Aged Care Research & Industry Innovation Australia

Evidence Theme

Transition care

REHABILITATION, REABLEMENT, & RESTORATIVE CARE

This evidence theme on transition care is a summary of one of the key topics identified by a scoping review of rehabilitation, reablement, and restorative care research.

Key points

- Successful transition care services should incorporate multidisciplinary care teams, proactively support those at risk of delayed discharge, consider individuals with cognitive impairment, and involve family carers.
- Transition care services should consider developing and integrating educational resources that explain the recovery process, prepare individuals for what to expect on returning home, and allow for improved communication and goal setting.
- Appropriate technology should be integrated into transition care services to improve knowledge dissemination, communication, access to care, and discharge planning.

What is transition care?

Transition care programs (TCPs) provide services that support older adults returning from hospital to their own home. Some individuals receive TCPs in residential aged care facilities to support a return home. These packages are time-limited (up to 12 weeks), personalised to the individual, and provide restorative care. [1] Transition care often consists of nursing, occupational therapy, physiotherapy, and other support services such as cleaning and shopping assistance. [2] These services aim to restore function and enable older adults to live as independently as possible in their own homes, whilst preventing hospital readmission and premature admittance to residential aged care facilities. [3]

What do we know about the delivery of transition care services?

Overall, each review reported specific, yet different research aims with some similarities. Three reviews examined qualitative evidence to determine:

- the perspectives of patients with hip fractures using transition care [4]
- experiences of patients with dementia using transition care [5]
- how active involvement in care affected the experience of transition from one environment to another. [6]

Three reviews focused on the outcome measures used in transition care services [5, 7, 8] and a further three investigated interventions provided in transition care. [9-11] The remaining reviews examined:

- the extent to which community participation was considered in transition care services [1]
- the specific roles of rehabilitation professionals in transition care [10]
- the adaptation of the oldest old returning home following discharge from intensive care [12]
- the importance of discharge preparation and continuity of care. [13]

The reviews identified that:

- Experiences of transition care could be improved with better information provision to service users on what to expect when returning home, [1] an increased understanding of care provider roles, and a more organised discharge planning process. [4]
- Technologies such as video conferencing might be used to reduce barriers to care such as distance, allow planning and delivery of services, and improve communication and care between service providers. [4, 14]
- Transition care for older adults is an integral service that can reduce rehospitalisation rates. These services need to be delivered by professionals who plan, deliver, direct care, carry out regular assessments, and communicate effectively with older adults and family carers. [10, 13]
- Older adults discharged from intensive care units require individualised and continued care following discharge home to allow them to regain their independence and prevent rehospitalisation. [12]
- Barriers to accessing transition care include the readiness of healthcare services to deliver care, poor process planning, and older adults' knowledge and uptake of supportive services. [9]
- Transition care services should support older adults to maintain the leisure and social activities they deem important. Continued participation can improve mobility, reduce falls, and increase community involvement and health-related quality of life. [1]
- Following the completion of transition care programs, it is unclear whether older adults regained their previous levels of mobility and independence. [7] Further evidence is required to determine whether continued support is required following the cessation of transition care packages.
- Transition care services commonly provided education and goal-orientated exercise and social support interventions addressing the older persons' mobility, rehabilitation, and activities of daily living. Treatments focus on transfers, stair climbing, strength and balance exercises, and the provision of mobility aids. [8, 11]
- The implementation of transition care for older adults living with dementia is not well understood and raises clinical concerns for the focus of person-centred, individualised, high-quality care whilst long-term support is being arranged. [5]

What can an individual do?

- Individuals should consider the difficulties faced by older adults returning home from the hospital and be involved in discharge and transition care planning at the earliest possible opportunity.
- Support the independence of older adults and promote individuals to retake ownership of their personal care and activities of daily living.

What can the organisation do?

- Organisations can develop and integrate additional resources that detail the recovery process, prepare individuals for what to expect on returning home, and allow for improved communication of support services available to older adults transitioning between care settings. [1, 4]
- Assess the needs of service users before, during, and after a care transition to deliver effective patient and family-centred care across a range of settings [4] and consider the development of transition care plans for each long-term patient whilst still in the hospital to aid better recovery and rehabilitation following hospital discharge. [12]
- Design and provide transition care services that incorporate multidisciplinary care teams, proactively support those at risk of delayed discharge, consider individuals with cognitive impairment, and involve care partners. [8]
- Support staff to recognise all states of patient involvement as valid, reflect on how their behaviours can influence involvement, and understand how these can impact patient safety and experience. [6]
- Support research to identify which aspects of transition care contribute to a successful discharge. [7]

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