Coordinating and Managing Care During Transitions Among Care Settings Teaching Strategy

Overview of Teaching Strategy

Older adults transitioning among care settings, such as from the hospital to home, especially those with multiple co-morbidities, are particularly vulnerable. Likewise, transitions are not necessarily limited to physical settings but can also include changes in activities, adjustment to the loss of a spouse or loved one, and changes in medication; all of which carry a vulnerability in optimizing health. There is recognition that decreasing the health complications in older adults during these transitional periods requires quality intraprofessional communication. This teaching strategy can be used to enhance student learning in beginning and/or advanced pre-licensure nursing courses. Students will examine common problems that cause poor transitions among care settings as well as discuss improvements that can be made to improve outcomes for older adults during the transitioning process.

Learning Objectives

Students will:

- Assess and recognize older adult clients' physical, emotional, and mental needs across care settings.
- Describe common problems associated with transitioning across care settings.
- Recognize and describe the impact of poor transitioning on older adults and the health care system.
- Understand the complexities of caring for older adults during transitions across care settings.
- Understand the importance of intraprofessional collaboration and communication in managing and coordinating care.
- Understand the specific role of nurses when providing care before and during transitions.

Learner Pre-Work

This teaching strategy focuses on assessing expectations, coordinating and managing care, and making situational decisions with older adults. The strategy enhances students' human flourishing, nursing judgment, and spirit of inquiry.

1. Overview: Millie Larsen is an 84-year-old Caucasian female who lives alone in a small home. Her husband Harold passed away a year ago and she has a cat, Snuggles, who is very important to her. Millie has one daughter, Dina Olsen, who is 50, lives nearby, and is Millie's major support system. Her current medical problems include: hypertension, glaucoma, osteoarthritis of the knee, stress incontinence, osteoporosis, and hypercholesterolemia. Tell students to become familiar with Millie Larson's unfolding case study.

2. Students should access and become familiar with The Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults. This assessment tool identifies 10 screening criteria to assess older adults' potential high risk for poor outcomes after hospitalization for acute or exacerbated chronic illnesses.

3. The following tools can be used in a variety of teaching/learning settings to enhance student learning and understanding of common problems associated with poor transitions, and improvements made to produce better outcomes for older adults during transitions: a) case studies and b) concept mapping.

    - Case studies are useful in helping students better understand the challenges individuals and families face during end-of-life transitions. Case studies foster students' critical thinking, by illustrating and contextualizing the complexities associated with end-of-life care. This approach is best suited for small group discussions or post-clinical debriefings/discussions.
    - Concept mapping facilitates students' critical thinking related to the needs of older adults and their families during end of life decision making. Concept mapping, based on a clinical situations or case studies, stimulates student thinking and broadens their conceptualization of important end of life care needs, as well as allowing them to individualize those needs to a specific context, individual, and family situations.

4. The above tools should address common problems during transitions across care settings, such as communication failure, poor care planning, poor continuity of care, increased medication errors, and inadequate patient and caregiver education. These tools should also further emphasize the essential and important role of the interdisciplinary team during discharge planning to other care settings.

Suggested Learning Activities

1. Case Study: Millie Larsen
   Utilize the case study of Millie Larsen. Is Millie Larsen at risk for common problems during transition across settings? Utilizing the Transitional Care Model (TSM): Hospital Discharge Screening Criteria for High Risk Older Adults, identify the risk factors for Millie.

2. Concept maps are graphical tools used to organize and represent knowledge in an organized manner. Concept maps facilitate critical thinking by allowing students to create visual frameworks of important constructs or components of a given situation and create propositional links between them. They stimulate critical thinking and creativity and can be particularly useful when helping students think about the importance of improving transitions across care settings to produce better patient outcomes. Below are several recent articles that have been published detailing the use of concept mapping in nursing education. Have students develop a concept map of the at risk factors for transition with suggested interventions by the nurse.

Suggested Reading

Naylor, M., & Keating, S.A. (2008). Transitional care: Moving patients from one care setting to another. *American Journal of Nursing*, *108*(9 Suppl.), 58-63. doi:10.1097/01.NAJ.0000336420.34946.3a

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