https://dx.doi.org/10.21088/ijsn.2277.467X.4215.4
IJSN
Volume 4, Number 2
© Red Flower Publication Pvt. Ltd

Transitional Care: Care during Changing Condition of Patient

Martis Pascaline V.

Meaning

- **Transition** means the process of changing from one state or condition to another.
- **Transitional care** means care given at the time of changing condition of patient.

Definition

- Transitional care refers to the actions of health care providers designed to ensure the coordination and continuity of health care during the movement between health care practitioners and setting as their condition and care needs change during the course of a chronic or acute illness.
- Transitional care also refers to the transition of young people with chronic condition to adult based services. A program in Australia GMCT transition care is an initiative aimed at improving continuity of care for young people with chronic health as they move from children's to adult health services.

Levels of Transitional Care

There are two level of transitional care:

Individual level

1. Early discharge planning with the development of standardized discharge policies and care plans.
2. Education of patients about discharge with reception of information and promotion of realistic expectations.
3. Steps to encourage patient's independence with early weaning from equipment and one to one nursing care.
4. Steps to ensure direct handover with appropriate and adequate written documentation, of ICU patients to staff in an intermediate care unit.
5. Daytime discharge with adequate warning to the intermediate care unit.
6. Steps to involve patient's families in the discharge process and to encourage questions from patients and patient's family members.
7. Development of written resources.
8. Visits by ICU personnel to patients in the intermediate care unit after discharge from the ICU.
9. Improvement in knowledge of the resources of intermediate care units and the Community.
10. Efforts to improve reciprocal communication with staff in intermediate care unit.

System level

1. ICU discharge or liaison nurses,
2. ICU follows up clinics,
3. Use of step-down and intermediate care units,
4. Development of an evidence base and research agendas related to transitional care,
5. Improvement in the resources of intermediate care units,
6. Improvement in access to community resources,
7. In-services training for staff intermediate care units and establishment of standardized transfer teaching programs,
8. Development of protocols or mechanisms for feedback from ICU patients.

Author Affiliation: Associate Professor, V.S.P.M'S, College of Nursing and Research Center, Nagpur.

Correspondance: Martis Pascaline V., V.S.P.M'S, College Of Nursing And Research Center, Lata Mangeshkar Hospital, Digdoh Hills, Hingna Road, Nagpur, Pincode 440019. (Maharastra)

Email: pascalinevilash@gmail.com

Concepts of Transitional Care

Care Transitional Measure (CTM)

The only currently nationally endorsed measure of care quality is the care transitional measures [CTM], which is a 15 item survey for administration to patients after discharge from the hospital. Dr Eric Coleman and his team at the university of Colorado at Denver and health sciences, center developed the CTM, as well as an intervention designed to improve patient outcome during transition.The care transitions intervention CTI, is a coaching to ensure that patients are comfortable in managing their own medications and their own health information understand the signs and symptoms that should lead them to contact a health care provider. Although the coaching intervention occurs for the first 30 days following the transition. This approach has been shown to significantly reduce hospital readmission as far as 6 months.

Care Transitions Intervention (CTI)

The Care Transitions Intervention (CTI) is a coaching intervention to assist patients in resuming self-care following a change in health status. It uses coaching techniques to ensure that patients are comfortable in managing their own medications and their own health information, understand the signs and symptoms that should lead them to contact a healthcare provider, and have assertion skills to ask important questions of providers. Although the coaching intervention occurs for the first 30 days following the transition, this approach has been shown to significantly reduce hospital readmission as far out as 6 months.

In 2002, the University of Colorado Denver implemented a program called Care Transitions Intervention®. As part of the program, a Transitions Coach works directly with patients and family members for 30 days after discharge to help them understand and manage their complex post discharge needs, ensuring continuity of care across settings. Participants in the program have a 20 to 40 percent lower hospital readmission rate at 30, 90, and 180 days post discharge.

Current Trends and Future Directions

Transition is a process or period in which something, undergoes a change and passes from one state, stage, form or activity to another. Ideally, health care transitions encompass safe and efficient movements of patients between different sectors, or levels of care. Within the health care system and appear to be fundamental in achieving beneficial outcomes for patients. Critically ill patients often experience multiple transitions as they move through different levels of care. The transfer of ICU patients to intermediate care units and subsequent ongoing provision of care is a daily occurrence in acute care hospitals. This care may be provided by ICU nurses, acute care nurses, physicians, and other health care professionals.

Transitional Planning as Collaborative Practice

Transitional planning is a collaborative process in which each health care team member works as a

subunit of the whole, thereby allowing the team to achieve results that individual providers could not accomplish in isolation patient and family are primary contribution in the process and information is required from each member of the health care team. The more complex a patient's need, the most disciplines will be required to complete an adequate assessment and transitional plan. The nurse is integral to the transitional planning process. Nurses by virtues of their role have the most consistent contact with the patient and therefore, have the most consistent opportunity to collect information, make observation and identify care needs and understand patient family concern. This unique opportunity makes the nurse's contribution to transitional planning invaluable.

Aspects of Transitional Planning and the Nursing Role

Comprehensive transitional planning requires in depth assessment in four functional domains like, physical, psychological, social, and economical.

Physical

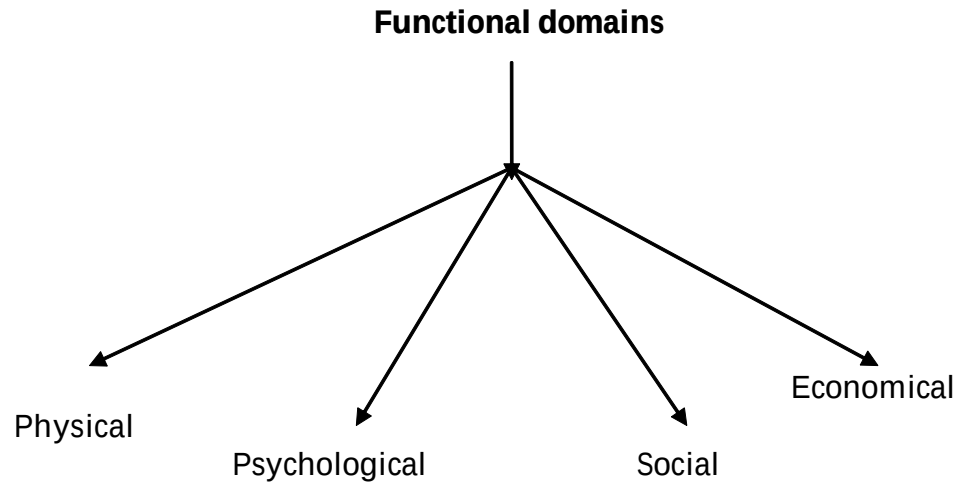
Physical function is the ability to perform self care, self maintenance and physical activities. It is divided between activities of daily living and instrumental activities of daily living [IADL]. ADL include bathing dressing, toileting, transferring, continence and feeding. These activities can represent a natural progression in both the loss of function and the return of ability on recovery or rehabilitation. IADLS, include meal preparation, shopping, transportation, laundry, housekeeping and medication administration.

Significance

Physical function is one of the most significant determinants of post hospital needs and the level of care, services and setting available to the patient. Given this fact, it becomes imperative that hospital care prevents unnecessary loss of function and promotes independence wherever possible. Assessment of physical function gives a picture of the patient's assets and/or deficits and creates a baseline that allows monitoring for changes so that decline can be prevented, function enhanced, and transitional planning needs identified.

Nursing role

Nurses in the acute care setting are in a pivotal position to assess function and target intervention to prevent loss of function and maintain an individual's self care ability. By obtaining information from the patient and family the nurse should assess the patients pre hospital ability to perform ADLS and should through observation and patient family feedback, regularly reassess the ability to perform ADLS during the course of care.



The nursing care plan should include interventions necessary to maintain independence and promotes self care. Attention to appropriate skin care, nutrition, and adequate rest and mobility can prevent complication that might hinder function. As the patient's condition allows, referral to physical and occupational therapy to assist in preventing deconditioning or in regaining self care capabilities may be appropriate. Given that sudden decline in function could signal underlying complication, any

observed decline in functional abilities should immediately communicated to the health care team.

Psychological

Psychological function includes thinking and perception, cognition (alertness, orientation memory, insight, judgment) and affect (emotional expression). One recent study has shown that individual attitudes, prior experiences, the intensive care unit experience, and the support of family and friends all influence physical and psychological recovery following discharge to the community from an ICU.

Significance

A persons thinking, emotion and behavior have significant impact on the ability to provide for the individual's essential needs, either directly or by allowing others to meet those needs. Depression, delirium and anxiety are of particular concern in hospitalized patients. Delirium is a disturbance in consciousness that develops over a short period, trends to fluctuate ever the course of a day, and is manifested by reduced clarity of awareness, impaired ability to focus, sustain or shift attentions recent memory disturbances, perceptual disturbances such as misinterpretations, illusions, or hallucination and disorientation to time and palace. Depression is characterized by a persistently depressed mood, tearfulness, hopelessness and a diminished interest in activities. Anxiety is the apprehensive anticipation of future danger or misfortune and is accompanied by dysphoria and increased arousal with difficulty falling or staying asleep, irritability, difficulty concentrating and hypervigilance. Problem such as delirium, depression and anxiety may be indicative of underlying factors that should be promptly corrected (e.g. infection or medication reaction). Left untreated they may interfere with the patient's ability to cooperate with and thereby benefit from care and treatment, learn about an illness and provide appropriate self care and exercise hospitalization, physical functional decline and the need for increased care and service as a part of any transitional plan.

Nursing role

The nurse should continuously assess and reassess the patient's cognitive and emotional status. Observation of the patients, their reactions and interactions, and more formal testing of orientation and memory will allow appropriate and timely intervention. If delirium is present, the nurse should immediately notify the physician so that any underlying causes can be identified and treated. The nurse should act to ensure patient's safety, because there is a potential for harm from poor judgment or agitation. With the depressed or anxious patient, listening to concerns, educating the patient and family about the occurrence of depression and anxiety in acute illness, and reassuring the patient and family that interventions are forthcoming is helpful. If further assessment or interventions is required, initiating referrals to social work, psychiatry or chaplaincy would be appropriate.

Social

Assessment of social function helps determine the amount of physical and social support available to patient and their level of satisfaction with that support. Elements of social function include the living situation (alone, spouse, children, communal), social contacts (frequency of contact with family, friends and others), social activities, social resources and environment (accessibility of services, safety, transportation) social support (who helps with emergency and daily needs), caregivers / caregiver burden (stress on health, finances, and emotional resources from provision of care), and quality of life (level of satisfaction with life).

Significance

The level of social function in relationship to physical care needs assists in determining patient's ability to return to their preadmission living circumstances, the need for additional resources, or the need for an alternative level of care. Caregiver stress has particular impact on the success of a transitional plan, and provision will entail.

Nursing role

The initial nursing assessment should always include an understanding of patient's pre-hospital living situation. During the course of treatment, the nurse should be cognizant of the patient's physical function in relation to their living situation and communicate concerns to the transitional planning team. The nurse is instrumental in helping the patient and family make appropriate decisions about transitional plans. Many families want to take even very complex patients home but have no clear understanding of what 24 hour care entails. The nurse should provide education about the disease, disease process and caregivers activities. If caregivers seem particularly unrealistic in their determination to provide care, the nurse should have them provide

daily care, under supervision, to gain an understanding of its complexity demand and burden thus better informing their decisions.

Economic

The economic domain includes income and insurance. Income could be in the form of a monthly social security check, pension, or dividends from investments. Many individual will have long term care insurance that may provide extensive resources for alternative care modalities outside of the hospital.

Significance

The assessment of a patents economic situation defines the number and kinds of resources available for transitional planning. Collaboration with social work, families, and significant others can provide important information in defining the economic resources available to the patient.

Nursing role

The nurse does not assume responsibility for assessment of the patient's financial and insurance situation. However when resources are limited the nurse may be able to assist the team with suggestions. That will make a transitional plan more economically feasible. For example suggestions about changing from intravenous to oral drug therapy or changing to a patient bed rather than renting a hospital bed, or consolidating follow up appointments to limit the expense of transportation would reduced the cost of care.

Conclusion

Transitional care encompasses both the sending and the receiving aspects of the transfer, is essential for person with complex care needs. Older adults who suffer from a variety of health conditions often need health care services in different setting to meet their many needs, for young people the focus is on moving successfully from child to adult health services.

References

1. Sailaja Busi. Textbook of critical care for nurses, principles, procedures and practice. I Ediiton. 2013. Paras medical publisher, Hyderabad. Pg. No 109, 117.
2. Javed Ansari. A textbook of medical surgical nursing-II. Edition 2010. S Vikas and company medical publishers India. Pg 1245-1247.
3. Roberta Kalplow, Sonya. R. Hardin Jones and Barelett. Critical care nursing Synergy for optimal outcomes. Edition 2007. Jones and Bartlett Publishers Sudburg Massaehsetts. Pg. No 641-644.
4. https://en.wikipedia.org/wiki/Transitional_care.
5. http://thefutureofnursing.org/resource/detail/transitional-care-model.