6TH SPX INTERNATIONAL COLLOQUIUM

6__8 OCT LUXEMBOURG

PATIENT EXPERIENCE AT THE HEART OF ALL CARE

A shared challenge across all models of support

FONDATION ROBERT SCHUMAN

HÔPITAUX ROBERT SCHUMAN

REHAZENTER LUXEMBOURG

fhl

HWL HEALTHCARE WEEK LUXEMBOURG

COMMUNICATION SESSION

Addressing the challenge of transitions within continuum of care

SPX INTERNATIONAL COLLOQUIUM

Long term impact interprofessional discharge workshops with patient experts

Continuity of care for vulnerable chronic kidney disease

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Practice Oriented Research
Focus line Empowerment

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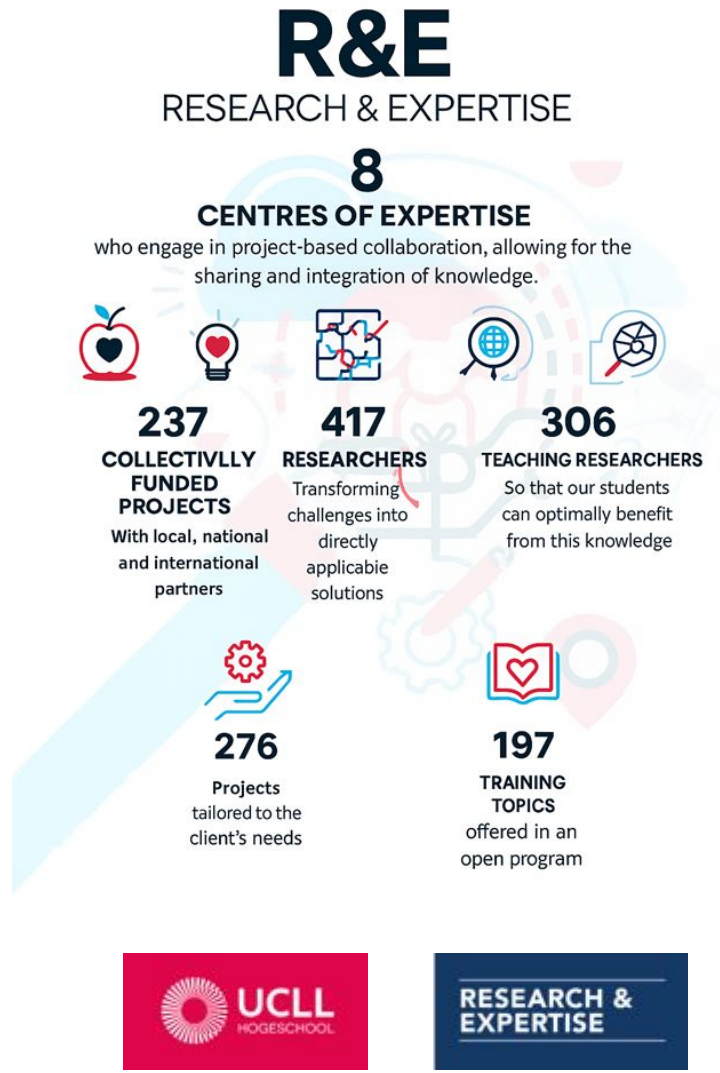

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(UZ Leuven, sd)

The Challenge

Gaps in Care transitions

Vulnerable patients with chronic kidney disease (CKD) frequently experience:

- Preventable complications and readmissions
- Unclear responsibilities during transition from hospital to primary care
- Insufficient patient education
- Poor information exchange between care providers

“The first time I was allowed to go home was on a Saturday , totally not informed and unprepared , and I didn’t have enough medication at home.”

Patient with CKD

Study objectives

Aim of the study

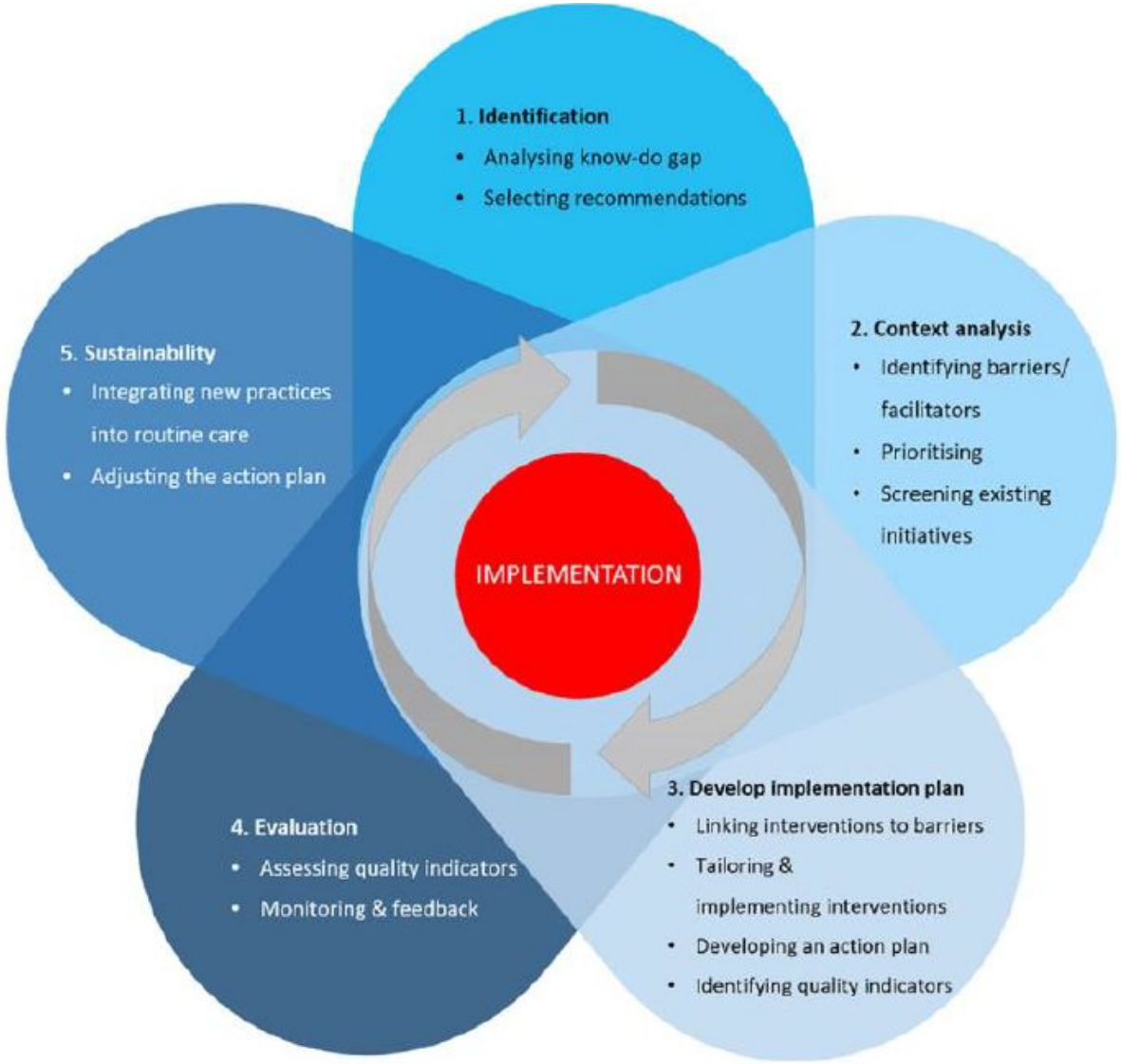
Implement and evaluate an interprofessional discharge intervention focused on:

- Shared decision-making
- Clear role allocation
- Patient empowerment

Examine long-term effects on healthcare providers' attitudes and practices

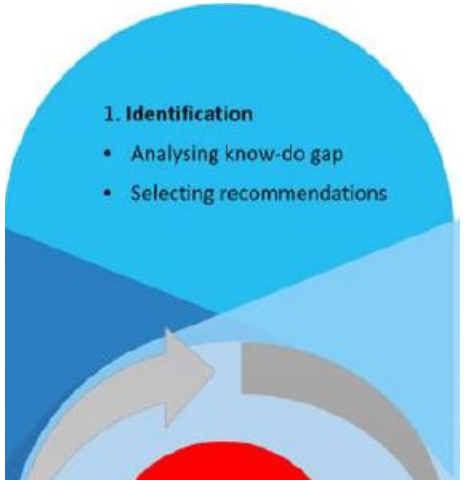
Methodology

1. Identification in collaboration with the unit
2. Contextanalysis
3. Develop implementation plan
4. Evaluation
5. Sustainability



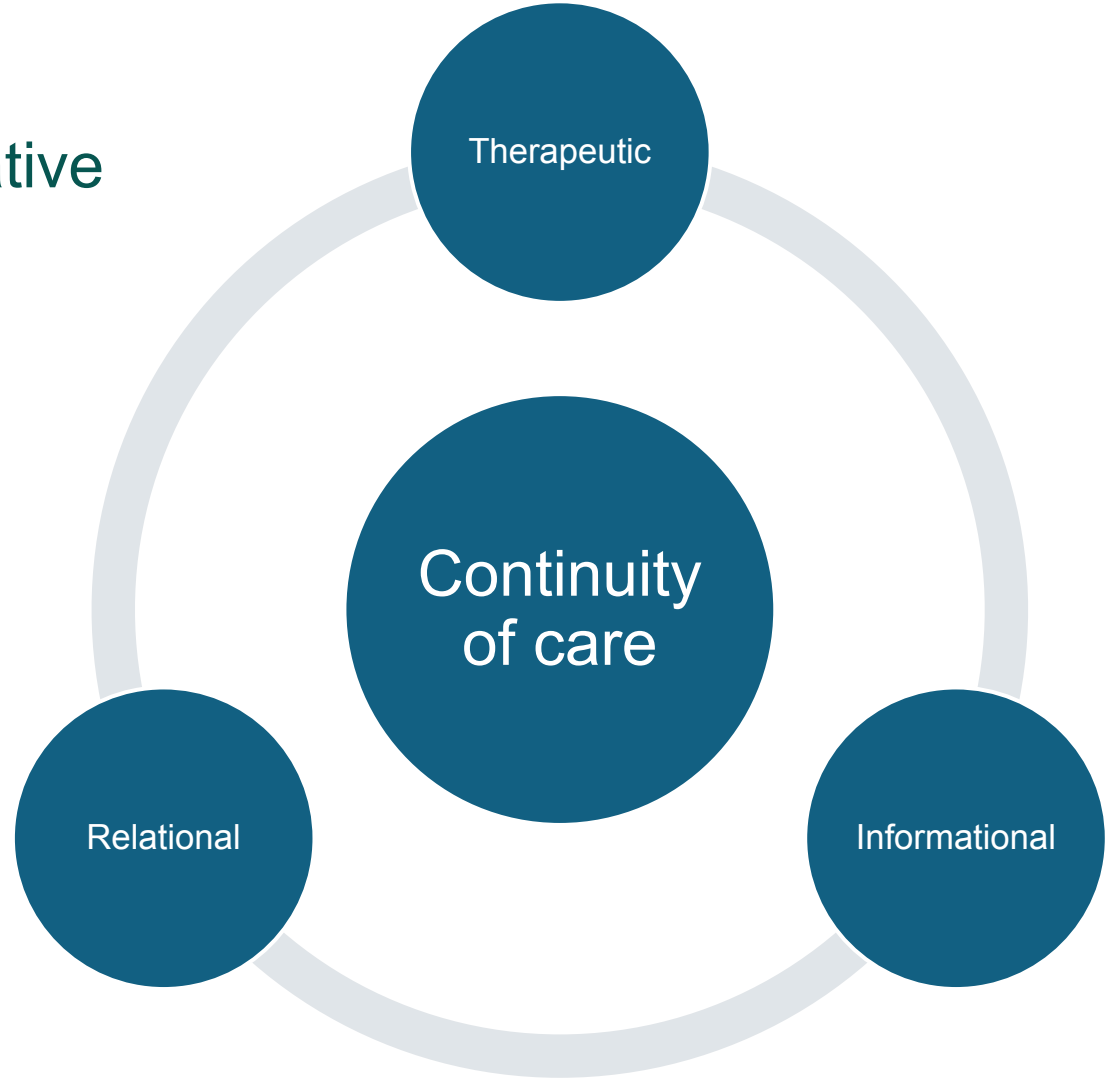
Peters et al., 2020 (Ebpracticenet)

Identification



Literature review and qualitative interviews with

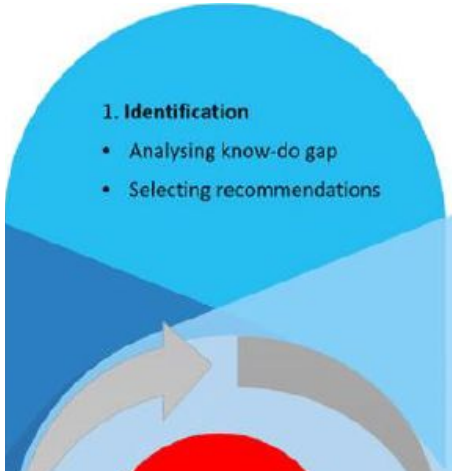
- patients/ caregivers (n=4)
- professionals (n= 16)

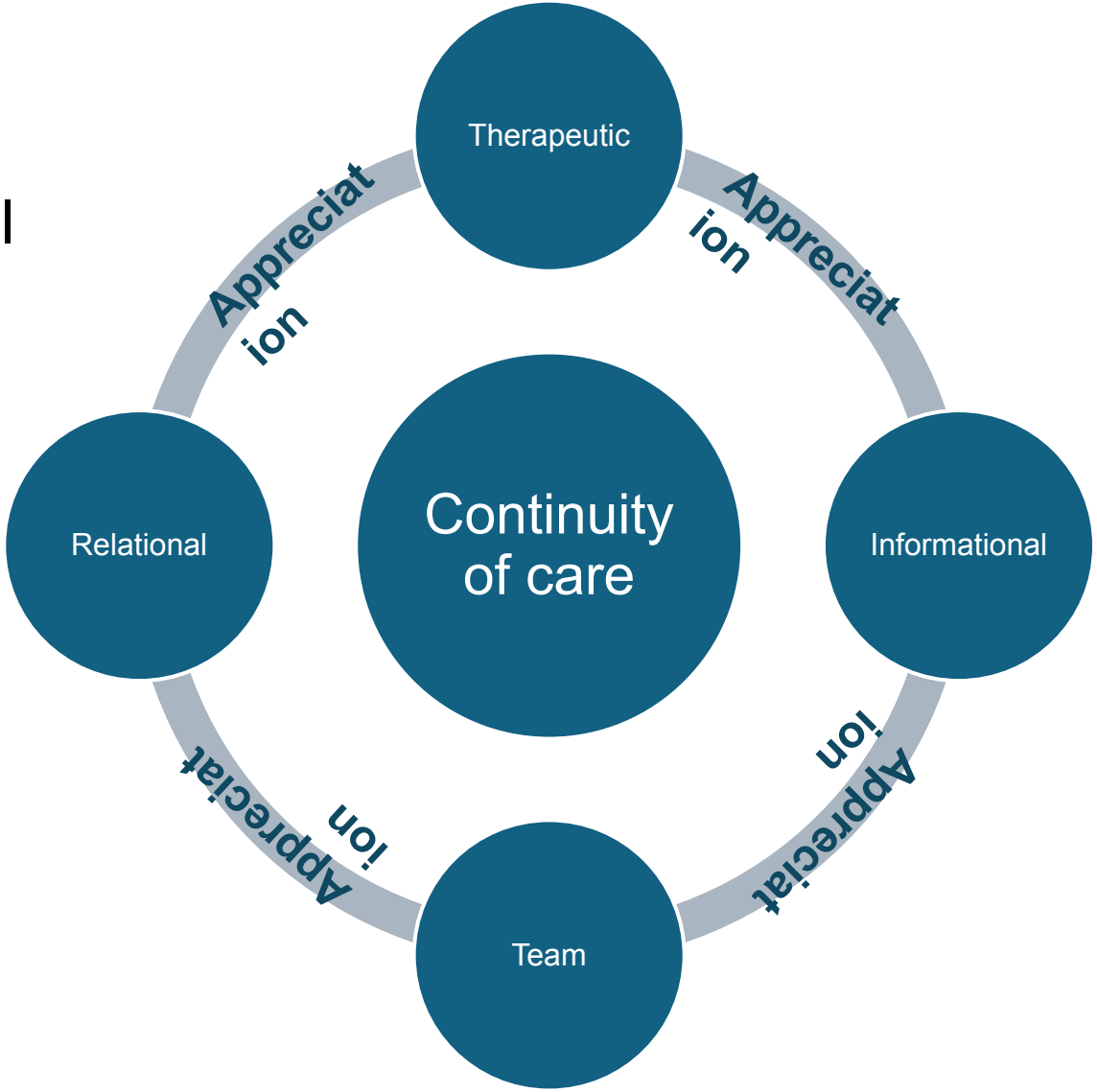


Identification

Analysis

Redefining transmural continuity of care

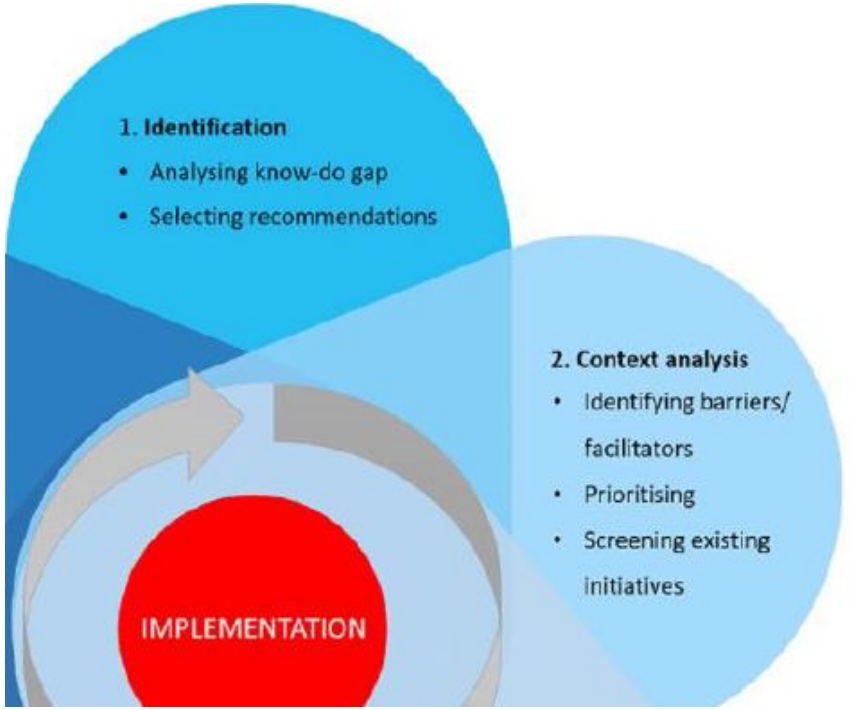




Identification + context analysis

5 identified gaps

- Clear and understandable communication between healthcare providers and patients
- Patient consultation (not just MDT)
- Clear assignment of tasks
- Clear agreements on information exchange in the department
- Comprehensive multidisciplinary discharge document



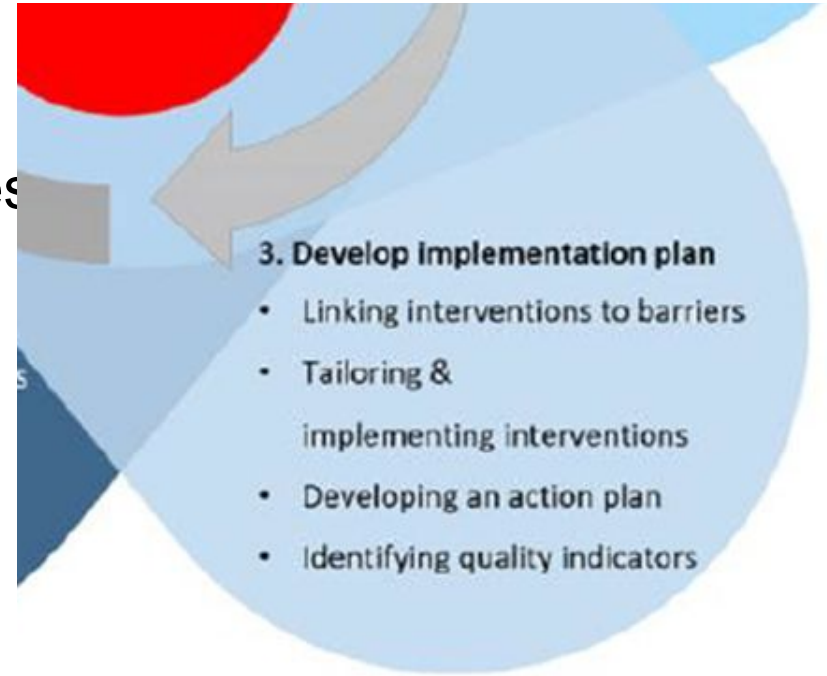
Develop implementation plan

Using the taxonomy of Kok et al. (2015)

A framework to identify implementation strategies

Identifying quality indicators

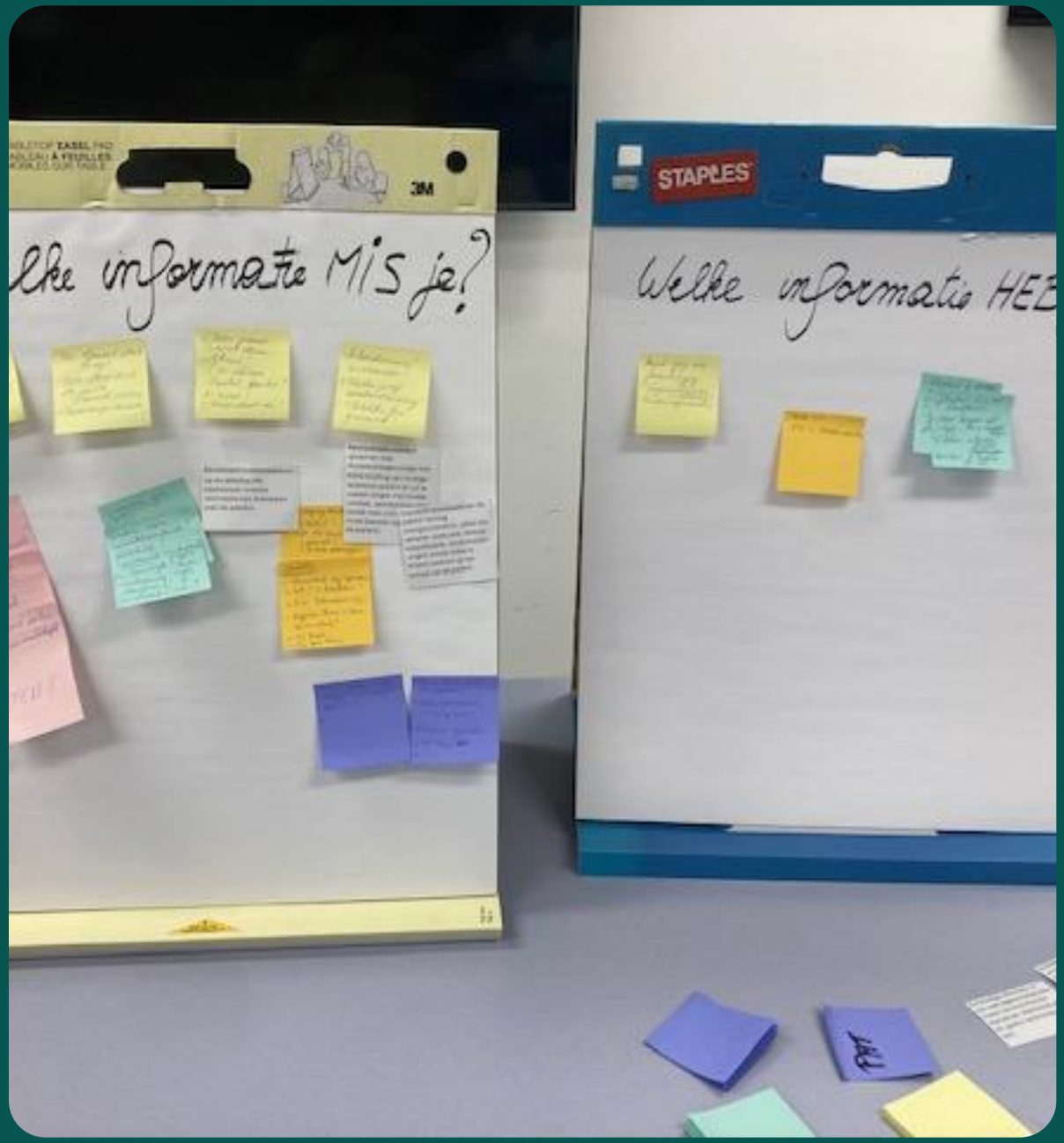
- Proces
- Structure
- Outcome



Development of tailored intervention

INTERPROFESSIONAL WORKSHOPS

Interprofessional Workshops



Co-created discharge Interprofessional

Workshop

Aim Workshop

The intervention

- Interprofessional collaboration with patient experts as equal contributors
- Structured discharge checklist co-developed with stakeholders
- Role clarification exercises with real-world scenarios
- Communication simulation between hospital and primary care providers

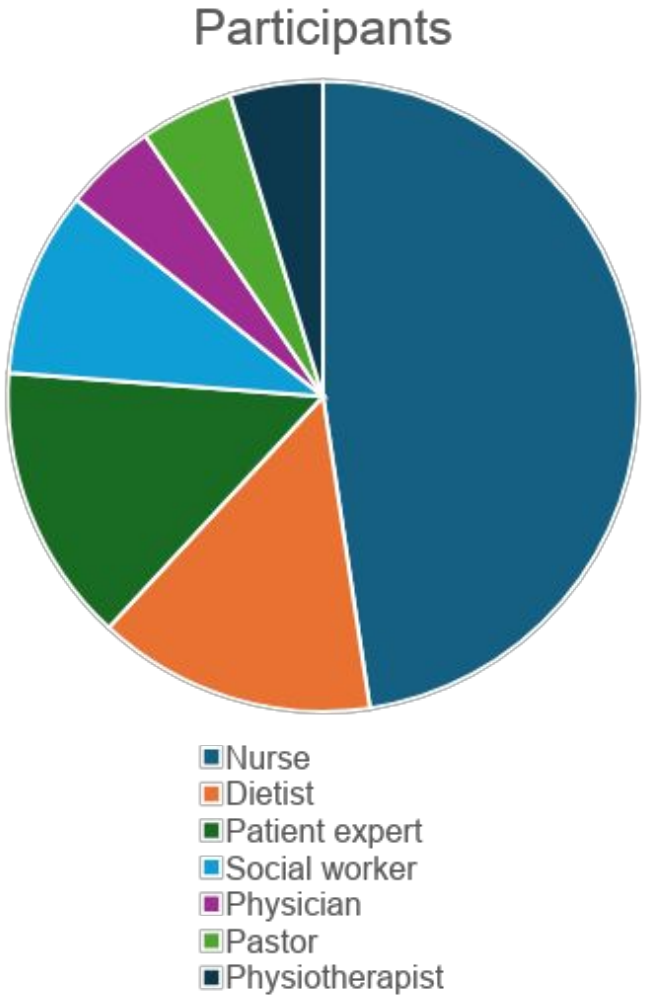
Co-created discharge Interprofessional

Workshop

Participant Composition

The intervention

- Nephrologists and (nephrology) nurses
- Social workers, dietitians and pastor
- Pharmacists and physiotherapist
- CKD **patient experts** with lived experience
- *Primary care caregivers*



Interprofessional Workshops

Case：Reel discharge case from the ward

Shifting Roles

- Professional caregivers discuss discharge responsibilities
- Flexibility in task division
- Take the perspective of the other

Interprofessional Discussion

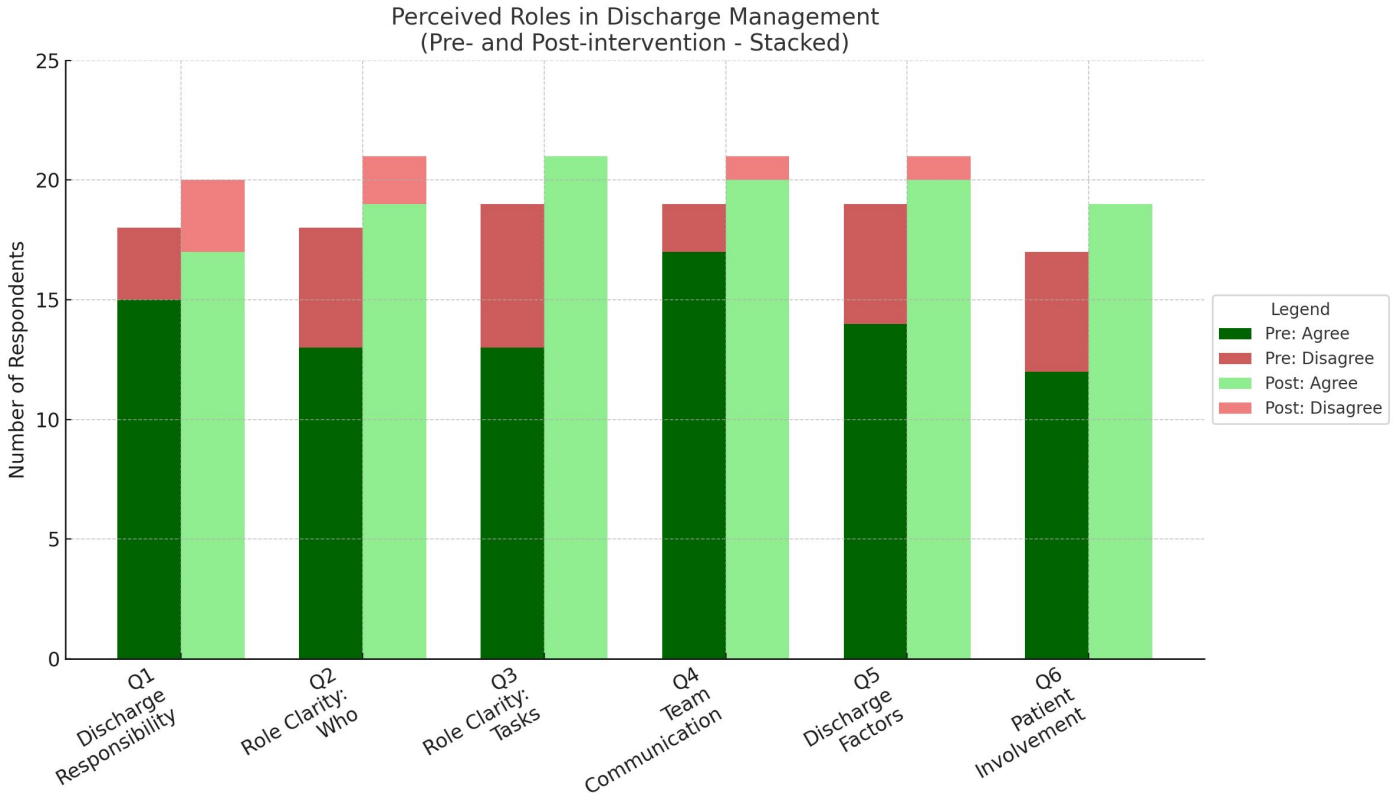
- Joint reflection on patient needs
- Dialogue as foundation for alignment
- Shared decision making

Checklist Development

- Tailored tool for vulnerable patients
- Practical support for continuity of care

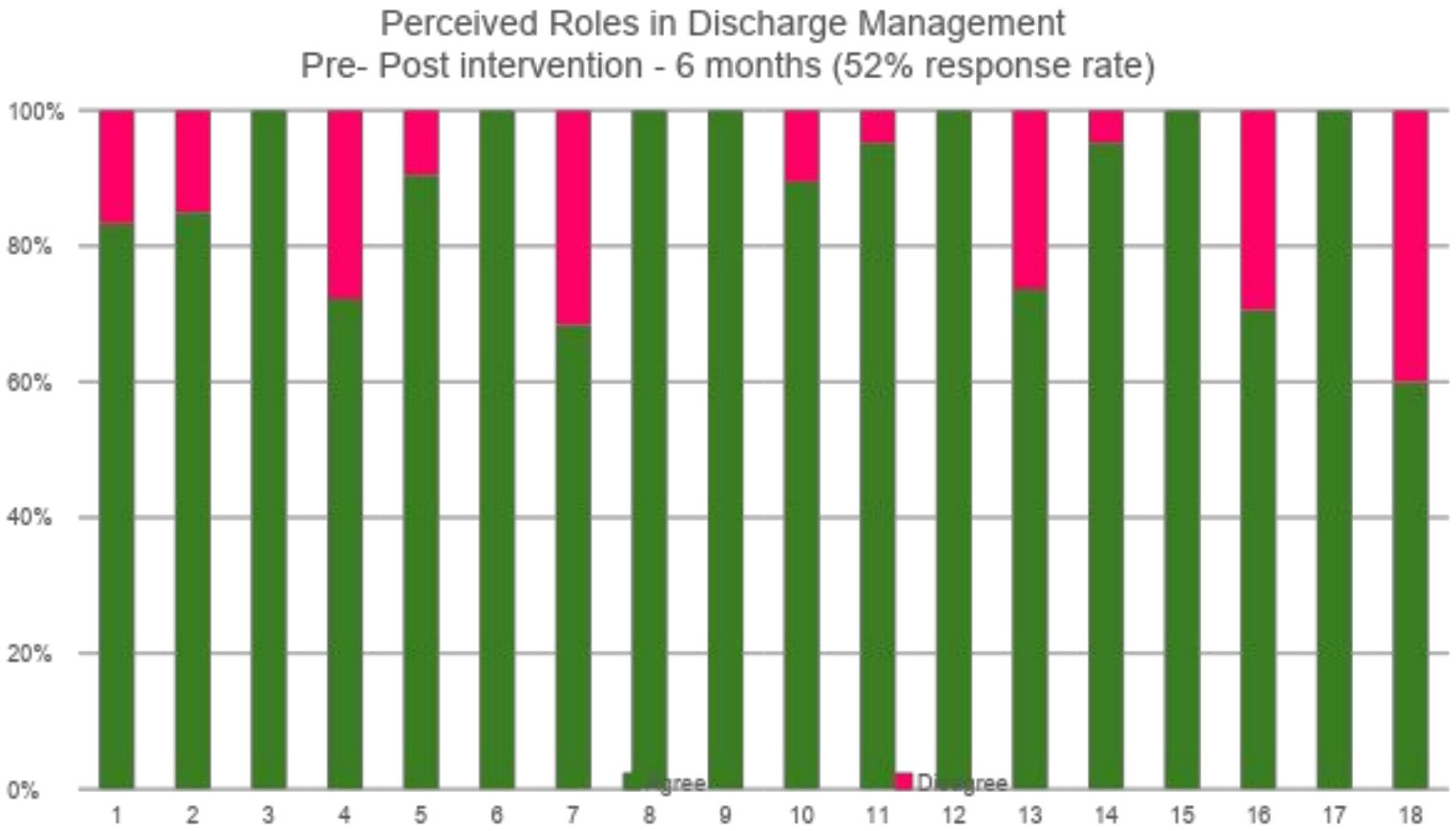
Evaluation

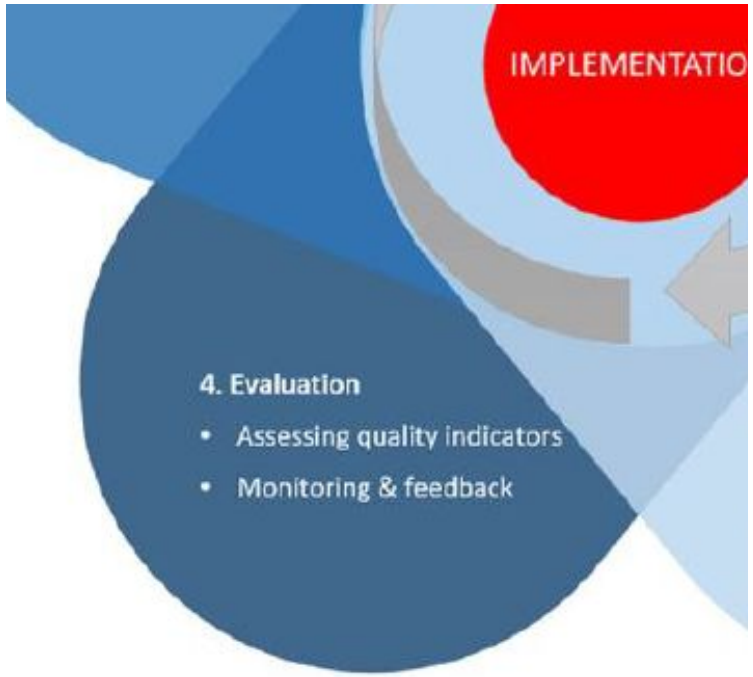
Immediate Results



Evaluation

Six months later





Long Term Impact

Six Month evaluation

Sustained Improvements

- Recognition of discharge as a shared clinical responsibility
- Maintained role clarity and knowledge about contact person
- Strong intra-team communication
- Continued patient engagement (69% of respondents)

Areas for Further Development

- Systematic patient involvement in discharge planning
- Communication with primary care providers
- Structural implementation of discharge checklist
- Regular reinforcement of workshop principles

Sustainability

- Dedicated team
- Engage in the various stages of the process
- Clear agenda

Transferability: Implementation in other units

Geriatric Unit

Addressing complex discharge needs of elderly patients with multiple comorbidities

Burn Intensive Care Unit

Focusing on specialised home care requirements and psychological support

Paediatric Orthopaedics Unit

Including family caregivers in rehabilitation planning and home adaptation

Conclusion & Recommendations

- **Co-creating** discharge intervention health care professional – Patient experts leads to **improved continuity** of care and **sustainable practice changes**
- Structured discharge checklist and interprofessional workshops effectivly foster **shared responsability, role awareness** and **collaboration.**
- **Regular** interprofessional workshops with patients experts should be integrated into standard hospital practice to **sustain improvements** and continually enhance care transitions.

Information and contact

Our research

https://www.voeding.ucll.be/continuiteit-van-zorg

Our workshop

https://research-expertise.ucll.be/nl/navormingen/interprofessionele-samenwerking

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SHARED
PATIENT EXPERIENCE