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Strategies to Enhance Adjustment and Well-Being During Relocation from Home to Long-Term Care Facilities

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Abstract

It may be a major life alteration that is often accompanied by emotional, social and physical stress factors, making the home-to-long-term-care transition a potentially significant and painful experience to older adults and their families. The current scoping review will be targeted at mapping the current interventions aimed at providing a smoother adjustment process in this context of relocation. A systematic search of peer-reviewed literature helped in the identification and analysis of those studies that concentrated on pre-transition planning, psychosocial support, staff training, and environmental modifications. The results depict that multi-component interventions such as individualized care planning, family involvement, and designed orientation programs are the most effective interventions, which can be used to reduce the probability of anxiety, improve adaptation, and improve the quality of life in general among residents. The review also identifies knowledge gaps of culturally-specific approaches, long-term results, and technology to facilitate transitions. Such understandings can inform the healthcare provider, caregivers and policy makers to formulate holistic approaches that facilitate well-being and effective adaptation in long term care environments.

Keywords: ***Transition care, nursing home relocation, older adults, psychosocial interventions, long-term care adjustment, family support, care planning.***

1.Introduction

Relocation between independent living at home and nursing facilities is one of the biggest transitions in the life of aged people and their relatives. This shift includes much more than a mere change of address--it changes the feelings of autonomy, social relations, and daily habits of a person completely. This is a multifaceted process that spans through several stages, starting with the first thought of placing nursing homes up to the ultimate adaptation into the institutional care, which provides many grounds to support and introduce various complications(1).

One can think of the transition pathway as comprising three different, but interrelated phases. The pretransition stage starts with the moment when family members, healthcare providers, or even the older adult in the nursing home first discuss the nursing home admission and proceeds until the selection of a particular facility. It is a time that is usually filled with hard discussions of loss of independence, ability to take care of the family, and care requirements in the future. Midtransition phase involves the time in which an elderly person gets ready to make the move and may be waiting to be placed, and then finally the physical transfer to the nursing home. Lastly, the post transition begins right after placement and is devoted to the very important process of adapting and acculturation to the new living environment.

Every stage is a challenge with its own challenges and stressors, which can seriously affect the well-being of all stakeholders. In the case of older adults, personal identity is likely to shift drastically, with loss of autonomy, habitual practices, social status, and long-held relationships. Institutional setting and its required order may seem confining and somewhat alien to the beasts when a person is at home. Such changes may occur in the form of depression, anxiety, confusion or behavioral problems especially in people with cognitive impairment.

Informal caregivers, usually members of the family who have over the years been offering care at home, have a different emotional and practical burden to bear during this shift. This is due to numerous feelings of guilt, as many of them see the choice to place their loved one in a nursing home as a failure or desertion of their loved one. The change in the position of a primary caregiver into an advocate and a visitor can be confusing, and the worries about the quality of care in the institutions and the adaptation of their loved one can introduce the continuous stress and anxiety. Also, caregivers have to negotiate elaborate healthcare systems, insurance necessary, and choices of facilities, frequently with the burden of grief and emotional upheaval of their own.

Healthcare providers participating in the process of transition also face a great difficulty in managing the healthcare provided in various settings and continuity of care plans. Medical information transfer, medication administration, care preferences, and communication of care preferences should be done with utmost attention to detail and

methodical procedures to avoid negative outcomes. Lack of coordination may lead to medication errors, missed diagnoses, duplication of services or gaps in care that undermine patient safety and well-being(2).

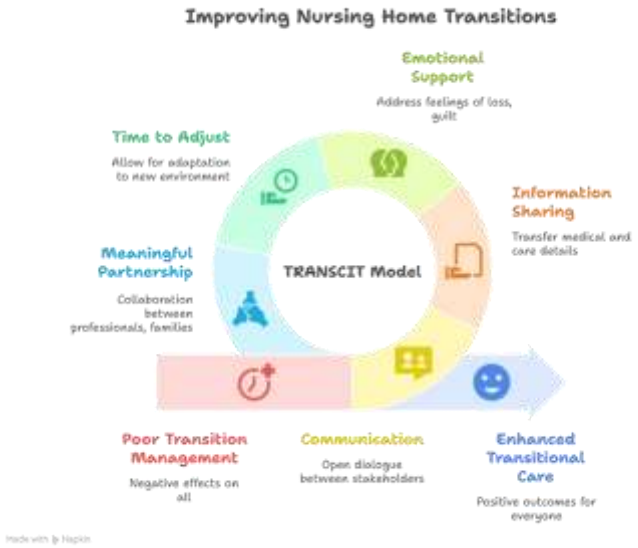

FIGURE 1 Improving Nursing Home Transitions

The effects of the poorly managed transitions do not stop at distress but lead to long-term negative effects. Studies have repeatedly shown that a disjointed transitional care may result in higher mortality rates, drug-related adverse events, delirium, and higher risks of falls in recent nursing home residents. In the case of family caregivers, the inadequate support during the transition process may lead to the long-lasting grief, depression, and poor relationships with the loved one as well as with the healthcare providers. There is also the lack of efficient transitions in the broader healthcare system, as the costs are increased because of service duplication, emergency visits and burnout of the staff among healthcare professionals dealing with crisis situations.

In view of such prominent obstacles, the importance of overall, evidence-based interventions that were aimed at enhancing transitional care has become more evident. Other global health care agencies such as the World Health Organization have reiterated the role played by multicompponent interventions that are effective in addressing the interrelated needs of older adults, their families, and health care providers during the transition process. These interventions ought to preferably cut across the three stages of transition and offer support and coordination in totality as opposed to the scenario where particular parts of the transition are managed independently.

Designing an effective set of interventions in transitional care should be based on an in-depth comprehension of available strategies, their major elements, and their efficiency in enhancing the outcomes of all stakeholders. The same can be used to shape more comprehensive programs that fill in gaps identified in the current practice and add value to what has already been successful. Moreover, the knowledge of the intervention environment can assist healthcare organizations, policymakers, and families to make more accurate decisions as to the most effective process of assisting individuals in their difficult transition in life(3).

Based on the comprehensive study of the needs of transitional care, TRANSCIT model has formulated five fundamental elements that are to be incorporated in the entire transition process; communication, information sharing, emotional and practical support, sufficient time to adjust, and meaningful partnership among healthcare professionals, older adults, and their families. These aspects demonstrate the intricate interaction of applied, emotional and relationship-based factors contributing to transition outcome that necessitate the inclusion of holistic approaches that take into account many dimensions of the experience at the same time.

This is an extensive evaluation of the existing state of research in the field of interventional research in home-to-nursing home transitions, the strengths and limitations of the current methodologies, and suggestions on future intervention development and application.

2.Fragmented Care: The state of Transitional interventions

The topography of the transitional care interventions shows disheartening trend of fragmentation that reflects the larger issue of the healthcare system in its approach to coordinating care. The existing literature shows that the

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majority of the current interventions are too narrow in their approach as they are only targeting certain stages of this transition process or are targeting particular groups of stakeholders instead of taking a multifaceted and integrated approach that the nursing home transitions complexity requires. This breakdown generates disconnections in support and coordination, which are capable of intensifying the stress and adverse consequences of institutional placement.

Through the analysis of the interventions that already exist, it is possible to note that most of them focus their attention on the posttransition period when the main focus is on enabling individuals to adapt to the nursing home life once they are already placed. Although adjustment support is indeed a significant factor, this rather limited perspective does not take into account the impact that the previous stages of the transition might have on final results. Studies repeatedly indicate that pretransition stage experiences, such as the quality of decision-making activities, family communication and pre-move preparation are important predictors of adjustment problems and post-placement satisfaction with care(4).

The focus on posttransition intervention can have a practical background since after being admitted to a facility, it is easier to identify and reach out to such individuals. Yet, such a reactive style overlooks some rich opportunities of prevention and early intervention that may potentially yield better results and decrease the severity of future support. The pre transition stage is an opportunity to be able to work with unrealistic expectations, improve family communication, make informed choices on the choice of the facility, and initiate the psychological preparation process, which is likely to relieve the actual transition.

The propensity to facilitate interventions to individual groups of stakeholders is also a major issue because it fails to acknowledge the interrelationship of the transition experience. The majority of interventions concentrate on only one of the older adult or their informal caregivers, and few concern the contribution of healthcare professionals, or seeking to enhance coordination within the care triad. It is this disjointed method that does not recognize the fact that the transition experience encompasses a number of multi-party interactions with each party having its own needs, perspective and contribution towards successful results(5).

The preeminence of caregiver-based interventions although in the pursuit of a crucial need, can contribute to the exclusion of the voices and preferences of older adults on the transition process unwillingly. It is common in studies to exclude older adults with cognitive impairment, even when it has been shown that people with dementia may and ought to participate in making decisions about their care to the extent they are able. Such exclusion does not only restrict our knowledge of their experience and needs, but also continues paternalistic practices, which might not correspond to the principles of person-centered care.

Although their role in the medical field is significant as they are expected to support transitions and deliver continuous care, they have been relatively understudied in intervention research. This is especially worrying considering the evidence that staff knowledge and attitudes as well as communications skills are pertinent factors affecting the transition process and the quality of care thereafter. Healthcare providers tend to be deficient in specialized training on the principles of transitional care and might be unaware of their role in assisting families and residents in the period of transition.

The kind of fragmentation that is witnessed in intervention research is part of a systemic concern in the delivery of healthcare where various providers, settings, and funding mechanisms impose artificial barriers that may hinder the provision of coordinated care. Multi-facilities (long-term care, hospitals, primary care practices, and community-based services) are observed to operate as independent bodies that have limited communication and coordination processes. This kind of organizational fragmentation complicates the implementation of interventions that cut across settings or necessitate a long-term partnership by provider organizations.

In addition, it is hard to compare effectiveness of various approaches or to accumulate successful aspects of a variety of interventions due to the absence of standardized outcomes measures and intervention protocols. The outcome measures have been varied and include depression and anxiety levels but also include satisfaction levels and patterns of facility use, thus making it difficult to conditionally synthesize their results or determine which elements of the intervention work best.

This piecemeal approach does not only have implications on research but also on care delivery in the real world. Disconnected services, conflicting pieces of advice, and gaps in support can be facts that families going through the transition process face and feel overwhelmed and unprepared. The healthcare provider might find difficulties in coordinating care between settings, which can result in redundant evaluations, differences in treatment strategies, or the loss of chances to resolve some arising issues.

Economical effects of discontinuous care are also important because inefficient transitions may lead to increased healthcare use, longer readjustment, and higher forms of adverse events that will call on further interventions. Emergency department visits, medication errors, and behavioral crisis in the first few weeks of nursing homes placement are indicators of human distress as well as wasted healthcare spending that can possibly be avoided with more coordinated strategies.

An awareness of these constraints has created the need to develop more holistic, inter-sectoral interventions that involve the entire transition experience experience and all the stakeholders concerned. These strategies would necessitate major shifts in the manner in which research is carried out, in the manner in which interventions are planned and executed, and the way in which healthcare systems plan and finance transitional care services.

3.Building Blocks for Effective Transition Support

The recognition of seven core intervention components based on the systematic analysis of existing programs brings a lot of value in terms of understanding the elements that are necessary in order to have a comprehensive transitional care support. These elements, i.e., education, relationships and communication, emotional well-being enhancement, personalized care, continuity of care, support provision, and ad hoc counseling, are the basic building blocks that can be integrated and modified to be more effective and responsive transition interventions. It is important to understand the distinctive contribution of each of the components and also acknowledge their interrelationship in terms of designing the programs that can meet the complex needs of persons and families in the course of nursing home transitions.

Education presents itself as the very most basic of ingredients, filling in the key information voids that may give rise to anxiety, false expectations, and bad decision making during the transition process. Best educational interventions are not just information provision, but involve skill training, problem-solving training, and health literacy improvement of long-term care. Families: Educating families on the progression of dementia, nursing home operations, rights of residents, and advocacy skills can point to a lot of success in the ability to navigate the care system. In the case of older adults, education on what to expect, how to remain autonomous in the institutional facility, and the ways of creating connections with staff and other residents can help them adjust and maintain their dignity(6).

The learning aspect should be well designed in accordance with the unique learning requirements, interests, and mental capacities of various audiences. The modes of information delivery must consider different learning styles and physical constraints and use visual presentation, demonstration, written material and peer-to-peer learning as necessary. When educational interventions are implemented is also crucial as certain information can be most beneficial at the stage of making decisions whereas other factors can be more significant after the fact of the placement.

Another important element that covers the interpersonal dynamics at the core of successful transitions is relationship and communication. The most successful interventions related to this domain aim at enhancing the communication patterns within the family, improving a relationship with healthcare professionals, and developing positive relationships with nursing home employees/consultants and other nursing home residents. The communication training can include conflict management, assertiveness training, and how to voice the concerns in a constructive way without breaking the relationships with care providers.

The relationship element acknowledges that transitions to nursing homes are taking place in multifaceted family systems in which the current communication, decision-making, and conflict resolution patterns play a critical role in the process. The interventions might be required to address the old family processes, assist the family members in adjusting to evolving roles and functions, and assist the creation of new relationship patterns that would accept the circumstances of institutional care. In the case of older adults, the intervention may be relationship-centered and focus on the development of strategies to retain relationships with family members and friends and form new social networks within the nursing home(7).

The enhancement of emotional well-being recognizes the significant psychological effect of nursing home transitions and offers specific measures in coping with the grief, anxiety, depression, and identity issues that is likely to occur. This element includes a range of therapeutic strategies such as cognitive-behavioral, mindfulness, reminiscence therapy and grief counseling. Interventions could be beneficial by enabling people to manage the losses related to the departure of home, establish coping mechanisms to manage living in the institutions, and ways of establishing meaning and purpose in their new surroundings.

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The emotional aspect should be responsive to the varying expressions and processing of emotional experience across individuals with consideration of cultural and personality differences and the effect of cognitive impairment on the emotional regulation. The interventions must offer numerous emotional expression and support options such as individual counseling, group activity, creative therapies and peer support programs.

One-on-one care is one of the basic transformations of the one-size-fits-all practices into the ones that are specially designed and structured to meet the needs, preferences, life experience, and situations of a particular individual. This component demands thorough evaluation procedures, which should entail not only functional skills and medical requirements but also personal values, cultural background, pattern of relationships and personal coping styles. Some of the personalized interventions may be designing individual care plans, changing style of communication to individual preference, or using meaningful activities and routines that the person had in his/her past life.

Continuity of care responds to the fundamental requirement of coordination and share of information between providers, settings and various stages of transition process. This aspect entails planned care coordination methods, such as standardized communication plans, shared documentation, and assigned care coordinators, who remain accountable to aligning seamless changes. Interventions related to continuity may involve organized handoff process, schedule of following contacts, and a system of maintaining constant monitoring and revision of care plans.

Support provision involves emotional support and practical support services that enable the persons and families to cope up with the difficulties involved in the nursing home transitions. This part may involve peer mentorship programs, family support groups, practical help in selecting a facility and paperwork or continuing counseling. The support interventions must be made to supplement but not substitute the natural support networks but adding resources at the time when the latter is facing difficult times.

Lastly, ad hoc counseling offers adaptive and responsive support which may be availed as and when required during crisis times, or during unforeseen circumstances. This element understands the fact that transitions are unpredictable processes during which needs can arise at any moment, and it will be necessary to respond to them immediately. Ad hoc services may also involve telephone consultation lines, emergency counseling or rapid response teams that can offer intensive services at specific times when things are especially challenging.

4.Methodological Challenges

The analysis of transitional care interventions shows that there are a number of important methodological challenges and limitations of research that limit our knowledge of what works and hinder the formation of evidence-based practice. All these limitations cut across the area of study design, outcome measurement, description of interventions and population representation, leaving gaps in the body of knowledge that need to be filled in to facilitate the field of transitional care research and practice.

Heterogeneity of outcome measures that has been adopted by different studies is one of the biggest issues that transitional care research encounters and it is almost impossible to compare the effectiveness of the intervention applied or even to perform meaningful meta-analyses. The indicators of success used by researchers have been various, which include psychological scales such as depression and anxiety levels as well as behavioral outcomes, satisfaction levels, the pattern of health care utilization, and quality-of-life factors. Although this diversity is indicative of the multivaried nature of transition experiences, it also makes it impossible to pool similar evidence that can inform practice choices and policy formulation.

The absence of standardized, validated outcome measures that describe transitional care situations is a specific shortcoming in the research infrastructure. Most studies are based on generic tools that might not reflect the specifics of nursing home transition processes or might be unable to detect the nature of transformation that the interventions are created to evoke. In addition, the timing of outcome measures also varies significantly among the studies where some measure immediate post-intervention outcomes and others assess longer term outcomes, thus it is hard to grasp the pattern of benefits of an intervention over a period of time.

Many intervention studies are marred by sample size limitations in which researchers find it difficult to obtain enough participants to observe a significant difference between the intervention and the control groups. Complexities of research in nursing home facilities, such as regulatory, staff collaboration, and study dropout, also add to the problems of obtaining sufficient statistical power. Small samples not only reduce the possibility of

identifying the intervention effects, but also limit the externalization of the results over larger samples of individuals undergoing transitions to nursing homes(8).

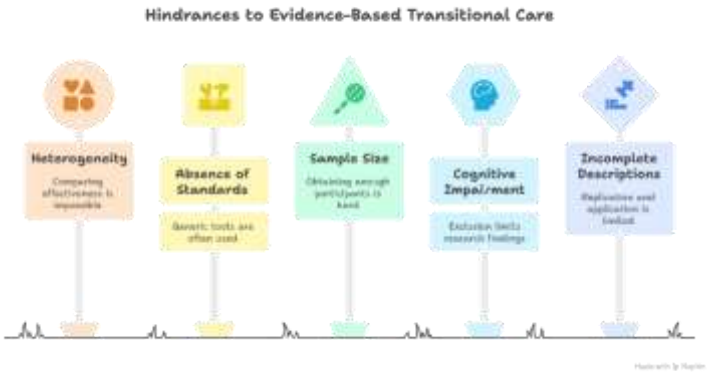

FIGURE 2 Hindrances to Evidence-Based Transitional Care

Another important limitation that limits research findings applicability is the exclusion of people with cognitive impairment on most intervention studies. Since a large percentage of nursing home population is slightly or significantly cognitively impaired, the type of interventions studied in cognitively intact patients might not be suitable or effective with the overall nursing home population. This omission is also ethically questionable in terms of how people with dementia are systematically marginalized in research which might benefit them.

Incomplete descriptions of interventions in most studies published impose a limitation on replication and application in practice. Scholars tend to be under-descriptive regarding intervention content, mode of delivery, training needs, or implementation process, and thus practitioners are unlikely to be able to repeat the work of effective intervention methods. Such a gap in reporting also interferes with attempts to determine which ingredients of effective interventions work or why certain approaches are more effective than others.

The single-site nature of most of the studies restricts the applicability of the results in other healthcare settings, cultures, or organizations. Nursing homes differ significantly in size, ownership pattern, staffing, resident and organizational culture and this can affect the effectiveness of the intervention. The results of those studies that are carried out within a single facility or healthcare system might fail to consider such contextual factors that might be contributing to a great extent in the results of interventions in different settings(9).

The question of follow-up in most studies is too short to capture the impacts of interventions in transitional care over a long period, or to determine the sustainability of any benefit realized. Adjustment of nursing home residents and their families is frequently a lasting experience long after the direct post-placement phase, but many researchers evaluate the outcome only during the first weeks or months after intervention administration. This shortcoming does not allow us to know whether intervention benefits can be long-term or whether we may need extra booster sessions or continuous support to sustain beneficial effects.

The absence of economic assessment of most intervention studies is a notable gap in the evidence base, especially, because of the focus on cost-effectiveness in healthcare decision-making. Very little research has been conducted on the cost of delivering transitional care interventions or even on whether any gains made are worth the investment. In the absence of economic data, healthcare organizations and policy makers do not have much information to make a decision regarding the way resources are allocated and which types of interventions are adopted.

5.Conclusion

To translate research results into the effective real-world transitional care program, the implementation strategies, system-level modifications, and continuous quality improvement strategies should be considered thoroughly, and they can facilitate the realization of the evidence-based interventions and their further implementation. Future research in the area should consider not only the future of intervention science but also the realities of application with regard to integrating comprehensive programs into the existing systems of healthcare delivery.

Among the most promising avenues of future research, the creation and validation of technology-enhanced interventions through which the scope of comprehensive support in transitional care can be expanded and the cost thereof can be lowered should be listed. Online tools might offer easy-to-use educational materials, help family

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members and healthcare professionals communicate with each other, offer automatic assessment and screening tools, and provide constant support via mobile apps or web-portals. The use of telehealth technologies might facilitate the provision of counseling services, family meetings, and follow-up assessment remotely, which is especially essential to such a family, where the nursing home are located sufficiently away or the family has a transportation constraint.

Nonetheless, technology-based interventions should be tailored to the physical abilities, digital literacy and inclinations of elderly people and their relatives. The interfaces and features developed must be accessible, intuitive, and culturally suited to the requirements of various user populations through user-focused design. It will be important to integrate with current healthcare information systems and workflows to make sure that technology improvements work side by side with, not to add complexity to, the care delivery processes.

Another direction of care coordination and intervention provision is the development of special transitional care coordinator positions. Such professionals may be valuable assets in terms of assisting the families in the process of transition, setting up the care across settings, implementing intervention protocols, and offering continuous assistance during the adaptation process. Depending on local needs and resources, transitional care coordinators may be located in a hospital, nursing home, healthcare system or community organization.

The implementation of transitional care coordinator programs would have to be carefully considered in terms of the role definition, the training needs, the structure of supervision, and the connection with the current care teams. Such practitioners would require expertise in the long-term care systems, family dynamics, counseling methods and care coordination principles along with the assessment, delivery of care and monitoring of outcomes skills.

Transitional care improvement efforts are another urgent area of practice and outcome development. Healthcare organizations might introduce more systematic solutions to the measurement of transition experiences, the identification of areas in which it could be improved and practice changes that would be tested in order to improve the quality of care. Plan-Do-Study-Act cycles and other quality improvement frameworks would support iterative process improvements in transitional care and organizational capacity building of continuous improvement.

The transitional care quality indicators may reflect family satisfaction measures, resident outcomes of adjustment, effectiveness of care coordination and negative events occurring throughout the transition. Consistent tracking of such indicators may assist organizations in recognizing trends, performance benchmarking, and trying to improve activities where they are most required.

The emergence of multi-organizational and multi-care setting collaborative networks is an essential movement toward correcting the discontinuity that is presently defining transitional care provision. These networks may be in the form of hospitals, nursing homes, primary care practices, community based organizations, and informal support systems collaborating to offer coordinated comprehensive support through the transition process.

Effective collaborative networks would need to have common protocols, communications, data sharing agreements and governance mechanisms that allow proper coordination without interfering with organizational autonomy. Certain financial incentives and regulatory requirements can be required to promote participation and accountability of the transition outcomes of network partners.

Transitional care approaches that are evidence based may be greatly promoted through policy initiatives at various levels of government. Federal Medicare/medicaid policies have the potential to offer better reimbursement of holistic transitional care services, provide quality standards of transition processes, and demand that transition outcomes be publicly reported. The state level policies may take care of the licensing and regulatory hurdles to new models of care delivery, help develop workforce development programs, and fund demonstration projects to explore promising strategies.

Local policy action may be taken in the form of zoning laws to enable the co-location of services, transport systems to enable the families to participate in the care, and community based programs to enable the ongoing support of nursing home residents and their families. The cooperation of cross-sectors, including healthcare, social services, housing, and transportation sectors will also be required to design the multilevel community-wide support systems of individuals undergoing nursing homes transitions..

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Conflicts of interest

The authors have no conflicts of interest to declare

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