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# **A Qualitative Study of Older Patients' and Family Caregivers' Perspectives of Transitional Care From Hospital to Home**

## **ABSTRACT**

**Background and Purpose:** The need for high-quality long-term healthcare services is increasing across the globe as the population ages. Strategies for improving transitional care from hospital to home are needed. This study aimed to explore the perspectives of patients aged 65 years and over and their family caregivers transitioning from hospital to home in an urban area of Turkey.

**Methods:** Thematic analysis of in-depth semi-structured interviews was conducted with older patients (n=14), with at least one chronic disease and admitted to the hospital for a minimum of 3 days, and family caregivers (n=11) who voluntarily participated.

**Results:** Main themes were 'confused feelings of safety and stress'; 'worried about being left alone'; and 'disrupted healthcare journey'. The proactive rehabilitation model was used to elaborate on the study findings and interpret the perspectives and experiences of older patients and their family caregivers, which can be used for improving the quality of care after discharge from hospital.

**Implications for Practice:** A high-quality transitional care programme requires taking care of the feeling of safety in older patients and their family caregivers by the multidisciplinary team and their enhanced involvement in care initiatives after hospital discharge.

**Keywords:** continuity of care, interdisciplinary care, nursing, older patient, safe care, transitional care, feeling of safety

## **INTRODUCTION**

The reported growth in the numbers of people aged 65 years and over is currently 8.5% worldwide (National Institutes of Health, 2016). According to the report by the World Health Organization (WHO) entitled "An Aging World: 2015", this percentage will jump to nearly 17% of the world's population by 2050, which translates to 1.6 billion people (WHO, 2011, 2016). WHO has declared 2020s as the decade of healthy aging, but older people are hospitalized three times as often as young adults and almost half of healthcare expenditure is spent on their hospitalization (US Centers for Disease Control and Prevention, 2010; WHO, 2020). Further it has been reported that almost 21% of all hospitalizations are readmissions (Kaya, Guven, & Aydan, 2018; Shebehe & Hansson, 2018) and older people with multiple chronic conditions are more likely to be readmitted within 30 days following hospital discharge

compared to those without any chronic condition (Lochner, Goodman, Posner, & Parekh, 2013). The increased number of chronically ill older people requires extensive health and aged care facilities by multiple healthcare providers across multiple care settings (Naylor & Sochalski, 2010) and frequent transfer between hospital and older people's own homes (Allen, Hutchinson, Brown, & Livingston, 2014). Therefore, placing the care needs of older adults at the centre of healthcare with respect to their preferences, living conditions, and facilitating their access to private and community healthcare resources can improve their quality of life (Allen et al., 2014). In this respect, the WHO's guidelines on Integrated Care for Older People (ICOPE) propose evidence-based recommendations to improve the health and well-being of older people and to move closer to achieving appropriate health coverage for the older generation in both urban and rural areas (WHO, 2017).

### **Significance of transitional care and family involvement**

Transitional care is defined by the WHO as the various points where a patient moves to, or returns from, a particular physical location or makes contact with a healthcare professional for the purposes of receiving health care, which includes transitions between the patient's own home, hospital, residential care settings and consultations with different health care providers in out-patient facilities (WHO, 2016).

One important aspect of health-related quality of life for older people is their safe access and transition to community healthcare services after hospital discharge. It has become clear how much patients and their family caregivers are challenged by poorly planned transitions. Studies on older patients with long-term mental health conditions report a high burden of care due to less than optimally treated physical, psychosocial and spiritual symptoms as well as high stress levels in caregivers particularly for the coordination and continuity of care in the patient's own home, which leads to frequent readmissions and an over use of healthcare services (Miyasaki & Kluger, 2015; van Vliet et al., 2016). Many older people need to be transferred to long-term care facilities and nursing homes after discharge from hospital. However, transition of care to their own home is encouraged in order to prevent rehospitalization and reduce healthcare costs (Carnahan, Unroe, & Torke, 2016).

The healthcare system's priority is to return patients to their own home being the place of greatest independence and comfort. Consequently, transitional care has been recognized as a vital component of the quality provision of healthcare in the shifting approach from hospital-centred care to home-centred care. It is associated with a reduction in the length of hospital stay, facilitating transfer of care from hospital to the community healthcare settings, reducing

emergency department visits, 30-day re-admissions following hospital discharge, healthcare costs, and improving patient safety (Allen et al., 2014; Rennke & Ranji, 2015).

Current transitional care programmes have been established based on the principles of multi-disciplinary collaboration, telephone follow ups as well as personal visits and the overall satisfaction with care in both healthcare providers and patients (Reeves et al., 2017; Schaeffer et al., 2018; Smith, 2016). Older adults, including those with long-term physical and psychological conditions, have been shown to benefit from transitional care programs with the involvement of patients and their families in terms of follow up visits and post-discharge assessments to ensure addressing their unmet needs (Altfeld et al., 2013; Detering, Hancock, Reade, & Silvester, 2010). However, further studies should be done to improve our knowledge of how transitional care programmes can improve patients' and their family caregivers' wellbeing and safety after discharge to their own home (Prusaczyk, Olsen, Carpenter, & Proctor, 2019).

The responsibility of facilitation of access to high-quality care and safety of patients' journey throughout the healthcare system is shared with patients and their family caregivers. Caring attitudes in the care continuum are developed through the participation of family caregivers and are the main aspects of a successful transitional care programme (Mitchell et al., 2018). The concept of family-assisted therapy aims at defining family caregivers' role in healthcare settings to have a complementary contribution to rehabilitation through training and supportive policies (Lawler, Taylor, & Shields, 2019). Accordingly, informal caregivers are placed in the best position for collaboration in the care plan and can resolve health and well-being-related issues and reduce healthcare costs (Bogaisky & Dezieck, 2015; Murray, Hardicre, Birks, O'Hara, & Lawton, 2019). However, there is a gap in our knowledge about how family caregivers can be empowered and involved in the care process at home (Allen, Hutchinson, Brown, & Livingston, 2017; Donald et al., 2015; Toles, Colón-Emeric, Naylor, Asafu-Adjei, & Hanson, 2017).

### **Background to transitional care in Turkey**

Patients aged 65 years and older represent nearly half of hospitalized patients in Turkey (Ministry of Health of Turkey, 2016). They are frequently transferred between the hospital, nursing homes and their own home for receiving acute, subacute, and long-term care (Naharci & Ouslander, 2016). While long-term care facilities provide healthcare services by nurses to dependent older people and those who need care (Ozmete, Gurboga, & Tamkoc, 2016), those older patients who are discharged from hospital to their own home undergo monitoring and

follow up by general practitioners and home healthcare services by the municipality or private sectors (Albayrak, Kahveci, Özkara, & Kasim, 2014; Torun, Tengilimoğlu, & Khan, 2016). Older patients after hospital discharge are referred to the outpatient clinic for follow-up care, control, and examinations related to the causes of hospitalization. Outpatient clinics are available for further consultations by specialists regarding therapeutic regimens (Republic of Turkey Social Security Institution, 2006). No standard model of transitional care services for older patients have been devised in Turkey (Albayrak et al., 2014; Naharcı & Ouslander, 2016), but efforts have been made to raise the level of priority of older people care in policy makers' agendas in order to improve their satisfaction with care and well-being in the healthcare journey (Caner & Cilasan, 2019).

There are growing numbers of qualitative studies on issues and unmet needs of older patients and the ineffectiveness of transitional care (Allen et al., 2017; Storm, Siemsen, Laugaland, Dyrstad, & Aase, 2014), but there is a lack of understanding of this phenomenon in Turkey. Variations in transitional care strategies in various healthcare systems (Rennke & Ranji, 2015) highlight the need to study it in different contexts and regions. Moreover, data collection regarding transitional care from hospital to own home from the perspectives of both older patients and their family caregivers can provide a comprehensive and insightful image of transitional care practice.

### **Theoretical background**

The proactive rehabilitation model has been chosen to illuminate the study findings and understand what interventions should be done by healthcare providers to help older patients and their family caregivers after hospital discharge in the process of transitional care to their own home.

Accordingly, healthcare professionals proactively help physically and mentally disabled older patients regain the highest levels of functional autonomy, well-being, quality of life, independence in the activities of daily livings and safety at home (Boult et al., 2009). This model comprehensively considers the proactive role of healthcare providers and their commitment to help older patients return to the normal life condition in their own home after hospital discharge. Therefore, (i) appropriate multidimensional assessments of the older patient's health condition by healthcare professionals are made; (ii) care planning is carried out in terms of education and training (Gill et al., 2002), medicines management (Tinetti et al., 2002; Ruikes et al., 2018), home modifications, problem solving, recovery techniques and safe performance (Gitlin, Hauck, Winter, Dennis, & Schulz, 2006; Bouman et a., 2008) for relieving

the underlying impairment impacting on their physical and psychological wellbeing; (iii) monitoring and follow up is carried out to assist with the implementation of caring strategies at home and improve the success of home care (Tinetti et al., 2002; Ruikes et al., 2018).

It has been shown that the application of this model in community healthcare settings can reverse frailty and enhance physical, mental, cognition, emotional, and social well-being in older patients (Tarazona-Santabalbina et al., 2016). It has also been effective for reducing healthcare costs including the reduction of hospital readmissions and emergency department visits (Donald et al., 2015; Polinski et al., 2016; Van Spall et al., 2017).

### **Purpose of the study**

This study aimed to explore the perspectives of patients aged 65 years and over and their family caregivers transitioning from hospital to home in an urban area of Turkey.

## **METHODS**

### **Design**

A qualitative exploratory descriptive study was conducted to enhance our understandings of contextual and cultural factors influencing the study phenomenon. The consolidated criteria for reporting qualitative research (COREQ) guideline was used for reporting this study (Tong, Sainsbury, & Craig, 2007).

### **Participants and settings**

Eligible participants were older people ( $\geq 65$  years) with at least one chronic disease who had been admitted to the hospital for at least three days. The patients were visited within two weeks of their discharge by the first author (ID). Purposive sampling was used to select the participants using the above-mentioned eligibility criteria (Holloway & Wheeler, 2010). Those with dementia or delirium according to hospital health records were excluded. Eligible family caregivers were the daughters, sons, and spouses of the older patients, aged over 18 years who helped them in the process of transitional care. A maximum possible variation in sampling in terms of gender, education level, and relationship with the older patient was considered.

Recruitment was performed during a two-month period from 11 February 2019 to 27 April 2019. Invitations to participate were made to 77 older patients and their family caregivers, who had been hospitalized with any type of chronic disease and spent at least three days in the internal medicine or palliative care wards in one teaching hospital. The first author (ID) reviewed the hospital records in conformity with the inclusion criteria, and contacted the older patients via phone and invited them to participate in the study. Those older patients and family

caregivers who accepted the invitation were visited and interviewed in their own home convenience to them. Patients and caregivers were interviewed individually and each participant completed a demographic questionnaire. All participants approached agreed to take part in the study.

### **Ethical considerations**

Approval to conduct this study was obtained from the research ethics committee of the University in which the second author (MIN) worked and the Board of Specialty in Medical Education of the hospital (decree code: 18/285) before commencing the study. All participants were informed of the study's aim and process. Verbal and written informed consent and permission to audio record the interviews were obtained from the participants prior to data collection. To ensure the confidentiality of participant information, transcripts were de-identified by allocating a pseudonym and code number. Interview transcriptions were used only for this research project.

### **Data collection**

An interview guide was developed and comprised of the following questions: What are your experiences of care transitioning? How was transitional care provided to older patients? How is the process of care at home after discharge from hospital? What concerns or challenges do you have during home care? How do you manage challenges of care at home? Furthermore, probing questions were asked to improve the depth of the interviews. The interview guide was pilot-tested with two participants and some modifications were made to improve the flow of the interview process.

The participants were interviewed in the Turkish language by the first researcher (ID). To ensure the participants' privacy and confidentiality, the interviews were conducted in their own home. The interviews' length varied from 15 minutes to 60 minutes and each participant was interviewed once. Data collection and analysis were simultaneously conducted with interviews ended as data saturation was reached to minimise participants' time burden as any additional collected data did not add to the variation and depth of findings.

The demographics questionnaire gathered information about the participants' age, gender, education level, older patients' relationship with the family caregiver, work experience and employment status of caregivers, and people living with them.

### **Data analysis**

Demographic data of the participants was transferred into Microsoft Office Excel<sup>®</sup> to report frequencies and percentages. The audio-recordings of the interviewees were transcribed

*verbatim* immediately after data collection by the first author (ID) who was an experienced qualitative researcher. A thematic analysis method (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013) was conducted for data analysis by the research team using an inductive approach. Thematic analysis helps with identifying, analysing, and reporting themes within data. For developing themes, the following steps were taken: (a) reading through the transcriptions several times for familiarizing with data, (b) generating initial codes through open coding and managing the codes using the R package as computer-assisted qualitative data analysis software, (c) developing themes and subthemes through an iterative process of comparing and contrasting codes in terms of similarities and differences, (d) reviewing and refining themes, and (e) identifying and naming themes and subthemes by the research team through holding discussion and reaching agreements.

### **Rigor**

The authors collaborated in coding the data and discussed the analysis process until themes were finalized. Triangulation was employed through comparison of the older patients' data to the caregivers' data in order to provide a more nuanced and contextualised interpretation of the data through writing. The interviewer tried to set aside her own presuppositions on the study phenomenon through writing field notes and only focused on the participants' perspectives during the interviews to ensure of reflecting their perspectives in the findings. The authors frequently assessed the analysis process to achieve a plausible and coherent description and interpretation of the study phenomenon. Also, a brief report of findings was provided to four participants to become ensure of appropriate reflecting of their experiences and perspectives. To allow for external auditing, a brief report of the study findings was given to two qualitative researchers who confirmed the data analysis process (Lincoln & Guba, 1985). The first author, as the bilingual researcher, ensured the validity of translation of the findings from Turkish to English for the purpose of publication.

### **RESULTS**

The participants consisted of 14 older patients and 11 family caregivers. Of them, 12 patients and five family caregivers were recruited from the internal medicine ward, and three patients and five family caregivers from the palliative care ward.

The older patients (n=14) and family caregivers (n=11) had a mean age of 79 years (range=67-90 years) and 47 years (range=32-60 years), respectively. The older participants' length of stay in the hospital was eight days, with a minimum and maximum stay of three and 15 days, respectively. Within the first two weeks after discharge from hospital, 11 older patients



visited emergency services or outpatient clinics and four of them were readmitted to hospital. The majority of the older participants were cared for by their own children (79%) at home. Family caregivers were mostly female (64%) and had a high school education level (58%). Also, 45% of them had more than four years' experience of caring and 46% had a fixed-work schedule (Table 1).

**Table 1.** Demographic characteristics of the older patients and their family caregivers

<b>Demographic information of older patients (n=14)</b>	<b>n (%)</b>	<b>Demographic information of family caregivers (n=11)</b>	<b>n (%)</b>
<b>Gender</b>		<b>Gender</b>	
Male	5 (36)	Male	4 (36)
Female	9 (64)	Female	7 (64)
<b>Education level</b>		<b>Education level</b>	
Illiterate	2 (14)	High school	8 (58)
Literate	1 (7)	University	3 (14)
Primary school	8 (58)	<b>Working status</b>	
High school	2 (14)	Fixed work schedule	5 (46)
University	1 (7)	Rotating shift work schedule	2 (18)
<b>Older patients' relationship with carers</b>		Unemployed	4 (36)
Spouse	2 (14)	<b>Experience of caring</b>	
Daughter/son	11 (79)	Less than 1 year	4 (36)
Paid carer	1 (7)	1-4 years	2 (18)
<b>Living alone</b>		5-7 years	5 (45)
Yes	2 (14)		
No	12 (86)		

The data analysis process on 477 initial codes from the interviews with the older patients (OP) and family caregivers (FC) led to developing three main themes: 'confused feelings of safety and stress'; 'worried about being left alone'; and 'disrupted healthcare journey'. Although the older patients and their family caregivers described their own perspectives, they mainly confirmed each other regarding various factors influencing transition of care to their own home. The themes with their descriptions and supported by the participants' direct quotations are provided.

### **Confused feelings of safety and stress**

There was a mixed feeling of satisfaction and dissatisfaction with discharge from hospital and transfer of care to own home among the participants due to the feeling of safety and being anxious of how to follow up their therapeutic regimen without a direct supervision by their own healthcare provider.

Satisfaction with an early discharge from hospital and the related feeling of safety at home was associated with avoiding hospital-acquired infections. Since older patients were more likely to acquire an infection during hospitalization, minimizing the length of hospital stays reduced this risk. Moreover, the older patients had more feelings of comfort, could sleep better in their own home and follow their daily life routines as they wished.

*“It was not helpful to stay at the hospital for a long time and could lead to more harm than benefit. There was a risk of getting a hospital infection.”* (FC 17)

*“Although it can be distressing for my mother and I to commute [to the hospital], it is good for my mother to get back to the normal life.”* (FC 15)

Transfer of care to their own home helped the older patients to feel more independence in daily life activities.

*“I said that I do not stay in bed, I am going to [the] kitchen ..., then I have my breakfast, I wash dishes..., I do not have the strength like before, but I know that it is normal.”* (OP 8)

A family caregiver stated: *“Before hospitalization, she was cleaning, cooking, and meeting all her needs without any help ...now she wants to walk. That is why she tries to properly eat...so she is diligent and does not surrender.”* (FC 17)

On the other hand, the participants mainly felt stress during the first day after hospital discharge due to being concerned about the older patients’ ongoing symptoms, unawareness of what they should do in critical situations, and the possibility of medicines’ side effects and potential adverse drug reactions.

*“A person like me who has been discharged with such a severe illness should not be said just ‘goodbye’ at the hospital door, because I do not return to a normal life. I am in a stressful situation. I have a rash on my skin and I do not know why it has been caused, or perhaps it is due to my medicines.”* (OP 1)

Another source of concern was follow up care at hospital settings, in terms of control and examination scheduling following discharge, booking an appointment, long waiting times and difficulties with access to specialist clinicians. Therefore, they preferred that all therapeutic interventions be completed before discharge.

*“They should not have discharged me to home, because this is difficult to book and catch the appointment. I am going to the outpatient clinic next week. I would feel safe if there would be treated at the hospital before discharge.”* (OP 11)

Continuance of some symptoms related to the older patient’s health condition after hospital discharge created a stressful situation for them. It was believed that older patient’s

complaints were not heard and clinical decisions for transition of care were made without the consideration of their health condition.

*“I returned [home], my blood pressure rose again, as I suffer from high blood pressure; I am scared of it. New medicines were given instead of paying attention to my current problems and checking those medicines given by the cardiologist.” (OP 9)*

*“I take a lot of medicines for high blood pressure, diabetes, heart disease..., I said to my physician to cut my prostate medicine; however, I still take almost 10 medicines daily. I take five medicines in the morning. Do I have to take all at once, or do I need to take them separately? (OP 1)*

Transition between outpatient clinics and home for follow up examinations was another source of stress for older patients and their family caregivers due to the difficulty in the transportation of older patients from their own flat to the ground floor, distance to the hospital and cost of transfer.

*“You know, my mother gave a blood test, and it was said that the results would be given a few days later ... There is not a bus from here to the hospital ... and every transfer by the taxi is costly ...” (FC 5)*

*“There is no elevator in every house. I sat my mother on the chair, then took her to the down stairs [the ground floor].” (FC 17)*

### **Worried about being left alone**

The facilitation of access to specialist clinicians or nurses after discharge was recognised as the source of being taken care of by the healthcare system. The possibility of checking on the older patients in emergency situations by calling them, and possibility of family caregivers calling the healthcare staff in the post-discharge period was highlighted as ways to decrease the feeling of remaining alone in care transitioning to own home.

*“We need someone who we can make a call to report that the blood pressure drops and asks for help and follow up ...” (FC 12)*

For instance, an older patient said: *“I contacted him [doctor] about newly prescribed medicine that led to allergy symptoms. The doctors just discontinued it [medicine]. Therefore, I feel that somebody take care of me.” (OP 15)*

The advanced online appointment systems and the lack of older patients' and their caregivers' knowledge of how to work with electronic devices were considered barriers to communicate with healthcare staff and make the bookings. The feeling of being separated from

healthcare services and difficulty to meet the needs of the older patients increased when the older patients were bound to bed or could not move.

*“That is to say, I am waiting, because I did not book appointment via the central appointment system of the hospital. My phone is already very old and outdated so I am unable to access the online appointment system. I do not know how to get connected with healthcare services.”* (OP 8)

A family caregiver mentioned: *“...for example, there are stitches on her ear...we had to come to this place [hospital] for removing stitches from the ear and dressing was changed ten days late due to issues in booking appointments and inability to communicate with our care provider.”* (FC 9)

### **Disrupted healthcare journey**

There was a lack of holistic plan in the healthcare system towards transitional care and the continuance of care in the post-discharge period. Accordingly, misperception of older patients and their family caregivers of their role and involvement in the therapeutic plan after discharge and lack of effective communication and transfer of information between healthcare settings resulted in the disruption of home care and hospital readmission.

Participants stated that doctors and nurses did not give enough information about the patient’s diagnosis, medications, treatment protocols and discharge planning during hospital discharge due to excessive workloads. Also, jargonistic language was used when talking about the patient’s health situation and not enough time was provided to the older patients and their family caregivers to ask their questions. Consequently, unanswered questions and uncertainties, and lack of understanding of how to follow up the care process led to confusion regarding how to stick with transitional care and revisiting healthcare settings.

*“I think that they [medical doctors] have to talk and describe, so they should not only say ‘this has been recovered, or that have not been changed’. It is said ‘take your patient to physical therapy’, but the reason is not explained.”* (FC 4)

An older patient said: *“They [medical doctors] said there was a problem with my liver and I can not remember its medical term. But, they did not say what the problem was and what I should do. When I get swollen [acid in the abdomen] or I have something worse I get back.”* (OP 8)

Older patients and their family caregivers were not provided with written information about the treatment protocol, medications, physical activity, and disease-specific recommendations on diet, and how to care for older patients. Written information removed

uncertainties on the arrangement of future consultations and examinations in outpatient clinics, because verbal information could have been forgotten due to the stressful situation during discharge.

*“For example, medicines and anything that should not be eaten can be listed, and given to us in the written format. When I have any question, I can look at the document and find the answer.”* (FC 9)

*“I did not have enough knowledge about them [required treatments]. He [the older patient] was hurriedly discharged. We came home without enough information.”* (FC 5)

Some older patients changed medicines’ doses, or quit them, based on their own decisions, because the therapeutic regime did not manage all chronic symptoms and they were not informed by healthcare staff of the consequence of lack of adherence.

*“I take a lot of medicines for my blood pressure, diabetes, heart diseases, ..., prostate. I can not take my eyes away from the clock. I am going out with a box of medicines in my pocket. So I feel like an addicted person to medicines.”* (OP 1)

A family caregiver stated: *“I am changing it [dosage of medicine], because I have no continuous access to doctors to adjust it [determine the right dosage], and I am adjusting its dosage based on the result [the international normalized ratio (INR)] to remain between 2-3...I know that it can be dangerous.”* (FC 11)

Incompliance with transitional care and lack of the feeling of support were attributed to not being updated of diagnosis and treatment steps by healthcare providers. Therefore, the older patients and their family caregivers were not empowered for following the recommended regimen at home.

*“They [doctors] do not ask me [about patient’s situation] about what I feel and what is going on with me ...”* (FC 4)

An older patient added: *“To feel supported, the doctor should call me that I can ask my questions about what will be the next step.”* (OP 9)

However, the family caregivers innovatively filled out the gap in their knowledge through relying on their own previous experiences in caring or seeking information about diseases and medicines from a relative with similar health conditions in order to manage health-related issues at home. In addition, when the family caregivers faced challenges with how to access healthcare information, they used public media to find answers to their questions.

*“Of course, I cannot benefit from healthcare services, because I do not have easy access to them. I seek for information if one of my family members or relatives have encountered similar problems in in the past.”* (FC 15)

*“Things mainly happen at home and the patient is a bit worried. I can find answers to small inquiries from media. so I should not necessarily wait for healthcare staff.” (FC 17)*

Information transfer between outpatient clinics and hospitals was inadequate for the continuity of the treatment process. Despite the older patients’ clinical records in the hospital, sometimes they had to describe all details of their health problems and medicines to other doctors and disclose all health records verbally to other hospitals’ staff. Repeated medical examination by multiple medical doctors at the outpatient clinic interrupted their treatment process and led to delays in making therapeutic decisions.

*“... They [healthcare staff] are just putting the patient on a drip in the emergency department or order a blood test and that is all. They do not try to get information from other healthcare settings of what has been done before for the patient.” (FC 3)*

*“I should share information about the older person everywhere [to doctors], because they order to repeat tests [blood tests], as we have a lot of trouble with repeating tests and going through examinations. The physician [in the internal medicine outpatient clinic] did not know about the patient’s health status...” (FC 3)*

When emergency department visits were necessary, ambulance services transferred the older patients to hospitals that were selected automatically by the emergency centre. Consequently, doctors and nurses were unable to arrange follow-up with transitional care because of not having background knowledge of the older patients’ health history.

*“I do not use the emergency and ambulance services to transfer the patient; they would transfer the patient to another hospital and therefore, healthcare staff have no knowledge of my health condition and do not know how to help.” (FC 16)*

## **DISCUSSION**

This is the first qualitative study on the perspectives of older patients and their family caregivers transitioning from hospital to home in an urban area of Turkey. Exploration of various factors affecting the feeling of safety in older patients and addressing related concerns during the provision of home care services have been emphasised in the international literature in order to devise a successful and high-quality care programme (Lang, Edwards, & Fleiszer, 2008; Leine, Wahl, Borge, Hustavenes, & Bondevik, 2017).

According to the proactive rehabilitation model, efforts by healthcare providers aiming at safe transitional care for older patients to own home depend on an appropriate multidimensional assessments of the older patient’s health condition of all factors affecting physical and psychological well-being and feeling of safety in older patients during the process of home care

(Boult et al., 2009). In this model, a safe transitional care programme requires an appropriate and adequate assessment of a patients' health and social condition before the development of individualised care, information support, preparation of the home environment after discharge, and communication and follow-up visits (Boult et al., 2009; Daliri et al., 2019; Storm et al., 2014). Similarly, this research improved our knowledge and understandings of how the participants felt unsafe and what factors increased their worries when transitioning to their own home. According to our study findings, the participants felt more safe and less stress at home, which was related to a reduction in patient safety incidents and feeling more independent and able to stick to their daily life routines. It is believed that involvement in the activities of daily living and being able to handle personal life affairs affect on the feeling of well-being in transitional care to own home (Andreasen, Lund, Aadahl, & Sørensen, 2015). In our study, age-related issues, the continuance of symptoms after discharge, inappropriate discharge and follow up plan after arrival to own home were stress factors for the participants. Similarly, Hench (2014) believes that illness-related symptoms, lose of control over the life situation, uncaring healthcare provider and unpredictable health conditions are the sources of feeling unsafe at home. Generally, difficulties in managing home care after discharge and complex health problems with respect to daily living and safety concerns are challenges to transitional care for older adults (La Manna, Bushy, & Gammonley, 2018; Neiterman, Wodchis, & Bourgeault, 2015; van Seben et al., 2019).

In the proactive rehabilitation model, care planning is carried out after a thorough multidimensional assessment in terms of education and training, medicines management, home modifications, problem solving, recovery techniques and safe performance in order to relieve the underlying impairment impacting on older patients' physical and psychological wellbeing (Boult et al., 2009). Our study participants believed that the continuity of care in transitional care depended on devising a holistic plan to meet their psychological needs and answer their concerns regarding medicines management, communication of the transitional care programme to the older patients and their carers in the written format and their active participation in care. A patient-centred programme with an emphasis on positive relationships with patients and engagement of both patients and their informal caregivers at the time of discharge has been emphasised in order to help with adherence to the therapeutic plan at home (Okraïnec et al., 2019). Also, respecting the patients' and their family caregivers' preferences to be empowered in transitional care can be reached through the provision of an opportunity to negotiate various aspects of the transitional care programme (Allen et al., 2017). If patients gain sufficient knowledge and a participatory attitude towards their own care (Storm et al., 2014; Vaismoradi,

Jordan, & Kangasniemi, 2015) through patient- and caregiver -centred communication and shared decision-making (Lindahl, Lidén, & Lindblad, 2011; Verhaegh, Jepma, Geerlings, de Rooij, & Buurman, 2019), the success of long-term care at home is guaranteed. Not being prepared or not giving sufficient and clearly outlined information regarding the discharge plan and interrupted process of information exchange between care settings enhance patients' concerns regarding the safety of care at home (Nielsen, Gregersen Østergaard, Maribo, Kirkegaard, & Petersen, 2019). Examples of endangering patient safety by medication errors due to inappropriate discharge programmes have been provided in the international literature (Hestevik, Molin, Debesay, Bergland, & Bye, 2019; Southerland et al., 2019).

According to the proactive rehabilitation model, monitoring and follow up is crucial to ensure of the implementation of caring strategies at home (Boult et al., 2009). Our study findings indicated that the facilitation of access to and education regarding how to contact with healthcare providers for follow up care and in emergencies situations, and the consideration of their knowledge of the use of internet were required to enhance the quality of the older patients' monitoring after hospital discharge. Facilitating patient's access to healthcare staff is the antecedent of the feeling of safety and consequently leads to his/her hope and calm (Mollon, 2014). However, discharge instructions often fail to provide enough instructions about how to access healthcare professionals and address acute care issues following discharge (Horstman et al., 2017). Integrated systems between hospital and community care, provision of multidisciplinary healthcare, initiating discharge planning in hospital, facilitating access to specialist for follow-up care and assigning a nurse as a clinical leader who arranges in-person home visits can facilitate follow up care and reduce the number of unnecessary hospital readmissions following hospital discharge (Coffey et al., 2019; Naylor & Sochalski, 2010). As a general notion, the delivery of community services via the internet also is a big challenge, because older people often prefer to discuss their health issues face to face and often due to not being familiar with how to navigate and utilize the internet for seeking reliable sources care (Andreasen et al., 2015).

### **Strengths and limitations**

The concurrent collection of data from both older patients and their family caregivers and consideration of their concerns and feelings of safety in transitional care from hospital to home are the strengths of this qualitative study. Conducting this study only in an urban area in Turkey causes limitation that may influence the transferability of the findings to other contexts. However, similar difficulties with transitional care in Turkey appear across various cultures/delivery systems. Therefore, our findings have implications for the improvement of the



quality of transitional care and reduction of unplanned hospital readmissions, emergency department visits, and overall healthcare costs across the globe.

## **CONCLUSION**

The results of this study provide evidence about factors affecting transitional care. Understanding these factors can help with designing future transitional care interventions by the multidisciplinary team using the incorporation of the perceptions of older patients and their family caregivers who should be actively involved in the process of transitional care.

## **IMPLICATION FOR PRACTICE**

Improving the quality of transitional care for older people and their family caregivers from hospital to their own home needs the consideration of their feeling of safety, capacity for continuing their daily life routines and ability to adhere to the therapeutic regimen at home. Provision of education and encouragement of their participation in the care process should be also emphasised when devising transitional care programmes by healthcare professionals. In addition, strategies should be devised regarding the facilitation of their access to healthcare settings and professionals after discharge and easy exchange of information between short-term and long-term healthcare settings.

Future research needs to collect data regarding the perceptions and experiences of healthcare service providers, policy-makers, and decision-makers using qualitative and quantitative research methods. Also, practical models aiming at the improvement of the quality of transitional care for older patients with chronic diseases from hospital to their own home should be devised and tested.

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