



Optimising nursing care of people living with dementia who transfer between hospitals and nursing homes



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Acknowledgement

'This work was funded by Alzheimer's Society (UK) Doctoral Training Centre in Dementia Care grant 224, with support from Skipton Building Society and Malcolm Joyce in memory of his wife Jean'

Supervisory Team



What is transitional care?

This study is focused on transitional care for people living with dementia when they move between hospital and nursing home.

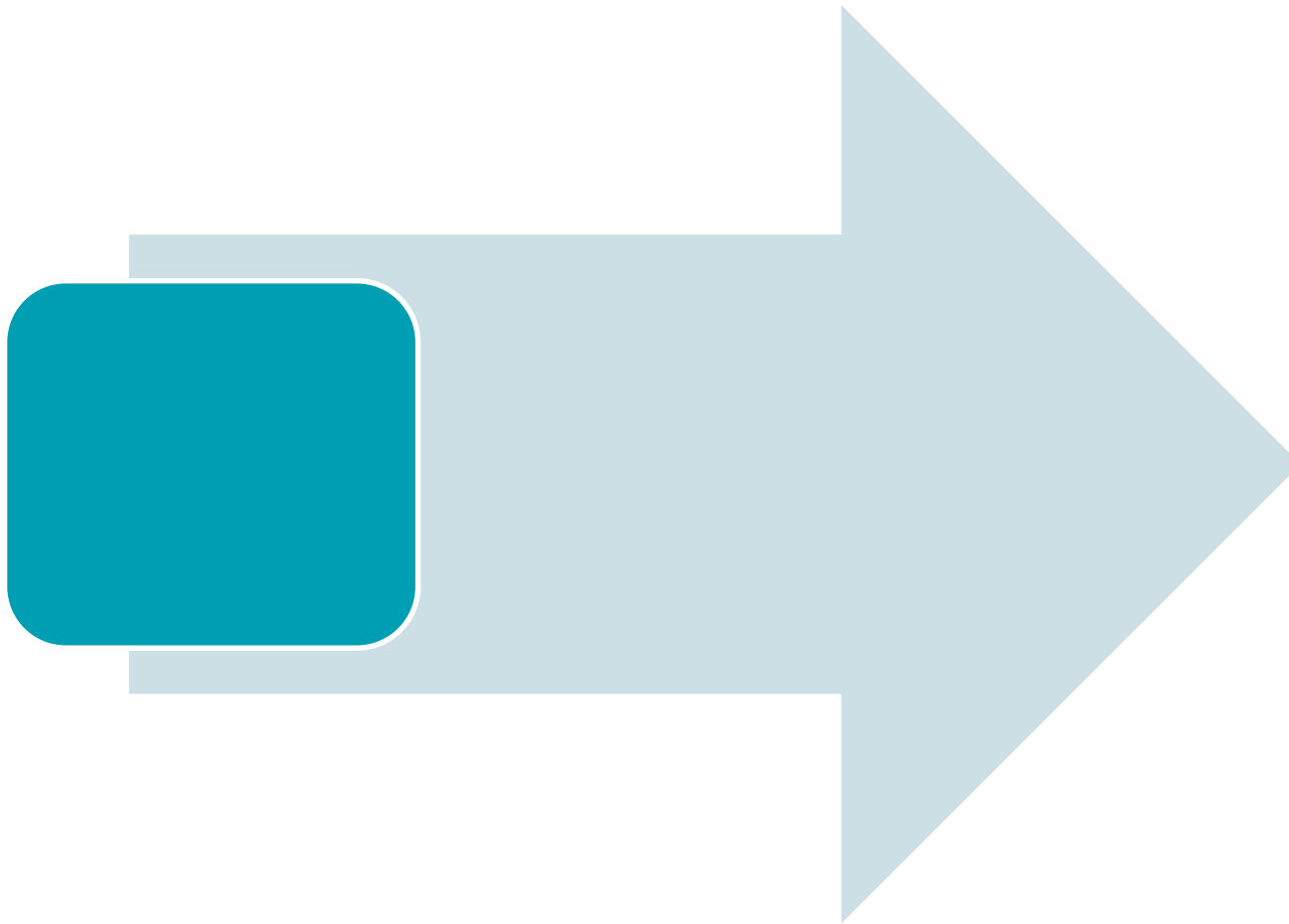
“a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location”

(Coleman et al. 2003:556)





Session outline



What we know: Hospital to care facility transitions

Resident and family outcomes

- Lack of follow up tests and medicines review (*Caruso, et al 2014*)
- Delays in fundamental care
- Risk of falls
- High levels of resident distress
- Re-hospitalisation
- Individual and family dissatisfaction (*King et al 2013; Gilmore-Bykovskyi et al 2017*)
- People living with dementia feeling unsettled and powerless (*Digby et al 2011*)

What we know: Nurses' role in transitional care

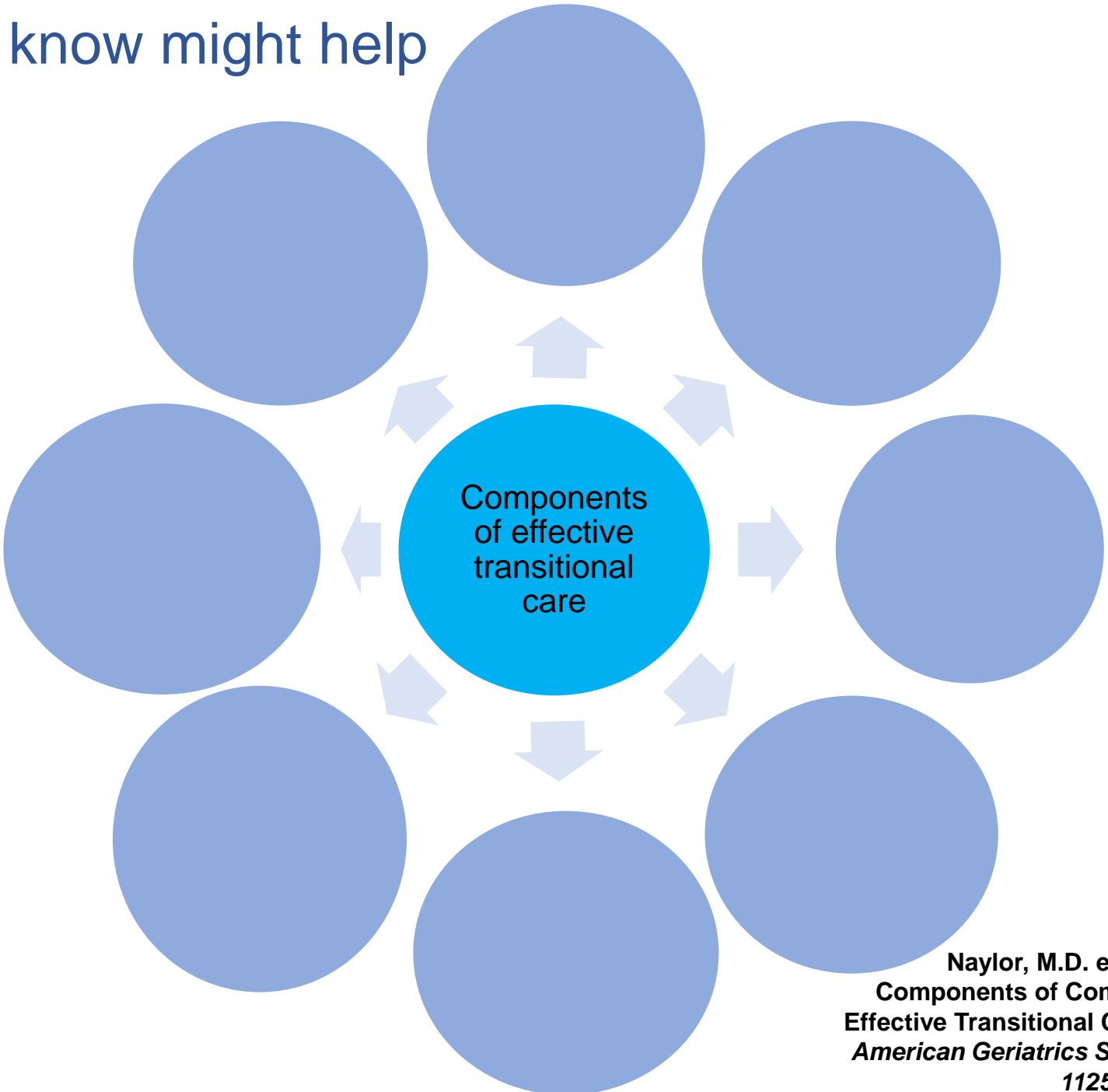
- Nurses have central roles within the discharge process (Nosbusch et al. 2011)
- Many NHS hospitals have nurse-facilitated processes (Lees 2012)
- Evidence has demonstrated that nurse-led interventions can improve discharge experience and reduce readmissions (in the home setting) (Naylor et al 2004, 2014)
- Timing of transitions can impact on the nurses' role in care homes or care facilities due to workforce capacity issues (Gilmore-Bykovskyi et al 2017, Kable et al 2017)
- Shift patterns and reliance on agency staff can be a barrier for getting to know patients affecting care continuity (Nosbusch et al. 2011)



What we know might help: **NICE guidance**



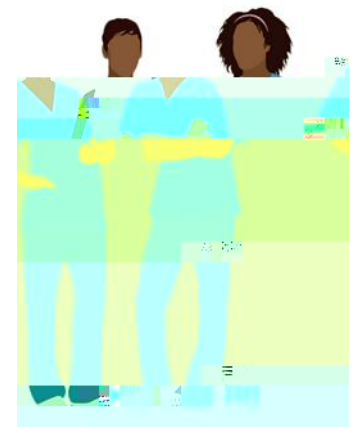
What we know might help



Naylor, M.D. et al. (2017)
Components of Comprehensive and
Effective Transitional Care. *Journal of the*
***American Geriatrics Society* 65 (6), 1119-**
1125.

Whaaaaaa'aaaa'

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Aim of research

To explore nurse perspectives on the roles they need to perform to ensure quality transitional care for people living with dementia who return to their nursing home from hospital; and the extent to which Naylor's components of effective transitional care are applicable to this transition

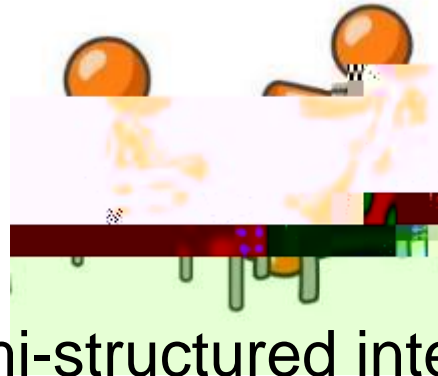


Research questions





Advisory group



Semi-structured interviews



Focus groups

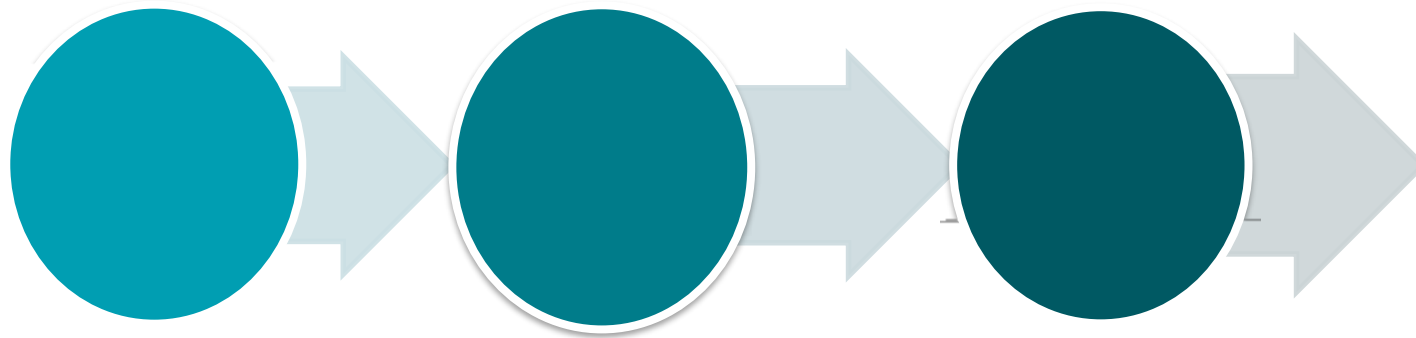


Inductive and Deductive
Analysis

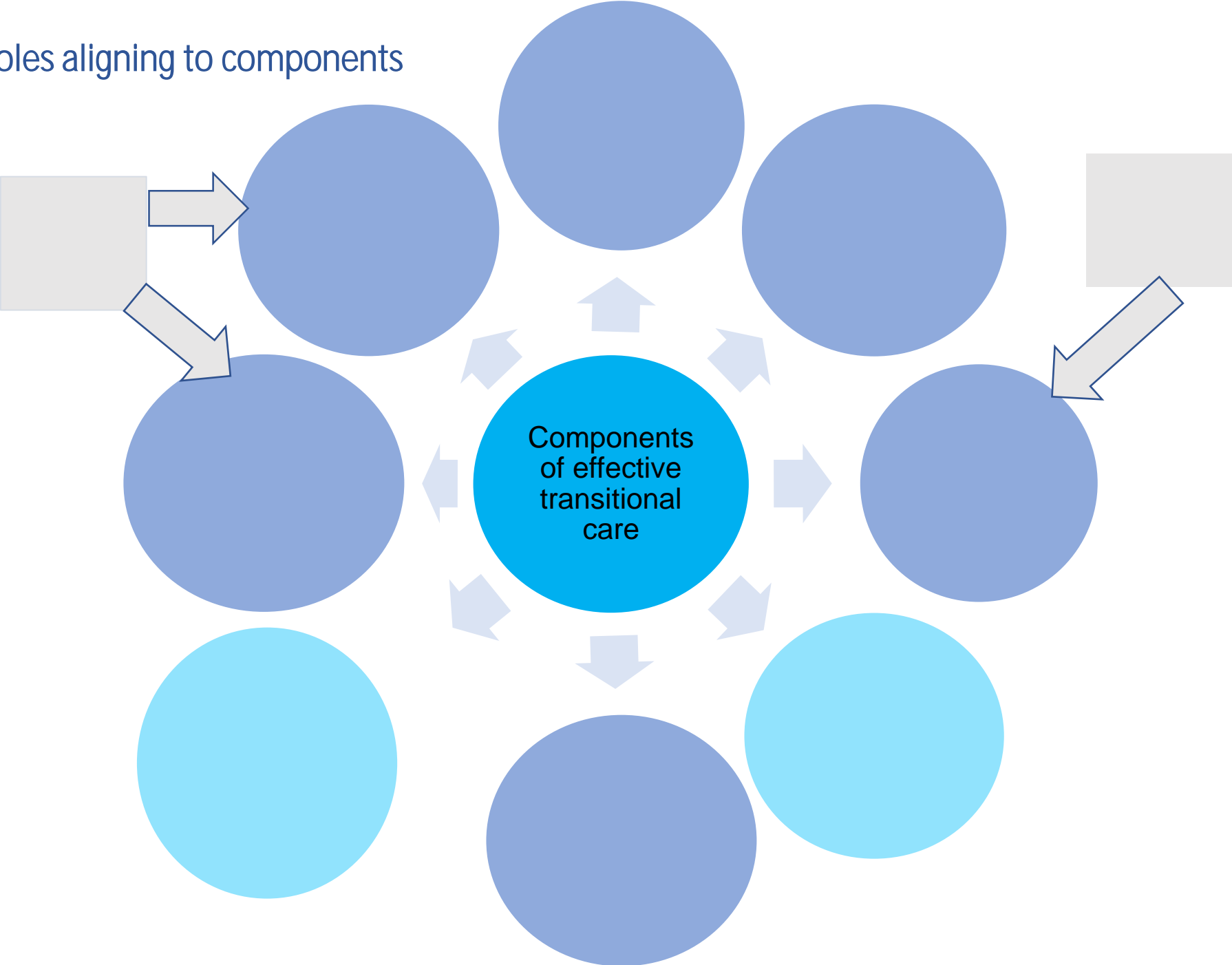




Finding: Nurses' roles in transitional care



2. Roles aligning to components

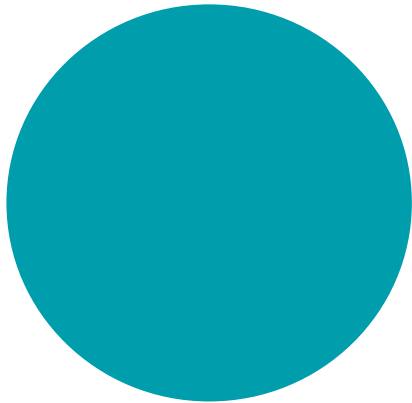


Care continuity

Naylor's definition

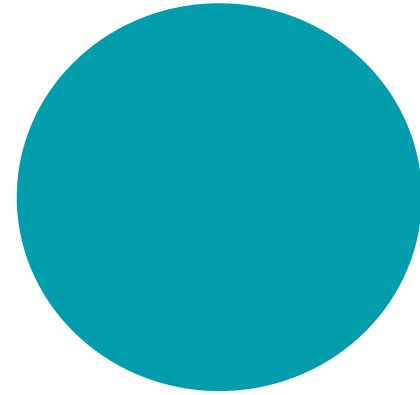
Management continuity:
comprehensive
implementation of
individualised care

New components for this transition



“it’s a two way discussion really between the care home and

*“More often I get call asking about the person, their abilities prior to going into hospital. And that they will be discharging fairly soon.”
(Care home nurse)*



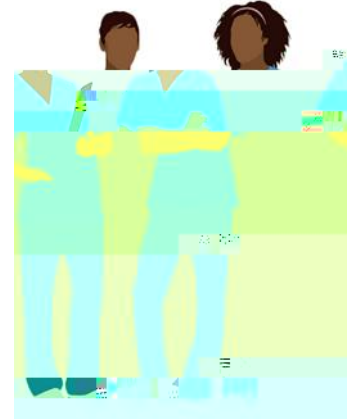




Conclusion

Study findings can be used to inform:

- Future hospital and care home policies
- Nurse education curricula and staff training.





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