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Review article

Continuing care for older patients during the transitional period

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ABSTRACT

Background: The world is facing increasing pressure with the continuous growth of the older population. Older patients are usually discharged with complex medical problems, high stress and vulnerability, and these factors place the elderly at risk for poor outcomes.

Purpose: The present review summarizes a method for providing appropriate and affordable health services by nursing professionals to meet older patient's health care needs during their transitional period which is defined as a period from discharge after hospitalization for a major disorder to recovery in a home setting.

Summary: Older patients with chronic diseases need seamless health care during a transitional period—a highly stressful and vulnerable period for them. Nurse professionals can conduct decent discharge planning to assist older patients with transitional problems through continuous healthcare. This review summarized the need of continuing care for older patients during the transitional period, the definition of discharge planning, the conceptual framework of discharge planning, and the professionals involved in discharge planning. It also highlights the problems of discharge planning and follow up intervention implementation in the mainland of China.

Clinical implications: Inadequate discharge planning and follow-up were leading factors associated with the readmission of discharged older patients. Further nursing-led discharge planning should be reinforced in China.

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1. World facing aging problem

Aging affects quality of life, clinical medicine, society, economics and ethics¹ and is the premier health service global issue. The International Council of Nurses on Healthy Aging² stated that the number of older people in developed and developing countries had noticeably increased during the twentieth century and continued to increase in the twenty first century. Nearly one million people cross the 60-year threshold each month. These people are from developed countries, such as the United States, where the number of older people has been increasing so rapidly that by the year 2013, 44.7 million people will be aged 65 and older, and by 2023, this number is expected to reach 61.4 million, representing approximately 18% of the total U.S. population.³ The report stated that the worldwide aging population was accelerating from nearly 500

million people over the age of 65 in 2008 to an estimated 2 billion in 2050.⁴

In the mainland of China, the percent of people aged 60 and above is 13.26%; therefore, China has the largest population of elderly.⁵ The population survey in 2010 in China showed that the proportion of people aged 65 and above has increased 1.9% since the year 2000. According to a national consensus report, there were 132 million people over the age of 65—approximately 9.7% of the total population in 2013.⁶ These statistics indicate that China's population is aging rapidly, and China is becoming an old society.⁷ By the year 2050, it is expected that 1/3 of the total population of China (i.e., 430 million people) will be aged 60 and above.⁸ In addition to this increasing number of older people in society, the number of older, frail people is also increasing. It is predicted that the “empty nest” of the older family will be approximately 90% by the year 2030 in the mainland of China.⁹ This rapid demographic change in aging will dramatically increase the demands on Chinese health care system and accordingly impact the nursing interventions required for the elderly in hospitals and communities.

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Health and welfare systems across the world are facing increasing pressure with the continuous growth of the older population. Approximately seventy percent of the elderly have chronic disease or disability.^{10–12} The most common chronic diseases afflicting the elderly are adult onset diabetes, arthritis, kidney and bladder problems, dementia, Parkinson's disease, glaucoma, lung disease, cataracts, osteoporosis, enlarged prostate, Alzheimer's disease, macular degeneration, depression, and cardiovascular disease.¹³

Older patients over 65 years accounted for 31 percent of acute care hospital admissions in the United States and 45 percent of hospital expenditures for adults.¹⁴ Facing an aging situation, there are concerns in society regarding the cost and quality of care.^{15,16} Increased attention, to reduce healthcare costs and achieve high quality patient care outcomes, has focused on how patient care is planned and implemented.¹⁷ The affordability of health service for the elderly is also a key concern in China. The health service system in China is facing challenges to provide a cost-effective health service especially for the elderly.

2. Continuing care to meet older patients' needs during their transitional period

Older patients are usually discharged with complex medical problems, high stress and vulnerability, and these factors place the elderly at risk for poor outcomes.^{18,19} Therefore, as the frailest patients, the elderly's' needs for nursing and medical care are often complex.²⁰ Furthermore, older patients with chronic diseases need seamless health care during transitional periods—a highly stressful and vulnerable period. Transitional care, such as a discharge planning program, facilitates the care process from hospital to home. Nurses can assist patients with transitions throughout the health-care continuum.

Health care providers have been concerned with the maintenance and improvement of the quality of care for hospitalized patients and are learning to develop tools to evaluate the quality and appropriateness of care rendered to patients at their institutions. Quality assurance involves monitoring and evaluating the quality and appropriateness of care. The process²¹ focuses on the outcomes of patient care; employs monitoring and evaluation methods to determine quality and appropriateness of patient planning and care; investigates the structure, process, and outcome components of the care provided; seeks to identify deficiencies in care provided and plans interventions to improve care; focuses on identifying appropriate or inappropriate patterns of care within and across hospitals but also conducts individual case reviews as necessary; and identifies ways health care providers can improve their delivery of care.

Older patients cannot often manage their health care needs, especially during their transitional period. Many no longer have family members who can assist with their needs or speak on their behalf. Nurses are expected to take management responsibility for their patient's health care needs. Continuing care is seen by many nurses as requiring skilled nursing input and is described by some nursing commentators to be wholly/unique to the domain of nursing.²² Continuity of care for older patients is recognized as essential for a positive outcome in these patients. Discharge planning for continuing care between hospital and community services provides care as well as cost effectiveness for older patients. Therefore, effective discharge planning is essential to ensure continuity of care.²³

Continuing health care is a coordinated delivery of ongoing health care services over time and across various settings and providers.²⁴ Older patients with chronic diseases are highly stressed and vulnerable immediately following their discharge.

Medical patients are at serious risk of discontinuity of care in the transfer from hospital to community.^{25–29} Older patients, compared with other patients, are particularly concerned about their ability to manage their illness after discharge, and they want more information related to medications, pain management, daily activities, and diet.³⁰ Reed et al³¹ investigated patient (65 and older) characteristics and risk factors at discharge associated with unplanned readmission within 14 days of hospital discharge. They identified that the risk factors included patient admission to two or more hospitals in the previous year, any medication dosage change in the 48 h prior to discharge, and a visiting nurse referral for follow-up. The protective factor, discharge from the geriatric evaluation unit, was also conducted.

Thompson et al³² interviewed twenty patients and their partners one month after a heart attack and concluded that services spanning the immediate post-discharge to early convalescence phase are rarely available. There was a lack of continuity and coordination between hospital and community services. However, this period is the time that the older patients are particularly vulnerable and likely to need support. The transition from hospital to home is characterized by uncertainty, difficulties with coping and distress.³³

3. A discharge planning program is needed in transitional periods

An exploratory descriptive study of ten female patients with myocardial infarction by Jackson and her colleagues³⁴ revealed that recovery was experienced as a complex process, the immediate post-discharge period being initially characterized by internal disorder, fear and uncertainty. A lack of reliable information was revealed throughout the study period, although by the end of the third week following discharge, some of the women had started to actively seek information from various sources.

Wong et al³⁵ demonstrated that patients who were readmitted to a hospital usually had unmet needs and developed complications from existing problems or they had inadequate rehabilitation. Therefore, it was evident that there was a great need for follow-up care after discharge. It was suggested that patients receiving simple advice from a health professional would return to former activities fairly quickly.³⁶ To meet older patients' needs during their transitional period, discharge planning implementation would bring these patients the benefit of collaborative quality improvement across the healthcare continuum.³⁷ Studies have demonstrated positive outcomes for hospitalized elders through continuing care, whereas a lack of continuous care contributes to poor outcomes. A discharge planning program (including home follow-up) has been demonstrated as a clinical pathway for effective continuing care.^{38–40}

4. Discharge planning

Adequate discharge planning is essential to ensure continuity of care.³⁷ Being involved in discharge planning will help ensure that patients receive the most appropriate level of care; have a planned post hospitalization program to meet continuing care needs; remain in the hospital for the shortest length of time; receive the highest level of quality care; and are not hospitalized unnecessarily.²¹

Discharge planning assists patients in connecting with caregivers and primary care providers about how best to manage their chronic needs after leaving the hospital.⁴¹ Discharge planning was defined by McKeehan⁴² as a process of activities that facilitate the transition of a client from one environment to another, with the

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