Patient Transitions in Care

Critical Care Strategic Clinical Network

Critical care is facing a growing, aging population coupled with increased complexity of presenting illness. Individuals with one or more conditions such as diabetes, congestive heart failure, coronary artery disease, stroke and chronic obstructive pulmonary disease have complex care needs involving primary care, home care, hospitals and specialists.

Establishing smooth transitions between these areas of care is critical to managing chronic conditions so that they do not worsen, potentially leading to hospitalizations that might have been avoided. In particular, transfer of patient care from an intensive care unit (ICU) to a hospital ward and to other health care providers has been reported in the literature as high risk, contributing to adverse events, dissatisfaction with care and readmission.

Goal

The PATIENT TRANSITIONS IN CARE project aims to improve patient transitions through the health system and prevent readmissions by standardizing practices for acute care capacity and demand management. This initiative will also provide a framework that uses common standards including the following components:

- Standardized admission/discharge and transfer criteria
- Standardized definitions regarding appropriateness of care setting
- Common triggers for consult and/or criteria for referral for critical care services and sub-specialty (Neuro, Liver, Oncology)
- Standardized discharge and transfer processes
- Consistent transfer checklists and tools to support patient safety

Alberta Health Services Inspiring solutions. Together.
Critical Care Strategic Clinical Network™

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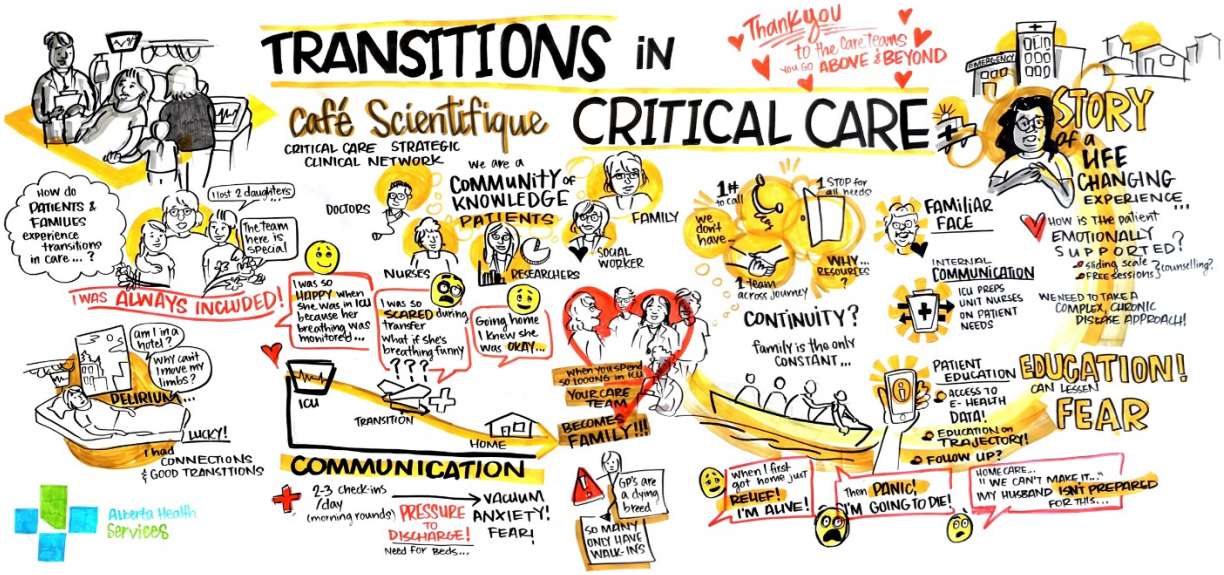

LIVE GRAPHIC RECORDING
Tiaré Jung | Drawing Change