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POSTER ABSTRACT

Co-Designing a Care Transition Intervention to Improve Nurse-to-Nurse Discharge Communication for Older Adults: A Pilot Study in Ireland

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Background: Effective discharge communication is critical for ensuring continuity of care for older adults transitioning from acute hospitals to Transitional Care Units (TCUs). However, documentation inconsistencies and communication gaps remain prevalent, impacting patient outcomes and care quality. This pilot study assessed the feasibility and reliability of a data abstraction instrument, and explored discharge planning practices to inform the development of a co-designed intervention aimed at improving nurse-to-nurse handoffs within an integrated care framework.

Methods: A retrospective chart review of 17 medical records (10% of the planned main study sample) was conducted in acute hospitals across Ireland. Data were extracted using a structured checklist derived from HSE's integrated discharge guidance (2014). Variables included demographics, clinical history, discharge planning elements, nursing communication, MDT involvement, and readmission data. Descriptive statistics were computed and Cronbach's alpha assessed internal consistency across four domains.

Results: The majority of participants were aged ≥91 years (29.4%) and female (70.6%). Notably, 58.8% of charts lacked an Estimated Length of Stay (ELOS) or Predicted Discharge Date (PDD), and 25% had no documented reason for discharge to TCUs. Only 70.6% had documented handoff communication between hospital and TCU nurses.

While 82.4% had a discharge nursing care plan, documentation modalities varied. Readmission occurred in 23.5% of cases, with 17.6% within 30 days. Instrument reliability was moderate (α = 0.49–0.60), indicating a need for item refinement. Qualitative reflections highlighted challenges with chart access, abstraction time, inconsistent documentation, and variability in staff interpretation.

Conclusion: The pilot confirmed the feasibility of the study design but highlighted critical gaps in discharge documentation and communication. These findings validate the need for a structured nurse-to-nurse communication intervention and inform revisions to the abstraction tool and data

collection protocol for the main study. Future directions include refining instrument constructs, improving inter-rater reliability, and standardizing documentation practices across care settings.

Keywords: Older adults, care transition, discharge planning, transitional care units, nursing communication, pilot study, Ireland, retrospective chart review, patient safety.