© The Authors 2021 International Practice Development Journal 11 (1) [12]
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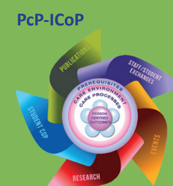
International Practice
Development Journal

Online journal of FoNS in association with the IPDC and PcP-ICoP (ISSN 2046-9292)



IDEAS AND INFLUENCES

Transitional nursing care for older inpatients: a person-centred research programme

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Submitted for publication: 3rd February 2021
Accepted for publication: 29th March 2021
Published: 19th May 2021
https://doi.org/10.19043/ipdj.111.012

Across the Western world, healthcare services are contending with the challenge of ageing populations. Switzerland is no exception, and faces the need to adapt its healthcare system to the needs of older persons. A disease-oriented approach is ill suited to the varied abilities, preferences and degrees of resilience among older people, and person-centred care is better placed to respond effectively to this situation (Ekman et al., 2013). Our team at the Institute of Higher Education and Research in Healthcare (IUFRS) of the University of Lausanne has developed a research programme to improve the healthcare experiences of older persons during hospitalisation and transition to discharge. We have identified different models and theories that promote a better understanding of the factors that impact on older persons' lives during these phases and of how to take them into account in nursing practice in order to encourage a person-centred approach.

The transition of care from hospital to home is a vulnerable time in the continuum of care for older persons (Arbaje et al., 2014). Transitional care is defined by Coleman and Boult (2003, p 549) as a 'set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location'. At the theoretical level, Meleis' transitions theory (2000) provides a perspective for interpreting and planning comprehensive discharge for hospitalised older persons. In designing our research programme, this theory helped us to link the older person's health problems (conditions of transition) in relation to hospitalisation (nature of transition), discharge preparation (nursing interventions) and the effects on the person (response models) (Mabire et al., 2015). From the transitions theory, Naylor et al. (2017) developed their transitional care model to guide nursing practice during this period. This model includes eight components:

- Patient engagement
- Caregiver engagement
- Complexity and medication management
- Patient education
- Caregiver education
- Patient and caregiver wellbeing
- Care continuity
- Accountability

This model makes us aware that when an older person's health deteriorates enough to warrant hospital admission, the person and their family will face issues far beyond the stabilisation and recovery of health, due to several contingent factors. However, while this model and the wider literature inform what nurses should do to ensure adequate transitional care, there is less knowledge about how to deliver transitional interventions that meet the older person's needs and priorities. For this reason, one of our research projects aims to understand, in the Swiss context, which people should receive transitional care, from whom and how.

The research projects we run or participate in range in size from the organisational to the individual: from transforming a Swiss teaching hospital to become more age-friendly, to looking at the experience of persons at the micro level (Fulmer et al., 2018). For example, seeking to implement a person-centred teaching intervention by nurses in relation to discharge preparation; and also to understand how to assess a person's medication literacy in order to identify their needs for education or assistance (Pellet et al., 2020; Gentizon et al., 2021). For these projects, we have been inspired by Shippee and colleagues' cumulative complexity model (2012), which is underpinned by the values and principles of person-centredness and invites us to consider a patient's 'workload' of healthcare-related demands and their capacity to address them. Workload in this respect encompasses the demands on the patient's time and energy, including those of treatment, self-care and life in general Shippee et al., 2012). As age increases, cognitive, physical, social or financial resources tend to decrease and negatively impact the capacities of older persons, putting them at greater risk of being overwhelmed by their care workload. Shippee's model invites us to look differently at people who are sometimes described as non-compliant with a treatment plan, as they may no longer have the resources to cope with the demands of their care.

Therefore, rather than add more and more care services for those who cannot cope, it is important to prioritise and make choices with the person, define what is necessary and desired, and ensure these priorities are understood as part of their continuity of care. Shippee's model applies equally as a philosophical vision underlying a project as broad as the age-friendly hospital and as a theoretical basis for defined nursing interventions. To operationalise the model in our person-centred discharge teaching project for instance, the intervention includes assessment of a person's life situation with the ICAN, or instrument for patient capacity assessment, (Boehmer et al., 2016; Pellet et al., 2021). The ICAN was developed using person-centred design principles and aims to facilitate discussions between a person and their healthcare providers to elucidate how a treatment plan can progressively adapt to the person's needs and wishes (Boehmer et al., 2016). Another example of applying person-centredness in nursing practice is the use of the patient's activation level. The concept of activation refers to the patient's knowledge, skill and confidence in self-management (Hibbard and Tusler, 2007). Considering a person's level of activation prompts nurses to set realistic goals for health management, taking into account the person's skills and balancing these with their resources and the burdens induced by the management of their health.

The models and theories presented in this article underpin our various research projects, either philosophically or by their concrete application in the interventions developed, enabling us to understand through the lens of person-centredness how transitional care can adapt to meet the older person's specific needs.

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