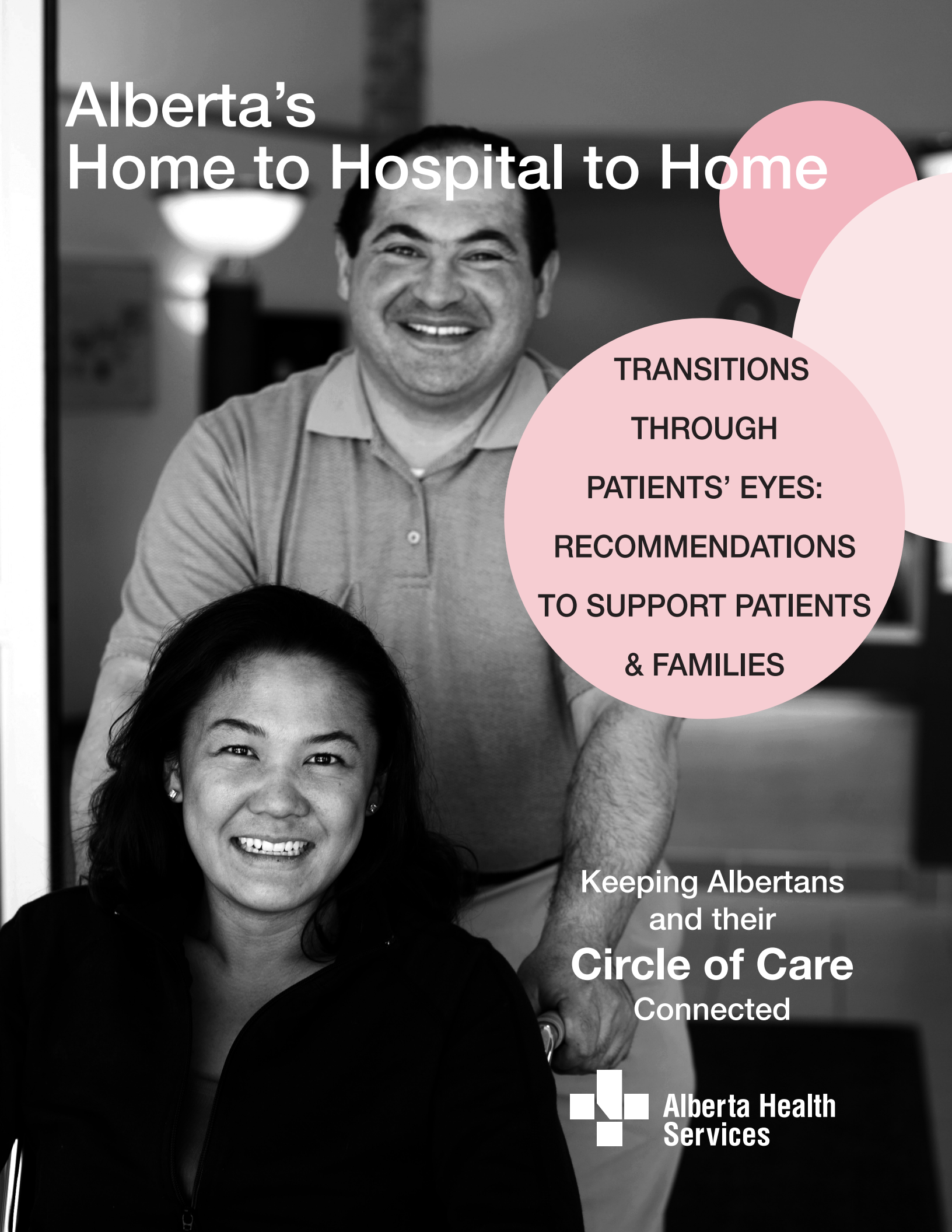

Alberta's Home to Hospital to Home

TRANSITIONS THROUGH PATIENTS' EYES: RECOMMENDATIONS TO SUPPORT PATIENTS & FAMILIES

Keeping Albertans and their

Circle of Care

Connected

Alberta Health Services

November 2020

This report has been prepared by the Patient Transitions Resources Team, comprised of volunteer Patient and Family Advisors and Alberta Health Services Primary Health Care Integration Network staff members.

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Prologue

Put yourself in the patients' shoes would be a fitting motto for all healthcare professionals and staff who help patients through their transition journey. In other words, kindness and empathy is what they do every day when helping transitioning patients. And we hear from patients how highly they value this because it reassures them and lifts their spirits at a most vulnerable time. Of course, there will be times when circumstances may make it difficult to put these two qualities into practice. We urge healthcare providers whenever possible to go the extra mile. After all, it is kindness and empathy that drive everyone's desire to ensure patients benefit from the best possible transition.

– The Patient Transitions Resources Team

Executive Summary

The Patient Transitions Resources Team is comprised of four patient and family advisors from across the province and three Alberta Health Services (AHS) Primary Health Care Integration Network (PHCIN) staff members. AHS tasked this team to work in alignment with Alberta's Home to Hospital to Home Transitions Guideline[1] to explore what patients and families need for a safe and patient-centred home to hospital to home transition journey.

To answer this, the team referred to their own transitions experiences and connected with other patients who shared their experiences. The team also reviewed current transitions-focused resources available for patients and providers in Alberta and explored how these resources align with Alberta's Home to Hospital to Home Transitions Guideline[1].

Through this work, significant transition-related themes emerged, such as cooperation, communication, trust, planning and access. These themes highlighted the critical importance and necessity of:

- shared decision-making
- clear and timely communication
- establishing trust and partnership
- collaborative and integrated care planning
- access to medical records/information

To support patients and families with safe and effective patient-centred transitions, the Patient Transitions Resources Team is proposing six recommendations to Alberta's health system leaders:

1. Commit to facilitating learning and development opportunities for healthcare providers to improve their skills in effective person-centred communication.
2. Develop tools for patients to guide their conversations with providers and empower active engagement during the transition process.

3. Provide patients with the QuRE (Quality Referral Evolution) Patient & Caregiver Journal[2] when a specialist referral is made.
4. Provide patients with an updated transition care plan and other relevant resources and documents, with their choice of electronic or print format.
5. Support a social movement[3] using various platforms to raise awareness of safe home to hospital to home transitions for patients, their families and community partners.
6. Develop with patients a transition care plan which reflects their individual input and circumstances.

Addressing these recommendations within the implementation of Alberta's Home to Hospital to Home Transitions Guideline[1] will help to:

- support clear communication between patients, families and providers
- empower patients and families to be active participants in their transition
- improve patient awareness and access to information and resources that will support their transition journey
- enhance successful implementation of Alberta's Home to Hospital to Home Transitions Guideline[1]

Introduction

Patient and family advisors and Alberta Health Services (AHS) both fully agree that patients and providers need strengthened support to make transitions in care safer and more efficient. It is widely accepted that poor transitions may hinder the safe and effective treatment of patients, increasing the risk of outcomes detrimental to their safety and health. They can also result in avoidable visits to the emergency room, and in general cause frustration, stress and despair for patients, families, caregivers and healthcare providers.

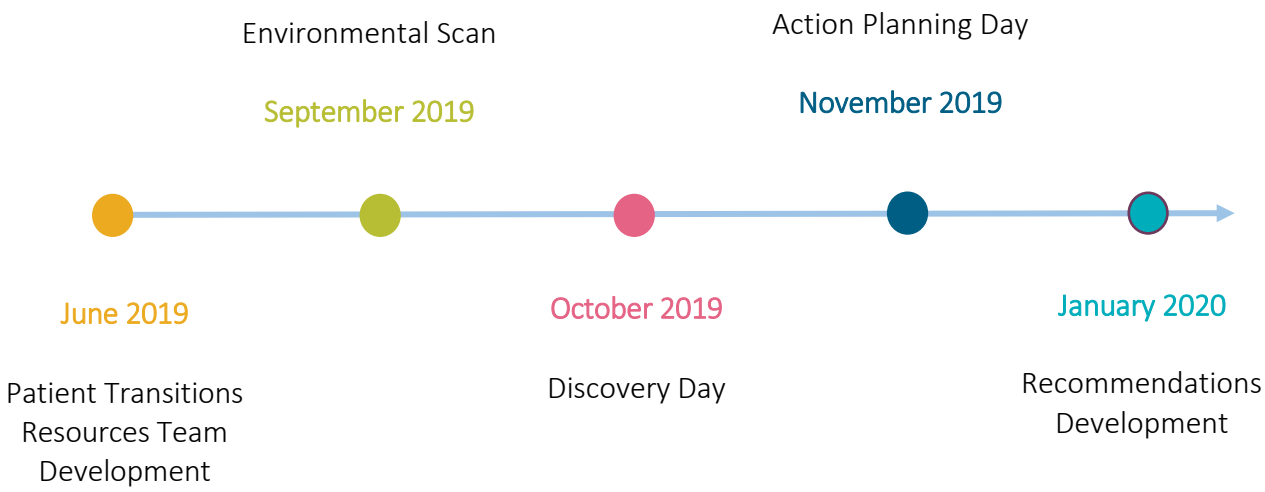
Healthcare providers, patient and family advisors, and other stakeholders across Alberta worked together to develop the leading operational practices found in the Alberta's Home to Hospital to Home Transitions Guideline[1]. The aim is to make coordination and continuity of care effective, safe and efficient at every stage of the transition process.

In addition to the development of the guideline, patient and family advisors from around the province partnered with AHS Primary Health Care Integration Network (PHCIN) staff to form the Patient Transitions Resources Team. This team was tasked to explore what resources patients and families need for an effective and patient-centered home to hospital to home transition journey.

To answer this question, the team referred to their own transitions experiences and those of other patients. They also reviewed current transitions-focused resources available in Alberta for patients and providers and explored how these resources coordinate and align with Alberta's Home to Hospital to Home Transitions Guideline[1]. Based on this work, the team makes six recommendations designed to ensure patients and families experience safe and effective patient-centred transitions.

Milestones

Timeline of Patient Transitions Resources Team Milestones



Patient Transitions Resources Team Development

PHCIN staff made it a priority to recruit patient and family advisors from across the province. Together, they formed the Patient Transition Resources Team.

PCHIN staff utilized the AHS Virtual Patient Engagement Network to advertise the opportunity to partner in the project (Appendix I). Interviews were conducted to get to know each candidate to ensure a good fit with diverse skills, knowledge and attitudes within the team (Appendix II). Two of the patient and family advisors agreed to be part of the team based on their previous work developing Alberta's Home to Hospital to Home Transitions Guideline[1].

PHCIN staff recognized the importance of taking time to build trust and a collaborative culture with the patient advisors. The members got to know each other, what mattered to them in this work and the overall purpose of the project.

What is HealthChange® Methodology?

A methodology promoting behavior change and shared decision making, by guiding providers and teams to embed person-centred practices into the work they do every day with patients.[4]

To build a strong foundation of trust and shared accountability, PHCIN staff used HealthChange® Methodology[4] in both in-person and virtual communications. The staff also leaned on other design methods such as the Project Canvas[5] and International Association for Public Participation Spectrum of Engagement[6] (IAP2 Spectrum) to ensure there was collective understanding of expectations, roles and norms within the team. Getting to know each team member and their skills and strengths has proven to be invaluable and made for a stronger, united team, working together for a common purpose.

What is a project canvas?

A visual tool that improves communication in project teams and provides a simplified project overview.[5]

What is the IAP2 Spectrum?

A tool that helps identify the level of engagement from patient and family advisors in a project or service.[6]

Environmental Scan

As a first step, members of the Patient Transitions Resources Team conducted an environmental scan to identify and collect current resources available across the province that support patient transitions.

The following stakeholders and transitions resources/tools were identified, many which have since been assessed and added to Alberta's Home to Hospital to Home Transitions Guideline[1]:

- AHS Access Improvement: QuRE (Quality Referral Evolution) Patient Handbook. (Note: the QuRE Patient handbook has since been updated, now called the QuRE Patient & Caregiver Journal[2])
- AHS Central Zone Transitions Team: Patient Oriented Discharge Summary[7] (PODS)
- AHS CoACT Collaborative Care: Standard Transition Process[8]
- AHS Connect Care: After Visit Summary[9]
- Alberta Medical Association (AMA): Patients Collaborating with Teams[10] (PaCT) Care Plan Template
- AHS Seniors Health, Community, Seniors and Addiction & Mental Health: Green Sleeve[11]
- AHS Solve It Forward: Emergency Department Patient Information (Appendix IV)

The Patient Transitions Resources Team and stakeholders met to better understand:

- the purpose of each developed tool
- how it is currently being used
- its intended impact on a patient's journey

Understandably, the scan did not identify all resources and further work will need to be done by AHS to engage additional stakeholders in Alberta.

Discovery Day

In October 2019, the Patient Transitions Resources Team facilitated Discovery Day, bringing 15 patient and family advisors and 7 stakeholders together to:

- understand a patient's experience throughout a transitions journey
- review and explore the resources/tools identified in the environmental scan

Preparation

Using a co-design[12, 13] method, each member of the Patient Transitions Resources Team played a significant role in informing the agenda, activities and roles for Discovery Day. At each step in the planning process, patient and family advisors on the team felt empowered through:

- mutual understanding of planned activities
- support to take an active role in the day
- clear expectations and defined roles

What is co-design?

Actively involving all stakeholders in all aspects of the design process to ensure the end result meets the identified goal of a project.[12, 13]

Discovery Day Activities

Empathy Mapping and Journey Mapping

A critical intention of the day was to improve understanding of home to hospital to home transitions from a patient's perspective and experience. Participants were divided into small groups and each group heard a patient share their home to hospital to home transition story. These stories were used to complete one empathy map[14] and one journey map[12] per group to collaboratively gain deeper insight into the transition process and experience.

World Café Activity

The team facilitated a World Café (Appendix III) activity to seek feedback on the existing patient transition tools identified from the environmental scan. Each tool was placed at its own station and participants were divided into groups. The groups took turns at each station to:

- understand where they felt the transition tool aligned within the patient transition journey

What is empathy mapping?

A tool that allows patients and family members to share their experiences and what matters to them.[14]

What is journey mapping?

A tool used to "…visualize a (patient's) experience from beginning to end and help…strategize moments for improvement."[12]

- offer feedback around resource strengths and potential areas for improvement

Scorecards allowed each group to rank the resource using a numeric scale and to offer narrative feedback.

Post Discovery Day

Post Discovery Day, the team synthesized and identified themes from the empathy mapping[14] and journey mapping[12] activities. As the team explored the findings, significant themes emerged related to cooperation, communication, trust, planning and access. These themes highlighted the critical importance and necessity of the following:

- **shared decision making** amongst providers, patients and families/loved ones, including recognition that all are valued members of the circle of care[1].
- **clear and timely communication** between providers, patients and families. This includes setting specific expectations and identifying roles within the circle of care[1]. It is important patients and families understand which provider to go to for follow up, questions and concerns.
- **establishing trust and partnership** among providers, patients and their families.
- **targeted care planning** that involves all members of the circle of care[1], both in community and acute care, to ensure continuity of next steps in patient care. This includes ensuring warm handoffs to any new members of the circle of care[1].
- **access to medical records/information** for all members of the circle of care[1]. Ideally, this information will be available in an electronic platform as well as written form.

What is a circle of care?

A patient's identified circle of care includes any and all healthcare providers (physicians, nurses, supportive care) and family, friends and/or caregivers that are involved with the care, treatment and well-being of a patient.[1]

Inconsistencies and/or omission of any of the above leads to poor experiences for patients and families/loved ones.

The team also reviewed the scorecards and collated feedback from the World Café.

Impact

The impact of Discovery Day was evident in the rich discussions throughout the day, the enlightening stories shared and the lessons learned. The day brought providers and patients — from different teams and different work — together, to bridge connections and see collective opportunities to support patient transitions. It helped build importance and ownership of the work within the Patient Transitions Resources Team by building empathy, curiosity and a call to action to improve home to hospital to home transition experiences for patients.

The impact of Discovery Day also influenced the Alberta's Home to Hospital to Home Transitions Guideline[1]. The day showcased patient transitions resources and validated their importance in ensuring patient-centred transitions. As a result, tools such as the QuRE Patient & Caregiver Journal [2] and PODS[7] have been incorporated into the "Tools and Resources" sections of the guideline.

Lessons Learned

Participants found the interactive day valuable and informative with opportunities to learn from one another and share lived experiences. However, they all felt that more time would have allowed them to dive deeper into each tool, offer more informed feedback and hear how other participants evaluated the resources.

In addition, participants would have preferred access to resources ahead of the World Café activity (Appendix III) to enable them to provide more comprehensive feedback.

As the limited time may have affected the evaluations of resources, the Patient Transitions Resources Team provided the option to offer more feedback through email.

Action Planning Day

After analyzing the feedback of Discovery Day and the World Café (Appendix III), the Patient Transitions Resources Team met in person to draw up the first set of recommendations to align with Alberta's Home to Hospital to Home Transitions Guideline[1].

Planning for the Day

For the most efficient use of time, the team carried out a great deal of preparation ahead of the meeting, including:

- a review of Discovery Day findings
- posting information for team members to review
- planning the format of the day
- setting specific expectations to ensure a clear understanding of the purpose of Action Planning Day

Process

In real time, the team conducted an intensive review of the collated feedback from the empathy mapping[14] and journey mapping[12], as well as the World Café activity (Appendix III). From there, the team developed six recommendations to support patients and families during home to hospital to home transitions. To guide the process, a visual tool was developed that shows where the data and recommendations align with the guideline (Appendix V).

> *"It was an **amazing experience**; it helped reassure me that **things are actually getting done**."*
>
> *Karen Moffat*
> *Patient & Family Advisor*

Recommendations

The Patient Transitions Team is proposing six recommendations, in alignment with Alberta's Home to Hospital to Home Transitions Guideline[1], to Alberta's health system leaders:

Recommendation # 1

Commit to facilitating learning and development opportunities for healthcare providers to improve their skills in effective person-centred communication.

Clear, understandable and continuous communication is essential throughout a patient's journey. Regardless of the transition point, healthcare providers need to improve how they exchange information with patients and families. This includes both written and verbal communication. The patient and family stories shared during Discovery Day made it clear that poor communication between patient and provider and/or provider to provider often hampers safe transitions. Examples include the use of jargon, not involving patient and/or family in the circle of care[1], and delays in follow-up. A culture shift is essential whereby patient-centred care and communication occurs during every patient encounter.

What does patient-centred care mean to patient and family advisors?

"Patient-centred care is about ensuring the physical, mental and emotional welfare of patients."

Helen Neufeld
Patient & Family Advisor

"Patient-centred care is looking at what is best for the patient based on their individual needs."

Patient Transitions Resources Team

"Patient-centred care is about shared collaboration and planning for the patient's whole journey."

Karen Moffat
Patient & Family Advisor

Recommendation # 2

Develop tools for patients to guide their conversations with providers and empower active engagement during the transition process.

Patient and family advisors have said that in the midst of the transition journey they don't always know what to ask their healthcare provider. Finding the right questions can be incredibly difficult if patients don't have a frame of reference they can use.

Alberta's Home to Hospital to Home Transitions Guideline[1] offers examples of questions and actions that patients and families should consider during their transition planning, such as: *What happens if I leave hospital and an urgent issue comes up?*

The Patient Transitions Resources Team further recommends developing patient tools that include examples of potential questions and discussion points to guide patients and families through their transition. Patient and family advisors, alongside healthcare providers would need to test the tools with patients around the province.

The questions and discussion points should be general enough for modifications to suit the differing needs of patients and families and aimed at helping them have meaningful

conversations with caregivers throughout their journey. They should be available in a patient-accessible electronic platform for all Albertans and based on work already completed, such as the AHS Emergency Department Patient Information booklet (Appendix IV), the Patient Orientated Discharge Summary[7] and work done by the AHS QuRE team.

The team recommend that AHS completes an additional environmental scan that includes other resources that support patient transitions, such as Choosing Wisely Alberta[15].

Recommendation # 3

Provide patients with the QuRE Patient & Caregiver Journal[2] when a specialist referral is made.

Many patients discharged from hospital need referrals to other care teams, including specialists. Teaching patients how to prepare for and take part in these appointments would help them get the most out of their visit. To accomplish this, the team recommends that AHS make the QuRE Patient & Caregiver Journal [2] available in a patient-accessible electronic record.

The team also recommends that discharge units offer the QuRE Patient & Caregiver Journal [2] to patients and families upon discharge from hospital and anytime they are referred to a provider outside their primary healthcare team. Ideally, the QuRE Patient & Caregiver Journal [2] will be linked to the transition care plan and offered to patients whenever a referral is required.

In order for these processes to succeed, all stakeholders will need to be engaged, including but not limited to, AHS Access Improvement team leading the work with the QuRE Patient & Caregiver Journal[2], AHS Connect Care, primary care, acute care, the multiple specialty access streams in the province and patient and family advisors.

Recommendation # 4

Provide patients with an updated transition care plan and other relevant resources and documents, with their choice of electronic or print format.

Patients and families access their information in various ways. A number of social determinants may factor into how patients are able to access electronic platforms, and it is critical that alternative methods to receive the resources are provided outside of electronic format. The team recommends all stakeholders establish structures to ensure that documents are available to patients and families in both electronic and paper format. Also, the team strongly suggests that all patient transitions resources be housed in the patient-accessible electronic platform so patients and families have a 'one stop' shop.

Recommendation # 5

Support a social movement[3] using various platforms to raise awareness of safe home to hospital to home transitions for patients, their families and community partners.

In order for the transitions resources outlined in this document to be utilized and implemented effectively, the Patient Transitions Resources Team recommends that AHS support a social movement[3] and awareness campaign that includes the public, circle of care providers and community partners.

What is a social movement?

A collective campaign resulting from people coming together informally to support a social goal or change in society's structure or values.[3]

PHCIN is exploring the opportunity to build momentum for safe and effective home to hospital to home transitions through a social movement[3]. Partnering with other groups who have developed patient transitions resources should be further explored by PHCIN as an opportunity to launch a social movement[3] campaign. Examples include the Together4Health[16] online platform, AHS CoACT Collaborative Care[8] and Green Sleeve[11].

What is storytelling?

"A story is a form of communication and a means to understanding and expressing experience: '*A story is a fact wrapped in an emotion that can compel us to take action and so transform the world around us.*'"[17]

The team recognizes that the voices of patients and families are critical to a campaign's success and impact. An important role patients and families would play is in sharing their own transition experiences, highlighting the human perspective to further accelerate the importance of improving patient transitions. Storytelling[17] is a great example of empowering the patient in a social movement[3] campaign.

Recommendation # 6

Develop with patients a transition care plan which reflects their individual input and circumstances.

Through empathy mapping[14] and journey mapping[12], it became clear that all patients in hospital require a transition care plan. Alberta's Home to Hospital to Home Transitions Guideline[1] highlights leading operational practices for transition planning and transition care plans. These care plans support the continuity of information from one transition step to the next. It is essential that the care plan be a collaboration between provider and patients and families. The Patient Transitions Resources Team believes that having a transition care plan should be non-negotiable and linked to a patient-accessible electronic platform. This point is further outlined in Alberta's Home to Hospital to Home Transitions Guideline[1].

Does everyone need a transition care plan?

As a result of the COVID-19 pandemic, more Albertans are requiring hospital and/or healthcare services. There is increased urgency to address transitions issues and the value of supporting care planning for all patients is evident now more than ever.

Summary

Recommendations and Key Partners

The following table provides a summary of the six recommendations along with potential key partners for implementation.

Recommendation	Currently Identified Resources*	Potential Key Partners
1. Commit to facilitating learning and development opportunities for healthcare providers to improve their skills in effective person-centred communication.	• HealthChange® Methodology[4]	• AHS HealthChange® Methodology Team • Patient and family advisors • AHS CoACT Collaborative Care Team
2. Develop tools for patients to guide their conversations with providers and empower active engagement during the transition process.	• QuRE Patient & Caregiver Journal [2] • AHS Emergency Department Patient Information (Appendix IV)	• Patient and family advisors • Primary care providers/Primary Care Networks (PCNs) • AHS Access Improvement
3. Provide patients with the QuRE Patient & Caregiver Journal[2] when a specialist referral is made.	• QuRE Patient & Caregiver Journal[2]	• AHS Access Improvement • AHS Connect Care • Patient and family advisors • Primary care providers/PCNs • Acute care • AHS CoACT Collaborative Care Team • AHS specialist clinics/services
4. Provide patients with an updated transition care plan and other relevant resources and documents, with their choice of electronic or print format.		• Patient and family advisors • AHS Access Improvement • AMA • AHS Connect Care

Recommendation	Currently Identified Resources*	Potential Key Partners
		• Primary care providers/PCNs • Acute care
5. Support a social movement[3] using various platforms to raise awareness of safe home to hospital to home transitions for patients, their families and community partners.	• Together4Health[16] • Green Sleeve[11] • CoACT Standard Transition Process[8]	• Patient and family advisors • Public • Healthcare providers • Community partners
6. Develop with patients a transition care plan which reflects their individual input and circumstances.	• After Visit Summary[9] • PODS[7] • PaCT Care Plan[10] template	• AHS Connect Care • AHS Central Zone Transitions Team • AHS CoACT Collaborative Care Team • Patient and family advisors

**additional environmental scans may be needed to further identify valuable resources*

Epilogue

Patients transition not only from home to hospital or from hospital to home. They continuously experience transitions in their care and many struggle to navigate the health system. Moving between primary care and specialists; being referred to a rehabilitation program; or seeking a new doctor are all examples of transitions. It is vital for patients to have a transition care plan that follows them along their journey, at every step in their care so they **achieve their own path to improved health**.

- *The Patient Transitions Resources Team*

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Appendices

Patient Engagement Opportunity to co-design Patient Transition Resources for Hospital to Home Transitions

Primary Health Care Integration Network is looking for patient and family advisors from the **North, South, and Calgary zones** who have experience with being discharged from hospital to join the Home-to-Hospital-to-Home (H2H2H) initiative to help develop Patient Transition Resources.

Background:

Work is underway in Alberta to improve transitions for patients from hospital to home. We have heard from patients that a patient designed discharge document is needed to support the discharge process and ensure the patient has what they need to manage well once they are back in their homes and community.

The goal of the project is to improve patients' self-management, increase continuity of care and support patients to access care in their community during the transition and discharge processes. This work must be done WITH the patient, not for the patient. This is why we need you!

Patient advisors will be involved at all levels of the project from the initial planning phase, through development and testing of documents/tools, to the final implementation phase of patient transitions materials throughout the province.

Our goal is to have five patient/family advisors form the core team – one advisor from each AHS zone. We already have advisors from Edmonton and Central zones involved, and are now seeking advisors from the North, South and Calgary zones.

All travel, parking, and related expenses will be covered if preapproved.

Patient advisor duties as co-leads:

- To initiate, plan and develop patient-designed resources
- Collaborate and co-facilitate face-to-face meetings
- Conduct research and analyze the current state of transitions (opportunities to conduct patient interviews, patient journey mapping or reviewing evidence)
- Actively participate and lead testing and revising developed resources
- Assist in expanding patient involvement in the project and ensure a diverse patient and family/caregiver perspective is embedded from across the province

Time Commitment:

The core team of patient advisors will meet from August - December. Meetings will be either virtual Skype/teleconference or face-to-face, to be determined by the team. Core team members will be expected to complete certain aspects of the work between meetings. Rough timeline:

- Selection of patient advisors (mid-August 2019) – Telephone conversations to determine if this project is a good fit for you
- Patient Advisor Team Kick Off (September 2019) – Face-to-Face in Edmonton or Red Deer (videoconference may be an option)
- Patient Focused Research and Design Planning (September - October 2019) – Skype/ teleconference meetings with possible in-person focus groups and interviews
- Design Sprint (October 2019) – 2-day Face-to-Face meeting in Red Deer
- Testing developed resources (November 2019) – Skype/teleconference meetings and focus groups
- Revising developed resources (December 2019 - January 2020) – Skype/teleconference

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Primary Health Care Integration Network

For more information or to get involved, Respond before August 7th, 2019:
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Patient Transitions Resources
Patient Advisor Interview Questions and Processes

Set the Scene:

- What's your understanding of why we've come here today?
- Hear more about them and determine if this patient advisor work is a fit for them
- Discuss expectations of the work and how it will benefit them
- Share specific information for zone (ie: how many patient and family advisors have applied. Different roles possible including the team. Discuss any limitations with travel or scheduling.)

Explain Roles:

- Who we are
- Our role is to guide the conversation and learn more about them and share about the project
- Their role is to share their previous experiences and how they see this work fitting into their life

Ask questions:

1. What motivated you to submit an expression of interest for this project?
2. Is there anything else about your experiences as a patient in Alberta that motivates you to contribute to how patient transition resources are developed?
3. Can you tell us about your experience(s) as a patient advisor?
4. What has your experience been with being discharged from hospital to home? What challenges have you or your family faced in your transition journey?
5. If you could change one thing about health care is delivered in Alberta what would that be?
6. What skills and strengths do you feel you can offer this project?
7. Given the requirements for this patient advisor co-lead position (see flyer) and everything else you have going on in your life right now, is this project something you can feasibly commit to? Is there anything that might get in the way of your commitment?

If committed, discuss next steps:

Activity	Commitment Time
Weekly Team Meetings	1 hour a week (virtually)
Patient Consultation Webinar	2 hour virtual session
Patient Journey Mapping	Full-day: in person in Red Deer or Edmonton
Team Planning and Recommendations	Full-day: in person in Red Deer or Edmonton

World Café Activity

Set Up:

One resource at each station; stations set up around the room

- Station 1: Patient-Orientated Discharge Summary (PODS)
- Station 2: After Visit Summary
- Station 3: Green Sleeve
- Station 4: Patients Collaborating with Teams Care Plan Template
- Station 5: Emergency Department Patient Information
- Station 6: Standard Transition Process (CoACT)
- Station 7: Quality Referral Evolution (QuRE) Patient Handbook

Instructions:

- Participants separated into small groups
  Each group has 10 min at a station to review resource and complete the following feedback form before moving on to the next station:

Where do you think this resource would fit in the transition journey?

(Please check all that apply)

- ☐ Prior to Admission
- ☐ Admission
- ☐ Discharge Planning Process
- ☐ Referral and Access to Community Supports
- ☐ Transition Care Plan
- ☐ Follow Up to Primary Care

How helpful would this resource be for you in your transition journey?

0.....1.....2.....3.....4

Not helpful Somewhat helpful Very helpful

How patient and family friendly is this resource?

0.....1.....2.....3.....4

Not Somewhat Very

What are the good parts of this resource?

What do you feel is missing from this resource?

From the perspective of a patient, caregiver and/or family member, what improvements would you suggest in this resource?


If you are in **pain,** or if your **symptoms change,** alert the triage nurse.
It is best not to eat or drink anything until the physician sees you.
Patient information
Emergency Department
This book is for you. You can share the information you add if you choose with the Emergency Department Doctor.
Alberta Health Services

Emergency Department Patient Information

1 Check in

Check in with the triage nurse at the desk. The triage nurse is someone who will initially check your condition in order to prioritize or serve patients based on urgency and pain level.

2 Other Options for "Non-urgent" Conditions

For "non-urgent" conditions, you have options for care. If you are planning on leaving the Emergency Department (ED), please let the triage nurse know.

Questions you have for the doctor in the Emergency Room & Notes to take:

Is there anything that you are most worried about or want the doctor to know about what matters to you?

3 **Wait Time**

While waiting for care, more urgent patient cases may come into the ED. This could increase your waiting time.

4 **Assessment & Treatment**

Once you are called into the treatment area, we will work with you to understand your health care problem, do a thorough assessment and provide any treatment you need.

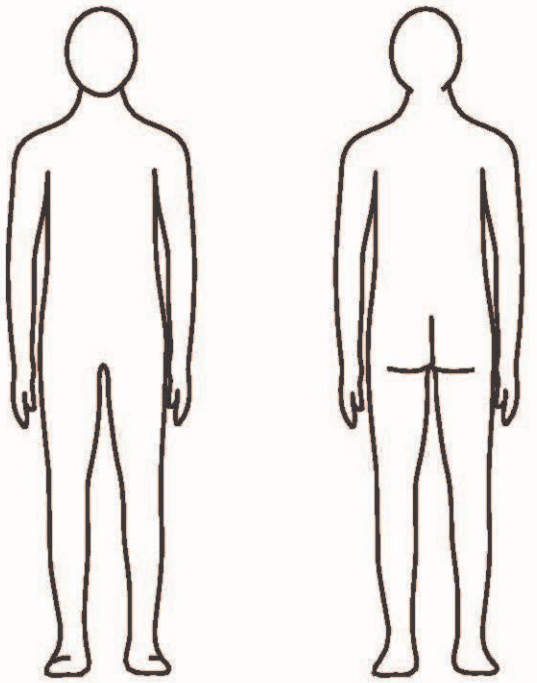
1 Check in

When you check in, a triage nurse will check your condition in order to prioritize or serve you based on urgency and pain level. The nurse may also check your temperature, blood pressure, and pulse.

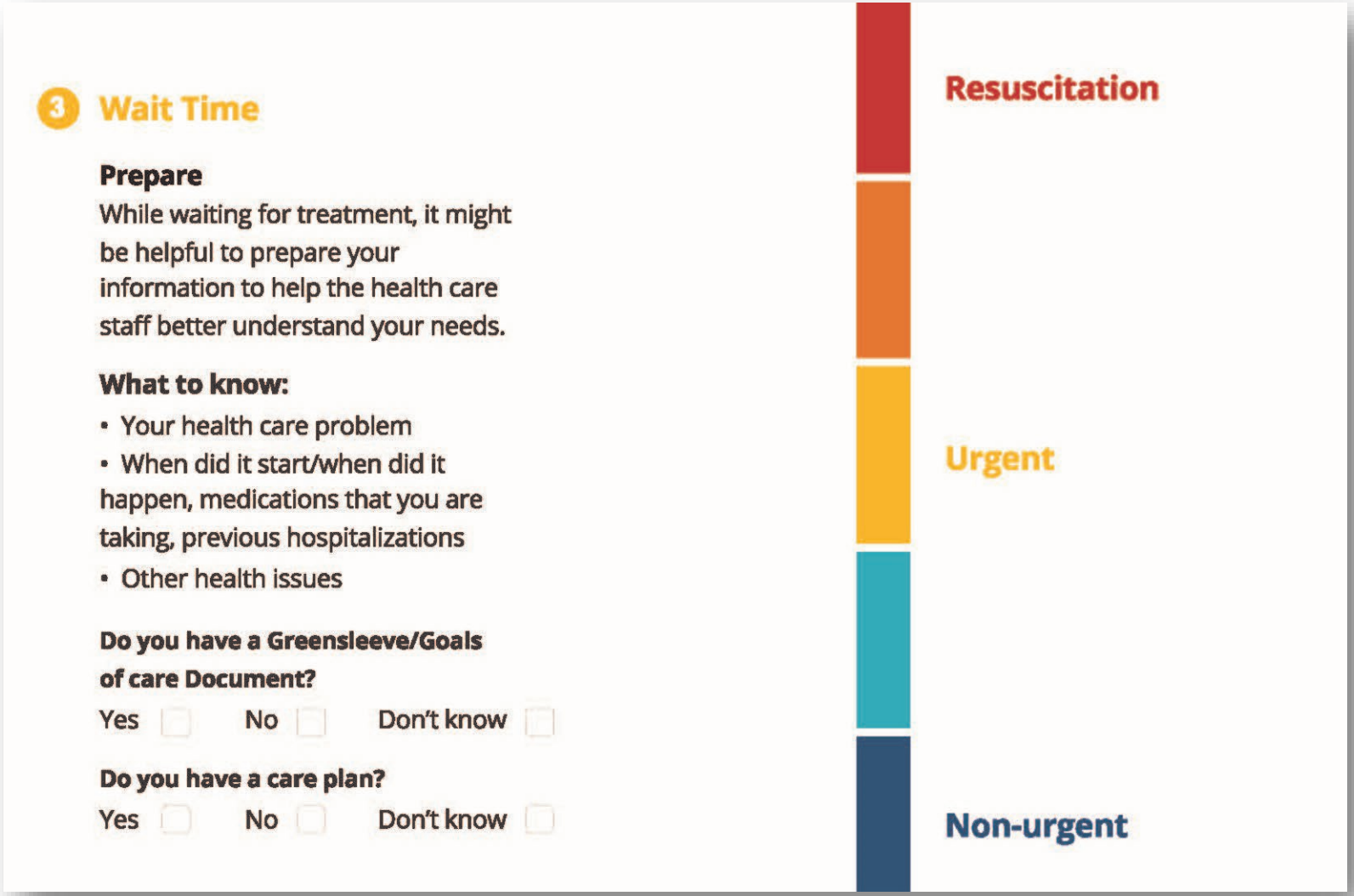
Patients in the emergency department are seen according to the urgency of their condition, not on a first come first serve basis.

You may be triaged as "non-urgent", this does not mean that you and your health concern are not important. It does mean that some other people who have more urgent issues may be seen before you.

Please indicate on these drawings where you feel discomfort and/or pain:



Front Back


3 Wait Time
Prepare
While waiting for treatment, it might be helpful to prepare your information to help the health care staff better understand your needs.
What to know:
• Your health care problem
• When did it start/when did it happen, medications that you are taking, previous hospitalizations
• Other health issues
Do you have a Greensleeve/Goals of care Document?
Yes No Don't know
Do you have a care plan?
Yes No Don't know
Resuscitation
Urgent
Non-urgent

2 Other Options for "Non-urgent" Conditions

When it comes to health care and treatment, you have options:

Family Doctor
Your best option for on-going health needs. If you do not have a family doctor - call Health Link Alberta to find a family doctor: 811

Urgent Care Centres
Extended hour access for unexpected non-life threatening health concerns, such as broken bones, pain, infections, and cuts.

Family Care Clinics
Extended hours care, especially for those who need a family physician, have chronic diseases, or have addiction or mental health needs.

Ambulatory Care Centres
Immediate attention for urgent, but non-life threatening conditions.

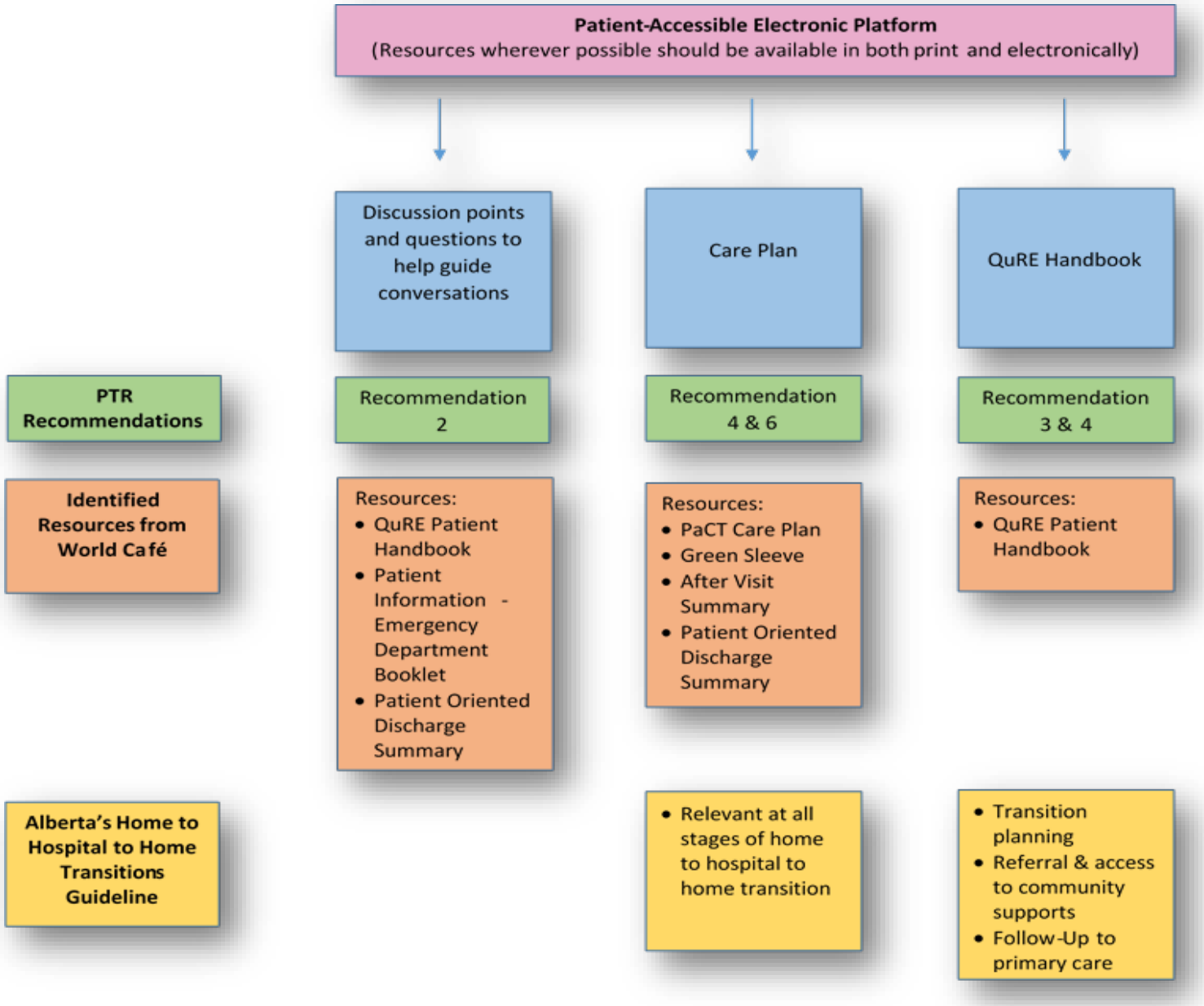
Walk-In clinics
Many offer extended hours helping with concerns such as sprains, ear infections and flu symptoms.

Community & Public Health Centres
Prenatal, health promotion, disease, injury prevention, and more.

Pharmacists
Renew prescriptions, assess minor condition symptoms, offer treatment or refer you to the most appropriate treatment location.

Health Link Alberta
If you have a health concern or you're not sure where to go for help, speak to a nurse on this free, round-the-clock, telephone advice and information service: **811** or **MyHealth.Alberta.ca**

If you plan to leave the emergency department, **please let the nurse know before you go.**


Patient-Accessible Electronic Platform
(Resources wherever possible should be available in both print and electronically)
Discussion points and questions to help guide conversations
Care Plan
QuRE Handbook
PTR Recommendations
Recommendation 2
Recommendation 4 & 6
Recommendation 3 & 4
Identified Resources from World Café
Resources:
• QuRE Patient Handbook
• Patient Information - Emergency Department Booklet
• Patient Oriented Discharge Summary
Resources:
• PaCT Care Plan
• Green Sleeve
• After Visit Summary
• Patient Oriented Discharge Summary
Resources:
• QuRE Patient Handbook
Alberta's Home to Hospital to Home Transitions Guideline
• Relevant at all stages of home to hospital to home transition
• Transition planning
• Referral & access to community supports
• Follow-Up to primary care