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Hospital-home transition of older persons in the light of Afaf Meleis's Theory

Transição hospital-domicílio da pessoa idosa à luz da Teoria de Afaf Meleis

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ABSTRACT

Objective: to analyze the facilitating and inhibiting conditions that influence the transition of care of older persons from hospital to home in the light of Afaf Meleis's Transition Theory. **Method**: qualitative, descriptive research, following qualitative research criteria and involving nine caregivers of older persons who were discharged from a hospital. A semistructured interview was carried out using a mobile device. Data was analyzed using content analysis and considering the precepts of Afaf Meleis' Transition Theory. **Results**: the conditions that facilitated hospital-home transitions were attributing positive meaning to going back home after discharge; spirituality/religiosity in dealing with the health condition/disease; financial stability; preparations being made for home care; and availability of social and community support. The conditions that made transition difficult were negative meanings of going back home; deficits for self-care in the elder; financial insecurity; a residence not prepared for home care; and the lack of social and community support. **Conclusion**: facilitating and inhibiting conditions of transition influenced in a positive and negative way, respectively, the work of home caregivers. Thus, nursing therapy can seek to enhance conditions that facilitate this type of care and reduce those that inhibit it.

Descriptors: Transitional Care; Health of the Elderly; Caregivers; Nursing Care; Nursing Theory.

RESUMO

Objetivo: analisar os condicionantes facilitadores e inibidores no processo de transição do cuidado hospital-domicílio da pessoa idosa à luz da Teoria das Transições de Afaf Meleis. **Método:** pesquisa qualitativa, descritiva, realizada com nove cuidadores familiares de pessoas idosas que haviam recebido alta hospitalar. Realizada entrevista semiestruturada via dispositivo móvel telefônico e a análise dos dados por meio da análise de conteúdo, considerando os pressupostos da Teoria das Transições de Afaf Meleis. **Resultados:** os condicionantes facilitadores para a transição hospital-domicílio foram o significado positivo para o retorno ao lar após hospitalização, a espiritualidade/religiosidade para enfrentamento da condição saúde/doença estabelecida, a estabilidade financeira, o preparo para gerenciamento do cuidar no domicílio e a disponibilidade de rede de apoio social e comunitária. Os condicionantes inibidores foram o significado negativo para o retorno ao domicílio, o déficit da pessoa idosa para o autocuidado, a insegurança financeira, a falta de preparo para o cuidar no domicílio e a ausência da rede de apoio social e comunitária. **Conclusão:** os condicionantes facilitadores e inibidores influenciaram, respectivamente, positivo e negativamente na forma como os cuidadores familiares atuam em domicílio, direcionando a terapêutica de enfermagem para potencializar os facilitadores e atenuar os inibidores.

***Descritores*:** Cuidado Transicional; Saúde do Idoso; Cuidadores; Cuidado de Enfermagem; Teoria de Enfermagem.

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INTRODUCTION

Afaf Ibrahim Meleis's Transition Theory addresses the transition process in all its dimensions. It considers the diversity and complexity associated to changes in life, health, relationships, and in the environment where the person lives in a unique and individual way.[1,2]. The transition can have a large impact, especially when related to disease, surgical procedures, recovery from diseases, and rehabilitation.[1]

With the aging of the population, health needs have become more complex. Older individuals are more susceptible to chronic disease which, in most cases, are incapacitating, leading to more hospitalizations and rehospitalizations[3]. Financial, emotional, and social costs are diminished when the transition of an older person from hospital to home is planned, using effective measures directed at individual needs.[4,5] A thorough evaluation of the transition process, carried out by specialized professionals, also contributes to reduce hospitalization times by using efficient strategies to prepare the elder and the family/caregiver for the necessary changes.[3,4]

However, a previous study has shown that, in practice, many institutions, especially in developing countries, are yet to implement discharge planning, opting instead for one-time brief conversations where instructions are provided by the nurse at the time of discharge.[6]

The transition from hospital to home is permeated by a series of changes that must be considered for the continuity of care. These include extra needs; a certain level of dependence from others; the acquisition of drugs and health materials; and changes in the domestic environment.[4] As a result, transition demands careful and proper planning, which includes analyzing the standard responses of elders and their caregivers, and determining the role of nursing in the transition process and the necessary nursing interventions.

The stages of transition cause changes which are conditioned by certain factors. Surveying empirical data by listening to older patients and their family/caregivers can enable us to ascertain what are the personal conditions experienced, including the surrounding community and related social questions. The meanings attributed to changes in attitudes, beliefs, culture, level of awareness about this process, financial conditions, as well as family and professional support networks, can have an influence by facilitating or inhibiting the transition.[1,2]

The transition of older persons from hospital to home requires special attention, not only to the diseased, but also to a context that involves family/caregiver and society, default responses, acknowledgement of risks, prevention, improvement of health conditions, and self-care. All of these are acctions that contribute for a healthy, safe, and comfortable transition.[6]

OBJECTIVE

To analyze the conditions that facilitate or difficult the transition of care of older persons from hospital to home, in the light of Afaf Meleis's Transition Theory.

METHOD

Exploratory, descriptive study, with a qualitative approach, deriving from main research named Hospital-Home Transition Care, carried out since August 2019, which investigates how care is provided to the older people during hospitalization and hospital-home transitions. This study was carried out in a teaching hospital, the reference in medium and high-complexity care in the state of Bahia. The hospital is part of the Single Health System (SUS) and is associated to a public university. Furthermore, it serves a significant number of older patients, which, in addition to the other characteristics mentioned, is another criteria used to choose it as the field of our research.

The conceptualization of the main project, including its data collection and result analysis, counted on the participation of researchers who had PhDs, were PhD students, MS students, or workers experienced in elderly care and in the process of hospital-home transition.

For this study, which is an excerpt of the main research, the participants were family caregivers of elders who were hospitalized and discharged. The following inclusion criterion was considered: being a family caregiver who participates in the daily routine at home after hospital discharge. The exclusion criteria were: caregivers of elders who passed away, who do not live or spend time with the elder, as well as those who did not know how to answer questions about the home care provided. Of 32 participants registered in the database, 23 were excluded; 8 did not know how to answer, 5 elders had passed away, and 10 could not be contacted despite three attempts of communication via phone at different dates and times. As a result, this study included 9 family caregivers.

Data collection took place from January to May 2021, using semistructured interviews which were conducted via telephone due to sanitary norms imposed by the COVID-19 pandemic. The interviews lasted for a mean of 20 minutes and followed a script which included sociodemographic characterization and questions about the conditions that facilitated or inhibited the transition of care from hospital to home.

The participants agreed to have their interviews recorded and transcribed in full. To guarantee the anonymity of the participants, they were identified using the letter I, for interviewee, in addition to a number that indicated the order in which they were interviewed.

Their statements went through orthographic corrections to facilitate understanding, but text meanings were not affected.

The first part of the interview script included a characterization of the participants, including their gender, age, city of origin, self-reported color, educational level, marital status, family income, and religion. The interview had another part with open, reflective questions about the factors that condition the transition, the meaning of going back home, the feelings of the caregiver, their impression about the guidance received at hospital discharge, the elements that made home care easier or more difficult, and questions regarding support from other relatives or professionals.

The information from these interviews underwent a thematic analysis as proposed by Bardin[7]. The data was also interpreted in the light of Meleis's Transition Theory[1]. Using this theory, we separated the conditions that facilitate or inhibit the transitions into categories.

The project was approved by a Research Ethics Committee under opinion No.: 4.768.573. Participants signed an informed consent and received a copy of it before the older patients were discharged.

This research followed the Consolidated Criteria for Reporting Qualitative Research (COREQ).[8]

RESULTS

The participants were nine family caregivers of older persons. They were from 23 to 67, and most were female, from inland Bahia. Three were from the capital of the state, and one was from the surrounding area. Regarding their color/race, most self-reported as brown, with two black participants, and one white. Educational level varied, with five having completed high school, three having completed higher education, and one having completed elementary education. Regarding their marital status, most interviewees had no partners.

Only one reported not having an income nor any form of welfare. Seven earned one minimum wage or more. Most participants had some form of religious belief, and were mostly Catholic.

According to Afaf Meleis's Transition Theory, the personal factors that condition the transition are the meanings attributed to change. Changing these factors depends on cultural beliefs and attitudes, socioeconomic conditions, and the preparation and knowledge of the elder and their family. During the transition of care from hospital to home, different meanings attributed to he process triggered positive feelings, such as happiness, gratitude, and peacefulness.

Oh, it was the best thing ever. For her and for all of us, right?! We were really happy, it's gratifying that she was able to come back with us, a blessing. (I2)

The simple fact she's coming back, right?! And we, even if we are the ones caring it's better to treat at home. She's fine, she lost a limb, but she can walk, thank God, and she's here with us. (I3)

Regarding their cultural beliefs and attitudes, faith and spirituality were found to facilitate the transition process, as they comforted the caregivers and relatives and helped them accept the condition established by the disease, helping the elders to focus on their care process.

[...] thank God she's healed, it closed, thank Jesus she didn't need to have her tendons removed, right? (I3)

My father went to the ICU twice, or was it three times, and I was there with him, keeping him company, so to me this was a miracle from God. (I4)

A stable socioeconomic status facilitated the transition process, since some families were able to adapt their home to increase accessibility for the elder.

We adapted everything. The bedroom, the living room, the front porch, the exit. We adapted a bathroom so a wheelchair could go win, a bathing chair, so we could fit it over the toilet. About the bathing chair we found a way to buy one. (I5)

When she started losing strength in the lower limbs we were renovating the house, so we took the opportunity to adapt the house for her. (I7)

The guidance provided by the multidisciplinary team before hospital discharge, as well as the follow-up after going back home, proved to be relevant factors in the transition process, helping in the acquisition of skills for care in order to promote the health and independence of the older person and the family caregivers.

The information we got at discharge helped because they really explained in detail how the follow-up would happen. (I3)

The hospital staff explained it all very well, how we should do it, what we should do for her, so we came home with no worries. (I8)

The community conditions that facilitated the transition were related to the support network of the older person, which was favored by the process of transition of care. Support from family and the social groups (neighbors and friends) was a resource available in the community that made it easier to deal with the changes that took place in the family context.

> *My friend lives in Rio, he managed to stay a few days here due to his work, so I had some help from him. (I6)*
> *Family, friends, and church helped a bit before the pandemic, with what they could [...] When it comes to caring for her, when I wasn't here, normally her siblings, my aunts that care for her, sometimes give financial support for petrol, fuel, car, things like that. (I7)*

The social conditions facilitated the transition process and were reported in the statements as coming from public health institutions such as family health units, municipal and state health departments, and the hospital, which represented federal support.

> *The municipal health department helped a lot. When he came back home, we were getting support from the health unit, and whenever we needed it, a nurse would come home. (I4)*
> *When a suspected infection appeared, it needed to be evaluated by a professional, and since we couldn't bring her here* (General Hospital)*, they got in touch with the people there and they went to our home. They give me support when I need and materials for wound dressings every month. (I9)*

During the transition of care from home to hospital, different meanings attributed to the process triggered negative feelings in family caregivers, especially considering feelings connected to conditions that inhibited the transition. These were conveyed by expressions that showed inexperience, effort, fear, feelings of imprisonment, discouragement, anguish, and incapacity.

Regarding cultural beliefs and attitudes, the actions of the elder that generated their dependence were prominent, in addition to conditions that hindered the transition. The economic vulnerability made the transition process more difficult, since some caregivers depended financially on other family members. The lack of knowledge and the feeling of being unprepared displayed the difficulties family caregivers had in the transition of care, since having knowledge allows one to have a better perception of the transition being

experienced, showing that they had to overcome challenges in order to adapt to this new context.

> *We feel trapped and discouraged because no one wants to see their loved ones in a bed, right?! (I5)*
> *I was really anguished because I'm almost all alone, just me and my husband, and he would have to see only me and my husband. (I6)*

The community conditions that inhibited transition were characterized by a feeling of being responsible for the care and having no family support. When the older person and the caregiver receive no support from other family members, as reported in their statements, they become overloaded, which leads to physical, emotional, and psychological fatigue.

> *The responsibility falls on me and his wife, we are the ones who have to deal with it. (I1)*
> *Our lives change, right. It's like having a baby, you have to care for him and pay attention to everything, all signs. I can't leave home during the weekends, during the days I work and study and she is there to help me. (I9)*

Regarding social conditions that inhibit transition, they include difficulties accessing services, as showed in the statements, and were a barrier in the organization of a return home. Due to the new coronavirus pandemic, some services were interrupted or changed, and no longer attended to the demands of the elders.

> *I was trying to get care at home, but we needed the neighborhood health unit to recommend it, and we couldn't get it, so home care was delayed. (I4)*
> *We are doing physical therapy, we paid for it because in the pandemic the municipal administration was not providing it. (I5)*

The analysis of the interviews and the precepts of the Transition Theory led to the construction of the categories of Facilitating Conditions of the transition of the elder from hospital to home, and the Inhibiting Conditions of the transition of the elder from hospital to home. These are personal, community, and social facilitators and inhibitors, which can be seen in figure 1.

Figure 1. Facilitators and inhibitors of the transition of care of older persons and their caregivers from hospital to home. Salvador (BA), Brazil, 2022.

FACTORS THAT CONDITION THE TRANSITION	
FACILITATORS	INHIBITORS
PERSONAL: Feelings of gratitude Spirituality and faith Stable socioeconomic status Preparation and knowledge	PERSONAL: Feelings of incapacity Self-care deficit Bad socioeconomic status Lack of preparation and knowledge
COMMUNITY CONDITIONS Support from family and friends	COMMUNITY CONDITIONS No family support
SOCIAL CONDITIONS: Institutional support from professionals	SOCIAL CONDITIONS: Difficulties accessing the health system

DISCUSSION

The process of transition of care from hospital to home can be influenced by facilitating or inhibiting conditions related to the older individual and their social and community contexts.[1]

Facilitating conditions contribute to a faster and healthier transition. Positive feelings emerge when the patient learns that they may be discharged and reunites with loved ones, which facilitates the process of transition of the older person and their family caregiver. Feelings of gratitude, happiness, and calm reflect the affective and harmonious bonds established throughout their lives.[9] Admiration, gratitude, and love for the older person have also been mentioned by family as facilitating conditions for the transition.[9,10,11]

As the statements of caregivers have shown, inexperience, lack of preparation, and lack of knowledge about how to care for an older person at home led to negative feelings after discharge, such as a feeling of incapacity which can be an inhibiting condition for a healthy transition. In accordance with these findings, other studies suggest that the lack of skill, training, and orientation hinder the quality of home care.[11,12]

The unexpected dependence of the older family member led to significant changes, worrying family caregivers who now had to face many difficulties.[10]

Transition outcomes are related to definitions and redefinitions of the self and the situation being experienced by the older individual and the family caregiver. Nonetheless, for a person to be part of a transition, they must be cognizant of the changes they are giong through.[1,2] The perception of change in the routine, as reported by the relatives, indicates

an awareness of the transformations that the disease of the older person can bring. It also highlighted the need of providing continuous care at home, and the consequent necessity of changing physical environments, redefining the older person's schedule and the care provided to them. Even if the changes seem insignificant, the results of the transition may still be positive. A concluded transition would mean, then, that the potential of triggering circumstances to cause ruptures and disorganization was neutralized.[1]

To investigate coping mechanisms that would allow family caregivers of older individuals to relieve tension, a study found that patterns of response based on beliefs and spirituality/religiosity were a support to cope in times of adversity, as the caregivers sought the aid of transcendent strength to continue providing care to the older person at home.[13] The families, in this study, resorted to spirituality/religiosity as a way to overcome the difficulties they faced. This can also increase their awareness about the state of health of the elder, going beyond the stage of transition towards new beginnings by resignifying the situation being experienced and gaining control.[1]

Thus, health workers should stimulate the spiritual/religious well-being of the patient as a form of therapy when it is reported or discussed in nursing evaluations.

Another condition of the transition that affected all families in this study, as well as all studies found about the topic, is the financial condition. Family economic stability allowed changing the physical structure of the patient's environment and acquiring medication and supplies for care easily.[9,14] On the other hand, economic difficulties are important inhibiting conditions, which can even lead to other ones, such as stress, anguish, and insecurity. These influence the care of the elder and are also considered to be inhibiting factors of the transition.[11,14]

From the perspective of family caregivers, safety in the hospital-home transition can be achieved by eliminating myths about care, providing orientation, and clarifying doubts. This facilitates the adaptation of the person to the position of caregiver.[11] A systematic review found that multidisciplinary and multicomponent interventions are effective in reducing the rates of geriatric patient readmission, with no increase in costs.[15] Therapeutic measures, such as education and promotion of self-care, maintaining relationships, and stimulating coordination seem to have an important role in reducing hospital readmission rates in elders.[15]

This study showed that the lack of training to provide care at home was an inhibiting condition for the transition of the older individual, which had been suggested by previous studies.[10,14] The lack of educational support to help these patients, especially in the early

stages of care after discharge, was found to hinder the adaptation of the elder when back home.[14]

The lack of discharge planning and of an appropriate transition for elders increases the risk of readmission and may have a negative effect on the functioning and quality of life of patients and caregivers. To reduce the risk of negative outcomes in these cases, an international study carried out with older individuals and their family caregivers considered the following aspects: evaluation of clinical, social, and health care conditions; formalization of institutional roles and of the teams designated for planning and coordinating discharge; knowledge about programs to manage care transitions; and the ability to give information during the transition of older patients from hospital to home care. The study found that it is essential for the hospital to organize the discharge of older patients.[3, 14, 15, 16]

A study conducted to ascertain the facilitating and inhibiting conditions of the health/disease transition process in a group of patients found that the search for family support was a facilitating condition, since it provided emotional support and comfort in the form of attention, listening, esteem, and companionship.[17]

In a similar study about community conditions, family caregivers mentioned the direct or indirect presence of other relatives in the dynamics of basic care provided to the elder, reducing the burden on the primary caregiver.[11]

The presence and need for neighbors and friends were also found to support the hospital-home transition, presenting themselves as facilitating social conditions[13,17] and showing the importance of having and creating support networks. An international study carried out with marital partners of older persons who became their caregivers showed that becoming caregivers was associated with more support from friends. Relationships formed with friends and neighbors were mentioned as conditions that favor the transition and triggered feelings of solidarity. Thus, they should be considered in the planning of care to the older individual.

The absence of a family network that can share the work of caring for the elder interferes with the experience of the family caregiver who provides care daily by causing physical and psychological fatigue. These findings are supported by recent studies,[10,11,13], in which the main caregiver had to carry out multiple activities to meet the needs of the elder, such as caring for their hygiene, diet, medication, wound dressings, and living a routine which requires them to be constantly beside the elder.

Regarding social conditions found in this study, access to services mentioned by family caregivers, supplies provided by health services, professional guidance, discussing and negotiating a care transition, and self-care learning are social processes that support

the independence of the older individual at home, helping to maintain their health, improving caregiver safety and reducing the risk of readmissions.[21,14,22]

Having a formal support network in the form of health services that are effective in elder care increases family satisfaction and can lead to improvements in the transition stages, as it helps improve self-care.

Difficulties accessing services were pointed out by family caregivers as obstacles that hindered their ability to continue providing care to the older person. This difficulty was attributed to the social distancing required to deal with the COVID-19 pandemic. The limited availability of these professionals and the insufficient coverage of their services inhibit a healthy transition of care from hospital to home. A previous study pointed out that, despite being geographically close, home care was only provided when the family caregiver requested it, with no planning or frequency.[13]

A study from Canada revealed that, according to family caregivers of older people, public home care services were not sufficient to meet the needs of the patients and were unavailable after discharge.[20]

By ascertaining which factors influence the hospital-home transition of the older patient and their relatives, the nurse can plan a therapy that takes advantage of the personal abilities of each family caregiver, integrating their knowledge and life stories, propagating knowledge, and bringing together resources that exist in their social and community environment in order to improve their quality of life and conduct an effective transition.

CONCLUSION

The conditions that facilitate the transition of older individuals from hospital to home were positive meanings attributed to the return home after discharge, spirituality/religiosity, financial stability, preparations for managing care at home, and the availability of social and community support. The inhibiting conditions of the transition, on the other hand, were negative meanings attributed to going back home; self-care deficits in the elder; financial insecurity; a residence not prepared for home care; and the lack of social and community support.

This study was limited by the fact that it only analyzed the caregivers of one region of the country, which does not represent the entire Brazilian context. Further research is necessary to expand the populations and regions studied. Another limitation of this study is the fact that data collection took place at a distance, due to the COVID-19 pandemic, which also inhibited professional-caregiver interactions.

The hospital-home transition process is complex, subjective, and involves multiple factors. This is why the nurse must pay careful attention to the relevant conditioning factors, promoting interventions that can enhance facilitating ones and mitigate inhibiting ones in order to contribute to a healthy transition.

CONTRIBUTIONS

Authors 1.2- Participated in the conception and design of the work; data collection, analysis, and interpretation; the writing of the article and its critical review and the final approval of the version to be published.

Authors 3,4,5- Participated in data collection, analysis and interpretation; the writing of the article and its critical review and the final approval of the version to be published.

CONFLICTS OF INTERESTS

Nothing to declare.

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