform.
- Continuous validation and review of completed questionnaires.
- Data entry on the same data collection day to insure data quality.

Table 3.2 below shows the reliability test result for all domains:

Table (2.3): Reliability estimates for the survey domains

Sn	Domains	No of paragraph	Cronbach's Alpha
1.	Planning	7	0.702
2.	Preparation	6	0.721
3.	Medication	10	0.891
4.	Health education	12	0.820
5.	Follow up	8	0.883
6.	Continuity of care	6	0.786
7.	Coordination	5	0.727

3.8.1.2 Validity

To ensure the face and content validity , the questionnaires were evaluated by eight experts in the field to evaluate its relevance and identify whether the questions agreed with the scope of the items and reflect the concept of research problem.

Eight experts with different background evaluated the questionnaire in order to assess its significance, consideration was given to their comments, where all question that reached less than (80%) consensus were removed (see Annex 7). In addition, a pilot study was performed before the actual data collection to examine patients responses to the questionnaire and how they got it. This enhanced the validity of the questionnaire after adapting it to be better understood.

- **Internal Consistency**

To check internal validity, the researcher calculated the correlation between each item and the corresponding field. Tables (3.4) present the correlation coefficient for each domain and the total of the corresponding field. The p-values (Sig.) are less than 0.05, thus the correlation coefficients of all domain are significant at $\alpha = 0.05$, therefore it can be said that all items of each field are consistent and valid to measure what it was set.

3.8.2 Qualitative part (in-depth interviews)

To ensure the trust of the qualitative component in this study. First, a peer review was conducted by health experts to evaluate the interview questions to ensure that they cover required dimensions. A member review was then done to ensure that the transcripts were correct and clear during the interviews. However, the recording of interviews and focus groups enhanced the tracking of information and the accuracy of transcripts. Finally, all the transcripts and recordings were kept for tracking the information by others at any time (Audit trail).

3.9 Data entry and analysis

3.9.1 Quantitative part

The researcher used the Statistical Package of Social Science (windows version 20, SPSS, Chicago, USA) program to give descriptive and inferential statistics. The variables was coded then entered into the computer. Data cleaning was done to check for any missing or error in data entry (through running frequency analysis). All suspected or missed values was checked by revising the available data collection forms. The collected data was organized and analyzed based on the objectives of the study. The following analysis was performed:

1-Descriptive statistical analysis was made by comparing frequencies and percentages of different variables to find out the mean, median, and other statistics.

2- Inferential statistics was made to examine the relationships between independent (categorical) variables and dependent variables (numeric scores) including t-test was used to compare two means of independent variables for example, to examine the relationship between gender (2 independent) (categorical) variables and transition of care domains

(dependent variables), one way ANOVA test used to compare means of more than two independent variables with one dependent variable, to examine the relationship between patient characteristic variables (more than 2 independent) variables, for example overeducation level, hospital and transition of care domains (dependent variables) and MANOVA test was used to compare means of more than one dependent variable with more than two independent variables. For example, the relationship between transition of care domains and departments.

3-The researcher determines the P value to be (<0. 05%) with (95%) confidence interval.

3.9.2 Qualitative part:

Open coding thematic analysis method was used to analyze the transcripts of the in-depth interviews and FGDs. The researcher obtained the main findings from the transcripts of the interviews and FGD. Then, categorization of related ideas, and comparison and integration between the quantitative and the qualitative findings was done to create rich items for discussion and representation.

3.10 Limitations of the study

- All participants were interviewed at the time of discharge , they are in a hurry to leave the hospital. Some participants might have provided hasty or inadequate answers to the study questions.
- People are poor and in need to receive services from hospitals. This might have lead them not to honestly disclose their real opinions about their transition of care processes.

Chapter 4

Results and Discussion

The results of quantitative and qualitative analysis of the data combined, including descriptive analysis of the demographic characteristics and inferential statistics to study the relationships between independent and dependent variables are listed herein under.

4.1 Descriptive Statistics

4.1.1 Demographic characteristics of participants

Table (4.1) shows the distribution of participants according to demographic characteristics; gender, age, residency and educational level.

Table (4.1): Distribution of the study participants by demographic characteristics

Variables	Number	%
Gender		
Male	203	53.0
Female	180	47.0
Total	**383**	**100.0**
Respondent		
Patient	228	59.5
Attendant	155	40.5
Total	**383**	**100.0**
Age		
25 years or less	83	23.5
26 -50 years	94	26.6
51 - 60 years	61	17.3
Above 60 years	115	32.6
Total	**353**	**100.0**
Mean age= 46.2, MD = 50.0 , Std= 23.7		
Governorates		
Gaza	274	71.5
North	95	24.8
Other Places (Mid Zone and South of Gaza)	14	3.7
Total	**383**	**100.0**
Education Level (participants)		
Secondary	143	37.5
University	105	27.6
Preparatory	80	21.0
Primary	28	7.3
Illiterate	25	6.6
Total	**381**	**100.0**

The results indicate that (53.0%) of study participants were males while (47.0%) were females, which is inconsistent with Al Ron (2009) where female respondents were (65.12%). About (59.5%) of respondents were the patients themselves and (40.5%) were their attendants. Some parents and others participated instead of the patients themselves because of the patients' tiresome and/ or illiteracy.

Regarding age, nearly (32.6%) of respondents' ages were more than (60), and (26.6%) their age was between (26 to 50) with a mean of (46.2) years.

As for the place of residency, (71.5%) of the participants were from Gaza City, out of which, (25%) from the north and about (4%) from other places, because the hospitals in which the study has been conducted were three in Gaza City and one in the North.

Respecting the respondents' education level;(37.5%) had secondary education, (27.6) had university education, while (21%) had preparatory education. (7.3%) were primary-educated and (6.6%) were illiterate.

The results herein detailed are not matching with PCBS population report of 2017 which shows that (4.4%) of GS population was over (60) and (2.8%) were illiterate (PCBS, 2017). That the study has focused on the elderly patients and other specific population.

4.1.2 Hospital Related Variables of the Study Participants

Table (4.2): Distribution of the study participants according to hospital related variables (N=383)

Items	Number	%
Hospital		
AL Shifa	236	61.6
Al Andonisi	67	17.5
Al Durra	46	12.0
Ophthalmology	34	8.9
Total	383	100.0
Department		
Surgical - Shifa	125	32.6%
Medical- Shifa	66	17.2%
Pediatric - Al Durra	46	12%
Cardiac - Shifa	45	11.7%
Ophthalmology	34	8.87%
Surgical - Andonisi	32	8.3%
Medical - Andonisi	25	6.5%
Cardiac - Andonisi	10	2.6%
Total	283	100%

Route of admission		
Emergency	314	82.0
Outpatient Clinics	38	9.9
Other Governmental Hospitals	10	2.6
PHC	9	2.3
Other	8	2.1
Private Hospitals	4	1.0
Total	383	100.0
Frequency of Admission		
Frequent admission	214	56.9
First time admission	162	43.1
Total	376	100.0
The Medical Procedures		
Treatment	313	81.7
Surgery	129	33.8
Examination	263	28.8
Consultation	36	9.4
Average Long of stay		
3 Days and less	167	43.6
From 4 to 7 Days	187	48.8
More than 7 Days	29	7.6
Total	383	100.0
Mean= 4.48, MD = 4.00 , Std= 2.81		
Mode of Discharge		
Home	369	96.3
According to patient request	7	1.8
Referral to another department	3	0.8
Referral to another hospital	4	1.0
Total	383	100.0

As displayed in Table 4.2, (61.6%) of the study participants have been discharged from AL Shifa Hospital, (17.5%) have been followed-up by Al Andonisi Hospital, and (12.0%) have followed-up by Al Durra Hospital, with (8.9%) followed-up by the Ophthalmology. The percentages are associated with the number of patients discharged annually from Al Shifa Hospital, which is the highest number at GS hospitals (MOH, 2018).

In addition, (17%) of patients were discharged from medical departments at Al Shifa Hospital, out of which, (6.5%) from medical departments at Andonisi Hospital, in other words, (23.5%) of the respondents were discharged from medical departments, while (32.6%) of the respondents were discharged from surgical departments at AL- Shifa Hospital, (8.3%) were discharged from surgical departments at Andonisi Hospital. Approximately, (41%) of the patients were discharged from surgical departments, (12%) from cardiac departments, and (12%) from paediatric departments. About (9%) of the patients were discharged from ophthalmology departments. The findings detailed in here

are consistent with the distribution of admitted patients according to Hospitals Directorate General Annual Report (MOH, 2018).

Besides, (82.0%) of the respondents were admitted into the hospital through the emergency department, out of which (10%) from outpatient clinics, while only (2.3%) were referred from primary health care centres. The result is higher than Abu Daggah (2014), who has studied discharge process at governmental hospitals in GS and concluded that (65%) of patients were admitted from emergency department, and (35%) were admitted through outpatient clinics. Also, the issue is related to the attendance rate at governmental emergency departments, which has been (715/1000)population with an increase of (7.3%) in 2018 compared to 2017, which is quite a large number of patients negatively reflecting on the quality of patient care, and bringing in a heavy work load at emergency departments.Ineffective (TOC) maybe one of the reasons behind.

About (57%) of patients were admitted more than once, while (43%) were admitted for the first time. Different from Abu Dagga (2014) which found that (42%) were admitted repeatedly and (58%) were first admitted patients, while According to the study of AL Ron (2009) (35%) of patients were admitted more than one time, which proves that the readmission percentage is increasing due to ineffective (TOC) and/or other factors.

The average mean of the length of stay has been (4.5 days), while the median stay in the hospital was (4) days, which has reduced in comparison to previous studies where the average mean of LOS has been (6.67), and the median has been 5 days (Abu Dagga, 2014), which is higher if compared with the average of LOS of all governmental hospitals based on the MoH annual report in 2018. The report shows that it has been (3.3 days). Decreased LOS makes a premature discharge, countless number of attendances to the emergency departments, which eventually would not only increase the admission rate but also accelerate discharge from hospitals.

4.1.3 Patients perspectives about transition of care processes

Patients' perspectives about transition of care processes have been listed into 8 domains; patient discharge planning, preparations for discharge, information exchange between the medical staff and patient, medication reconciliation, health education for patient and/or his/her family, follow-up appointments continuity of care and coordination.

Within the scoring of patient perspectives about transition of care process, the survey questions have been assessed according to 5-points Likert scale ranging from strongly disagree, disagree, neutral, agree, and strongly agree.

4.1.3.1 Discharge Planning

Table (4.3): Distribution of the study participants according to their responses about discharge planning

Items		S. Disagree	Disagree	Neutral	Agree	S. Agree	Mean	Relative Mean
Agreement of the patient with discharge plan	N	7	59	31	244	42	3.67	73.4
	%	1.8	15.4	8.1	63.7	11.0		
Providing the patient with enough information about his diagnosis	N	5	34	81	221	42	3.68	73.6
	%	1.3	8.9	21.1	57.7	11.0		
Providing the patient with enough information about his prognosis	N	23	73	110	153	24	3.21	64.2
	%	6.0	19.1	28.7	39.9	6.3		
Informing the patient estimation about length of stay in hospital	N	21	194	34	114	20	2.79	55.8
	%	5.5	50.7	8.9	29.8	5.2		
The medical staff answer the patient questions & complaints	N	4	26	107	205	41	3.66	73.2
	%	1.0	6.8	27.9	53.5	10.7		
The medical staff ask about the patient social status and needs	N	24	96	129	128	6	2.99	59.8
	%	6.3	25.1	33.7	33.4	1.6		
Informing the patient with adequate time to make decisions prior to transfer from hospital	N	10	79	104	171	19	3.29	65.8
	%	2.6	20.6	27.2	44.6	5.0		
Mean = 66.53, Median = 65.71 , Std= 11.27								

Table 4.3 shows that **(**63%) of the participants have reported that they agreed with the medical staff about their discharge plan, while (11%) strongly agreed. Conforming with Abu Dagga (2014) whose result pointed out that about (29%)of heath care providers replied with the answer (always or usually) that the discharge planning should begin at

the day of admission, while (65%) of the participants mentioned that the discharge planning should start at the day of care transition.

In addition, more than (70%) of the participants indicated that they have been informed about their diagnosis, while less than half have been informed about their prognosis. Through FGDs one senior doctor explained '*Generally speaking, we do not pay attention to provide patients with information about their diseases' prognosis, the effort is made only to manage their treatment during hospitalization*' (FGD, doctor), which does not go in line with the study of Duguid (2012) who highlighted that sharing information with the patient and his/her family, and involving them in discharge planning helps to bring in an effective health care and makes the key to successful discharge planning. Another FGD participant has proposed that '*If we direct our attention to increase the patient awareness about prognosis, this will increase the compliance for treatment, especially for chronic patients*' (FGD, doctors). Through patient's interviews, one patient said '*I was admitted to the hospital, and today I was discharged, and I don't know anything about my illnesses*. Shepperd et al (2013) stated that the discharge planning, if made, would improve the patient understanding of his/her illness and prognosis, furthermore, would positively better the patient satisfaction with services and improve patient outcomes and quality of life.

More than half of participants have agreed that they have had a chance to ask about their health condition. FGDs revealed that patient and family ask several questions and they usually answer their questions, but most patients have many attendants, each one asks the same questions at different times, which interrupts their work and confuses the medical team *as* a nurse said *'regulations for numbers of attendants and visitors are a must'* (FGD, nurse). Also they ascertain that the main concern for the health team is to deliver medical care to the patient, which is a priority, while no standard discharge planning is available, and the decision is not shared with patients, it all depends on the clinician's behavior, attitude and individual communication skills .In addition KIIs confirmed that there is no discharge planning at our hospitals, while inpatient departments are overcrowded with patients, the number of staff is not adequate. they cannot give a specific group of patients to a specific nurse due to the lack of staff. According to the required working hours, there is a shortage of nursing in hospitals of (17%) and most of

the nursing work an unpaid overtime, so, nurse work is functional, one patient is passed through several nurses, one nurse withdraw samples out, another nurse writes down the vital signs, and a third nurse gives treatment and so on, each nurse does specific task for specific number of patients, therefore, there is neither clear discharge plan nor accountability for it, which is consistent with Al Massri (2009) who has conducted a study in the WB about discharge process and found that more than half of health care providers do not implement transition of care planning.

In addition, (35%) of the respondents agreed the medical staff gave them an estimate of their length of stay in hospital. As for informing the patients and assessing their (LOS), FGD participant doctors explained that they cannot predict the average stay of the patient, especially in cases of multiple diseases and unclear diagnosis, the patient and his/her family are inquiring all the time about when to leave, while they cannot give a clear answer to their question and most of the times, one doctor gives an answer and another doctor gives an opposite answer, which causes a lack of confidence for the patient, it also involves the health team into troubles and problems with patients 'and about this point one patient said bitterly '*everything is bad from the moment of entry to the moment of discharge, and dealing with the patient is not good, nobody answers my questions'*. What has been mentioned goes inconsistent with Solomon et, al (2013) who stressed that the discharge plan should be modified according to the needs of the patient throughout the duration of his/her illness in the hospital, and the patient's needs should be updated with the patient and his/her family to meet their expectations. The overall mean score was (3.3) out of (5) (66.5%). Despite the researcher taking note that the concept of discharge planning as a structured process has not been understood by most of the patients. Kripalani et al (2007) stated that patients and their families have had wide variation in their knowledge of the health care system and how should the health providers engage them in the process. FGDs disclosed the fact that health providers do not know that discharge planning is a process which requires several stages to be achieved. Their view point was that the discharge plan is a set of procedures to be done only at the care transition time as one nurse said '*There is no organized discharge planning at our hospitals, the process is going randomly without specific responsibilities or accountability'* (FGD, nurse). The misunderstanding of care transition planning for

patients and staff should be dealt with at the moment of admission, otherwise, it may lead to unsatisfactory consequences for the patient, overloud on health providers and increase of cost.

4.1.3.2 Preparations for discharge

Table (4.4): Distribution of the study participants according to their responses about preparations for discharge from hospital

Items		S. Disagree	Disagree	Neutral	Agree	S. Agree	Mean	Relative Mean
The patient understood how to manage his health after discharge	N	11	33	34	257	48	3.78	75.6
	%	2.9	8.6	8.9	67.1	12.5		
The patient understood the warning signs and symptoms which need a doctor call	N	14	82	104	160	23	3.25	65.0
	%	3.7	21.4	27.2	41.8	6.0		
The patient understood whom he will call if he noticed warning signs and symptoms	N	16	79	115	149	24	3.22	64.4
	%	4.2	20.6	30.0	38.9	6.3		
Providing the patient with a telephone number to contact	N	84	251	10	28	10	2.03	40.6
	%	21.9	65.5	2.6	7.3	2.6		
Assessment of psychological readiness for transition	N	20	86	143	120	14	3.06	61.2
	%	5.2	22.5	37.3	31.3	3.7		
Assessment of physical ability to perform daily activities	N	7	19	118	182	57	3.69	73.8
	%	1.8	5.0	30.8	47.5	14.9		
Mean = 63.43, Median = 63.33 , Std= 11.90								

As shown in table (4.4), the majority of patients have implicated how to manage their health after discharge, (67%) of patients have agreed, and (12.5%) of patients strongly agreed. The result which proves incongruent with Mabire et.al (2019) in which (58%) of patients have indicated that they received interventions to prepare themselves for self-care. Yet, less than half of participants have agreed that they have understood the warning signs and symptoms which need a doctor call, and whom to call upon request, conforming with Mabire et.al (2019) study which explained that (30%) of patients have received interventions to prepare themselves for symptomatic management.

In addition, less than half of participants have agreed that they have been informed about whom to call if they have noticed any warning signs, and more than (85%) of participants have reported that they have not been provided with a contact telephone number of a person to call if they had a health problem. This conclusion was justified by the KIIs that most of patients admitted from the emergency department to inpatient department, there is no specific consultant for every patient, so, if the patient has noticed any warning signs, he/she would return back to the emergency department, except if the patient follows-up his/her disease at a private doctor clinic, the private doctor almost works at the governmental hospital, he then communicates with the patient personally, in general ,in our system patient is not provided with a telephone number to contact when the need arises. Not providing the patient with a telephone number to contact is one of the problems that the researcher believes it causes the increase in emergency department visitors and the heavy burden borne by emergency medical staff. Through FGD discussions, a senior doctor has commented '*As long as there is no specific consultant who would supervise the patient during the period of hospitalization, and agree with the patient on the discharge plan, therefore, there would be no specific person to communicate with the patient in the event of any emergency, an so the patient will return to the emergency department'*(FGD, doctor). Decision makers should find a way for patients to communicate with their therapists, and take their advices by telephone instead of attending to the emergency department.

Only (31.3%) of participants have agreed and (3.7%) strongly agreed that the medical staff assessed their psychological readiness before transition. FGD participant revealed that they do not assess the psychological state of the patient before discharge and only care about the clinical improving of the patient. In this context, policy makers have mentioned that they have worked to integrate the psychological health at the emergency departments in some hospitals, while a big number of staff has been trained on the basics and diseases of psychology as well as the mechanism to provide urgent help and guidance, moreover, a referral system to refer the psychological cases has been developed, if the medical team noticed that some patients admitted to the hospital departments were in need of psychological support, they will be referred to the psychology department in the hospital, this kind of service has been made available at 3 central hospitals, nevertheless, it only works at the mental health of the individual rather than the psychological preparedness before the care transition. The overall mean score has been 3.1 out of 5 (63.43%), that means more effort must be done by health providers to improve patients readiness and preparation before transition.

4.1.3.3 Information exchange

Table (4.5): Distribution of the study participants according to their responses about information exchange between medical staff and patient

Variable	Yes		No		Total	
	N	%	N	%	N	%
Providing the patient with discharge sheet	372	97.1	11	2.9	383	100.0
Explaining the information written in the discharge sheet	232	60.6	151	39.4	383	100.0
Providing the patient with the final diagnosis written on the discharge sheet	354	92.4	29	7.6	383	100.0
Discharge sheet included the clinical history before admission	215	56.1	168	43.9	383	100.0
Discharge sheet has included investigations and clinical procedures done in hospital	336	87.7	47	12.3	383	100.0
Discharge sheet has clarified if the patient has drug or food hypersensitivity	107	27.9	276	72.1	383	100.0
Discharge sheet has clarified the medical condition at the time of care transition	337	88.0	46	12.0	383	100.0
Discharge sheet has clarified medications prescribed for the patient after transition from hospital	370	96.6	13	3.4	383	100.0
Discharge sheet has been written with understood and clear language and it contained little of medical terms and abbreviations	147	38.4	236	61.6	383	100.0
Informing the patient about the need to show the discharge sheet to other health care providers	174	45.4	209	54.6	383	100.0
Mean = 69.03, Median = 70.00, Std= 17.56						

As shown in table 4.5, most of the patients have been provided with a discharge sheet (97%), and about (3%) have informed that they did not have a discharge sheet, while the researcher believes that the patients did not recognize that they got it. About (60%) of the patients have reported that the medical staff has explained the information written in the discharge sheet, which goes in line with Abu Dagga (2014) study where **(**62%) of respondents have understood the information they received. In addition, (92%) of patients have been provided with final diagnosis. Although the diagnosis was written on the discharge sheet, several patients showed a lack of understanding of their diagnosis.

Also, (56%) of the participants have been provided with the clinical history before admission and (87%) of discharge sheets have included investigations and clinical procedures done in hospital while (88%) of discharge sheets have explained the patient medical condition at the time of care transition. In comparison with Mahrous (2013) study, where (44.3%) of patient have not been satisfied with the information that should meet their needs and (45%) of patients have not been satisfied with the information, which should answer their questions about what have to be done after discharge, while (68,2%) of respondents have not received information about the medical condition to be used at other points of care transition.

FGDs has affirmed that the discharge form have to be changed in a way that allows writing all the necessary instructions one senior doctor said '*Discharge paper is not informative at all and the format of discharge paper does not include all the information about the patient history, there is no space for patient instructions, sometimes, we write instructions in an additional paper'* (FGD, doctor). And about information exchange with patients FGD participants agreed that there is no time to explain the information for the patient upon discharge time, furthermore, the inpatient beds are fully occupied, the emergency department is overcrowded, and the repeated interruptions of emergency admissions often leave the team with insufficient time to speak to the patients before transition to home. One nurse said *'Most doctors provide the patient with a discharge sheet without seeing him/her, and the sheet is sent to the patient by nurses, which leaves him/her without knowledge about the importance of the discharge sheet'* (FGD, nurse). Several patients during the interviews complained that they did not understand the discharge summary and they suggested to be written in Arabic, one patient said '*I don't know the value of the discharge sheet, and I don't understand whom I'm going to give it and what I'm going to do with it'.*

In addition, (96%) of discharge sheets describe the medications prescribed for patients after transition from hospital. According to the researcher's observation, the sheet only contains the names of drugs without any clear information. It is often written in a bad handwriting, which may lead to medication' errors. And (28%) of participants' discharge sheets explain whether the participants have drug and/or food hypersensitivity or not, which is an essential information for the patient safety, especially during the care transition. Through FGDs, one participant has commented that '*several cases of preventable deaths which have taken place during the past year, have been documented due to ceftriaxone hypersensitivity'*. Deaths that may be prevented if the information had been available for the medical staff through the discharge sheet to be handed by the patient to the attending physician in case of care transition. And (62%) of participants have denied that discharge sheet has been written with understood and clear language. Also, the discharge sheet only contained some of medical terms and abbreviations. What has been mentioned has not been consistent with the Agency of Health Research and Quality (AHRQ) which has recommended that the discharge summary should be written at the level of third or fourth primary grade, in a language that the patient prefers. If and when the discharge summary has been written accordingly, it may help the patient deal with his/her illness. Managers confirmed that the discharge sheet don't contain more detailed information of value for the patient, therefore, they suggested that the discharge sheet has to be filled by a doctor with a medical secretary, in order to include the important medical information for the patient and other health providers, it must also include the specific instructions of the patient, and the instructions have to be written in native language with little medical abbreviations.

More than half of the participants (55%) have not been informed about the need to show the discharge sheet to other health care providers. For the same point, one manager has concluded '*I do not blame doctors, because we often have insufficient beds which sometimes result in early discharge of the patients, and the time is insufficient to explain the information of discharge summary to the patient'(KII).* Another key informant pointed that ineffective information exchange between health care providers causes many problems during transition from one hospital to another' then elaborated that *'The reality of the transition from one hospital to another works as "a divorce" in which the next hospital starts the investigations from the beginning, irrespective of what have been done for the patient in the hospital transferred from'*. Doing the investigations all over again

causes an overuse of resources and overload of work, as well as radiological exposure, which together bring back the risk again and all the hazards that threaten the patient safety.

Traditionally, the discharge summary was used mainly for documentation of acute hospital care with little need for information transfer, because the physician used to get the patient's file at the follow-up meeting at the outpatient clinics.

Regarding the information exchange between health care providers at the outpatient clinics, policy makers mentioned that many steps have been taken to computerize the health information system, yet these steps go slowly due to many hindrances, the most important of which is the lack of financial resources to purchase ready-made computer programs to replace the old ones , in addition to the lack of internet reliable networks to support the computerized system .One of the best achievements is computerizing the out-patients clinics, in order to strengthen the communication among the health care providers, regrettably, the process has not been completed at all the hospitals, and a gap is still found in the system, especially when the patient is transited from one physician to another, where nothing is clear about the patient's health condition, particularly with the weak health documentation for the patients' paper files. One manager mentioned '*The drug stores, radiology departments, and laboratory departments have been all computerized, nevertheless, the clinical information has been partially computerized*' (KII) ,this results in the lack of knowledge about the clinical history of the patients attending to the out-patients clinics, and patients attending to the emergency departments, moreover, a computerized program that incorporates the primary health care centers with the hospitals is not available yet ,which is consistent with Abu Hamra(2014) study findings about the assessment of electronic health record readiness in GS , who found that most of the integration of information and communication technology found with administrative functions and barely she found health information about medical or nurses notes or clinical results.

FGD participants spotted the light toward The Cancer patients attend Al-Shifa Hospital, because of the lack of admission beds at Al- Rantisi Hospital, the patients are admitted to the medical departments without the mere knowledge about their clinical history and/or the clinical interventions made for them before. Furthermore, the health team only count

on the patient’s family information and medical reports available with them, while the medical team try only to treat the symptoms upon patient admission.

As for the information exchange between health providers at the same department, managers have described the handoff process; that hand off between hospital nursing is perfect and organized, while the time overlaps between shifts. Before any shift, the information regarding the patient's full name, diagnosis, treatment and clinical interventions during the shift are delivered, the treatment plan is also handed to the next shift nurses; yet, this technique has failed with the physicians, the physicians do not commit to the overlap handover, instead, they use specific register of handover for specific and unstable patients . In fact, the handover process is verbally done in hospitals, the team tried to use SBAR handoff method, which is a model for handover according to the standards required for safety, but they have not been able to stick to it, about this point one key informant said *' the handover process is not officially documented, since the number of patients in the department is high, and the handover process using this model takes a long time, which may exceed two hours, while the time of handover is only half an hour'* (KII*).*

4.1.3.4 Medication reconciliation

Table (4.6): Distribution of the study participants according to their responses about Medication reconciliation

Items		S. Disagree	Disagree	Neutral	Agree	S. Agree	Mean	Relative Mean
Understanding the daily taken drugs	N	15	65	20	256	27	3.56	71.2
	%	3.9	17.0	5.2	66.8	7.0		
Understanding the drugs taken only when needed	N	15	89	81	177	21	3.26	65.2
	%	3.9	23.2	21.1	46.2	5.5		
Understanding changes on the medication list before admission	N	19	105	116	132	11	3.03	60.6
	%	5.0	27.4	30.3	34.5	2.9		
Understanding the reason of taking each drug	N	21	109	80	154	19	3.11	62.2
	%	5.5	28.5	20.9	40.2	5.0		
Understanding drug doses and frequency	N	26	130	57	155	15	3.01	60.2
	%	6.8	33.9	14.9	40.5	3.9		
Understanding the route of administration of drugs, before or after food	N	33	135	78	126	11	2.86	57.2
	%	8.6	35.2	20.4	32.9	2.9		
Understanding symptoms or side effects of drugs and how to monitor and whom to contact if noticed	N	54	222	55	47	5	2.29	45.8
	%	14.1	58.0	14.4	12.3	1.3		
Understanding drug –drug interactions and how to avoid	N	68	186	79	44	6	2.31	46.2
	%	17.8	48.6	20.6	11.5	1.6		
Understanding how and from where to get the drugs	N	18	101	99	139	26	3.14	62.8
	%	4.7	26.4	25.8	36.3	6.8		
Understanding where the medication to be kept at home	N	27	110	88	141	17	3.03	60.6
	%	7.0	28.7	23.0	36.8	4.4		
Mean = 59.18, Median = 60.00, Std= 14.36								

As shown in table (4.6) the majority of the participants have reported that they understood the drugs types to take daily, (67%) have agreed, and (7%) have strongly agreed, while about half of them have clearly understood the drugs to take only when

needed. These are better than the results of Abu Daggha (2014), where the over mean score has been (42.9%) for the domain of information of medication after discharge. However, (37%) of participants have clearly recognized changes on their medications list before admission. About (45%) have realized the reason of taking each drug, doses and frequencies, while (41%) have become aware about how to keep the drugs at home. In addition, (33%) of participants have reported that they comprehended the instructions about the drug use. Similar to Mahrous (2013) results in which (35.3%) of patients did not get any information about the medications, (53.3%) of patients did not know the reason for prescribing each medication, while (69.3%) of patients did not realize the side effects of the medications. Kriplani and colleagues (2007) findings reported that about (13%)of participants have agreed that they need to understand the side effects of drugs, how should the drugs be monitored, the drug interactions, and how to avoid, also (31%)of participants have recognized how and from where they will get the drugs, (26%)have been uncertain about the medications name, dose, frequency and route of administration and he has recommended the patient should be provided with the reason for prescribing each medicine and the discharge summary should explain the reasons for including new medications and alterations to previous treatment. Otherwise, serious medication errors may occur. The overall mean score has been (59.18%), which reflects the prime importance to develop medication reconciliation regulations.

According to Cawthon et al (2012), the majority of patients have indicated that it was "quite helpful" to speak with a pharmacist about their medications before discharge. (72.8%), particularly about how to take the medications, and how to manage prevent the side effects. Receiving an illustrated medication list (69.6%) and a follow-up phone call after discharge (68.0%) has been also considered relatively helpful. Patients with limited health literacy have expressed the great benefit. Patients have also reported feeling more comfortable speaking with their outpatient health care providers about their medications. Through patient interviews, many patients reported severe suffering to access the drugs, and not to get the necessary information about them, one patient said ‘I don’t know anything about my drugs, even if I know, I have no money to buy it, I do not know whether I was treated or punished!!’.

Through FGDs, senior pharmacists have informed that in our hospitals, the drugs are dispensed for inpatients by unit dose drug distribution system, when a patient transferred from one department to another, patient cardex is revised by pharmacists at the inpatient

pharmacy, the drug doses are checked, drug-drug interactions, and the physicians are contacted if the need arises to change the medications and the team asks for lab results for specific drugs, which need adjustment or microbiological cultures for antibiotic use, the cooperation between physicians and pharmacy team varies, but in general, the use of unit dose system assures safe drug use for inpatients but there is no contact between the pharmacy and admitted patients; no knowledge is available about the patient previous drug history before admission, furthermore, the system does not help to get information about the patient medication list, except when the pharmacist of interest communicates with patients directly as one pharmacist mentioned *'we as pharmacists lack to relation with patients during discharge'*(FGD, pharmacist). FGDs revealed that pharmacists are not available at the time of transition, and are not involved in drug prescription at discharge at all ,counseling's about medications at care transition is a physicians and nurses' role with the absence of pharmacists at the care transition process, which is a big problem that threatens patient medication safety as their pharmacological information is not accurate as one pharmacist mentioned *'Out of my follow-up for patients, I believe that patients with co-morbidities usually do not understand their medications, while many patients are admitted or readmitted due to drugs' side effects, neither the patient nor the doctors realize that'* (FGD, pharmacist). The clinical pharmacy department is not included within the organizational structure of our hospitals and the quality of drug information differs from one doctor to another, some physicians take good care of patient consultation about the drugs, while others do not care and delegate the task to nurses ,one doctor said *'We usually discuss the changes on patient medication list, and the purpose of change haphazardly'* (FGD,doctor). FGD participant highlighted another critical point that most drugs which are prescribed for patients at care transition time are not dispensed from the hospital pharmacy, some are not included in the essential drug list of MoH, therefore the patient will buy the drugs from a private pharmacy, while other drugs within the essential drug list will be dispensed from a primary health care center, therefore, the medical staff of the hospital don't not care to give information to the patient, because the patient will get drugs from a place outside the hospital, and he will ask the private pharmacist all the questions about the instructions of the drugs-taking. One manager has mentioned *'The absence of a communicative relationship between the pharmacist and the admitted patients brings in negative consequences, therefore, the MoH are working on training part of the hospital pharmacists to become clinical*

pharmacists with the purpose of taking a more effective role with the team of therapists, in order to help reduce the medication errors'(KII).

About the medication dispensing system ,at our hospitals, drugs are not dispensed to patients discharged from hospitals, except some specific drugs for convulsion, hepatitis, kidney failure, cancer and other specific chronic diseases for the patients in need, mainly for secondary care, a specific list and protocol have been made for that, and the health staff are committed to use, other drugs outside the specific list are dispensed from the primary healthcare because there is no outpatient pharmacy, except for some serious and costly drugs, where the patients receive part of their medication from the hospital and the remainder from the primary health care, one key informant astonishingly asked *'How would the drug's interactions be reviewed if the drugs are dispensed from different places'*(KII). This fragmentation may result in incomplete prescription, it will end with the hospital pharmacist counselling the patient for some drugs, while the private pharmacist outside will council the patient for the remaining drugs, which may cause incomplete picture for the patient medication and drug interactions, that no one neither care about nor know about , which all evidently lead to medication errors, medication side effects, repetition of some drugs to the same patient, and incorrect drug dosing for some drugs when taking other ones which must be adjusted. Regarding the same point one manager said painfully *'The system could not be changed, if the outpatient pharmacy dispense all drugs for all discharged patients, this requires a large number of pharmacists to work in the hospital, and may eventually cause increased expenditures of the MOH, while the refugee patients receive their medications from the UNRWA'* (KII).

4.1.3.5 Patient and family education

Table (4.7): Distribution of the study participants according to their responses about patient and family education

Items		S. Disagree	Disagree	Neutral	Agree	S. Agree	Mean	Relative Mean
Providing the patient with written instructions	N	63	147	13	150	10	2.73	54.6
	%	16.4	38.4	3.4	39.2	2.6		
Providing the patient with verbal instructions	N	21	47	65	216	34	3.51	70.2
	%	5.5	12.3	17.0	56.4	8.9		
Clarifying the instructions for the patient and family	N	15	47	81	220	20	3.48	69.6
	%	3.9	12.3	21.1	57.4	5.2		
providing the patient with instructions to take care of wounds, incision or refereeing him to a medical center	N	11	138	98	114	17	2.97	59.4
	%	2.9	36.5	25.9	30.2	4.5		
Informing the patient if need physiotherapy and determine the duration	N	23	159	122	37	9	2.57	51.4
	%	6.6	45.4	34.9	10.6	2.6		
If physiotherapy is needed, referring the patient to a medical center	N	27	165	131	25	4	2.47	49.4
	%	7.7	46.9	37.2	7.1	1.1		
Informing the patient about home needs for his/her health condition	N	22	104	181	69	5	2.82	56.4
	%	5.8	27.3	47.5	18.1	1.3		
Informing the patient how to change his/her life style	N	22	111	154	89	5	2.85	57.0
	%	5.8	29.1	40.4	23.4	1.3		
Informing the patient how to change diet after transition from the hospital	N	26	89	120	119	11	3.00	60.0
	%	7.1	24.4	32.9	32.6	3.0		
Informing the patient about the daily level of activity allowed	N	25	109	137	105	6	2.89	57.8
	%	6.5	28.5	35.9	27.5	1.6		
Informing the patient how to monitor his/her weight	N	39	136	131	43	0	2.51	50.2
	%	11.2	39.0	37.5	12.3	0.0		
Informing how to use the needed medical equipment	N	35	63	204	69	5	2.86	57.2
	%	9.3	16.8	54.3	18.4	1.3		
Mean = 56.24, Median = 56.67 , Std= 10.67								

As shown in table (4.7), more than half of patients have not been provided with written instructions to take care of their health, (38.4%) disagreed, (16.4%) strongly disagreed and (3.4%) were uncertain while (56.4%, 9%) of them have agreed and strongly agreed respectively that they have been provided with verbal instructions. In comparison with

Abu Daggha (2014), (24%) of her participants have received written instruction while (63%) have received verbal information. FGD participant commented *'We try as much as possible to teach the patients, and nursing often does this task'* (FGD,nurse). Another one added *'If the patient is diabetic, we give him/her instructions about the food list and how to inject insulin, in case of bedridden patient, we explain the care instructions to the family, and inform how to care with folly catheter, and when to change another one'*.(FGD,nurse). FGD nurses agreed that when the patient asks any questions, they almost answer his/her questions, whereas if no questions were made, no one cares and they usually care to educate new patients, as they think that old patients with chronic diseases know how to take care of their health and know the details about their drugs, so they do not need education. In the preparation of the patient before discharge, if the patient needs to use nebulizer, suction, gastrostomy, ryle tube, the nurses learn the patient and their families before discharge, yet, for simple cases discharged on antibiotics, they do not care about.

In addition, only (4.5%) strongly disagreed and (30.2%) has agreed that they got instructions to take care of wounds or incision. At this point, one FGDs participant has commented *'We lean the patient how to take care of their surgical wound after surgery, and clarify the need either for a nurse at home or to attend at a primary health care center, sometimes the patients do not care and return back to the hospital with surgical site infection'*(FGD,nurse). He then added *'What we need is health education for all community members, as patients and their families do not understand the nature of diseases and its complications, so they do not follow the instructions'* (FGD,nurse). Through FGD of doctors, they elaborated that they try to give instructions to the patient before the care transition, and prepare him/her for the next steps, because if they do not do so, the patient will return to the hospital again, yet the doctors' behavior differ from one to the other and sometimes, the pressure of work makes it difficult to give the patient his/her right, since this task and /or responsibility is not documented in the job description'(FGD,doctor). One manger has commented *'Patient education is generally not a priority for all health care providers, whether physician, nursing or pharmacist'*(KII).*FGD nurse participants complains that the nurse gives instructions to the patient before discharge, nevertheless, the patient does not trust the information*

given from the nurse, and waits to ask the doctor, which is due to the lack of an integrated health team. KKIs mentioned that the great interest in patient education focuses on reproductive health more than other health care services, as mothers are educated about family planning and nutrition, a special form has been developed to educate mothers and we will gradually promote education for other health services. Also, one manger said *'Patient education is relatively poor, and the evident proof is diabetic patients and their related complications, the hospital nursing work is limited only to giving treatment and making dressing, the patients leave the hospital without adequate counseling, and the role of primary health care is week'*(KII).

The mean score for this domain is (56.24%), and reflect that working on patient education is minimal, while patients should be informed about their illness and the treatment plan, they need educational programs to be organized between primary health care and hospitals, to identify roles and responsibilities, when, where, how, as well as making brochures and guidance sessions.

4.1.3.6 Follow up appointments

Table (4.8): Distribution of the study participants according to their responses about follow-up appointments

Items		S. Disagree	Disagree	Neutral	Agree	S. Agree	Mean	Relative Mean
Providing the patient with follow-up appointment	N	12	47	30	264	30	3.7	73.2
	%	3.1	12.3	7.8	68.9	7.8		
Participating and agreement with the patient on follow-up plan	N	15	75	114	167	12	3.2	64.4
	%	3.9	19.6	29.8	43.6	3.1		
Participating with family in the follow-up appointment	N	15	68	106	182	12	3.3	65.6
	%	3.9	17.8	27.7	47.5	3.1		
You have been informed about the place of follow-up	N	16	84	100	162	21	3.2	64.6
	%	4.2	21.9	26.1	42.3	5.5		
Receiving advice about the importance of follow-up at the outpatient clinic in the hospital	N	17	62	73	178	53	3.5	69.8
	%	4.4	16.2	19.1	46.5	13.8		
Receiving advice about the importance of follow-up at the primary healthcare centers	N	23	60	117	134	49	3.3	66.6
	%	6.0	15.7	30.5	35.0	12.8		
Providing the patient with a date to take the delayed lab results	N	26	89	153	98	8	2.9	58.6
	%	7.0	23.8	40.9	26.2	2.1		
Informing the patient about some lab investigations required on the date of follow-up	N	24	116	149	77	7	2.8	56.0
	%	6.4	31.1	39.9	20.6	1.9		
Mean = 64.52, Median = 65.00 , Std= 14.23								

As shown in table (4.8), in relation to the respondent's perception about the follow-up appointments, (77%) have reported that they have been provided with follow-up appointments, less than half have agreed that they have participated and agreed on their follow-up plan, and (50%) have reported that their families have participated in follow-up appointment. Most of the FGD respondents have agreed that patients are not involved in the follow-up appointments, within *the* noisy environment which do not encourage the health team to engage the patients, moreover, the inpatient departments are overcrowded with visitors. A senior doctor said '*How can we discuss the follow- up appointment*

details with the patient and his family, if the patient has ten attendants and many visitors'(FGD, doctor). Another doctor has added ' *Most doctors give the patient's discharge sheet out without looking, afterwards, the nurse informs them to go to the outpatient clinic, in order to book an appointment*(FGD, doctor).Some cases are booked at the outpatient clinics in the hospital, particularly acute cases two weeks after, others are booked for primary health care centers.

Another FGD respondent has noted that *'some patients do not know how to book and where, and they then return after sometime to book, delaying their follow-up date'* (FGD, doctors).

Nearly (60%) of respondents have agreed that they have received advice about the follow-up at the outpatient clinics, while less than half have been advised to follow up at the primary healthcare centers. The respondents in the FGDs have emphasized that as long as there is no discharge plan for the patient, there will be evidently no follow-up plan, the entire system is based on the doctor's decision, the nursing team almost inform the patient where to go for the follow- up after the doctor writes the discharge sheet, later, the patient gets his/her medications from a primary healthcare center or buy the medication at a private pharmacy. One nurse added *'When it comes to the patient and his family, all that matters is how they will get the medications, and the culture of the client is that the drug is the only diseases' rescue'* (FGD, nurses). Besides, all the key informants at hospitals have agreed about the weakness of primary healthcare role, which reflect on the increase in the pressure on hospitals, the culture of our patients is to go to the primary health care only to get medications, the role of primary health care for discharged patients is limited to giving medications, as the primary health care centers are crowded with patients only a few days a month, the days after receiving the order from the central drug warehouses. In the same context one manager has mentioned *'Failure to activate the primary health care causes an overload on the outpatient clinics, which result in poor follow-up and poor patient guidance added to prolonged waiting lists and waiting times'* (KII).

In this regard, an endocrinology doctor has said *'60% of diabetic patients attending to the outpatient clinic at AL Shifa hospital are uncontrolled diabetes, 100 patients attend to the specialized diabetes clinic on one day divided to 2 doctors, the patients need both*

health education and effective follow-up programs, the patient is not given the adequate time, which brings in complications and increased admissions' (FGD, doctor).

In addition, only (28.3%) of the respondents have got a date to take the delayed lab results. At this point, a head of laboratory department in a general hospital has explained how delayed tests are handled, that if a patient has been discharged from the inpatient department, and there were delayed laboratory results, the lab department sends the results to the department which requested them. The results are archived in the patients' files to be reviewed at the follow-up visit, while neither the patients nor the doctors are communicated about the results. The poor follow-up of the laboratory results has been identified as one of the key processes which results in unsafe patient health care by the World Alliance of Patient Safety, and it is a particular problem for patients moving between hospitals and community settings (Organization, 2008). Thus, the health policymakers should pay attention to the problem.

The overall mean of the follow-up domain has been (56.24%), which indicates the level of malpractice. Through interviews with patients a lot of patients suggest to improve follow up system, provide an electronic home booking system and find a reminder system for the patient to go to the date of the examination, in order to facilitate follow-up and bookings.

4.1.3.7 Continuity of care

Table (4.9): Distribution of the study participants according to their responses about continuity of care

Items		S. Disagree	Disagree	Neutral	Agree	S. Agree	Mean	Relative Mean
Information about institutions needed for continuity of care	N	23	110	102	130	16	3.0	60.4
	%	6	28.9	26.8	34.1	4.2		
Ensured who will take care of the patient at home	N	30	121	117	103	10	2.9	57.0
	%	7.9	31.8	30.7	27	2.6		
Clarifying the patient disease and needs to whom will take care of him/her at home	N	21	95	129	124	12	3.0	60.6
	%	5.5	24.9	33.9	32.5	3.1		
Ensuring safe transportation after discharge	N	18	59	110	160	34	3.4	67.0
	%	4.7	15.5	28.9	42	8.9		
Coordination with other agencies according to patient needs	N	52	133	120	53	4	2.5	50.2
	%	14.4	36.7	33.1	14.6	1.1		
Coordination with the primary healthcare centers for follow- up	N	57	182	89	28	2	2.3	45.2
	%	15.9	50.8	24.9	7.8	0.6		
Mean = 56.7, Median = 65.00 , Std= 14.23								

As shown in table (4.9), In relation to the respondent's perception about continuity of care, less than half of participants (38%) have received adequate information about institutions needed for continuity of care. The results were related to Abu Dagga (2014) findings, who has reported that (35%) of healthcare providers have provided their patients with knowledge about a referral resource after discharge (always and usually). In addition, (30%) of respondents have reported there has been a coordination with the primary health care center, while nearly (15%) have agreed there has been a coordination with other agencies according to the patients' needs.

In this context, KIIs showed that discharge of the patient from the hospitals is perceived that the hospital has discontinued the relationship, if a patient is discharged from the surgery department, and he/she needs physiotherapy, the communication between the hospital and the primary care centers is weak, for example; if the patient has been referred to a primary health care center, none of the hospitals will be informed to which

center the patient has been referred, nor will the hospitals get any information whether the patient will follow-up with MoH centers or UNRWA.

In regard to communication between hospitals and PHC, one manger has pointed out that the medical staff in hospitals do not coordinate with the primary healthcare centers, as they recognize that the patients have follow-up files at the primary health care centers, and that they get their drugs from there, therefore, the patient gets an appointment at the outpatient clinic in the hospital, and at the same time visits his/her primary health care center individually without any prior coordination, which means that the chronic patients receive health services at the outpatient clinics of hospitals and the primary care centers at the same time.

Through KIIs, mangers pointed to some suggestions to improve continuity of care. One manager said *'if the hospitals provide the primary care centers with specialized doctors for chronic diseases, and arrange specific timetables that allow patients to receive all health services divided between primary health care centers and hospitals ,the coordination for patient hospitalization will be properly done, and feedback will be easier and more safe for continuity of care'* (KII).

All primary health care centers have the authority to refer patients to hospitals, nevertheless, if there has been a clear policy of referral between the primary health care centers and hospitals, the admission percentage to hospitals will decrease, and the health situation will be better, *in this context one key informant suggested 'if there have been specific centers have the approval to refer to hospitals, which will nominate specific physicians, since the number of doctors is limited, it will be easier for hospitals to coordinate and/or give feedback about the patient'(*KII).

The communication channels between primary and secondary health care from one side, and between hospitals and community health services from the other side are relatively poor. The MoH should strengthen the communication between hospitals and primary health care centers. FGD respondents pointed that we have specific criteria for the referral from MoH hospitals to rehabilitation centers, has been developed prior to the referral of the cases, where a representative from the rehabilitation hospital will be present to assess the case, and if it is compatible with the referral criteria, specific form called Form No.1 is released and the patient is referred to the rehabilitation hospital. The representative from the rehabilitation center one of FGDs responders explained the

procedures after a patient transition, if the rehabilitation hospital requests any information about the patient, the rehabilitation hospital contacts with the hospital the patient has been referred from, in order to complete the information about the patient, in case the patient has any complications, and in need of hospital care, the rehabilitation center will contact the hospital to turn the patient back. He has added '*when the patient is referred from the hospital, the relationship with the hospital is broken, while no communication is made from the hospital'* (FGD, rehabilitation center representative).

As for transportation, nearly half of the participants have agreed that the medical staff have ensured safe transportation for them. And through interviews with patients a large number of patients complained about their transportation to home specially surgical patients, one patient said '*The worst thing that happened to me is not being taken home by ambulance from the hospital, an ambulance was requested at my expense and this is very expensive*'.

Most of FGDs participants and mangers have agreed that a policy exists for transportation of patients from one hospital to another to secure patients' movement. Although there is no ambulance available in all hospitals, however, the hospital has a policy to ask for ambulance when referring a patient from one hospital to another, the treating physician determines the type of ambulance, there may be delays in the arrival of the ambulance, but it does not affect the patient's life, as long as the patient is inside the hospital, in the event that the requested ambulance is an intensive care one, the response will be fast, and the patient will be referred with a follow-up sheet from the referring hospital, in which the patient history ,clinical condition and recommendations are written and filed*'* (KII). For the same point, a senior nurse has mentioned that '*In our hospitals, the patient is referred from one hospital to another or from one department to another within the hospital with good care, yet, if the condition of the referred patient is stable, the patient will be referred accompanied by nurse, but if the patient condition is unstable, the patient will be accompanied by an intensive care physician'* (FGD, nurse).

One of KIIs highlighted the transition policy between governorates that the MoH tries to reduce the movement of patients between hospitals, so that the central health services exist in each governorate, however, some services centralized are in AL Shifa Hospital in Gaza and the European Hospital in the South, which reduces transitions between

hospitals particularly for intensive care cases, and ensure equity of health services distribution with specific map of services (Annex 8. Transition of pediatric patients in Gaza is from the secondary hospitals to Al Rantisi tertiary hospital and to the surgical departments in Al-Shifa medical complex, the distribution of the health services at all governorates result in positive and negative outcomes, at one hand, services spread across the hospitals, due to the occupation division of Gaza to many sections since 2005, which has a negative impact of the scattered human resources, beds, drugs and IV fluids, at the other hand, the positive impact is that a map of health services has been integrated.

Regarding the referral policy between the hospitals, when a patient moves from one hospital to another, a referral is requested from the treating physician, the doctor who will coordinate with other hospitals should be a senior one, if the case is accepted, the referral form will be released from the hospital with a brief report on the health condition one manager comments *'The hospital has been using the referral form for 10 years, it focuses on the patient referral process, and it should be updated to include all the details related to the patient, the process is effective, but the hospital has not assessed to how safe it is'* (KII).

4.1.3.8 Care Coordination

This part of the study was asked for patients who were transferred from one department to another within the hospital or from one hospital to another.

Table (4.10): Distribution of the study participants according to their responses about coordination of care

Items		S. Disagree	Disagree	Neutral	Agree	S. Agree	Mean	Relative Mean
Information about the aim of referral	N	1	9	1	21	10	3.71	74.2
	%	2.4	21.4	2.4	50	23.8		
Readiness of medical staff at the referral department /hospital	N	1	10	3	22	6	3.52	70.4
	%	2.4	23.8	7.1	52.4	14.3		
Medical staff at the referral department /hospital was familiar with the patient disease	N	3	11	3	19	6	3.33	66.6
	%	7.1	26.2	7.1	45.2	14.3		
You felt health providers respect each other's	N	1	5	7	19	10	3.76	75.2
	%	2.4	11.9	16.7	45.2	23.8		
Satisfaction with the communication of medical team	N	8	12	2	15	5	2.93	58.6
	%	19	28.6	4.8	35.7	11.9		
Mean = 69.05, Median = 72.0 , Std= 17.52								

As shown in table (4.10), (74%) of participants were received adequate information about the aim of referral, (66%) agreed that medical staff at the referral department /hospital was ready for them, and (60%) of participants reported that medical staff at the referral department /hospital was familiar with their disease, (69%) of participants felt health providers respect each other's while less than (50%)of participants reported that they are satisfied with the communication between the medical staff. Overall mean score (3.4) of (5) (69.05).

About the coordination of medical team between each other at the same department or between different departments or different hospitals all managers and FGDs respondents agreed that there are regulations for coordination but there is a lack of team work between health providers at all levels and any coordination is far away from patients. If there is a patient will be transferred from one hospital to another, medical staff coordinates with the medical staff at the other hospital and informs him the patient's diagnosis and condition and what is expected the other hospital refuses or accepts it, but the patient himself not involved and does not know that he will be transferred, which is confirmed by one nurse who said 'after communication between physicians then with the ambulance ,the last person to be informed is the patient and his family'(FGD,nurse). About coordination between departments during the transition from one department to another for example from medical department to surgical or others, the coordination between physicians and nurses of the two departments is going on verbally by telephone, and sometimes poor communication and lake of documentation causes some interruptions which cause transfer patients by nurse to nurse coordination, then doctor at the second department refuse the patient due to misunderstanding which causes problems with the patient and his family ,in the same context one patient said *'they told me you will be transferred from the medical department to the surgical department ,then after leaving, doctors at the surgical department refused and return me back, I was so ill, then I became worse'*. And about transition from the emergency department to inpatient departments, decision of admission from the emergency department is taken by GP doctors, for example a patient complains of abdominal pain, will be admitted to hospital and diagnosed query appendicitis, then the other day, surgeon discharge him due to wrong diagnosis of GP doctors, at pediatric hospitals any patient with pyrexia admitted to hospital and then discharged the other day due to unneeded admission One senior nurse was speaking with frustration *'How will the patient be transitioned effectively from the hospital if he is admitted ineffectively?'* then another participant *added* '*if we look to admission, we will find a large number of patients admission for a period of less than 24 hours'* (FGD, nurse). The process going on in the way that a nurse at the internal department receives the patients sent with admission sheet from the emergency department and then admitted to the doctors' room for evaluation, at this point one doctor comments *'sometimes the patient is admitted even the doctor of the internal department*

don't agree, then the patient will be discharged the other day' (FGD, doctor).One manager pointed that *'we have established a policy of existence of senior doctor at the emergency department all the time to decrease admission, but the problem is the significant decrease in the number of senior doctors, a large number of expert and senior doctors have left work because of the high work loud, low salaries and difficult life at GS'* (KII). At the same point another key informant added *'We are suffering from a great shortage of medical staff, specially doctors and nurses, we lost many employees and at the same time, there is no employment compensate this shortage, compensation is by temporary unemployment employees, who don't own experience"* (KII).

Ineffective admission causes work loud on health providers, misuse of resources, weakness the quality of care for the patients of complex situation and sever illnesses. Another weak point ,when the patient is admitted from the emergency department to inpatient departments, if the patient is previously admitted to the hospital, he will be registered at the department that he was previously admitted in, but when he admitted next time, he will be admitted to any department and the next day he will be transferred to the department he was registered at before, due to weakness of health information system which cause overload work and unsatisfaction of patients. About coordination between general departments and intensive care units, all mangers and FGD respondent agreed that transition of any patient to intensive care unit must follow specific criteria for admission and prioritization according to availability of beds. When a patient transferred to intensive care unit, after performing the basic procedures, then doctors discuss with patient family, explaining everything related to the patient, his situation and all the possibilities of his condition, explaining the hospital system and the dates of visits*, one manger commented 'the most committed department to sign the patient consent form is the intensive care unit, while other departments are not committed to use it and involve patients'* (KII).

And about cardiology department one doctor mentioned '*There is good communication between emergency department and cardiology department, if a patient with MI arrived the hospital ,directly referred to CCU unit without any investigations at the emergency department to safe patient timely'*(FGD,doctors).

Health care providers pointed to the communication at kidney dialysis unit , the number of patients is increasing, 486 patients at governorate of Gaza and North using only 55 machine, dialysis for patients continues for midnight 2-3 AM, there is good communication with maintenance department if any machine disrupted, internal departments and ICU due to presence of dialysis department inside Al-Shifa complex ,but the main problem is due to fragmentation of the service for the patients at North Gaza, dialysis is done at Al Shifa hospital and the medications got from Al Andonisi hospital with increase the patient suffering.

And about the collaboration and behavior of health providers when a patient transferred between departments one manager said '*The biggest problem we face in our hospitals is working individually and lack of teamwork, if there is a team involved in the treatment of the patient is composed of a doctor, pharmacist, nurse and psychological support the results would be better'* (KII). More over the performance varies between the departments because the specialized departments do not provide full service to the patient, for example, when diabetic foot patient is transferred to the department of vascular surgery for a problem in his foot they forget that he is a diabetic patient or has other morbidities need monitoring and care only about the vascular problem of his foot and this is generally the problem of specialized sections which can deteriorate the patient situation. One of FGDs participants commented at the same point '*Although there are specialists with higher degrees, they work individually, for example, the surgeon is only care in prescribing analgesics and antibiotics to the patient and does not care if the patient has other diseases such as diabetes, hypertension or others, when the patient deteriorated ,consult internist doctor'*(KII).

With regard to the coordination between hospitals and primary health care centers ,participants mentioned that when the patient referred from primary care to the hospital, he is transferred without prior contact or coordination with the hospital, where the patient is transferred according to his geographical area only, as the patient arrives at the hospital as one doctor commented *'the primary care referral sheet is taken as a "visa" to enter the hospital only, medical team at the hospital don't care about the primary health care information at referral form and start assessing the patient as new case.'*(FGD, doctor).

4.2.3.8 Overall patient perspectives about transition of care process

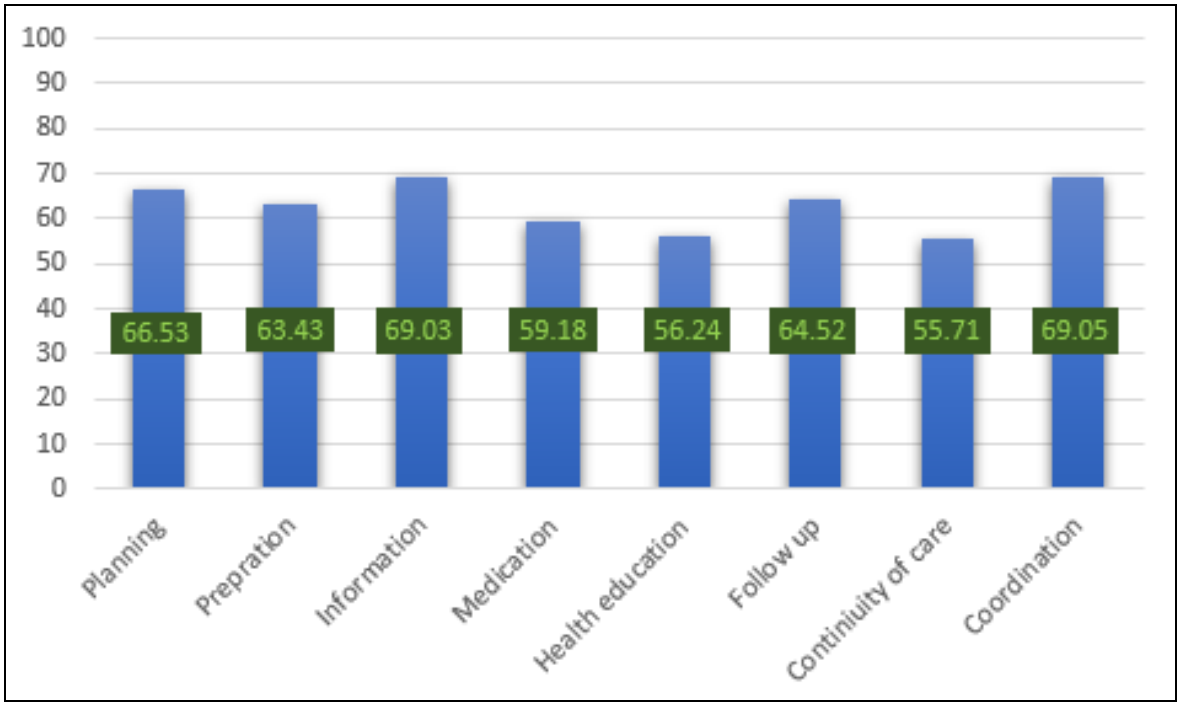

Figure (4.1): Overall patient perspectives about transition of care process

As shown in figure (4.1), the mean scores of (TOC) domains ranged from (55.7%) to (69%). The highest score is for 2 domains the domain of information transfer and the domain of coordination (69%) , followed by planning (66.53) and the lowest was for the domain of continuity of care (55.71). These results indicate that the patients perspective about transition of care processes were moderate which is inconsistent with qualitative analysis for transition of care domains, which was more deep than the quantitative analysis. In addition patient rights are not well known by the patients and their families, and they are not aware of to having adequate and comprehensive transition of care processes. When the patients understand their rights and care, they will evaluate their care effectively.

4.2 Inferential Statistics

This part represent the relationship between study domains and its relation of participant demographic variables regarding hospital, gender, age group and education level.

4.2.1 Relationship between care transition process and hospitals

Table (4.11): Differences between care transition domain scores by hospitals

	Hospital	N	Mean	Std	F	Sig.
Planning	AL Shifa	236	65.19	9.35	23.440	<0.001
	Al Andonisi	67	63.92	11.61		
	Ophthalmology	34	80.59	7.60		
	Al Durra	46	66.77	14.60		
	Total	383	66.53	11.27		
Preparation	AL Shifa	236	61.69	8.00	27.855	<0.001
	Al Andonisi	67	65.22	11.74		
	Ophthalmology	34	78.53	11.32		
	Al Durra	46	58.55	18.83		
	Total	383	63.43	11.90		
Information	AL Shifa	236	72.84	17.38	30.955	<0.001
	Al Andonisi	67		12.98		
	Ophthalmology	34	80.88	7.93		
	Al Durra	46	57.83	15.19		
	Total	383	69.03	17.56		
Drugs	AL Shifa	236	60.82	11.08	38.690	<0.001
	Al Andonisi	67	52.21	12.50		
	Ophthalmology	34	75.82	11.22		
	Al Durra	46	48.61	19.39		
	Total	383	59.18	14.35		
Education	AL Shifa	236	57.93	7.71	18.922	<0.001
	Al Andonisi	67	57.76	10.30		
	Ophthalmology	34	55.34	10.26		
	Al Durra	46	46.01	17.25		
	Total	383	56.24	10.67		
Follow up	AL Shifa	236	67.98	8.79	54.817	<0.001
	Al Andonisi	67	57.13	12.30		
	Ophthalmology	34	76.76	12.55		
	Al Durra	46	48.48	21.42		
	Total	383	64.52	14.23		
Continuity of care	AL Shifa	236	58.97	9.67	28.919	<0.001
	Al Andonisi	67	52.89	12.93		
	Ophthalmology	33	57.58	13.16		
	Al Durra	46	41.74	17.84		
	Total	382	55.71	13.06		
Coordination	AL Shifa	17	63.06	17.86	2.009	0.129
	Al Andonisi	11	78.55	6.76		
	Ophthalmology	2	76.00	5.66		
	Al Durra	12	67.67	21.87		
	Total	42	69.05	17.52		

As shown in table (4.11), One-way ANOVA test used to compare mean differences of participants perceptions between care transition domains. Participant perspective about the domain of planning, the difference was statistically significant in relation to hospital they discharged from (p-value <0.001). To find the direction of these differences, post hoc Scheffe test was performed and showed that ophthalmic hospital patients elicited higher scores (mean-80.59), compared to other hospitals. Also, the domain of preparation, the difference was statistically significant (p-value <0.001), according to post hoc scheffe test ophthalmic hospital had elicited the higher mean score (78.53%). And in the domain of information transfer the difference was statistically significant (p-value <0.001) by post hoc Scheffe test ophthalmic hospital had elicited the higher mean score also (80.88%). For the domain of medications, the difference was statistically significant (p-value <0.001), by post hoc Scheffe test, Ophthalmic hospital and Al Shifa hospital had elicited the higher mean score (75.82%), (60.82%) respectively. Health Education domain the difference was statistically significant (p-value <0.001), Al Dorra hospital had the lowest mean (46.01%) indicated by post hoc scheffe test. And for follow up domain, difference was statistically significant (p-value <0.001), by post hoc scheffe test for the favor of Ophthalmic hospital. Continuity of care domain difference was statistically significant (p-value <0.001), by post hoc scheffe test Al Shifa hospital had the higher score (67%) and Al Dorra hospital had the lowest mean score (41.74%)

Most domains the highest score was for Ophthalmic hospital and this result is consistent with (Habib, 2016) which reported that patients at Ophthalmic Hospital reported positive perception about quality of care, patient responses about meeting expectation domain was (71.5%). One of FGDs participants pointed that '*The Ophthalmology Hospital works at the primary, secondary and tertiary level at the same time, the only hospital for eye specialty, for North, Gaza and middle governorates, so there is integration of the service at the same place, increase the opportunity for quality improvement and the response for patient needs and expectations'* (FGD,doctor.*)* One manger reported that *' At the emergency department of the Ophthalmic Hospital consultant is available for 24 hours* to *evaluate difficult cases and give advice to new doctors, which is a critical point for the effective admission and results in effective care transition'*(KII), another FGD respondent mentioned *'After surgery, a written paper is given in which clear and ready instructions are given to the patient at the discharge'* (FGD,doctor).

4.2.2 Relationship between care transition domains and hospital departments

Table (4.12): Differences between care transition domain scores by hospital departments

Domain	Department	N	Mean	Std	F	Sig.
Planning	Medical - Shifa	66	63.68	5.90	**2.201**	**0.054**
	Medical - Andonisi	25	59.77	11.37		
	Surgery - Shifa	125	65.51	11.26		
	Surgery - Andonisi	31	66.82	11.66		
	Cardiac - Shifa	45	66.54	7.30		
	Cardiac - Andonisi	10	63.71	9.24		
	Total	302	64.86	9.87		
Preparation	Medicine - Shifa	66	61.31	4.37	**4.000**	**0.002**
	Medicine - Andonisi	25	60.40	11.48		
	Surgery - Shifa	125	62.03	9.93		
	Surgery - Andonisi	31	67.74	10.90		
	Cardiac - Shifa	45	61.33	5.96		
	Cardiac - Andonisi	10	69.00	12.58		
	Total	302	62.45	9.07		
Information	Medicine - Shifa	66	75.61	15.00	**11.425**	**0.000**
	Medicine - Andonisi	25	54.40	11.58		
	Surgery - Shifa	125	70.08	17.39		
	Surgery - Andonisi	31	58.71	13.84		
	Cardiac - Shifa	45	76.44	19.56		
	Cardiac - Andonisi	10	58.00	12.29		
	Total	302	69.37	17.73		
Drugs	Medicine - Shifa	66	65.12	6.96	**24.223**	**0.000**
	Medicine - Andonisi	25	50.40	12.88		
	Surgery - Shifa	125	55.71	11.62		
	Surgery - Andonisi	31	50.13	11.35		
	Cardiac - Shifa	45	68.71	6.18		
	Cardiac - Andonisi	10	60.40	9.47		
	Total	302	58.85	11.90		
Health Education	Medicine - Shifa	66	59.82	5.01	**6.738**	**0.000**
	Medicine - Andonisi	25	54.87	10.49		
	Surgery - Shifa	125	55.45	8.77		
	Surgery - Andonisi	31	59.30	10.64		
	Cardiac - Shifa	45	62.04	4.83		
	Cardiac - Andonisi	10	60.83	7.91		
	Total	302	57.91	8.34		
Follow up	Medicine - Shifa	66	66.25	6.13	**16.469**	**0.000**
	Medicine - Andonisi	25	52.10	11.29		
	Surgery - Shifa	125	68.70	10.36		
	Surgery - Andonisi	31	60.97	12.41		
	Cardiac - Shifa	45	68.50	6.96		
	Cardiac - Andonisi	10	57.75	11.57		
	Total	302	65.60	10.66		
Continuity of care	Medicine - Shifa	66	57.83	7.08	**5.470**	**0.000**
	Medicine - Andonisi	25	48.67	10.89		
	Surgery - Shifa	125	59.68	11.00		
	Surgery - Andonisi	31	54.84	13.38		
	Cardiac - Shifa	45	58.67	8.97		
	Cardiac - Andonisi	10	54.67	12.88		
	Total	302	57.55	10.70		
	Cardiac - Andonisi	10	71.67	16.65		
	Total	302	72.55	12.22		

As shown in table (4.12), ANOVA-test used to compare mean differences of participants perceptions of care transition by hospital department admitted to Al Shifa and Al Andonisi Hospitals. The difference in means among departments were statistically significant for six domains, domain of health education, difference in means was statistically significant(p-value<0.001). The highest means was for Al Shifa (62.0%) and Andonisi (60.8%) cardiac departments, domain of information (p-value<0.001) the higher means was for cardiac (76.44%) medical (75.61%) of Al Shifa departments, domain of medication (p-value<0.001), the highest means was for AL Shifa departments, cardiac (68.71%**)**, medical(65%). Preparation domain (p-value=0.002) the highest means was for Andonisi cardiac department (69%), follow up (p-value<0.001) higher means was for surgery (68.7%), cardiac (68.5%), medical (66.2%) of Al Shifa departments. In most of the domains perception of patients discharged from Al-Shifa departments was higher than Al Andonisi departments of the same specialty. Through KIIs, managers pointed that the Andonisi hospital provides services in the northern Gaza area which is very crowded, the cultural and social level is low, the region's population is extremely poor which increases the proportion of diseases in this region, this causes the hospital to be overcrowded, and the hospital suffers from a severe shortage of beds. Medical staff are forced to early discharge for patients. During patient interviews, most of the patients discharged from the Andonisi hospital, expressed their sorrow resulting from their lack of readiness to discharge.

As for the cardiac departments in both hospitals, the staff of departments are experts and the heads of departments are highly efficient and disciplined. Treatment, procedures of prompt referral, rapid intervention and catheterization are excellent.

4.2.3 Relationship between care transition domains and gender

Table (4.13): Differences in care transition domains scores by participant gender

Demographic Data	Gender	N	Mean	Std	T	Sig.
Planning	Male	203	65.33	11.56	-2.211	0.028
	Female	180	67.87	10.81		
Preparation	Male	203	62.58	12.62	-1.489	0.137
	Female	180	64.39	10.99		
Information	Male	203	68.42	17.10	-0.722	0.471
	Female	180	69.72	18.08		
Drugs	Male	203	57.08	14.58	-3.069	0.002
	Female	180	61.54	13.76		
Health Education	Male	203	54.70	11.02	-3.039	0.003
	Female	180	57.98	10.02		
Follow up	Male	203	64.24	14.20	-0.409	0.683
	Female	180	64.83	14.30		
Continuity of care	Male	203	55.34	14.05	-0.589	0.556
	Female	179	56.13	11.87		
Coordination	Male	27	68.74	19.15	-0.151	0.881
	Female	15	69.60	14.72		
	Female	180	76.20	14.15		

As shown in table (4.13), the difference in means of domain scores according to the gender of participants .Females patients reported significantly higher scores (p-value =0.028) in relation to discharge planning than males with mean (67.87%), similarly the domain of medications (p-value =0.002) with mean of (61.54%) and also in the domain of health education (p-value =0.003) female perceptions are higher than males. However, the difference in means of other domains were not statistical significant. This result is inconsistent with Abu Dagga (2014), where difference in means regarding gender were not statistically significant. And consistent with Cleary et al (2002) study which pointed that female participants rate more positive score about care. This finding could be attributed to the care of females to ask and discuss her illness with health providers Almborg et al (2008) suggested that when patients are shared with information and decision making about their illness are more satisfied about care and their expectations will be realistic.

4.2.4 Relationship between care transition domains and age

Table (4.14): Differences in care transition domains scores by participant age

Domain	Age	N	Mean	Std	F	Sig.
Planning	25 and less	83	65.44	12.07	**1.173**	**0.320**
	25 – 50 Years	94	65.29	11.80		
	51 – 60 Years	61	68.34	10.58		
	Above 60 Years	115	66.68	9.74		
	Total	353	66.31	11.03		
Preparation	25 and less	83	63.33	12.21	**0.379**	**0.768**
	25 – 50 Years	94	63.83	10.24		
	51 – 60 Years	61	65.19	10.50		
	Above 60 Years	115	63.65	10.71		
	Total	353	63.89	10.90		
Information	25 and less	83	63.73	16.87	**5.662**	**0.001**
	25 – 50 Years	94	68.72	16.80		
	51 – 60 Years	61	74.26	16.88		
	Above 60 Years	115	72.26	18.12		
	Total	353	69.66	17.61		
Drugs	25 and less	83	55.71	16.84	**5.773**	**0.001**
	25 – 50 Years	94	58.19	12.73		
	51 – 60 Years	61	61.77	13.34		
	Above 60 Years	115	63.13	11.21		
	Total	353	59.84	13.74		
Health Education	25 and less	83	52.49	11.68	**8.637**	**0.000**
	25 – 50 Years	94	57.13	9.53		
	51 – 60 Years	61	58.63	7.57		
	Above 60 Years	115	58.86	7.90		
	Total	353	56.86	9.60		
Follow up	25 and less	83	61.17	16.07	**5.281**	**0.001**
	25 – 50 Years	94	66.68	11.58		
	51 – 60 Years	61	67.50	10.66		
	Above 60 Years	115	67.57	10.27		
	Total	353	65.81	12.48		
Continuity of care	25 and less	83	52.41	14.92	**5.872**	**0.001**
	25 – 50 Years	94	57.91	9.93		
	51 – 60 Years	61	58.96	9.82		
	Above 60 Years	114	58.45	10.40		
	Total	352	56.97	11.66		
Coordination	25 and less	11	69.09	16.69	**0.093**	**0.963**
	25 – 50 Years	7	70.29	19.98		
	51 – 60 Years	3	70.67	23.44		
	Above 60 Years	12	66.67	13.68		
	Total	33	68.61	16.22		

As shown in table (4.14), the difference in means regarding age are statistically significant for five domains: the domain of information exchange, medications, health education, follow up and continuity of care (p-value =0.001) (Table 4.14). The

perception of participants (51-60) years and above (60) years is the highest scores for the five domains, which is also indicated by post hoc scheffe test. This result is congruent with previous studies, for example Zahen et al (2002) showed that older patients are more satisfied than younger patients about healthcare. Cleary et al. (2002) pointed that older patients rated higher satisfaction scores about their behavioral health care and health plan more highly than did other patients . Zaslavsky et al. (2001) found that there is a linear effect of increased satisfaction with increase age. Older patients suffer from home care, and who will take care of them at home 24 hours, at the hospital, the nursing staff provides them with care throughout the day. Medicines, disposables and everything they need are provided at the hospital, especially in light of the difficult economic situation in Gaza, the family bears its burdens. FGD participants mentioned that some of old patients readmitted to hospital due to neglection at their home. One manager mentioned that '*Most of the medicines for chronic diseases are not available in primary care, due to poverty and the tragic situation in the community, and the elderly patient cannot buy these drugs which deteriorate their health then back again to hospital*' then he added painfully '*The hospital has become a "reservoir" for all complications in the community'*(KII). According to (Courbage, Abu Hamad, & Zagha, 2016) study which pointed that number of NCDs patients will increase with aging of the population during the next years, which will result in dependence on others for assistance in performing the activities of daily living, especially among the older elderly, foreshadowing a significant increase in the need for healthcare and social support services. The healthcare system should respond by establishing geriatric and palliative services. An increase in the number of elderly patients requiring assistance in all features of their care, including Activities of Daily Living (ADLs), will impact the staffing requirements for nursing services in hospitals. Although the practice of nursing home stay is not currently widespread in Palestine, the proportion of the elderly who need nursing homes will increase. Nursing home use globally increases with advancing age, especially for females above the age of 85. Changing family structures mean less family support for older people and the need for nursing facilities.

4.2.5 Relationship between care transition domains and education level

The difference of domains scores by participants education level are not statistically significant for all domains, although several studies have been found that the highest level of education reported less perception with their health care than lower levels of education (Zahen et al,, 2002; Zaslavsky et al., 2001).

Table (4.15): Differences in care transition domains scores by participant education level

Domain	Patient Education	N	Mean	Std	F	Sig.
Planning	University	105	66.34	12.47	0.918	0.453
	Secondary	143	67.39	11.45		
	Preparatory	80	66.29	9.96		
	Primary	28	67.86	9.79		
	Illiteracy	25	63.09	8.29		
	Total	381	66.62	11.16		
Preparation	University	105	63.37	11.47	0.903	0.462
	Secondary	143	63.80	12.85		
	Preparatory	80	62.63	11.11		
	Primary	28	66.90	11.36		
	Illiteracy	25	61.47	9.33		
	Total	381	63.51	11.81		
Information	University	105	68.19	16.69	1.775	0.133
	Secondary	143	68.32	18.95		
	Preparatory	80	68.88	18.00		
	Primary	28	68.21	12.78		
	Illiteracy	25	78.00	15.00		
	Total	381	69.03	17.59		
Drugs	University	105	58.63	14.70	0.647	0.63
	Secondary	143	58.24	14.97		
	Preparatory	80	60.63	12.87		
	Primary	28	60.43	15.40		
	Illiteracy	25	61.68	10.19		
	Total	381	59.23	14.22		
Health Education	University	105	54.86	11.35	1.422	0.226
	Secondary	143	55.73	12.14		
	Preparatory	80	58.19	7.96		
	Primary	28	57.38	8.71		
	Illiteracy	25	57.73	4.33		
	Total	381	56.26	10.57		
Follow up	University	105	66.40	16.39	0.646	0.63
	Secondary	143	63.90	14.73		
	Preparatory	80	64.28	11.71		
	Primary	28	63.48	12.44		
	Illiteracy	25	63.00	8.66		
	Total	381	64.58	14.15		
Continuity of care	University	104	56.22	14.67	0.708	0.587
	Secondary	143	54.29	13.84		
	Preparatory	80	56.54	10.78		
	Primary	28	57.74	12.64		
	Illiteracy	25	55.60	7.12		
	Total	380	55.63	13.05		
Coordination	University	10	71.20	16.74	0.341	0.796
	Secondary	21	66.29	17.28		
	Preparatory	7	72.00	17.74		
	Primary	4	73.00	24.95		
	Illiteracy	0	.	.		
	Total	42	69.05	17.52		

4.2.6 Relationship between care transition domains and average LOS

Table (4.16): Differences in care transition domains scores by participant average LOS

Domain	Average long of stay	N	Mean	Std	F	Sig.
Planning	3 days and less	167	66.69	12.46	0.540	0.583
	4 – 7 days	187	66.71	10.20		
	More than 7 Days	29	64.43	10.87		
	Total	383	66.53	11.27		
Preparation	3 days and less	167	63.31	14.03	0.151	0.86
	4 – 7 days	187	63.35	10.04		
	More than 7 Days	29	64.60	9.74		
	Total	383	63.43	11.90		
Information	3 days and less	167	68.44	17.28	0.299	0.742
	4 – 7 days	187	69.73	17.15		
	More than 7 Days	29	67.93	21.77		
	Total	383	69.03	17.56		
medication	3 days and less	167	61.32	16.01	3.569	0.029
	4 – 7 days	187	57.26	12.99		
	More than 7 Days	29	59.24	10.86		
	Total	383	59.18	14.35		
Health Education	3 days and less	167	54.96	12.30	2.723	0.067
	4 – 7 days	187	56.93	9.01		
	More than 7 Days	29	59.20	9.79		
	Total	383	56.24	10.67		
Follow up	3 days and less	167	62.68	16.95	3.011	0.050
	4 – 7 days	187	66.32	11.70		
	More than 7 Days	29	63.45	10.38		
	Total	383	64.52	14.23		
Continuity of care	3 days and less	166	53.35	14.68	4.987	0.007
	4 – 7 days	187	57.34	11.21		
	More than 7 Days	29	58.62	12.58		
	Total	382	55.71	13.06		
Coordination	3 days and less	13	64.62	20.45	0.824	0.446
	4 – 7 days	23	69.91	17.05		
	More than 7 Days	6	75.33	11.43		
	Total	42	69.05	17.52		
	4 – 7 days	187	72.80	14.48		
	More than 7 Days	29	75.17	12.17		
	Total	383	75.15	14.84		

As shown in table (4.16), the difference in means of the care transition domains according to the lengths of stay are statistically significant for two domains, medication (p-value=0.029). the post hoc Scheffe test indicates statistically significant variance between patients (3 days and less) LOS whose reported higher score (61.32%) and patients (4-7 days) whose mean score was (57.26%). Usually patients longer length of stay are sever illness patients and in need to multiple drugs and may be costly drugs specially with the high shortage of NCD drugs according to the report of MOH (2018) while lower length of stay patients less acute cases and complexity and need simple medications. The second statistically significant domain is continuity of care (p-value=0.007), the post hoc Scheffe test indicates statistically significant variance between participants of (More than 7 Days) LOS who reported the highest score (58.62) and (3 days and less) who reported the lowest score (53.35%), while follow up domain difference in mean are not statistically significant but at the cuff point that participants of (4–7 days) LOS reported the highest score (66.32) which inconsistent with Almborg et al (2008) findings that longer of stay patients reported less satisfied with, goal-setting and in identifying patient needs. This result reflect that patients with short length of stay in need to more involvement and assistant .However, the difference in means of other domains were not statistical significant.

4.2.7 Relationship between care transition domains and frequency of admission

Table (4.17): Differences in care transition domains scores by participant frequency of Admission

Demographic Data	Frequency of Admission	N	Mean	Std	T	Sig.
Planning	First Time	162	66.84	12.14	0.499	0.618
	Several Times	214	66.26	10.42		
Preparation	First Time	162	64.07	13.31	0.909	0.364
	Several Times	214	62.94	10.80		
Information	First Time	162	68.83	18.89	-0.155	0.877
	Several Times	214	69.11	16.61		
Drugs	First Time	162	58.98	15.52	-0.142	0.887
	Several Times	214	59.19	13.38		
Health Education	First Time	162	55.93	11.79	-0.447	0.655
	Several Times	214	56.43	9.84		
Follow up	First Time	162	65.48	16.29	1.206	0.229
	Several Times	214	63.69	12.45		
Continuity of care	First Time	161	53.91	14.59	-2.215	0.027
	Several Times	214	56.92	11.65		
Coordination	First Time	15	76.80	14.20	2.329	0.025
	Several Times	26	64.15	18.01		

As shown in table (4.17), The difference in means of domains according to frequency of admission are statistically significant for two domains, continuity of care (p-value=0.027) and coordination (p-value=0.025). In regard to continuity of care, the participants admitted several times reported higher score than participants of first-time admission While in regard to coordination participants of first-time admission reported higher score than several times admission. This is incongruent with the study of Kangovi et al (2012) who studied readmitted patient's perspective and his finding was (11.8%) felt unprepared for transition from hospital, (10.6%) suffered from inability to perform daily activities , (5.7%) couldn’t adhere to discharge medications, (5.0%) didn’t get discharge medications; (4.7%) lack of social support .

Chapter Five

Conclusion and Recommendations

5.1 Conclusion

This study was conducted to assess the effectiveness of the transition of care processes in governmental hospitals in GS from the perspective of patients, health providers and decision makers. The study was performed by linking the quantitative method to the qualitative method to explore the current practice, areas of strengths and weaknesses in relation of care transition.

The results show that the overall perspective level of patients was relatively moderate while health providers and key informants reported lower perspective than their patients. The domains of perspective about transition of care processes are included; discharge planning, patient education, medication reconciliation, information exchange, follow up appointments continuity of care, and coordination. The highest perception level of patients was toward coordination of care while the lowest level was toward continuity of care.

The study highlighted that there are no systematic transition of care process at Gaza governmental hospitals, the process is not identified with its structure and steps, to patients, providers and managers. There is a lack of knowledge and a lack of understanding of care plans during hospitalization. It is seen only as discharge procedures and not as continuous and organized steps which takes into account the social conditions and the needs of patients and support them after transition. Hospitals do not have a policy and regulation for the transition of care with specific responsibilities, leading to the lack of a clear discharge planning.

Health providers and their managers agreed they focus on the clinical improvement of the patient for which they are accountable, the rest of his needs of education, psychological support and preparation for discharge depends on the individual skills of employees, the ability to communicate and give. It is the responsibility of the family to bear the burden on the patient.

The study showed poor provision of PCC, there is not enough time for medical staff and may not care to involve the patient and his family with his treatment plan and tell them about the expected time of his/her stay in the hospital, and answer questions that the patient and family ask about their health or educate the patient about his illness and prognosis.

It has also been shown that there are a lot of patients, do not know the symptoms that require medical help post discharge. Most patients are discharged from the hospital without being provided to whom they communicate after discharge when a change in their health status occurs, forcing patients to return to emergency departments ,to be seen by doctors who don't know their medical history. There is no source of information about previous admitted patients in the emergency department. This may cause preventable readmission.

The study showed the emergency system's weakness, lack of consultants around the clock in emergency departments, this sometimes leads to ineffective admission which increases the number of admissions, increasing the burden on medical staff and wasting resources. This is caused by the drop in senior medical professionals and their resignation because of salary decreases and Ministry of Health's challenging working environment.

As for the psychological preparation of the patient, there are efforts by the Ministry to support mental health and gradual integration in hospitals, to respond to the difficult social and psychological situation of the population.

The study also revealed the majority of patients are provided with discharge sheet, providers, their managers, and many patients agreed that the discharge sheet is not a sufficient source of patient information. It must be change to become more informative, not all information necessary for continuity of care is written. There is no place to write instructions for the patient, in addition, it is written in English and medical terms that the patient does not understand.

Efforts have also been made to improve the computerized information system in hospitals but they are incomplete. There are still many gaps that prevent access to information in time for the doctor especially at admission and follow-up at the outpatient clinic. The lack of information leads to duplication of laboratory and imaging tests and many drug errors, especially when the patient moves from one hospital to another, provided with a referral paper that does not contain sufficient information about the patient. It also shows that the process of transmitting information during hand-off effectively performed among nursing staff, but it's not the way it should be for medical staff.

The study also revealed the fragmentation of the system in the provision of medicines to the patient. Despite a good follow-up by pharmacists for drugs that are administered to admitted patients, however, there is no adequate communication between the pharmacist and the patient. The medication reconciliation process is therefore not done. As a result, many patients do not know about their new medicines and the list of medicines has changed and they do not know the purpose of these drugs and the needed instructions besides poor access to their medications.

The study showed that a significant number of patients did not receive written instructions to take care of their health, and some received oral instructions. Patient education is generally not a priority for all health providers, whether physician, nursing or pharmacist. Patient education is not performed during hospitalization, some instructions is given before discharge. As a consequence, the patient is less conscious of the conditions for coping with his/her health, this may cause the condition of the patient to deteriorate after discharge and possible readmission.

It has also been shown also that most patients receive a follow-up appointment after discharge, but patients are rarely involved with a follow-up plan. In addition, the general tendency of the doctors to book for follow-up at the hospital's outpatient clinic because of their mistrust of the level of care in primary care centers and the primary care outlook is a place to get only medicines, this causes large numbers of outpatient clinics, long waiting lists, long waiting time and poor quality of follow up.

The research also showed a lack of a clear policy to remind the patient of incomplete laboratory test findings upon discharge, which may include pending results that endanger patient life.

Healthcare provider and managers stressed about the poor communication channels between primary and secondary care, and between hospitals and community services. Since the relationship with the patient is broken upon discharge from the hospital, there is no contact between the hospital doctor and the primary care doctor, or between the private sector physicians. The patient is left to cope with his/her own illness through his/her family without hospital support or community support.

While the study showed, although there are no ambulances available in all hospitals, however a policy on the place to ensure the safety of patients during movement and

transfer between departments and hospitals, safe transportation during transition includes safe medical or nursing attendant depending on the patient's stability.

In addition, the study showed that the ministry is working on equitable distribution of services among governorates to reduce the movement of patients and maintain their safety, however, there is a centralization of some services in basic hospitals to prevent the waste of resources and the lack of adequate medical staff,

About the coordination of medical team between each other at the same department or between different departments or different hospitals that appeared there are regulations for coordination but there is a lack of team work between health providers at all levels and any coordination is far away from patients.

The study participants showed their dissatisfaction with the weakness of the emergency system due to poor coordination between emergency doctors and doctors in the inpatient departments, but there is good communication when a patient moves from any department and an intensive care unit. As for communication between employees, 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. In addition, coordination between staff is usually conducted orally, significant problems occur due to lack of documentation.

5.2 Recommendations

This study has shown that there are several gaps in the health care system that prevent the effective transition of care in governmental hospitals. It stressed the need to modification the current transition of care system. These recommendations need to be considered for this modification. The study covered eight key domains, from the perspective of patients, service providers, middle managers, and decision-makers. These recommendations are therefore based on a comprehensive analysis of the transition of care at several levels. The study has shown that one of the main reasons for the weakness of the care transition is the crowdness of the inpatient departments. Hospital work combined between primary and secondary healthcare,

There must be changes at the strategic level as follows:

- The need to work to strengthen the role of primary care and increase the performance of its staff in order to reduce the burden on hospitals, develop clear policies and

protocols for common diseases and allocate responsibilities between primary care and hospitals to relieve serious pressure on outpatient clinics.

- Strengthen the emergency departments, triage system, and the establishment of clear criteria ,policies and clinical practice guidelines for hospital admission.
- Work to develop a comprehensive health information system for all health institutions containing all the information about the patient including master patient record to facilitate the timely arrival of information and to insure continuity of care.
- Establishing and strengthening geriatric and palliative services responding to the increasing numbers of elderly people, hospitals will have to increase their sensitivity and ability to care for the acutely and chronically ill aging population.

The changes at the level of the general administration of hospitals;

- Develop national transition of care policies to ensure continuity of care and integration of services. Dissemination and training of service providers on its application
- Encourage patient-centered services in the transition of care and work with the patient and their parents as a true partner in the therapeutic process.
- Identify specific people to follow up and monitor the transition of care and support them and strengthen their role by the hospital administration until the behavior of staff changes.
- Develop a system for evaluating patients at risk of readmission , using specific tools, to determine if the patient is low risk , moderate or a high degree of risk of readmission ,to work to increase support for these patients.
- Develop medication reconciliation policy and procedures by standardizing the patient's drug list and implementing computerized drug ordering which include components of medication reconciliation elements.
- Expanding the role of pharmacists in medication reconciliation and the transition of care processes. Pharmacists should be encouraged to monitor all medicinal products of the patient, to ensure the medicine is delivered correctly and fully and provide them direct contact with patients and other health care providers.
- Establishing an accounting policy and analyzing the reasons for re-admitted patients and re-admitted patients to the emergency department.

- Work to change the components of the discharge form so as to ensure that it contains all the necessary information about the patient and allocate a place to write instructions for the patient in Arabic.
- Developing the follow-up system after discharge and linking it to the patient's situation, and the development of a reminder system to confirm the date of follow-up and work to raise the awareness of patients and their families of the importance of follow-up.
- Increase the attention to the psychological evaluation of the patient before discharge and the development of a checklist to assess the patient psychologically.
- Work to educate the patient health about various diseases and exploit his stay at the hospital to raise their health awareness.
- Work to develop a system to specify the number of patient attendants and give attention to the specific attendant of the patient who take care of him at home to teach him and inform him on the needs of the patient of medicines and supplies and needs at home.
- Develop a way for the patient to communicate with the hospital after disrchage to give guidance instead of going to the emergency department again.

5.3 Suggestions for further research

- Study reasons of readmission of patients and its reflection on the patient and the hospital.
- Study medication errors during transition of care processes.

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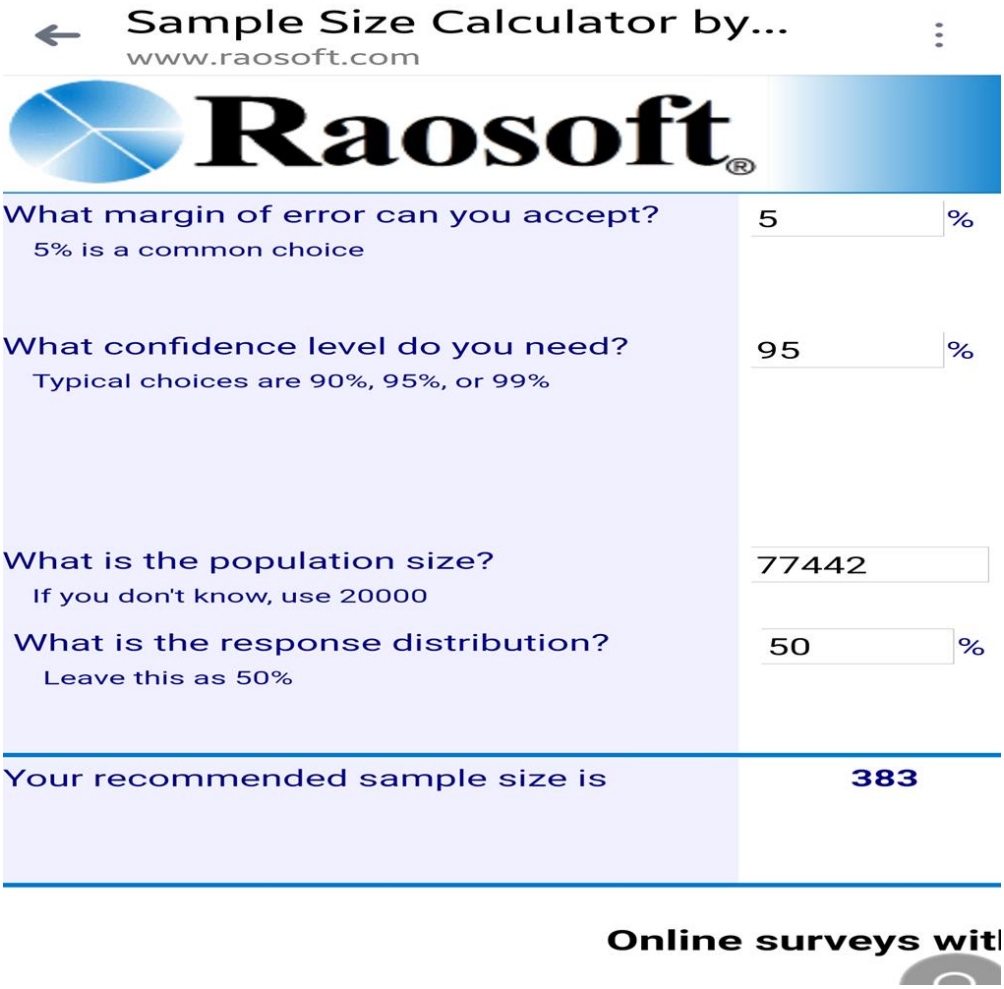
Annexes

Annex (1): Sample size calculation.



Annex (2): Questionnaire in Arabic

استبانة

عزيزي المشارك/عزيزتي المشاركة أنا رولا سامي أبوضلفة / طالبة في جامعة القدس أبو ديس أعمل بوظيفة رئيس قسم الصيدلة ومنسقة الجودة وسلامة المرضى بمستشفى الدرة للأطفال بقطاع غزة أود أن أعلم سيادتكم انه قد تم اختياركم للاشتراك في دراسة بحثية بعنوان

"تقييم فاعلية انتقال الرعاية بالمستشفيات الحكومية في قطاع غزة "

"Assessment of transition of care process in Gaza governmental hospitals"

كجزء من متطلب للحصول على درجة الماجستير في الصحة عامة –الإدارة الصحية.

تهدف هذه الدراسة إلى تقييم مدى فاعلية عملية خروج المريض من المستشفى إلى المنزل أو من قسم لآخر في نفس المستشفى او من مستشفى إلى مستشفى آخر، وتوضيح ممارسات عمليات الخروج المطبقة في مستشفياتنا الحكومية .

ان المعلومات التي ستزودنا بها مهمة جدا حيث ستساعد على الوقوف على نقاط القوة والضعف في أسلوب انتقال الرعاية الصحية بالمستشفيات من أجل تعزيز عمليات خروج فاعلة وتحسين التواصل مع المريض وتقديم خدمة نوعية تضمن استمرار الرعاية المقدمة للمريض، وبالتالي تقديم خدمة صحية أفضل للمواطن الفلسطيني .

لذا يرجى التكرم بالإجابة على جميع الأسئلة الواردة في الاستبانة وذلك بغرض الخروج بنتائج وتوصيات تسهم في تحسين عمليات انتقال الرعاية وسوف تستخدم المعلومات الواردة لأغراض البحث العلمي فقط .

إن مشاركتك في تعبئة هذه الاستبانة لها أهمية كبيرة ، والمعلومات التي سيتم الحصول عليها في هذه الدراسة لن تؤثر على الخدمات المقدمة لك ولأفراد عائلتك، وسيتم التعامل مع البيانات الخاصة بسرية تامة.

إن مشاركتك بتعبئة الاستبانة اختيارية وغير ملزمة لك وبإمكانك الانسحاب اذا لم تشعر بالارتياح واذا وافقت على المشاركة بتعبئتها قد تستغرق 15 دقيقة .

شكـــرا لحســـن تعـاونكـــم...

الباحثة / رولا سامي أبوضلفة

تقييم فاعلية انتقال الرعاية بالمستشفيات الحكومية

الرقم التسلسلي:	
أولاً: البيانات الشخصية	
المستشفى :	
قسم /أقسام الدخول:	
تاريخ الدخول:	
تاريخ الخروج:	
من قام بتعبأة الاستبيان ؟	المريض □ مرافق للمريض □
الجنس:	ذكر □ أنثى □
عمر المريض:	
مكان السكن:	محافظة الشمال □ محافظة غزة □ محافظة الوسطى □ خان يونس □ رفح □
المؤهل العلمي للمريض:	جامعي □ ثانوي □ اعدادي □ ابتدائي □ أمي □
المؤهل العلمي لمرافق المريض: **(في حال قام بتعبأة الاستبيان بالنيابة عنه)**	جامعي □ ثانوي □ اعدادي□ ابتدائي □ أمي □
آلية دخول المستشفى: (تحويل من)	العيادات الخارجية □ الطوارئ □ مستشفى حكومي آخر □ مستشفى خاص □ الرعاية الأولية □ أخرى □
سبب الدخول / تشخيص مرضك:	
عدد مرات الدخول:	دخول أول □ دخول متعدد □
الإجراءات الطبية التي أجريت لك:	فحوصات □ علاج □ عمليات □ استشارات □
مدة المكوث داخل المستشفى:	..... يوم
مكان / سبب الخروج:	المنزل □ حسب الطلب □ تحويل لقسم آخر □ تحويل لمستشفى آخر □

الجمل الآتية متعلقة بالتخطيط للخروج قبل انتقال الرعاية من المستشفى :

الرقم	الجملة	لا أوافق بشدة	لا أوافق	محايد	موافق	موافق بشدة
1	عند دخولك المستشفى، تناقشت أنت والفريق الطبي المعالج واتفقتم على خطة علاجك.					
2	عند دخولك المستشفى ، قام الفريق الطبي بتزويدك بالمعلومات الكافية عن تشخيص حالتك					
3	عند دخولك المستشفى ، قام الفريق الطبي بتزويدك بالمعلومات الكافية عن احتماليات تطور مرضك					
4	عند دخولك المستشفى تم اعطاءك تصور عن المدة المحتمل أن تقضيها بالمستشفى					
5	أثناء مدة مكوثك بالمستشفى أجاب الفريق الطبي المعالج على أهم الأسئلة التي طرحتها عليهم بما يخص مرضك					
6	الفريق الطبي بالمستشفى سألك عن احتياجاتك و ظروفك الاجتماعية .					
7	الفريق الطبي بالمستشفى قاموا بتبليغك قبل وقت كاف لأخذ قرار خروجك من المستشفى					

الجمل التالية تتعلق بالتحضيرات لخروجك من المستشفى :

الرقم	الجملة	لا أوافق بشدة	لا أوافق	محايد	موافق	موافق بشدة
1	لقد فهمت بشكل واضح كيف عليك أن تتابع وضعك الصحي بعد الخروج					
2	تم توضيح العلامات والعوارض الطارئة والخطرة التي تتطلب منك مراجعة الطبيب إثر ظهورها					
3	فهمت بشكل واضح لمن ستتوجه عند ظهور العلامات والعوارض الخطرة التي تتطلب مراجعة الطبيب (طبيب أخصائي بالمستشفى، طبيب رعاية أولية، قسم الطوارئ،.....)					
4	تم تزويدك باسم ورقم تليفون للتواصل في حال حدوث أي مشاكل في حالتك الصحية.					
5	قام الفريق الطبي بتقييم استعدادك النفسي للخروج .					
6	قام الفريق الطبي بتقييم قدرتك للقيام بالنشاطات اليومية					

الجمل الآتية لها علاقة بالمعلومات التي تم تزويدك بها :

الرقم	الجملة	نعم	لا
1	عندما خرجت من المستشفى، تم تزويدك بورقة خروج مكتوبة وواضحة		
2	قام الفريق الطبي المعالج بشرح المعلومات المكتوبة بورقة الخروج الخاصة بك		
3	تم تزويدك بمعلومات عن تشخيص واضح لسبب دخولك المستشفى		
4	ورقة الخروج موضح فيها تاريخك المرضي قبل الدخول للمستشفى		
5	ورقة الخروج موضح فيها العمليات والإجراءات الطبية التي أجريت لك أثناء إقامتك بالمستشفى		
6	ورقة الخروج موضح فيها إذا كان لديك حساسية مفرطة من دواء معين أو طعام		
7	ورقة الخروج موضح فيها وضعك الصحي عند الخروج من المستشفى		
8	ورقة الخروج موضح فيها الأدوية الموصوفة لك بعد الخروج من المستشفى		
9	ورقة الخروج مكتوبة بلغة مفهومة وواضحة وتحتوي على القليل من المصطلحات الطبية والاختصارات		
10	تم اخبارك بضرورة إبراز ورقة الخروج عند احتياجك للخدمة الطبية أو الصحية		

الجمل التالية تتعلق بالأدوية الموصوفة عند الخروج :

الرقم	الجملة	لا أوافق بشدة	لا أوافق	محايد	موافق	موافق بشدة
1	عندما خرجت من المستشفى فهمت بشكل واضح ما هي الأدوية التي ستتناولها بشكل يومي					
2	عندما خرجت من المستشفى فهمت بشكل واضح ما هي الأدوية التي ستتناولها عند الضرورة فقط					
3	عندما خرجت من المستشفى فهمت بشكل واضح التغيرات التي قررها الفريق المعالج على قائمة أدويتك قبل دخولك المستشفى					

4	عندما خرجت من المستشفى فهمت بشكل واضح، الهدف من تناول كل واحد من الأدوية					
5	عندما خرجت من المستشفى فهمت بشكل واضح جرعات الدواء وموعد تناوله					
6	عندما خرجت من المستشفى فهمت بشكل واضح التعليمات الخاصة بكيفية تناول الدواء (بعد الأكل أو قبله)					
7	عندما خرجت من المستشفى فهمت بشكل واضح الأعراض الجانبية للأدوية التي يجب أن أراقبها ومع من سأتواصل حال حدوثها					
8	عندما خرجت من المستشفى فهمت بشكل واضح التفاعلات بين الأدوية وكيف أتجنبها					
9	عندما خرجت من المستشفى فهمت بشكل واضح كيف ومن أين سأحصل على الأدوية					
10	عندما خرجت من المستشفى فهمت بشكل واضح كيف سأقوم بحفظ الأدوية بالمنزل					

الجمل الآتية تتعلق بتعليم المريض وأسرته:

الرقم	الجملة	لا أوافق بشدة	لا أوافق	محايد	موافق	موافق بشدة
1	قبل خروجك من المستشفى قام الفريق الطبي بتزويدك بتعليمات مكتوبة للعناية بصحتك					
2	قبل خروجك من المستشفى قام الفريق الطبي بتزويدك بتعليمات شفوية للعناية بصحتك					
3	قام الفريق الطبي بالشرح لك ولأسرتك هذه التعليمات					
4	قام الفريق الطبي بتوجيهك لكيفية الغيار على الجرح– ان وجد– أو توجيهك لمركز صحي مناسب					
5	قام الفريق الطبي بإخبارك إذا كنت تحتاج علاج طبيعي أو تمارين خاصة وتحديد المدة					
6	إذا كانت حالتك تستدعي جلسات علاج طبيعي تم توجيهك لمركز معين					

7	قام فريق المعالجين بإخبارك عن الاحتياجات المنزلية لحالتك					
8	قام فريق المعالجين بإخبارك عن كيفية تغيير نمط حياتك					
9	قام فريق المعالجين بإخبارك عن النظام الغذائي الواجب اتباعه بعد خروجك من المستشفى					
10	قام فريق المعالجين بالشرح عن مستوى النشاط اليومي المسموح به بعد خروجك من المستشفى					
11	قام فريق المعالجين بالشرح كيف تتابع وزنك بعد خروجك من المستشفى					
12	قام فريق المعالجين بالشرح عن الأجهزة الطبية التي ستستخدمها بعد الخروج وكيف ستستخدمها (إن وجدت)					

الجمل الآتية تتعلق بالمتابعة بعد الخروج:

الرقم	الجملة	لا أوافق بشدة	لا أوافق	محايد	موافق	موافق بشدة
1	قبل خروجك من المستشفى تم تزويدك بتعليمات واضحة عن موعد الحجز للمراجعة					
2	تم اشراكك وموافقتك على خطة المتابعة					
3	تم اشراك عائلتك بمواعيد المتابعة					
4	تم اخبارك بالمكان الذي ستقوم بمتابعة حالتك فيه بعد الخروج					
5	نصحت بأهمية المتابعة بالعيادات الخارجية التابعة للمستشفى					
6	نصحت بأهمية المتابعة بمراكز الرعاية الأولية					
7	تم تحديد موعد لاستلام نتائج التحاليل الطبية المنتظرة					
8	تم ابلاغك بتحاليل طبية عليك اجراءها بعد الخروج لازمة لمتابعة حالتك ومهم وجودها عند المراجعة					

الجمل الآتية تتعلق باستمرارية تقديم الرعاية :

الرقم	الجملة	لا أوافق بشدة	لا أوافق	محايد	موافق	موافق بشدة
1	أعطيت المعلومات عن المراكز والمؤسسات التي يمكن أن تحتاجها لاستكمال الرعاية فيها					
2	قام الطاقم الطبي بالتأكد من سيقدم لك الرعاية بالمنزل					
3	قام الطاقم الطبي بالشرح الكافي عن مرضك لمن سيقدم لك الرعاية بالمنزل					
4	قام الفريق الطبي بالتأكد من تأمين وسيلة نقل آمنة لك عند الخروج					
5	تم التنسيق مع أي مؤسسات لتلبية احتياجاتك الصحية					
6	تم التنسيق مع مراكز الرعاية الأولية للمتابعة بعد الخروج					

<u>الجمل الآتية تتعلق بالتنسيق بين مقدمي الخدمة :</u>

هل تم تحويلك من قسم لآخر داخل المستشفى ؟ أو من مستشفى لآخر ؟

نعم ☐ من قسم ..... لقسم .....

أو من مستشفى .....لمستشفى .....

لا ☐

اذا كانت الإجابة بنعم:

الرقم	الجملة	لا أوافق بشدة	لا أوافق	محايد	موافق	موافق بشدة
1	تم الشرح بشكل واضح الهدف من التحويل					
2	كان الفريق الطبي بالقسم / المستشفى الذي تم تحويلك اليه جاهز لاستقبالك					
3	تعتقد بأن الفريق الطبي بالقسم /المستشفى الذي حولت إليه كان على دراية تامة بحالتك المرضية					
4	شعرت باحترام مقدمي الخدمة لبعضهم البعض					
5	شعرت بالرضا عن التواصل بين الفريق الطبي					

برأيك ما هي أحسن ميزة في عملية خروجك ؟

.....

برأيك ما هو أسوأ شيء في عملية خروجك ؟

.....

ما هي اقتراحاتك لتحسين عملية الخروج ؟

.....

Annex (3): Questionnair

Dear participant:

I am Rola Abu Dalfa, a student at the Master Degree of Public Health program, -Health management Track, at Al Quds University, conducting a research study about Assessment of transition of care process in Gaza governmental hospitals. The study is part of the requirements for the fulfillment of the master degree of public health.

The study aims to the assessment of effective discharge of patient from the hospital to home , or from one department to another at the same hospital or from one hospital to another to highlight the procedures of care transition at governmental hospitals .your information is so important ,it will inform about strength and weakness of transition of care process for improvement of the process .

Participation in the study involves filling an interviewed questionnaire about your experiences. Filling the questionnaire takes approximately 15 minutes of your valuable time.

Although participation in this study is voluntary and you have the right to participate or not to participate, your participation is highly appreciated. You are free to participate or to withdraw at any moment.

Confidentiality will be maintained, and your name and contacts will not be mentioned at all, and the information you will provide will only be used for the research purposes. Again, I would like to thank you for agreeing to participate

Rola Abu Dalfa

No..						
1-Personal data						
Hospital						
Department						
Date of admission						
Date of discharge						
Who filled the questioner		Patient		Attendant		
Gender		Male		female		
Age						
Residency	North	Gaza	midzone	khanyonis	Rafah	
Patient education level	University	secondary	preparatory	primary	illiterate	
Attendant education level	University	secondary	preparatory	primary	illiterate	
Route of admission	Outpatient clinic	Emergency department	Governmental hospital	Private hospital	Primary care	others
Diagnosis						
frequency of admissions	First time		Second time			
Medical procedures	Treatment	surgery	Examination	Consultation		
Long of stay	3 Days and less		From 4to 7 days	More than 7 days		
Mode of discharge	Home	According to patient request	Referral to another department	Referral to another hospital		

Theses sentences are related to discharge planning:

NO	Items	Strongly disagree	disagree	neutral	agree	Strongly agree
1	Agreement of the patient with discharge plan					
2	Providing the patient with enough information about his diagnosis					
3	Providing the patient with enough information about his prognosis					
4	Informing the patient estimation about length of stay in hospital					
5	The medical staff answer the patient questions & complaints					
6	The medical staff ask about the patient social status and needs					
7	Informing the patient with adequate time to make decisions prior to transfer from hospital					

These sentences about preparation for discharge:

NO	Items	Strongly disagree	disagree	neutral	agree	Strongly agree
1	The patient understood how to manage his health after discharge					
2	The patient understood the warning signs and symptoms which need a doctor call					
3	The patient understood whom to call if warning signs and symptoms are noticed					
4	Providing the patient with a telephone number to contact					
5	Assessment of psychological readiness for transition					
6	Assessment of physical ability to perform daily activities					

Theses Sentences are related to information exchange:

No	sentence	yes	No
1	Providing the patient with discharge sheet		
2	Explaining the information written in the discharge sheet		
3	Providing the patient with the final diagnosis written on the discharge sheet		
4	Discharge sheet included the clinical history before admission		
5	Discharge sheet has included investigations and clinical procedures done in hospital		
6	Discharge sheet has clarified if the patient has drug or food hypersensitivity		
7	Discharge sheet has clarified the medical condition at the time of care transition		
8	Discharge sheet has clarified medications prescribed for the patient after transition from hospital		
9	Discharge sheet has been written with understood and clear language and it contained little of medical terms and abbreviations		
10	Informing the patient about the need to show the discharge sheet to other health care providers		

Theses Sentences are related to medications:

NO	Items	Strongly disagree	disagree	neutral	agree	Strongly agree
1	Understanding the daily taken drugs					
2	Understanding the drugs taken only when needed					
3	Understanding changes on the medication list before admission					
4	Understanding the reason of taking each drug					
5	Understanding drug doses and frequency					
6	Understanding the route of administration of drugs, before or after food					
7	Understanding symptoms or side effects of drugs and how to monitor and whom to contact if noticed					
8	Understanding drug –drug interactions and how to avoid					
9	Understanding how and from where to get the drugs					
10	Understanding where the medication to be kept at home					

These sentences are related to patient education:

NO	Items	Strongly disagree	disagree	neutral	agree	Strongly agree
1	Providing the patient with written instructions					
2	Providing the patient with verbal instructions					
3	Clarifying the instructions for the patient and family					
4	providing the patient with instructions to take care of wounds, incision or referring him to a medical center					
5	Informing the patient if need physiotherapy and determine the duration					
6	If physiotherapy is needed, referring the patient to a medical center					
7	Informing the patient about home needs for his/her health condition					
8	Informing the patient how to change his/her life style					
9	Informing the patient how to change diet after transition from the hospital					
10	Informing the patient about the daily level of activity allowed					
11	Informing the patient how to monitor his/her weight					
12	Informing how to use the needed medical equipment					

Theses sentences are related to follow up appointments:

NO	Items	Strongly disagree	disagree	neutral	agree	Strongly agree
1	Providing the patient with follow-up appointment					
2	Participating and agreement with the patient on follow-up plan					
3	Participating family in the follow-up appointment					
4	Informing the patient about the place of follow-up					
5	Receiving advice about the importance of follow-up at the outpatient clinic in the hospital					
6	Receiving advice about the importance of follow-up at the primary healthcare centers					
7	Providing the patient with a date to take the delayed lab results					
8	Informing the patient about some lab investigations required on the date of follow-up					

Theses sentences are related to continuity of care:

NO	Items	Strongly disagree	disagree	neutral	agree	Strongly agree
1	Information about institutions needed for continuity of care					
2	Ensured who will take care of the patient at home					
3	Clarifying the patient disease and needs to whom will take care of him/her at home					
4	Ensuring safe transportation after discharge					
5	Coordination with other agencies according to patient needs					
6	Coordination with the primary healthcare centers for follow-up					

Theses sentences are related to care coordination

Have you been referred from one department to another at the same hospital?

Yes…… from department ……. To department……

Or from hospital……to hospital……

No…….

If the answer is yes

NO	Items	Strongly disagree	disagree	neutral	agree	Strongly agree
1	Information about the aim of referral					
2	Readiness of medical staff at the referral department /hospital					
3	Medical staff at the referral department /hospital was familiar with the patient disease					
4	You felt health providers respect each other's					
5	Satisfaction with the communication of medical team					

Main positive issues of your transition of care process?

……

……

Main negative issues of your transition of care process?

……

……

What are your suggestions to improve transition of care processes?

……

……

……

Annex (4): FGD and KII questions

Focus group discussions

1- How can you describe transition of care process at our hospitals among different levels (from hospital to home – from one department to another –from one hospital to another, etc…).

2- Quantitative findings showed that most of patients were not oriented about their time of discharge or estimation of LOS at hospital. How can you explain that?

3- Tell me about hand –off process during TOC (teamwork-respect-involvement of patients-availability of information –tools of communication).

4- Quantitative finding showed that Less than half of patients agreed that they know who to communicate if they watched warning signs and most of them not provided with telephone number to call. How you explain that? From your point of view process in place to assure the patient knows and understands what issues require immediate intervention and why (teach –back, simple instructions) .

5- How do you prepare patients and their families for TOC ? (education, training , support on identified tasks including, safe and effective use of medical equipment, diet and nutrition, pain management and rehabilitation techniques)

6- How do you deal with patients at risk of readmission (like number of previous admissions, health literacy and confidence in self-care, complexity of medical condition, multiple comorbidities).How could critical information be quickly and easy available to health providers about those patients ?

7- Quantitative finding showed that there is poor coordination between hospitals and primary healthcare centers for follow up after discharge .how you explain that. How is the referral system is going on to ensure continuity of care

8- Quantitative finding showed that Most of patients don't clearly provided with information needed about their medications .why do you think ?.

9- From your point of view what are the barriers to effective transition of care ?

10- In your opinion, how can we improve transition of care processes at our hospitals?

Key informant interview questions

1- How can you describe transition of care process at our hospitals among different levels (from hospital to home – from one department to another –from one hospital to another, etc…).

2- Tell me about the structure, rules, health information system, policies, guidelines and regulations on transition of care processes at our health system

3- How can you describe the behavior of health providers and policy makers toward transition of care processes

4- From your point of view what are the requirements for whole system approach to patient care lead to linked and coherent processes and avoid fragmentation between different levels and different providers.

5- From your point of view what are the barriers to effective transition of care?

Annex (5): Helsinki permission.

المجلس الفلسطيني للبحث الصحي

Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال ماسسة استخدام المعلومات البحثية في صنع القرار

Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee

For Ethical Approval

Date: 04/06/2018 **Number:** PHRC/HC/399/18

Name: Rola Sami Abu Dalfa الاسم:

We would like to inform you that the committee had discussed the proposal of your study about: نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:

Assessment of the effectiveness of transition of care process in Gaza governmental hospitals

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/399/18 in its meeting on 04/06/2018 و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Signature

Member **Member**

Chairman

Genral Conditions:-

1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-

E-Mail:pal.phrc@gmail.com

Gaza - Palestine غزة - فلسطين

شارع النصر - مفترق العيون

Annex (6): General Directorates of Hospitals permissions

State of Palestine
Ministry of health

دولة فلسطين
وزارة الصحة

السيد : رامي عيد سليمان العبادله المحترم

التاريخ:03/01/2019

رقم المراسلة 273663

مدير عام بالوزارة //الإدارة العامة لتنمية القوى البشرية ـ /وزارة الصحة

السلام عليكم ,,,

الموضوع/ تسهيل مهمة الباحثة// رولا زايدة

التفاصيل //
بخصوص الموضوع أعلاه، يرجي تسهيل مهمة الباحثة/ **رولا سامي زايدة**
الملتحقة ببرنامج ماجستير الصحة العامة – مسار الإدارة الصحية – كلية الصحة العامة- جامعة القدس أبوديس في إجراء بحث بعنوان:-
"Assessment of the effectiveness of transition of care process in Gaza governmental hospitals"
حيث الباحثة بحاجة لتعبئة استبانة من عدد من المرضى المخرجين من أقسام المستشفيات (للبيت أو لقسم أخر أو لمستشفى أخر) مستشفى العيون ومستشفى الدرة ومستشفى الاندونيسي ومجمع الشفاء الطبي، كذلك اجراء مقابلات مع عدد من المرضى وعدد من مقدمي الخدمات الصحية إضافة لعدد من أصحاب العلاقة من إدارة الوزارة.
نأمل توجيهاتكم لذوي الاختصاص بضرورة الحصول على الموافقة المستنيرة من المرضى الذين هم على استعداد لمشاركة أفي الدراسة ومن ثم تمكين الباحثة من التواصل معهم، بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية.
وتفضلوا بقبول التحية والتقدير،،،
ملاحظة / تسهيل المهمة الخاص بالدراسة أعلاه صالح لمدة 6 شهر من تاريخه.

محمد ابراهيم محمد السرساوي
مدير دائرة/الإدارة العامة لتنمية القوى البشرية ـ

التحويلات

■ محمد ابراهيم محمد السرساوي(مدير دائرة)	← رامي عبد سليمان العبادله(مدير عام بالوزارة)	إجراءاتكم بالخصوص(03/01/2019)
■ رامي عبد سليمان العبادله(مدير عام بالوزارة)	← عبد اللطيف محمد محمد الحاج(مدير عام بالوزارة)	إجراءاتكم بالخصوص(08/01/2019)
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■ عبد اللطيف محمد محمد الحاج(مدير عام بالوزارة)	← شوقي ابراهيم عبد القادر سالم(مدير مستشفى)	إجراءاتكم بالخصوص(08/01/2019)
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Annex (7) List of arbitrators

	Name
1.	Dr. Yehia Abed
2.	Dr. Bassam Abu Hamad
3.	Dr. Ahmed Shatat
4.	Dr. Khaled Abu Al Eish
5.	Dr. Nael Skaik
6.	Dr.Ayman Al Soos
7.	Dr.Nashwa Skaik
8.	Bassam Mosalem

Annex (8): Map of services at Governmental Hospitals

State of Palestine
Ministry Of Health
Hospitals General Administration

دولـــــــة فلسطيـــــن
وزارة الصحة
الإدارة العامة للمستشفيات

توزيع الخدمات التخصصية بمستشفيات وزارة الصحة لعام 2018

م	الخدمة التخصصية	الشفاء	ناصر	الأوروبي	الأقصى	النصر	الإندونيسي	بيت حانون	الدرة	الرنتيسي	العيون	النجار	الهلال
1	الجراحة العامة	*	*	*	*		*	*				*	
2	الجـــــراحـات التخـــصصية												
2.1	جراحة القلب / كبار	*		©									
2.2	جراحة القلب / أطفال			±									
2.3	قسطرة القلب كبار	*		*									
2.4	قسطرة القلب أطفال	*		±									
2.5	جراحة الصدر	*		*									
2.6	جراحة الأعصاب	*		*			+						
2.7	جراحة الأوعية الدموية	*		*			+						
2.8	جراحة العظام	*	*	*	*		*					*	
2.9	جراحة الأطفال	*		*	+			*					
2.10	جراحة العيون			*							*		
2.11	جراحة المسالك البولية	*	*		*		+						
2.12	جراحة أنف و أذن و حنجرة	*	*	*				*				+	
2.13	جراحة الوجه و الفكين	*	*										
2.14	جراحة اليد و الأعصاب الطرفية	*		+									
3	جراحة اليوم الواحد	*	*	*	*		*	*			*	*	

م	الخدمة التخصصية	الشفاء	ناصر	الأوروبي	الأقصى	النصر	الإندونيسي	بيت حانون	الدرة	الرنتيسي	العيون	النجار	الهلال
4	تفتيت الحصى	*		*									
5	الحروق و التجميل	*	*										
6	النساء و التوليد	*	*		*								*

م	الخدمة التخصصية	الشفاء	ناصر	الأوروبي	الأقصى	النصر	الإندونيسي	بيت حانون	الدرة	الرنتيسي	العيون	النجار	الهلال
7	العـــــناية المكثفة												
7.1	عناية مكثفة كبار	*	*	*	*		*						
7.2	عناية مكثفة أطفال			*		*			*	*			
7.3	عناية مكثفة قلب	*	*		*		*						
7.4	عناية مكثفة مواليد (حضانة)	*	*	*	*	*							*
8	طب أطفال		*	*	*	*		*	*	*		*	
9	باطنة عامة	*	*	*	*		*	*				*	
10	خدمـــات الباطـــنة التخـــصصية												
10.1	أمراض الجهاز الهضمي و المناظير	*	*	*	+		+		+	*			
10.2	أورام و دم / كبار			*						*			
10.3	أورام و دم / أطفال			*						*			
10.4	أمراض كلى و غسيل دموي	*	*		*		+			*		*	
10.5	أمراض باطنة أعصاب	*	*	+	+		+		+	*			
10.6	أمراض الروماتيزم	*	+	+			+			+			

م	الخدمة التخصصية	الشفاء	ناصر	الأوروبي	الأقصى	النصر	الأندونيسي	بيت حانون	الدرة	الرنتيسي	العيون	النجار	الهلال
10.7	أمراض الصدرية	*	+	+			+	+	+	*			
10.8	أمراض الدم الحميدة	*		*						*			
10.9	أمراض الجهاز الهضمي والكبد	*		*	+		*			+			
10.10	أمراض غدد صماء كبار	*	+	+	*		*	+					
10.11	أمراض غدد صماء أطفال			+						*			
10.12	أمراض جلدية	+	+										
11	**خدمات التصوير الطبي**												
11.1	التصوير المقطعي CT	*	*	*	*		*			*			
11.2	تصوير الرنين المغناطيسي MRI	*		*									
11.3	تصوير ملون Fluoroscopy	*	*		*		*			*		*	
11.4	تصوير المسالك IVP	*	*		*	*	*		*	*		*	
11.5	تصوير الثدي Mammography	*	*	*			*						
11.6	بانوراما الأسنان	*	*										

(*) خدمة كاملة (+) خدمة جزئية (©)خدمة موقوفة (±) خدمة وفود

الخدمة الكاملة :- الخدمة التي يوجد لها فريق طبي مكتمل و مرضي منومين وعيادة خارجية.

الخدمة الجزئية:- الخدمة التي ليس لها فريق طبي مكتمل .

د. عبد اللطيف محمد الحاج

مدير عام المستشفيات

عنوان الدراسة: دراسة تقييم فاعلية انتقال الرعاية بالمستشفيات الحكومية

اعداد: رولا سامي أبو ضلفة

اشراف: د معتصم حمدان

ملخص الدراسة

إن عملية انتقال الرعاية هي عملية انتقال المسئولية من مقدم خدمة لأخر في داخل المستشفى او مستشفى اخر او انتقال المسئولية من مقدم الخدمة بالأقسام الداخلية للعيادات الخارجية او الرعاية الأولية او للمريض نفسه وعائلته ومقدمي الخدمات بالمجتمع .وصف الأدوية عادة ما يتغير في مرحلة الانتقال حيث يطلب من المريض ان يقوم بإيقاف أدوية معينة او البدء بدواء جديد او تغيير جرعات بعض الأدوية، وعند خروج المريض من المستشفى للمنزل يبدأ بتحمل مسئولية عنايته بنفسه وتظهر التحديات للمريض وعائلته عند عودتهم للمنزل وتحت تلك الظروف، التخطيط الغير فعال و ضعف التنسيق والتواصل يقلل رضا المرضى ويسهل حدوث الأخطاء الطبية ويساهم في تكرار إعادة الدخول.

الهدف من الدراسة

تقييم محاور الانتقال الفاعل للرعاية الصحية بالمستشفيات الحكومية، التخطيط للخروج، تحضير المريض، تعليم المريض، إدارة الأدوية، استمرارية الرعاية، التنسيق للرعاية و الترتيبات للمتابعة بعد الخروج.

وأيضا من أهداف الدراسة معرفة سلاسل الإجراءات لانتقال الرعاية بالمستشفيات الحكومية والوضع القائم ومواطن القوة والضعف لعمليات انتقال الرعاية الحالية ومعرفة انطباع المرضى ومقدمي الخدمات وصناع القرار عنها لتوجيه الضوء حول هذه المنطقة ووضع توصيات للتحسين والتطوير.

منهجية الدراسة

وقد أجريت هذه الدراسة بطريقة التثليث الكمي والكيفي .في الجزء الأول الكمي من خلال اجراء مقابلات مع المرضى المخرجين من المستشفيات لتعبئة الاستبانة الخاصة بهم، شمل مجتمع الدراسة على383 مريض من 4 مستشفيات، مستشفيين عامين وهما مجمع الشفاء الطبي، المستشفى الأندونيسي، ومستشفيين اختصاصيين وهما مستشفى الدرة للأطفال، ومستشفى العيون التخصصي. حيث تم استخدام عينة عشوائية لاختيار المستشفيات المشاركة والمرضى المشاركين من كل مستشفى.

بينما تكون الجزء الثاني وهو النوعي من جزئين، حيث قيام الباحث بإجراء خمس مجموعات بؤرية للنقاش مع مقدمي الخدمات بالمستشفيات المجموعة الأولى كانت مع الأطباء العاملين بالمستشفيين العامين والمجموعة الثانية مع الأطباء العاملين بالمستشفيين الاختصاصيين، والمجموعة الثالثة من التمريض العاملين بالمستشفيين العامين والمجموعة الرابعة مع التمريض العاملين بالمستشفيين الاختصاصيين والمجموعة الخامسة كانت من عدة تخصصات صيادلة، اخصائي علاج طبيعي، أخصائي مختبرات، أخصائي أشعة، ممثل عن مركز لإعادة التأهيل وممثل عن المجتمع المحلي . الجزء الاخر من الطريقة النوعية، قام الباحث بإجراء مقابلات رسمية مع مدراء من وزارة الصحة ومدراء من المستشفيات.

وقد تم تحليل البيانات باستخدام الحزمة الإحصائية للعلوم الاجتماعية (SPSS) حيث أجريت التوزيعات، الترددات والنسب المئوية، الجداول، واستخدامt-test، one way ANOVAلإيجاد العلاقات بين المتغيرات.

نتائج الدراسة

أظهرت الدراسة أن من بين المشاركين في الاستبيان (53%) ذكور، (47%) اناث، حوالي (23%) منهم أعمارهم من 25 سنة فأقل، (26.6%) أعمارهم ما بين 26–50 سنة، (17%) أعمارهم من 51–60 سنة، (32.6%) أعمارهم فوق 60 عام معظمهم من محافظة غزة (71.5%) وحوالي (25%) من محافظة الشمال والباقي من محافظات مختلفة .بالإضافة الى ان (27.6%) لديهم مؤهلات جامعية، (37.5%) حاصلين على الثانوية العامة.

أما بالنسبة لمحاور الدراسة التي تم من خلالها تقييم مدى فاعلية انتقال الرعاية الصحية قد شملت على ثماني محاور وقد تراوحت نسبة هذه المحاور من (56.7%) إلى (69.05%) حيث أن إجمالي نسبة وجهات نظر المرضى كانت متوسطة وكانت أدنى نسبة فيما يخص محور استمرارية الرعاية وأعلى نسبة فيما يخص محور التنسيق بين مقدمي الخدمات .

بالنسبة لمحور التخطيط للخروج فكانت نسبته (66.5%) أما محور التحضير للخروج فكانت نسبته (63.4%) ومحور تبادل المعلومات نسبته (69%) ومحور إدارة الأدوية نسبته (59%) أما محور تعليم المريض فكانت نسبته (56%) .

ولقد بينت النتائج وجود فروق ذات دلائل إحصائية في وجهات نظر المرضى تعزى للمتغيرات التالية : المستشفى حيث أن أظهرت الدراسة أن مستشفى العيون كان الأعلى بالنسبة لوجهة نظر المرضى في 5 محاور (p–value <0.05) وأيضا كانت هناك نتائج إيجابية حول متغير القسم في 6 محاور، حيث ان أقسام القلب والجراحة بالمستشفى الأندونيسي كانوا اعلى من باقي الأقسام بمحور التحضير للخروج (p–value <0.05) بينما أقسام الباطنة والجراحة والقلب بمجمع الشفاء كانوا الأعلى بالنسبة لمحور تبادل المعلومات (p–value <0.05)، وتبين أيضا أن فروق ذات دلالة إحصائية بمحور إدارة الأدوية لقسم القلب بمجمع الشفاء الطبي (p–value <0.05)، وأيضا بالنسبة لمحور تعليم المريض فكان هناك فروق ذات دلالة حيث ان اعلى نسبة كانت لأقسام القلب بمستشفى الشفاء والإندونيسي (p–value <0.05)، أما بالنسبة لمحور المتابعة بعد الخروج فكانت النسبة الأعلى لأقسام الجراحة والقلب بمجمع الشفاء الطبي (p–value <0.05)، وأخيرا محور استمرارية الرعاية أشارت الدلالة الإحصائية الى أن أقسام مجمع الشفاء الأعلى بالنسبة لوجهات نظر المرضى (p–value <0.05).

وبينت الدراسة أيضا وجود فروق ذات دلالة إحصائية لمتغير الجنس بثلاث محاور حيث أن وجهة نظر الإناث كانت أعلى عن الذكور بمحور التخطيط للخروج ومحور إدارة الأدوية ومحور تعليم المريض (p–value <0.05)، وأيضا متغير العمر فكانت فئة المرضى الذي تزيد أعمارهم عن 51 –60 سنة و كذلك المرضى الذين تزيد أعمارهم عن 60 سنه هي الأعلى بالنسبة لخمسة محاور محور المعلومات و الأدوية والتعليم والمتابعة بعد الخروج ومحور استمرارية الرعاية (p–value <0.05)، وكذلك تبين وجود فروق ذات دلائل إحصائية بمتغير عدد أيام المكوث حيث أنه كانت هناك علاقة إيجابية بين محوري إدارة الأدوية(p–value <0.05) حيث كانت النسبة الأعلى لعدد أيام المكوث الأقل من 3 أيام، و محور استمرارية الرعاية حيث كانت النسبة الأعلى لعدد أيام المكوث الأكثر من 7 أيام، وكذلك بالنسبة لمتغير تكرار الدخول للمستشفى حيث تبين وجود فروق ذات دلائل إحصائية بمحور استمرارية الرعاية حيث كانت النسبة الأعلى للمدخلين للمستشفى عدة مرات بينما بمحور التنسيق للرعاية فكانت الفروق ذات دلالة إحصائية حيث ان الأعلى بوجهة النظر للمدخلين لأول مرة . هذا ولم يكن هناك فروق ذات دلائل إحصائية تعزى لمتغير سنوات التعليم.

لقد بينت الدراسة عدم وجود عملية منظمة لانتقال الرعاية بالمستشفيات الحكومية حيث أن هناك عدم وجود خبرة لدى العاملين بالمستشفيات بعملية التخطيط للخروج وتعتبر مجموعة من الإجراءات التي تنفذ وقت الخروج وليست بمفهوم عملية متكاملة تبدأ من يوم الدخول وتستمر بعد خروج المريض لضمان استمرارية الرعاية بالإضافة لعدم تحديد المسئوليات بين مقدمي الخدمة بالنسبة لإجراءات انتقال الرعاية.

وبينت الدراسة أيضا ان اكتظاظ المرضى بأقسام الطوارئ وعدم وجود طبيب استشاري على مدار الساعة يؤدي الى دخول غير فاعل وازدحام الأقسام بالمرضى مما يزيد العبء على العاملين ويقلل من جودة العمل والاهتمام بالمرضى ذوي الحالات الصعبة في عملية تحضيرهم و تثقيفهم حول مرضهم مما يقلل من فاعلية عملية انتقال الرعاية .بالإضافة لعدم تمركز الخدمات حول المريض حيث أنه لا يتم التعامل مع المريض كشريك حقيقي بالعملية العلاجية ،بالإضافة الى أن تعليم المريض وتثقيفه حول مرضه ليست أولوية لدى الطاقم الطبي ويعتمد على المهارات الفردية بالتواصل والقدرة على العطاء. وتبين أيضا وجود منظومة فاعلة لإدارة الادوية داخل المستشفيات خلال عملية انتقال الرعاية ،بينما هناك ضعف في عملية تثقيف المريض حول أدويته عند الخروج وعدم تطبيق نظام التسوية الدوائية للمريض والموصى بها من قبل منظمة الصحة العالمية .واكد المشاركون بالدراسة على مأمونية نقل المرضى بين المستشفيات بوسائل نقل آمنة وبمرافقة طبية أو تمريضية ،بينما اتفق المشاركون بالدراسة على عدم توفر المعلومة حول التاريخ المرضي للمريض بالوقت اللازم لعدم اكتمال نظام المعلومات مما يتسبب بالتواصل الغير فاعل بين مقدمي الخدمات، هذا وقد أجمعوا على أن نموذج الخروج وكذلك نموذج التحويل بين المستشفيات بحاجة لتحديث ليعطوا معلومات أكثر فاعلية .

وأوضحت الدراسة أيضا أن عملية الاستلام والتسليم بين مقدمي الخدمة تتم بشكل منظم تمريضيا ولكن بحاجة لتقويتها طبيا. وأيضا أظهرت الرسالة وجود بروتوكولات لانتقال الرعاية بين الأقسام والعناية المركزة بينما يسود التواصل الغير فاعل بين الأقسام المختلفة ومقدمي الخدمة فيما بينهم وضعف منظومة العمل ضمن فريق متكامل مما يؤدي الى عدم فاعلية التنسيق والتواصل بين الفريق الطبي أثناء فاعلية انتقال الرعاية، وعدم التنسيق والتواصل بين الرعاية الأولية والمستشفيات وكذلك مقدمي الخدمات بالمجتمع.

توصيات الدراسة:

- وضع سياسة وتنظيم لعملية انتقال الرعاية بكل محاورها.
- تقوية نظم المعلومات الصحية لضمان وصول المعلومة عن المريض بالوقت المناسب.
- تقوية منظومة الطوارئ ووضع بروتوكولات وسياسات للحد من الدخول الغير فاعل.