An evaluation of a transitional care programme for older adults in a general hospital in the Netherlands: Needs, preferences and perspectives of the average old and the oldest old

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The whole is more than the sum of its parts

Aristotle

In remembrance of Roland van Linge

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ABSTRACT

Title

An evaluation of a transitional care programme for older adults in a general hospital in the Netherlands: Needs, preferences and perspectives of the average old and the oldest old

Aim

This research aimed to evaluate a transitional care programme for older adults who were acutely admitted to a general hospital, with a special focus on health outcomes and healthcare utilisation for the oldest patients and to clarify patients' and health care providers' perspectives on the care provided.

Background

Populations around the world are ageing, and many older adults have complex health problems owing to multimorbidity. Consequently, they experience many transitions in care. During the past decade, transitional care for older adults has become increasingly important in terms of safe transitions and prevention of adverse events during transitions.

Methodology and methods

A mixed methods research design, based upon pragmatism and critical realism, was used in a parallel convergent design study. Measurements in the quantitative phase of the study were based on the The Older Persons and Informal Caregivers Survey Minimal Dataset (TOPICS-MDS). Data from the hospital registry and questionnaires were used. In the qualitative phase of the study reflexive thematic analysis was used on data gathered in interviews with patients, hospital nurses and community nurses and two focus group meetings with the geriatric team, and staff and managers from the home care organisations.

Findings

The quantitative part of the study did not show any significant results of the effect of the Transitional Care Bridge (TCB) programme on the prevention of functional decline, health care utilisation and other health outcomes. However, the study revealed an increase in preventive care in the more frail TCB group. The qualitative part of the study reveals the programme was valued by patients, family members and professionals. The familiarity with the programme and personal attitudes of professionals may have influenced expectations and outcomes. Many patients enrolled in the programme were very frail and often

unaware of the programme. As they often already received some kind of home care, patients were initially referred to the usual carers. The assessment of the care needs of the oldest patients to some extent fail to recognise what would contribute most to ageing well at home. Professionals in hospital as well as home care organisations struggled with motivation towards the programme and felt they still remained working within their silos. Professional roles were not always clearly defined, valued and reflected upon, and outcomes relating to collaboration reveal a gap between the different worlds of hospital and home.

Contribution to current knowledge

Transitional care interventions should be redeveloped for and with the oldest adults and their informal caregivers and address their needs during the period shortly after discharge, and help them build structure into their daily routines, resume activities and exercise. Reflective practices on shared values, implications and outcomes should be developed as a competence within and between all involved organisations of transitional care. More reflective and emergent research approaches are needed to inform policies on ageing well in place and prevention.

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LIST OF ABBREVATIONS

ADL	Activities of Daily Living
APN	Advanced Practice Nurse
CAS	Complex Adaptive System
CBS	Central Bureau Statistics
CD	Chronic Disease
CGA	Comprehensive Geriatric Assessment
CN	Community Nurse
CR	Critical Realism
ED	Emergency Department
EFQ	European Qualification framework
GDPR	General Data Protection Regulation
GP	General Practitioner
GT	Grounded Theory
ICOPE	Integrated Care for Older People
IOM	Institute Of Medicine
ISAR-HP	Identification of Seniors At Risk – Hospitalised
IPA	Interpretive Phenomenological Analysis
IQR	Inter Quartile Range
LoS	Length of Stay
OECD	Organisation for Economic Co-operation and Development
RCT	Randomised Controlled Trial
RN	Registered Nurse
RTA	Reflexive Thematic Analysis
SD	Standard Deviation
SNAQ	Short Nutritional Assessment Questionnaire
SSM	Self Sufficiency Matrix
TA	Thematic Analysis
TCB	Transitional Care Bridge
TCB-A	Transitional Care Bridge - Amsterdam
TCB- S	Transitional Care Bridge - Study

TCM	Transitional Care Management
TCP	Transitional Care Plan
TCI	Transitional Care Intervention
QoL	Quality of life
UC	Usual Care
UClan	University of Central Lancashire
WHO	World Health Organisation

LIST OF TABLES AND FIGURES

CHAPTER 1 INTRODUCTION TO THE STUDY

1.1. Outline of transitional care

These days, populations around the world live longer, and the number of adults aged over sixty is increasing rapidly (WHO, 2022). In recent decades, multimorbidity – the co-occurrence of more than one chronic health condition in an individual – has emerged as a major challenge for healthcare[1] systems (Calderón-Larrañaga et al., 2019). Since older adults especially experience high rates of multimorbidity, the health – and social care needs of this group are increasing. The often-complex health problems require care in multiple settings and the involvement of various professionals (Van Campen, 2011; Van der Vlegel-Brouwer, 2016; Van Oostrom et al., 2012). Consequently, older adults experience various transitions in care, including transfers from home-to-hospital, hospital-to-home, hospital-to-skilled care facility, and skilled care facility to-home and/or homecare.

Based upon these demographic developments, transitional care has become one of the most pressing topics in global efforts to optimise collaboration and coordination between professionals in the delivery of care during these transitions (Tarrant et al., 2015). An increasing body of evidence reveals that older adults coping with multiple chronic conditions are particularly vulnerable to breakdowns in care during transitions when they are at risk of medical errors, communication-related adverse events, as well as problems with care fragmentation (Naylor et al., 2009). Insufficient communication between providers and across healthcare settings; inadequate patient and family caregiver communication; poor continuity of care; and limited access to services are among the major factors contributing to poor quality and high costs (Naylor et al., 2009).

This study focuses on the transition from hospital to home. Hospitalisation is a high-risk event for many older adults. The risk of undesirable and potentially avoidable outcomes during and after hospitalisation is high. Globally, almost 5% of the elderly develop an avoidable complication (avoidable adverse event) during hospitalisation (Buurman et al., 2011). In the Netherlands, the latest numbers show 6.9% of potentially avoidable complications, of which 20.1% is related to medication (Merten et al., 2013). Globally, about 20% of the elderly (65+) are re-admitted to hospital, and of these, 25% die in the first three months after discharge. More than 30% of the elderly experience - usually permanent - functional decline after hospitalisation (Buurman et al., 2011; Hoogerduijn et al., 2012; van Seben et al., 2016).

Transitional care programmes have subsequently emerged to address these care needs. The care

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[1] *Healthcare* means the business, institution, or activity offering medical services. It can also mean the set of medical services that an organisation or country provides. *Health care* is the set of actions by trained and licensed professionals to maintain or improve a patient's health.

needs of older adults are the central focus of transitional care programmes, though care needs is a concept that means different things to different people. To professionals, assessment is often based on practice data to identify needs. However, the risk of this approach fails to recognise the specific needs of those who should benefit from healthcare. An additional risk of viewing needs only in terms of healthcare overlooks other factors that impact on health (Jordan & Wright, 1997). Care needs were defined by van Meijel et al. (2004, p. 86), a group of Dutch researchers, as one of the building blocks of intervention design. These building blocks are 1) Literature review; 2) Problem analysis; 3) Needs analysis; and 4) Current practice analysis. The formulation of care needs is an intrinsic and essential part of problem analysis, and includes the client's perspective of the problem, in addition to his or her defined needs and requests for care (van Meijel et al., 2004).

1.1.1. Definition of transitional care

The first transitional care model was developed in 1981 by a multidisciplinary team at the University of Pennsylvania. Initially, however, this was developed for all patients with chronic care needs, rather than being focused on older adults (Naylor, 2012). In 2003, the American Institute of Medicine (IOM) identified frailty associated with old age as one of the fields for national action (Adams & Corrigan, 2003). This report states that this field was one of several areas with serious and widespread quality problems, such as a high intensity of errors, along with gaps in healthcare quality. Services for frail older adults were often poorly co-ordinated, funded and, in addition, inadequately met the important care needs or wishes of older adults (Adams & Corrigan, 2003, p.64-65). At that point in time, however, insights were lacking regarding the intensity of the intervention needed to effectively and efficiently improve the health- and cost- outcomes for this patient group. Since then, various transitional care programmes for older adults have been developed and refined, often based upon the initial work of Naylor and Coleman (Coleman, 2003; Naylor, 2004; Naylor & Keating, 2008). These programmes aimed to address the unmet needs of hospitalised older adults. Nevertheless, many of the transitional care programmes addressing the care needs of older adults have similar components, which combine several elements at the three steps of the transition: 1) before the patient leaves the hospital; 2) at the time of discharge; and 3) within 48 hours and up to 30 days after discharge. A transitional care programme is a complex intervention, including several interventions by collaborating health professionals (Coleman, 2003; Naylor & Keating, 2008). The interventions may be carried out by the community nurse (CN), an advanced practice nurse (APN), a geriatrician and/or a hospital nurse, in collaboration with the general practitioner (GP) (Coleman, 2003; Naylor & Keating, 2008). Despite two decades of research and implementation, the scaling up of transitional care interventions remains challenging (Fakha et al., 2021; Naylor et al., 2009; Naylor & Sochalski, 2010).

Transitional care can be defined as a broad range of services and environments designed to promote the safe and timely transfer of patients between levels of care or across settings which bridge the gap between and among a diverse range of providers, services and settings (Coleman & Boult, 2003; Naylor, 2002). In a recent concept analysis, transitional care is described as an important concept for nurses and others involved in healthcare provision systems (Shahsavari et al., 2019). It is a systematic care process that involves the patients, their families, and multidisciplinary members of the healthcare team and aims at improving the consequences of illness associated with patients, their families, caregivers and healthcare systems. In transitional care, co-ordinated, structured and comprehensive care is designed by considering the conditions of the patients and their families; the healthcare system structure; the environmental conditions; and social support to bridge the gap between hospital and out-of-hospital care (Shahsavari et al., 2019).

Most recently the definition of transitional care was extended in a Delphi study to which I contributed as a participant and co-author. Intermediate and transitional care in the Delphi study were defined as '*time-limited services that ensure continuity and quality of care, promote recovery, restore independence and confidence at the interface between home and acute services, with transitional care representing a subset of intermediate care'* (Sezgin et al., 2020, p.2399). Both intermediate and transitional care are best delivered by an interdisciplinary team within an integrated health and social care system, where a single contact point optimises the service access, the communication and the co-ordination (Sezgin et al., 2020).

1.1.2. Definition of 'old'

Although the World Health Organisation (WHO) defines older people as those 60 years or older, several other concepts of 'old' exist. The elderly population is defined by the Organisation for Economic Co-operation and Development (OECD) as people aged 65 and over (OECD, 2021). Older adults are most often divided into two or three categories: transition to old age or 'youngest old' (from 65 to 75 years); average old age or 'middle-old' (from 75 to 85 years); and 'oldest old' (85 years and older) (Breaz, 2015; Lee et al., 2018). Individuals older than 85, often referred to as 'the oldest old', are the fastest growing segment of the older population in many countries (Sorrell, 2011; Tomassini, 2005; Tsoi et al., 2014). Another classification of 'old' is the 'third age', as it follows childhood (the 'first age') and work and parenting (the 'second age'). After the 'third age', between 65 and 84 years old, comes the 'fourth age' of those above 85 (van Dyk, 2016). The competing narratives of the 'third age' (opportunity) and the 'fourth age' (threat) contribute to negative stereotypes of old age (Higgs & Gilleard, 2014). According to van Dyk (2016), this negative perspective is constantly enhanced by the current absence of very old persons in theoretical analyses.

The study presented in this thesis was located in the Netherlands, where the term ‘geriatric’ is widely used and, as a result, I use this term when referring to specialist care for the elderly. The geriatric team, as referred to in this thesis, comprises an interdisciplinary team of geriatricians, geriatric nurses and geriatric physiotherapists, working in the clinical environment of the hospital. They provide geriatric care throughout the hospital and support other professionals in their care for older people. The most frail and complex patients are admitted to the geriatric unit of the hospital.

1.2. The transitional care programme under study

The general hospital under study developed a transitional care programme for older adults who are admitted to hospital after visiting the emergency department (ED) and are then discharged home in collaboration with home care organisations, GPs, and social services. This programme is based on the Transitional Care Model developed by Coleman and Naylor (Coleman & Berenson, 2004; Naylor & Keating, 2008). It was later adapted for the Dutch context (Buurman et al., 2010; Verhaegh et al., 2014). In 2016, *The Transitional Care Bridge Programme (TCB)* was developed and tested in an academic hospital on internal medicial wards in Amsterdam during a randomised controlled trial (RCT) study (Buurman et al., 2016; Buurman et al., 2010). In this thesis *TCB-A* will be used when referring to this initial study in Amsterdam. The TCB focuses on the transfer of care between the hospital, community care nurse (CN), and homecare, which provides a pro-active, multi-component, nurse-led transitional care programme that follows patients for a period of six months after hospital admission. The programme was found to reduce mortality by 36% at one month after discharge. After 6 months, this percentage still remained at 26% (Buurman et al., 2016). Based on these results, this programme was embraced by the healthcare insurers in the Netherlands. It was recommended that further studies should be conducted, exploring whether the programme might improve patient safety during the vulnerable period that occurs shortly after hospital discharge (Buurman et al 2016). Therefore, in this study, I followed the dissemination and implementation of the TCB in a regional hospital in the Netherlands, following 50 patients receiving the conventional care and 50 patients within this transitional care programme, at three points in time: before discharge (baseline); at one month after discharge; and at three months after discharge. The TCB programme under study in this thesis will be referred to as *TCB-S*.

In this programme, the identification of at-risk seniors starts at the ED of the general hospital. All older patients admitted to the ED and subsequently to the hospital were screened by the Identification of Seniors at Risk-Hospitalised (ISAR-HP) (Hoogerduijn et al., 2012). Patients at high risk of functional decline, as determined by the ISAR-HP, filled out a triage questionnaire with their informal caregivers, which had been developed by the geriatricians of a general hospital. This questionnaire of 25 questions is based on a literature review carried out by the geriatricians of the general hospital under study (see Appendix 8). If five questions in this questionnaire are answered with ‘Yes’, or if one of the five selected key questions is answered with a ‘Yes’, the geriatric consultation team would visit the patient and a comprehensive geriatric assessment (CGA) is carried out. The CGA is a multidimensional, usually interdisciplinary, diagnostic process, which is used to determine the medical, psychological, and functional capabilities of a frail older patient, in order to develop a co-ordinated and integrated care plan for their treatment and long-term follow up (Ellis & Langhorne, 2005). This care and treatment plan was discussed with the patient and the primary care giver and was carried out during admission, in accordance with the medical and nursing care team at the ward where the patient was admitted. In cognitively-impaired patients, part of the CGA is conducted by interviewing the primary care giver. In all cases, a registered nurse (RN), on the ward where the patient was admitted, undertook screening for delirium, malnutrition, activities of daily living (ADL) functions, mobility and fall risk (VMS, 2009). The RN began the appropriate interventions based on the results of the screening. If necessary, other disciplines were consulted, such as a dietician, a pharmacist or occupational therapist. In 2016 the TCB was incorporated into the programme.

In the programme of this general hospital, a CN visited the patient one day before discharge from the hospital and was given information by the healthcare team at the hospital. This same CN would then visit the patient at home within 48 hours of their discharge from hospital, and again after 2, 6, 12 and 24 weeks. The main issues of discussion during these visits were medication safety: appropriateness of care arranged during hospital admission: resources: social network: and support for the informal caregiver. At the start of the visits, the CN would also create an additional care plan that included health-related goals that the patient wished to achieve. At the end of the programme, the CN discussed the care plan with the patient’s General Practitioner (GP) and would leave the patient in the care of the GP. The CNs used a template to document each meeting.

In this research, the ‘in-hospital’ component is considered as part of the customary care, apart from the visit of the CN prior to discharge (Step 4).

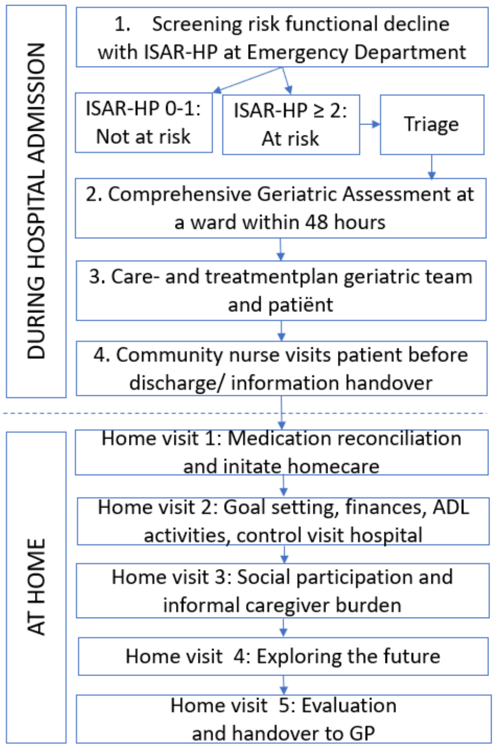


Figure 1.1. Components of the Transitional Care Bridge

1.3. Aims and objectives

This research aims to evaluate the implementation of a transitional care programme for older adults who were acutely admitted to a general hospital, with a special focus on the effects of the programme on people who are 85 and older. The aim of the study is, therefore, twofold, examining both the process and the product.

Firstly, this study's aim is to explore the outcomes of a transitional care programme for older patients, especially the oldest old, who were admitted to a general hospital and who were subsequently discharged to their home. Based on previous transitional care programme evaluations, it is expected that the transitional care programme would enhance the self-rated health, self-management skills, and the quality of life of the patient, while reducing the number of GP visits, ED visits, as well as re-admissions. Therefore, the delivery of the programme in practice will be explored.

Secondly, this research aims to clarify patients' and healthcare providers' perspectives of the care provided. In particular, the views of the oldest patients, who have been treated in a general hospital and were enrolled in the transitional care programme, will be explored.

1.4. Research question

What is known about transitional care programmes for older adults, discharged from hospital to home; the working elements of these programmes; the outcomes; and the experiences of professionals and patients?

Subsidiary questions:

1. How did patients and health professionals experience the programme in general?
2. How were the parts of the intervention delivered?
3. What was the effect of the intervention on self-management, self-rated health, quality of life, and the number of GP visits, ED visits, and admissions to care homes?
4. Which similarities and differences could be observed in the different age groups of the elderly?

1.5. Research setting

The specific research context for this study is the area served by a general hospital in the Netherlands in Capelle aan den IJssel, a town near Rotterdam. At the start of this study, for the surrounding towns, the percentages of the entire population who were 65 years and above, were: Rotterdam 14.%; Capelle aan den IJssel 14.9%; Zuidplas 13.8%; and in Krimpen aan den IJssel 19.6% (RIVM, 2014).

In the general hospital in Capelle aan den IJssel , of all ED visits in 2012, 26% of patients were over 70 years old (6,679 older patients) and 48% were admitted for long-stay care (which is more than 48 hours) in hospital (3,206 older patients). After discharge, 10% were re-admitted within 30 days (668 older patients). In 2014, the number of acutely admitted patients through the ED increased to 3,800. Of all older patients admitted to the hospital in 2014, 53% were 80 years or older. In 2016, the number of acutely admitted patients was over 4,000. Within 30 days of discharge, 15% of these patients were re-admitted. GPs caring for older adults and older adults who visited the ED in the general hospital complained about the lack of timely exchange of information; inadequate discharge planning; and the lack of connection to community services. As a result of these experiences and the expected increase in the numbers of older people in the communities surrounding a general hospital, the hospital under study focused on improving care for older people and becoming a senior-friendly hospital.

1.6. Motivation for the study

After starting my career as a nurse, I worked in several management roles and on different wards in the hospital. It became clear to me that hospital care was in fact ‘elderly care’, but care for the elderly was fragmented, and hospital care was viewed upon as acute care. During my last management role, as head of the orthopedic and short stay care department, I developed a care pathway for patients with hip fractures in collaboration with the main homecare organisations in the local area. During this period, I encountered entirely different views of professionals on elderly care in the hospital in comparison to professionals working in care homes or rehabilitation centres. After I finished my Masters' study on care trajectory design, I became the policy advisor on integrated care in the hospital. Together with the homecare and care home organisations, specialists and general practitioners, I developed several care pathways and a collaborative view on care for the elderly. Transitional care was a top priority, as the number of hospital beds and the length of stay (LoS) diminished. In 2015, the national elderly organisations, together with the main insurer, developed a senior-friendly quality mark for hospitals. As a policy advisor, I worked together with the ED; the geriatric department and managers; specialists; and wards to obtain this quality mark. Everyone became more aware that hospital care was in fact 'elderly care', and that, over 70% of the time, it was older patients who occupied hospital beds. As it became clear that re-admissions were frequent, the hospital developed a transitional care programme for older patients, based on the TCB-A (Buurman et al., 2010). The development and implementation of this programme is the subject of this study.

From an early point in my career, I realised that health and social services for elderly should be looked upon as a complex adaptive system (van der Vlegel-Brouwer, 2013). As the many interacting professionals and organisations have their own viewpoints, norms and values, it is the level of connectedness between these agents that defines the complexity of the network and the level of development (Evans & Baker, 2012). More recently, I developed a more intense view on this perspective of the world, which Everard van Kemenade and I describe as the 'emergence paradigm' (Van Kemenade & van der Vlegel-Brouwer, 2019). In the 'emergence paradigm', a collective of stakeholders, including patients and/or citizens, explore and co-create new solutions. This paradigm is underpinned by the research philosophy of pragmatism or participatory research. Research in this paradigm aims to inform our understanding of the dynamic interactions which, in turn, leads to novel practices which respond to the real world context of local levels (van der Vlegel-Brouwer et al., 2020).

In my own life, I have encountered many problems and worries during transitions in care in the periods when I took care of my father, mother, father-in-law and several aunts. Often, other family members and I had to advocate on their behalf to address fragmentation of healthcare services to ensure their wishes were valued. My own wish for the future, as I turn 55, is to be able to live at home independently all my life, with the proper support of healthcare.

To add to the validity of a study, researchers should reflect on their personal views and insights of a phenomenon (Dowling, 2006). My role as a researcher is likely to have been influenced at every stage of this research process, as well as on the interpretation of the findings of this research, as my professional and personal background provide the lens through which I interpret the world. As a researcher, I was intimately involved in both the process and the product of the research endeavour. Being trained as a nurse, and working as a policy advisor on integrated care during the research process, will both have influenced my research, as well as my personal experiences.

1.7. Structure of the thesis

In the second chapter, the history, context and background of care for older adults will be described. In Chapter Three, what is already known about transitional care will be discussed. In Chapter Four, the theoretical perspectives of mixed methods research and the underpinning ontology and epistemology of this study are described in detail. Based on these perspectives, methods of data collection and data analysis are discussed. In Chapter Five, the findings and the analysis of the quantitative data is described and examined, which is followed by the qualitative findings and analysis in Chapter Six. A synthesis of the findings and analysis is described in Chapter Seven and is further discussed in Chapter Eight, and which concludes with recommendations for practice, policy and research. In the final chapter, Chapter Nine, I describe my personal reflections on this study.

1.8. Summary

Populations around the world are ageing, and many older adults have complex health problems due to multimorbidity. Consequently, they experience many transitions in care. Transitional care for older adults has become increasingly important for the safe transitions and prevention of adverse events during these transitions. As the care needs of older adults are the central focus, needs assessment and needs analysis are the basis in the development and delivery of transitional care. Many transitional care programmes share similar components in order to ensure continuity and quality of care, to promote recovery, and to restore independence. This study evaluates the implementation and outcomes of the TCB programme in the area of a general hospital in the Netherlands, as compared to more conventional care. In this research, the “in-hospital” component is considered part of normal care, apart from the visit of the CN before discharge. The CN will visit the patient five times during the subsequent six months at home. This study addresses the question as to which features of this transitional care programme work best; for which group of older adults; in which respects; and why. The study will contribute to knowledge as to how well the transitional care programme works for the different age groups of older adults, and will provide insights into the perspectives of patients and professionals on the programme.

Chapter 2 CARE FOR OLDER ADULTS: AN EXPLORATION OF THE MACRO-, MESO- AND MICRO-LEVEL

2.1. Introduction

In the previous chapter, I described the relevance, and purpose of the study and provided a brief overview of the history of the development of transitional care. In this chapter, the context and background of the ageing population and the impact on care for older adults will be addressed at the macro-, meso- and micro-levels. This background is necessary as transitional care is part of the entire care continuum for older adults and, as such, is part of the same complex environment.

The macro-level in this study is the global and national perceived structural, legal, regulatory, demographic and economic conditions that are beyond the influence of individual organisations or practitioners. The meso-level is the local institutional and network factors and collaborations between organisations and communities, that define the parameters of service delivery. The micro-level is the day-to-day practice on a clinical level, including interactions with patients that affect how services are delivered and perceived by professionals and patients.

2.2. Macro-, meso- and micro-level

2.2.1. The macro-level: The global and national background

Globally, people around the world are living longer and, therefore, populations are ageing (WHO, 2022). This demographic transition will have an impact on almost all aspects of society. Chronic non-communicable diseases are the major cause of death among older people, both in more developed and less developed countries. Already, there are more than 1 billion people aged 60 years or older and this is projected to reach approximately 2.1 billion by 2050 (WHO, 2022). The United Nations declared 2021 to 2030 as the 'Decade of Healthy Ageing' with the WHO leading international action to improve the lives of older people, their families and communities (WHO, 2020). There are four areas outlined in the WHO (2020) 'Plan of Action'. These four areas include: 1) changing how we think, feel and act towards age and ageing; 2) ensuring communities foster the abilities of older people; 3) delivering person-centred integrated care and primary health services responsive to older people; and 4) providing access to long term care for older people who need it (WHO, 2020, p. 4).

The WHO does not define healthy ageing as having no pathology, since diseases happen throughout life, but as being able to continue to do what we have reason to value for as long as possible (WHO, 2016a). Limiting the number of dependent older people in coming years will be a major economic and human challenge. To enable as many people as possible to age in good health, the WHO developed the 'Integrated

Care for Older People' (ICOPE) approach, which offers schemes and guidelines for systems (macro-level) and services (meso-level) and for the primary care givers (micro-level) (Rudnicka et al., 2020; WHO, 2016a). The objective is to prevent or delay the onset, as well as to decrease the severity, of care dependency. The goal is to enable as many people as possible to age in good health and to optimise the functional ability of older people by 2030 (Tavassoli et al., 2021). This is in line with Huber (2011) who defines health as "the ability to adapt and to self-manage" (Huber et al., 2011, p.3.). Integrated health systems are promoted as a means to improve access, quality and continuity of services in a more efficient way, especially for people with complex needs (e.g. multiple morbidities) (Valentijn et al., 2013). Integration initiatives need actions at macro-, meso- and micro-levels. Strategies can target different levels of service: policy; legislation; workforce development; information and communication technologies; and funding (macro-), service- and organisational-level (meso) or citizen/patient or clinical level (micro-) (de Carvalho et al., 2017).

In the location of this study in the Netherlands, it is estimated that the percentage of people who are 65 years and older will rise from 16% (2.7 million people) in 2012 to 26% in 2060. Of this group, one third will be 80 years or older (RIVM, 2014). In Europe, as well as in the Netherlands, of all older people aged 65 years and older, 66% have at least one chronic disease, and 40% have two or more chronic diseases. In addition, of all people aged 75 years and above, 50% have multiple complex conditions (RIVM, 2014). In 2010 in the Netherlands, 62.6% of people older than 85 years lived independently. This steadily increased to 70.1% by 2015 and 73.6% by 2020 (Statistics Netherlands [CBS], 2022). The Netherlands has had a national policy in the last decade aimed at allowing people to stay in their own home for as long as possible. Since then, many care homes have been closed. From 2018, this policy was supported by the national programme 'Longer Independent Living' (Dutch Ministry of Health, 2018).

In the Netherlands in 2012, 16% of people aged 70 years and older were admitted to hospital each year (Statistics Netherlands [CBS], 2012). Of these patients, 30% experienced functional decline after hospitalisation, often resulting in a decline in health-related quality of life and autonomy (Hoogerduijn, 2010). Re-hospitalisation rates for these patients were nearly 20% within three months, and 25% of these patients died within the first three months after discharge. Of all discharged older adults from hospital, 10.9% were re-admitted within 30 days (Van der Ven et al., 2015). One-quarter of the re-hospitalisations within 30 days of discharge from hospital are believed to have been preventable (van Walraven et al., 2012). These numbers have been confirmed in the Dutch context (Van der Ven et al., 2015; van Seben et al., 2016).

The ageing population may be a challenge to ED care, in particular, because of the limited geriatric training and resources to cope with the more complex needs of older patients (Hofman, 2017). Research in the Dutch context by van Campen (2011) and de Klerk et al. (2019) has indicated many deficiencies in the care of this high-risk population, including failure to recognise or evaluate problems that could benefit from a more careful assessment. Recognising geriatric problems and quickly starting the correct interventions can delay or even prevent adverse health outcomes. These interventions should include the transition from hospital to home, as this transition can be a challenging experience for older people. These challenges are somewhat increased as the typical length of stays in hospital continue to drop and more older people remain living at home (De Klerk et al., 2019; Van Campen, 2011). The fact that many older people suffer from functional or cognitive decline after hospitalisation makes it even more important to ensure that older patients and their families receive the proper care, that ensures and encourages them to remain living at home (Hoogerduijn et al., 2010; Stafford & Gulwadi, 2020).

As part of the 'Dutch National Programme for Elderly Care' (2008-2016), the diffusion and active dissemination of evidence-based innovations was encouraged with funding from 'The Netherlands Organisation for Health Research and Development' (ZonMw), including the TCB programme (Wehrens et al., 2017). The funding could be used to pay for the visits of the CN during hospital stay as, during this implementation, this was not included in the reimbursement of the care insurers.

2.2.2. Meso-level: Organisational and service level

Since the health dynamics of older age are related to increased needs for healthcare, it may be expected that increasing age would be associated with increased healthcare utilisation (WHO, 2015, 2016b). More than half of older people are likely to experience multimorbidity in high-income countries and the prevalence of this is increasing in middle- and low-income countries (Abebe et al., 2020; Asogwa et al., 2022). Multimorbidity can lead to interactions between disorders; between one disorder and treatment recommendations for another; and between drugs prescribed for different disorders. As a result, the effect of multimorbidity on functioning, quality of life, and mortality risk may be much greater than the individual effects that might be expected from these disorders. For people who live in deprived areas, multimorbidity occurs 10 to 15 years earlier than in the most affluent areas. The most important consideration for an older person is likely to be their functioning. Comprehensive assessments of functioning in older age are also much better predictors of survival and other outcomes, than the presence of diseases or even the extent of co-morbidities (WHO, 2015). Integrated care for older adults with multimorbidity is being increasingly proposed by policy makers who are intent on improving the effectiveness and efficiency of health and social services (Reinhard, 2013). Integration of care, according to Goodwin (2016, p1), is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people, by cutting across multiple services, providers and settings. Where the result of such multi-pronged efforts to promote integration lead to benefits for people, the outcome can be called 'integrated care' (Goodwin, 2016).

As the goal of transitional care is to facilitate and support seamless transitions across the continuum of care, and to achieve and maintain optimal adaptation, outcomes and quality of life for patients, families and caregivers, transitional care can be considered as a part of integrated care (Allen et al., 2014; Markle-Reid et al., 2020; Threapleton et al., 2017). Older adults with multimorbidity experience a complex of both medical and social problems and they frequently require continuous care in multiple settings. They must deal with many different caregivers, which makes information exchange and co-ordination of care a priority (Edgren, 2008). Due to the multiple conditions, older persons can be at risk of opposing advice, adverse effects of treatment, or receiving multiple medications with consequent difficulties with adherence (Fortin et al., 2004; Le Reste et al., 2013; Marengoni et al., 2011; Smith et al., 2012; Van Oostrom et al., 2012). Based on the trends towards early discharge from hospital and more recovery at home, transitional care programmes have emerged to support adjustment at home after discharge from hospital; providing the necessary care; and enhancing the self-management capabilities of the elderly (Coleman & Boult, 2003; Naylor & Keating, 2008).

At least one in five older adults are at risk of hospital re-admission (Andreasen et al., 2015). “A large proportion of these readmissions are considered preventable and often viewed as a result of inadequate coordination of care between hospital and community services and ineffective post-discharge follow-up support” (O'Donnell, 2021, p.1628). The elderly are especially at risk of medical errors, communication-related adverse events and problems in care fragmentation during transitions. Transitional care interventions aim to improve care transitions from hospital to home and to reduce hospital re-admissions for chronically ill patients (Braet et al., 2012; Verhaegh et al., 2014). Interventions can be divided into two group: discharge preparation (discharge planning) and discharge support (or aftercare) (Braet et al., 2012). Many of the programmes have similar components, combining several actions at the three steps of transition: 1) before the patient leaves the hospital; 2) at the time of discharge; and 3) within 48 hours and up to 30 days after discharge (Coleman & Berenson, 2004; Naylor & Keating, 2008).

2.2.3. Micro-level: citizen and patient level

Several factors influence health and the perception of the health of older people with multimorbidity, such as their social network; socio-economic status; cultural and personal attitudes to health and disease; prior experiences with the healthcare system; living alone status; education level; and patient’s coping strategies (Ament et al., 2012; Sturmberg, 2014).

A systematic review by Reich et al (2020) on what successful ageing means to older adults showed that older adults across countries and regions shared similar general perspectives. Highly valued social engagement and positive attitude were mentioned most, along with independence, spirituality, physical and cognitive functioning (Löffler et al., 2012; Reich et al., 2020). People with multimorbidity experience a poorer quality of life, yet, according to several studies, some try to preserve their autonomy to the best possible extent; hold positive attitudes towards life; and try to find hope, meaning and purpose, in a desire to regain identity and a sense of self-worth (Duggleby et al., 2012; Fortin et al., 2004; Holm & Severinsson, 2013). Larsson et al (2009, p. 99) found that "being occupied and staying healthy and sound in mind are stressed as important by the oldest old adults even if reduced energy and functional constraints limit activities". Older adults have a strong volition to manage independently (Larsson et al., 2009). There is a lack of understanding of coping strategies over time during the ageing-in-place experience and how this can be supported (Stafford & Gulwadi, 2020). The focus on optimising older people's intrinsic capacity over the course of their life and ensuring healthy ageing makes it clear that a different set of outcome indicators is needed to reflect intrinsic capacity; functional ability; quality of life; and the attainment of goals defined by the older person (de Carvalho et al., 2017). Traditionally, healthcare research has used indicators of disease, disability, longevity, patient and provider satisfaction, healthcare utilisation, hospitalisation, institutionalisation and cost, as will be addressed in the next chapter.

2.3. Summary

The macro-, meso- and micro-levels are all important in the background and context of transitional care. On the macro-level, people around the world are living longer and, therefore, populations are ageing. As a result, the United Nations declared 2021 to 2030 the 'Decade of Healthy Ageing'. The four areas of the WHO's plan for action are reflected in the ICOPE approach, with the objective of preventing or delaying the onset of care dependency, as well as decreasing its severity. In the Netherlands, 73.6% of the older adults of 85 years and older live independently. As older adults are admitted frequently to hospital and almost 30% suffer functional decline after hospitalisation, healthcare resources are under pressure. This highlights the importance of high quality transitional care from hospital to home, and is considered important in preventing re-hospitalisations and focuses on enhancing the intrinsic capacity of older people and the support of healthy ageing.

Chapter 3 LITERATURE REVIEW

In this chapter, building on my exploration in the previous chapter of the macro-, meso- and micro-levels of transitional care as a subset of integrated care for older adults, I specifically focus on literature relating to the third goal of the WHO's plan of action: "delivering person-centered integrated care and primary health services responsive to older people" (WHO, 2020, p. 4).

As this study is a mixed methods study, and the research questions in this study, as stated in Chapter 1, also addresses qualitative aspects, a different type of literature review had to be carried out, that addressed the main building blocks of transitional care, as well as the experiences of patients and professionals. Grant and Booth (2009) identified fourteen different review types and associated methodologies. However, a different type of literature review still seemed necessary, with a more integrative approach (Grant & Booth, 2009; Noble & Smith, 2018; Souza et al., 2010). As this study's aim is to articulate the underlying mechanisms and then interpret the available evidence, in which both the unique contributions of quantitative and qualitative studies are valued, an explanatory synthesis was chosen. In this "synthesis by explanation*"*, as defined by Rousseau et al. (2008), no hierarchy of evidence is recognised and every unique contribution of evidence will be triangulated and discussed (Rousseau et al., 2008, p.41.). This is in line with Pawson (2005), who stated that the worth of the study can only be determined in synthesis, by each study's contribution to pattern-building (Pawson et al., 2005). This approach is heavily practice-oriented, and thus pragmatic, yet its explicit critical realist basis keeps it strongly focused on providing theoretical explanations. This ontological and epistemological viewpoint will be addressed in more depth in Chapter 4 Methodology and Methods.

3.1. Purpose of the literature review

The purpose of my literature review was to gain insight into the theoretical background, effectiveness and experiences with transitional care initiatives and programmes. The insights gained from this review guided the methodology of this study. By comparing the outcomes of the different papers reviewed in this study to the research question of this study, the gap in knowledge was addressed. The guiding research question for this literature review was:

What is known about transitional care programmes for older adults, discharged from hospital to home, the working elements of these programmes, the outcomes, and the experiences of professionals and patients?

3.2. Process of the literature review

For this review, a literature search was conducted using the terms: *older adults*, or *elderly* or *older people*; and *discharge from hospital* or *hospital to home*; and *hospitalisation*; and *transitional care* or *transition**; and *experiences* (for search strings see appendix 3). The year 2004 was chosen as a starting point, as this was the year Naylor published the first transitional care model for older adults (Naylor, 2004). As the body of literature from 2004 on transitional care is very extensive, the databases Pubmed, Cinahl, Cochrane, Embase, and subsequently the web search engine Google Scholar were searched for reviews, systematic reviews, and meta-analyses, that included quantitative as well as qualitative studies. In addition, I scanned the reference lists of selected articles ('snowballing'). The inclusion criteria shown in Table 3.1. were used:

Inclusion criteria
Transitional care programme or intervention with at least a post-discharge component
Hospital to home
Older hospitalised adults ≥60 years old
Multiple health conditions
Reviews
Qualitative and quantitative studies
Studies reported in English, German or Dutch
Published after 2004

Table 3.1. Literature review inclusion criteria

Siu and Comerasamy (2013) describe defining the literature sample as an iterative process (Siu & Comerasamy, 2013). During this iterative process, multiple types of information and evidence were identified. The process was far from linear, as I had to return to the literature after I identified which concepts were missing or remained unmentioned, such as *independence* or *self-management*. The data were analysed and sources were organised according to patterns and themes. In my analysis and synthesis of the findings, I focused on explaining why (or not) the interventions work, to enable informed choices for this study.

In order to evaluate the body of evidence, all literature was critically appraised by a standardised tool to systematically assess the trustworthiness, relevance and results of published papers. Several tools are available (Buccheri & Sharifi, 2017). For this study, the most appropriate tools to address quantitative as well as qualitative research were the Joanna Briggs Institute's (JBI) critical appraisal tools (Australian based) or the Critical Appraisal Skills Programme (CASP, 2021). CASP was chosen since this tool has been more widely used in Europe over the past 25 years (Aromataris et al., 2015). Based on these questions in the different appraisal tools, each study was assigned an overall quality rating: high (++), medium (+) or low (-).

3.3. Findings

An initial search revealed 754 records. Duplicates were removed. After reviewing the titles and abstracts, 659 were excluded. 113 papers were assessed. 90 studies were excluded based upon the inclusion criteria of this literature review.

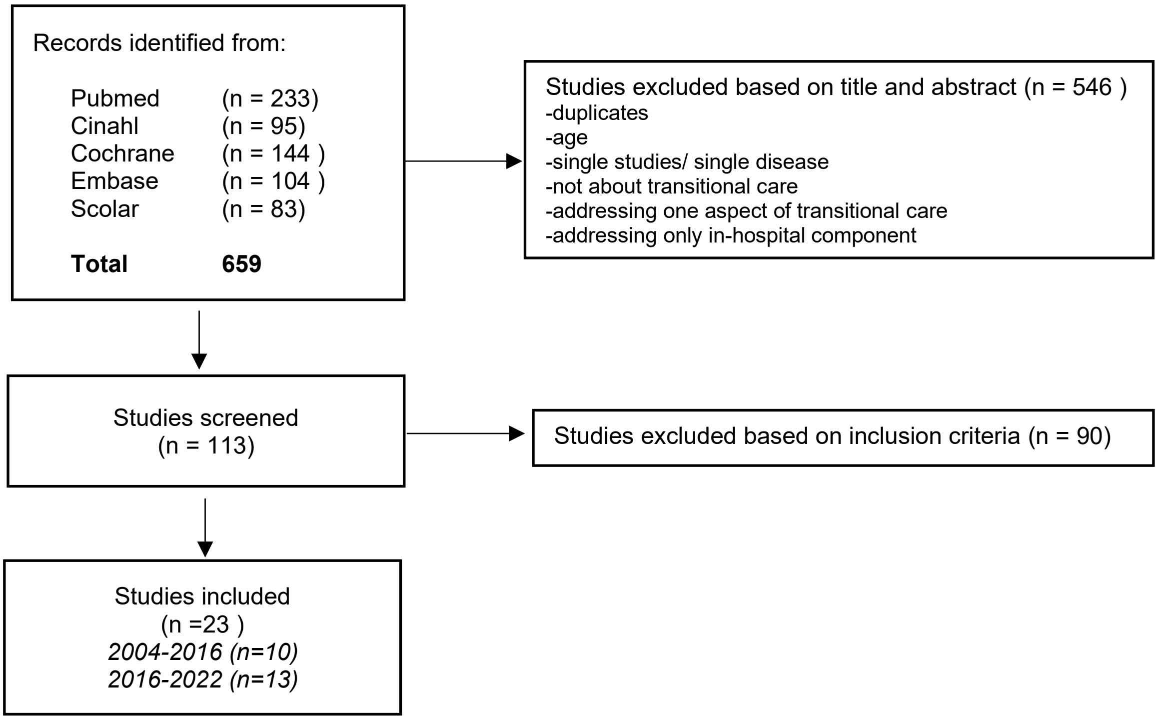


Figure 3.1. Prisma flow diagram on the identification of studies

In this literature review, I make a distinction between the literature published before and after 2016, as the initial data collection for this study took place between 2015 and 2016. During these years, patients were followed in the usual care group (2015) or the TCB-S group (2016) over a period of 3 months.

In total, 23 studies were included in the literature review. All the reviewed articles differed to some extent in their objectives. Themes addressed in the articles are listed in Table 3.2, with a reflection on what each theme indicates. Ten studies were found before 2017 and 13 studies after 2016. Of these studies, 6 included both qualitative and quantitative studies in their reviews. One study included only qualitative studies. Thus, 16 studies were quantitative reviews, of which the majority included only RCT studies and other comparative designs.

Theme	Studies 2009-2016	What this theme is indicating	Studies 2017-2022	What this theme is indicating
Quality of care	Naylor, 2008 Verhaegh, 2014	Access to care, improving transitions and improving patient handovers	McGilton, 2019 Morkisch, 2020 O'Donnell, 2021	Interdisciplinary care teams, proactively admit those at risk of delayed discharge, accommodate persons with cognitive impairment and involve care partners, education and goal-oriented interventions.
Effective communication and collaboration	Laugaland, 2012 Allen, 2012 Hudson, 2014	Several types of interventions improve communication between professionals and with patient and family members. Improved multi-professional communication has a positive impact on health care utilisation and satisfaction.	Allen, 2017 Morkish, 2020	A lack of dialogue and lack of understanding of others' roles are barriers to communication in transitional care for older adults.
Person and family care experiences and satisfaction	Naylor, 2008 Laugaland, 2012 Allen, 2014 Mabire, 2016	Outcomes reflecting person- and family-centred care were limited including those pertaining to the patient and carer experience.	Allen, 2017 Hestevik, 2019 Murray, 2019 Morkish, 2020 O'Donnell, 2021 Meulenbroeks, 2021 Lee, 2022	Person and their family/ caregiver involvement is limited or absent; feeling uninvolved leads patients to act autonomously, creating the potential to cause harm. Focus is mainly on the in-patient experience and only implicitly targets the family.
Outcome measures of rehospitalisation, LOS, medication, readmissions, mortality, QoL	Allen, 2014 Verhaegh, 2014 Hudson, 2014 Bryant-Lukosius, 2015 Mabire, 2016	Transitional care can reduce re-hospitalisation. Risk factors for re-hospitalisation were often listed as exclusion criteria or not reported. Only high-intensity interventions were associated a reduction in healthcare utilisation. No difference in QoL.	Le Berre, 2017 Mora, 2017 Weeks, 2018 Føns Rasmussen, 2021 Liebzeit, 2021 Meulenbroeks, 2021 Lee, 2022	Better outcomes on lower mortality, lower ED visits and lower re-admission rates. No difference in QoL. Most significant impact within 30 days after discharge.
Target group	Piraino, 2012 Mabire, 2016	Published studies of transitional care interventions do not often include older adults at highest risk of re-hospitalisation.	McGilton, 2019 Morkish, 2020	Patients, mainly women, with multiple chronic conditions.

Table 3.2. Main themes in the reviewed articles

The studies included in this literature review from 2009 to 2016 are listed in Table 3.3. below.

Author	Title	Country	Research question	Findings	Conclusions
2009-2016					
Naylor et al. (2008)	Transitional care: Moving patients from one care setting to another	USA	To understand the state of the science related to transitional care models for older adults in the United States and the roles of family caregivers in these models	The search identified three promising approaches to improving the quality of care for chronically ill older adults: 1) increasing older adults' access to proven community-based transitional care services; 2) improving transitions within acute hospital settings; 3) improving patient handovers to and from acute care hospitals	In general, these approaches have focused explicitly on the patient and only implicitly target family caregivers.
Boling , P A. (2009)	Care transitions and home health care	USA	Review of models of transitional care interventions	Effective transitional care intervention processes, linked with strong home care programmes can reduce re-hospitalisation by a third in some less intensive models and by half in more intensive models.	Transitions of care are hazardous times with much at stake. There should be a checklist before discharge. In teaching the needs of the patient, family and providers should be considered.
Laugaland et al. (2012)	Interventions to improve patient safety in transitional care – a review of the evidence.	Norway	Focus on the effects of discharge interventions on patient safety, e.g. adverse events confined to elderly patients (>65) who have been discharged	Several intervention types aimed at the improvement of communication that contribute to safe transitional care. Intervention types included profession-oriented interventions (e.g. education and training), organisational/cultural interventions (e.g. transfer nurse, discharge protocol, discharge planning, medication reconciliation, standardised discharge letter, electronic tools), or patient and next of kin oriented interventions (e.g. patient awareness and empowerment, discharge support).	Successful interventions have been proven to reduce re-admission rates, adverse drug events, healthcare utilisation, increased patient, family satisfaction and decreased cost. Future interventions should take into account multi-component and multi-disciplinary interventions, including combining several single interventions. Transitional care knowledge should be introduced in curriculums for both nurses and physicians, in addition to multidisciplinary training at an early stage of their education.

Piraino et al. (2012)	Transitional care programmes: who is left behind? A systematic review.	Canada	The objective of this review is to determine if patients included in studies of transitional care interventions are truly at high risk of re-hospitalisation.	Risk factors for re-hospitalisation were often listed either as exclusion criteria or were not reported at the baseline by the studies. One study included patients with all identified risk factors for re-hospitalisation. Eight out of fourteen studies excluded patients with cognitive impairment and three studies excluded those with dementia. In fewer than half of the studies reviewed did patient characteristics reflect a relevant comorbidity distribution. Patients with a life expectancy of less than a year were excluded.	These data suggest that published studies of transitional care interventions do not often include older adults at highest risk of re-hospitalisation, raising concerns about the generalizability of their results.
Allen et al. (2013)	Multi-professional communication for older people in transitional care: a review of the literature.	Australia	To synthesise literature about multi-professional communication between service providers within transitional care for older people, with particular attention on outcomes, enabling contextual factors and constraints.	Specified discharge worker roles, multi-professional care co-ordination teams and information technology systems promote better service satisfaction and subjective quality of life for older people, when compared with standard hospital discharge. There is limited empirical research investigating the role of nurses specialising in the care of older people within discharge communication pathways.	Improved multi-professional communication reduces rates of re-admission and the length of stay, indicating greater cost effectiveness and efficiency. Lack of dialogue and lack of understanding of others' roles are barriers to communication in transitional care.

Allen et al. (2014)	Quality care outcomes following transitional care interventions for older people from hospital to home: a systematic review.	Australia	(1) identify and synthesise research, using randomised control trial designs, on the quality of transitional care interventions compared with standard hospital discharge for older people with chronic illnesses, and (2) make recommendations for research and practice.	Transitional care interventions reported in most studies reduced re-hospitalisations, with the exception of general practitioner and primary care nurse models. All 12 studies included the outcome measures of re-hospitalisation and the length of stay, indicating a quality focus on effectiveness, efficiency, and safety/risk. Patient satisfaction was assessed in 6 of the 12 studies and was mostly found to be high. Other outcomes reflecting person and family centred care were limited, including those pertaining to the patient and carer experience, carer burden and support, and emotional support for older people and their carers.	Gaps in the evidence base were apparent in the quality domains of timeliness, equity, efficiencies for community providers, effectiveness/symptom management, and domains of person and family centred care.
Verhaegh et al. (2014)	Transitional care interventions prevent hospital re-admissions for adults with chronic illnesses.	Netherlands	To examine if interventions were associated with a reduction of re-admission rates in the short term (30 days or less), the intermediate term (31–180 days), and the long term (181–365 days).	Transitional care interventions are associated with reduced intermediate-term (31–180 days) and long-term (181–365 days), all caus hospital re-admissions of chronically ill patients. In subgroup analyses, it was found that only high-intensity interventions were associated with reduced short-term (30 days or less) re-admissions.	To reduce short-term re-admissions, transitional care should consist of high-intensity interventions that include care co-ordination by a nurse; communication between the primary care provider and the hospital; and a home visit within three days of discharge.
Hudson et al. (2014)	Transitions in a wicked environment.	USA	To synthesise the current body of knowledge concerning transitional care for patients 65 years of age and older moving from the acute care setting to home.	Several themes emerged related to care delivery systems. These include: communication challenges (17 articles); physician challenges (14 articles); nursing challenges (11 articles); availability of community resources (10 articles); inconsistent outcome measures (6 articles); and a lack of leadership support (1 article).	There are few strategies that do not negatively affect an alternate agenda. Conscientious leaders should consider transitional care in the context of its complex nature in order to achieve optimal patient care.

Bryant-Lukosius et al. (2015)	The clinical effectiveness and cost-effectiveness of clinical nurse specialist-led (CNS) hospital to home transitional care: a systematic review.	Canada	To summarise systematic review results specific to the clinical efffectiveness and cost-effectiveness of masters's prepared CNs providing transitional care.	Caregivers in the intervention group had better emotional, symptom and depression scores between 2 and 4 weeks after discharge. There were no group differences in health resource use. At 24 weeks, there were fewer re-hospitalisations.	There is predominantly low-quality evidence that CNs-led transitional care improves patient health outcomes, including mortality, and reduces hospital length of stay, re-hospitalisation rates and costs.
Mabire et al. (2015)	Effectiveness of nursing discharge planning interventions on health-related outcomes in discharged elderly in-patients: a systematic review.	Switzerland	To determine the best available evidence of the effectiveness of discharge planning interventions, involving at least one nurse on health-related outcomes, including, but not limited to, functional limitations, symptom management, unmet needs and/or health-related quality of life for elderly in-patients discharged home.	Nurse discharge planning did not significantly reduce hospital re-admission rates (odds ratio [OR] = 0.73, 95% confidence intervals [CIs] = 0.53-1.01, P = 0.06). The overall effect score for length of stay was significant (weighted mean difference = 0.29, P < 0.01), suggesting that discharge planning increased the length of hospitalisation. The effectiveness of discharge planning did not significantly impact QoL (mental OR = 0.37, P = 0.19 and physical OR = 0.47, P = 0.15).	Findings of this review suggest that nursing discharge planning for elderly in-patients discharged home increases length of stay, yet neither reduces re-admission rates nor improves QoL.

The studies included in this literature review from 2017 to 2022 are listed below.

2017-2022					
Le Berre, et al. (2017)	Impact of transitional care services for chronically Ill older patients: a systematic evidence review.	Canada	A systematic review to determine the impact of TC interventions for older patients with CD, transitioning from hospital to home, with regards to mortality, service use (ED, hospital re-admission, re-admission days) and QoL	Compared to usual care, significantly better outcomes were observed: a lower mortality rate at 3, 6, 12 and 18 months post-discharge; a lower rate of ED visits at 3 months; a lower rate of re-admissions at 3, 6, 12 and 18 months; and a lower mean of re-admission days at 3, 6, 12 and 18 months. No significant differences were observed in quality of life.	Transitional care for older patients with CD discharged from hospital to home leads to better outcomes in mortality, re-admission and re-admission days. Decision-makers, managers and clinicians should take these results into account when developing policies and interventions for this population. This review clearly identified a sustained improvement in mortality rates compared to UC beginning at 6 months after discharge.
Mora et al. (2017)	Nurse practitioner-led transitional care interventions: An integrative review.	USA	This article examines whether nurse practitioner (NP)-led TCM interventions as compared to standard care decrease hospital re-admission rates in older adults.	Synthesis of three RTCs, one meta-analysis, and four non-randomised studies reviewed TCM interventions that included the following interventions: follow-up phone calls post-discharge; home visits; and handoverto the patient's primary care provider. These interventions, although not exclusively led by NPs, decreased hospital re-admission rates.	Although most of the studies reported reductions in hospital re-admission rates for adults older than the age of 60 with multiple comorbidities, only two studies offered rates that were statistically significant. The level of evidence is insufficiently high to allow for generalizability, warranting further study.

Allen et al. (2017)	User experience and care integration in transitional care for older people from hospital to home: a meta-synthesis.	Australia	Expand understanding about user experience and care integration by synthesising users' experiences, including the experiences of older people, carers, and hospital- and community-based health providers.	Four themes emerged: 1) 'Who is taking care of what? Trying to work together'; 2) 'Falling short of the mark'; 3) 'A proper discharge'; and 4) 'You adjust somehow.' Users experienced discharge and transitional care as 'negotiation and navigation of independence (older people, carers), or dependence (health providers)'.	Although the design of quality user experiences in discharge and transitional care should be a focus in evolving interventions and models, there is still a potential application in current practices. Health providers should encourage practice cultures that support questioning and discussion, in relation to older peoples' and carers' needs for independence in care transitions.
Weeks et al. (2018)	The impact of transitional care programmes on health services' utilisation in community-dwelling older adults: a systematic review.	Canada	To identify and synthesise the best available evidence on the impact of transitional care programmes on various forms of health services' utilisation in community-dwelling older adults.	Transitional care significantly reduced hospital re-admission rates at 30 days (odds ratio [OR] 0.75, 95% confidence intervals [CIs] 0.62–0.91, $p < 0.01$), 90 days (OR 0.77, 95% CIs 0.59–1.02, $p = 0.04$), and 180 days (OR 0.67, 95% CIs 0.46–0.99, $p < 0.01$). Narrative synthesis indicated little impact of transitional care on emergency department and nursing home usage; increased use of primary care/physician usage; and decreased home health care usage.	First, transitional care reduces re-hospitalisation rates over time, with the largest effects seen at 30 days. Secondly, transitional care may increase the utilisation of primary care services and thus have a favourable impact on preventative care. Thirdly, transitional care may reduce home health usage. Fourthly, transitional care interventions of one month or less appear to be as effective as longer interventions in reducing hospital usage.

Hestevik et al. (2019)	Older peoples' experiences of adapting to daily life at home after hospital discharge: a qualitative meta-summary.	Norway	This meta-summary aims to integrate current international findings in order to enhance the understanding of older peoples’ experiences of adapting to daily life at home after hospital discharge.	Patients and caregivers occupy and move through multiple states of involvement, in response to perceived interactions with healthcare professionals, as they attempt to resolve health- and well-being-related goals. ‘Non-involvement’, ‘information-acting’, ‘challenging and chasing’ and ‘autonomous-acting’ were the main states of involvement. Feeling uninvolved as a consequence of perceived exclusion leads patients to act autonomously, creating the potential to cause harm.	The results emphasise the importance of assessment and planning; information and education; preparation of the home environment; the involvement of the older person and caregivers; and supporting self-management in the discharge and follow-up care at home. Health professionals should actively cultivate their communication skills with an awareness of older peoples’ experiences, priorities and goals, in order to provide healthcare focused on what is most relevant to older people in transitional care situations.
Murray et al. (2019)	How older people enact care involvement during transition from hospital to home: a systematic review and model.	UK	Using the lens of older people transitioning from hospital to home, the overarching aim of the current study was to develop a model of patient involvement in care.	Types of involvement included ‘non-involvement’; ‘information-acting’; ‘challenging and chasing’; and ‘autonomous-acting’. Non-involvement represented a state in which people became passive recipients of care and even absent/failed care. The absence of patient and caregiver involvement was evident in all studies. Being more active often failed since healthcare professionals did not appear to 'consider' or understand the expressed desires, nor did they know how to respond.	Non-involvement is not a desired state for most patients but a consequence of system-level forces and other contextual factors, that act to erode efforts to become involved.

McGilton et al. (2019)	Understanding transitional care programmes for older adults who experience delayed discharge: a scoping review.	Canada	This scoping review aims to answer: 1) What are the socio-demographic and/or clinical characteristics of older patients served by TCPs?; 2) What are the core components provided by TCPs?; and 3) What patient, caregiver, and health system outcomes have been investigated, and what changes in these outcomes have been reported for TCPs?	TCP patients were typically older women with multiple chronic conditions and some cognitive impairment, functionally dependent and living alone. The review identified five core components of TCPs: assessment; care planning and monitoring; treatment; discharge planning; and patient, family and staff education. The main outcomes examined were functional status and discharge destination. Of 37 studies, only 10 reported on interventions to address the educational and training needs of patients, family and/or clinical staff.	TCPs can influence outcomes for older adults, including their return home. TCPs should be designed to incorporate interdisciplinary care teams, proactively admit those at risk of delayed discharge, accommodate people with cognitive impairment and involve care partners.
Morkisch et al. (2020)	Components of the transitional care model (TCM) to reduce re-admission in geriatric patients: a systematic review.	Germany	To identify and summarise the components of the Transitional Care Model implemented with geriatric patients (aged over 65 years, with multi-morbidity) for the reduction of all-cause re-admission.	Three articles met the inclusion criteria. One of the included trials applied all of the nine Transitional Care Model components described by Hirschman and colleagues and obtained a high-intensity level of intervention in the intensities assessment. This and another trial reported reductions in the re-admission rate ($p < 0.05$), but the third trial did not report any significant differences between the groups in the longer follow-up period (up to 12 months). Only the two trials that showed a reduction in the re-admission rate, applied an educational component.	Multicomponent and multidisciplinary interventions are likely to be effective reducing re-admission rates in geriatric patients, without increasing cost. Components such as the type of staffing; assessing and managing symptoms; educating and promoting self-management; maintaining relationships; and fostering co-ordination seem to have an important role in reducing the re-admission rate.

O'Donnell et al. (2021)	The Effectiveness of Transition Interventions to Support Older Patients from Hospital to Home: a Systematic Scoping Review.	Australia	The aim of this review was threefold: a) describe the different types of transition interventions for older adults that provide both in-hospital and post-discharge support; b) evaluate how effective these interventions are in improving health and well-being outcomes and hospital re-admission rates; and c) evaluate the implementation of these interventions.	Twenty studies met the inclusion criteria. Four types of interventions were identified: education-based (10/20); goal-oriented (4/20); exercise (4/20); and social support interventions (2/20). The interventions were delivered by nurses for an average of 3 months. Education and goal-oriented interventions were effective in improving health and well-being outcomes. The impact of interventions on mitigating hospital re-admissions was inconclusive. Only five of the studies examined implementation.	The majority of interventions were not shown to mitigate hospital re-admission rates. Goal-based and educational interventions were most effective in improving the physical health, independent functioning, and overall quality of life of older adults transitioning from hospital to home.
Fønss Rasmussen et al. (2021)	Impact of transitional care interventions (TCIs) on hospital re-admissions in older medical patients: a systematic review.	Denmark	To identify and synthesise available evidence on the impact of transitional care interventions with both pre-discharge and post-discharge elements on re-admission rates in older medical patients.	The majority of interventions in the transitional phase between hospital and home appears to reduce re-admission rates among older patients discharged from a medical ward. Some studies reported both a positive impact or no impact on the re-admission rate following similar care interventions.	The majority of TCIs have a positive impact on re-admission rates among older medical patients, although the most significant impact was seen within 30 days of hospital discharge.
Liebzeit et al. (2021)	A scoping review of interventions for older adults transitioning from hospital to home.	USA	To examine the current scope of hospital-to-home transitional care interventions, including their mechanisms and ability to mitigate a broad range of sub-optimal outcomes.	The most common outcomes were related to re-admission and mortality. Only 14/44 studies assessed functional status. 24/44 examined quality of life. Only one study had a positive impact on functional status. Transitional care interventions remain heterogenous. There are a few key components that are commonly targeted.	To improve outcomes beyond healthcare utilisation, a paradigm shift is required in the design and study of care transition interventions, including components such as, including older adult and care-giver engagement, education, and well-being.

Meulen-broeks et al. (2021)	The value of caregiver-inclusive practices in geriatric transitions of care: a systematic review.	Australia	To assess whether transitional care programmes, that integrate caregivers, provide better value care than routine care.	Of the 23 studies: 11 investigated patient/caregiver experience; 21 studies assessed population health; 16 studies examined the cost of care; and 2 studies investigated the healthcare professional experience. Unplanned ED use, LOS, and unplanned re-admission were considered to be both a health outcome and a cost. In total, 130 health-related outcomes were extracted. Quality of care transitions, preparedness for discharge and satisfaction increased, at least temporarily, in all included studies.	Currently, there is a paucity of good quality evidence to determine whether caregiver-inclusive transitional care interventions provide better value than routine care when using the policy framework of the quadruple aims. The evidence is mixed. All evidence of trends need to be interpreted with caution as the evidence is of poor quality.
Lee et al. (2022)	This study aimed to investigate the transitional care of frail older adults and its effectiveness.	South Korea	The research questions: 1) What transitional care intervention (i.e., from hospital to home) that is not disease-specific has been established for frail older adults? and 2) How effective are these transitional care approaches?	Transitional care reduced re-admission at six months, but at no other points in time. Likewise, mortality and quality of life were affected at six months but at no other times. The most measured outcome was re-admission (n = 13), followed by mortality (n = 9), function (n = 7), quality of life (n = 5), and self-rated health (n = 5). Statistical significance effects were reported in the followings: n = 6, re-admission; n = 0, mortality; n = 3, function; n = 2, quality of life; and n = 4, self-rated health.	The intervention effectiveness was inconclusive; therefore, an evidence-based yet novel approach is necessary to establish an adequate transitional care intervention for frail older adults.

Table 3.3. Included studies in the literature review

As stated earlier, I make a distinction between the literature published before and after 2016, since the initial data collection for this study took place between 2015 and 2016. This will enable me to address the literature in the general discussion of this thesis, which was written after the data collection in this study, and separately from the literature that was already known at the start of this study.

In the next section, firstly, the literature from 2008 to 2016 is addressed, and then subsequently in the following section, the literature from 2017 to 2022 will be examined.

3.3.1. Transitional care 2008-2016

Transitional care is a multi-component and multi-disciplinary intervention (Laugaland et al., 2012). Ten of the reviews between 2008 and 2016 were focussed on chronically ill older adults in general, rather than having a focus on one specific disease of hospitalised older adults, who were subsequently discharged home. The building blocks of the successful interventions shared similar features, such as early geriatric assessment; education and training; a transfer nurse and assigning a nurse as the clinical manager or leader of care; discharge planning; medication reconciliation; a discharge letter; patient awareness and empowerment; and in-person home visits to discharged patients (Boling, 2009; Laugaland et al., 2012). A home visit within three days; care co-ordination by a nurse; and communication between the hospital and the primary care provider were components of transitional care that were significantly associated with reduced short-term re-admission rates (Verhaegh et al., 2014). Most of the reviews also showed other positive effects on care, such as fewer re-hospitalisations and reduced LoS, although these were mainly in high intensity interventions (Allen et al., 2014; Boling, 2009; Bryant-Lukosius et al., 2015; Verhaegh et al., 2014).

Interventions included in the reviews differed widely in terms of duration, content and intensity. In almost every review, authors mentioned the heterogeneity between the studies, which could have an impact on the size of the differing effects (Mabire et al., 2016). Nurses were mainly the primary professional caregiver in transitional care interventions. Globally, there is a diversity in the education levels of nurses who provide transitional care (Bryant-Lukosius et al., 2015; Mabire et al., 2016). Many of the literature reviews on transitional care from 2008-2016 mentioned studies that had strict inclusion criteria, focused mainly on randomised controlled trails (RCTs), and often left excluded the most vulnerable patients (Piraino et al., 2012). Most transitional care interventions focused on vulnerable, chronically ill patients throughout critical transitions in health and healthcare, the time-limited nature of services, and the emphasis on educating patients and family caregivers to address the root causes of poor outcomes and to avoid preventable re-hospitalisations (Naylor & Keating, 2008). The number of studies included in the reviews that also focused on patient and family satisfaction was low, and satisfaction, when addressed, was mostly found to be high (Allen et al., 2014). Other outcomes reflecting personal and family perspectives were limited (Verhaegh et al., 2014). Communication was a specific theme in some of the reviews. Although communication was often challenging, improved multi-professional communication had a positive impact on the quality of care, healthcare utilisation and satisfaction (Allen et al., 2013; Hudson et al., 2014; Laugaland et al., 2012).

3.3.2. Transitional care 2017-2022

In addition, in the thirteen reviews from 2017- 2022, there is a strong focus on healthcare utilisation as an outcome measure (Lee et al., 2022; Meulenbroeks et al., 2021; Mora et al., 2017). Transitional care interventions remain heterogenous, but there are a few key components that are commonly targeted. Liebzeit et al. (2021) found that the majority of RCTs for older adults transitioning from hospital to home focus on a similar limited set of outcomes: re-admission or re-hospitalisation; mortality; and quality of life.

In the reviews from 2017 to 2022, there appears to be more evidence that quality transitional care supports older people living with multiple chronic health conditions to remain living in their own homes in accordance with their wishes (Allen et al., 2017). It is, however, noteworthy that functional status is often not assessed in studies. For instance, functional status is only included in 14 out of 44 studies in the review of Liebzeit et al. (Liebzeit et al., 2021). Some reviews after 2017 mention significantly better outcomes on mortality; ED visits; and re-admissions within three months after discharge (Le Berre et al., 2017). One systematic review showed an increase in the utilisation of primary care services and this was considered as a favourable impact on preventative care (Weeks et al., 2018). Several reviews state that there is uncertainty about the overall effectiveness of transitional care interventions. Only high-intensity interventions were associated with reduced short-term (30 days or less) re-admissions (Morkisch et al., 2020). Interventions of one month or less appear to be as effective as longer interventions in reducing hospital usage (Fønss Rasmussen et al., 2021; Weeks et al., 2018).

The reduction of adverse events has also been related to interventions with a multidisciplinary approach, as well as communication between health professionals during the transition of the patient from hospital to home (Morkisch et al., 2020). Education and communication also encompass the professionals and multi-disciplinary collaboration. The reviews, however, show a lack of dialogue, as well as a lack of understanding of others' roles as barriers to communication in transitional care for older adults (Allen et al., 2017; McGilton et al., 2021). Components such as the type of staffing; assessing and managing symptoms; educating and promoting self-management; maintaining relationships; and fostering co-ordination seem to have an important role in reducing the re-admission rate (Morkisch et al., 2020). There is, however, a tendency to focus on the patient and not on the family as the primary target of the intervention. Families are typically only implicitly targeted (Allen et al., 2017). “During hospital discharge and transitional care, older persons commonly experience situations where health care professionals do not consider their needs to understand and actively engage in questioning, discussion and information-seeking” (Hestevik et al., 2019, p.9.). This may be due to an over-estimation of the person’s understanding of the post-discharge treatment plan and the assumption that a person knows more about treatment and recovery than they actually do (Hestevik et al., 2019). Hestevik et al. (2019) showed that older people make great efforts to find ways to adapt to life’s new situations, to be able to contribute and not be a burden. This study showed that an inadequate assessment of personal needs evoked feelings of frustration and led to limited social interactions, social isolation and loneliness. These findings indicate that when environmental and psychosocial needs are unaddressed, it affects self-management and the recovery at home after discharge.

Identified intervention types are education-based interventions, goal-oriented interventions, exercise, and social support interventions. Of these types, education-based and goal-oriented interventions are effective in improving health and well-being outcomes (O'Donnell et al., 2021). There is, however, a lack of studies which relate to implementation and intervention reliability, which might hinder the assessment of the lack of positive impact (O'Donnell et al., 2021).

Nine of the thirteen reviews excluded older patients under 65 years old. The systematic review by Morkisch et al. (2020) could only include three studies based upon the criterion of 65 years and older. However, the age range did not often reach beyond the age of 85 (Werner et al., 2019; Weeks et al., 2018).

3.4. Synthesis of the evidence

The building blocks of the successful transitional care interventions share similar features, such as early geriatric assessment; education and training; a transfer nurse and assigning a nurse as the clinical manager or leader of care; discharge planning; medication reconciliation; a discharge letter; patient awareness and empowerment; and in-person home visits to discharged patients. Transitional care programmes report better outcomes than the usual type of care. There is, however, a lack of congruent outcome measures. Meulenbroeks et al. (2021) revealed 130 health-related outcomes in their review. Outcomes in studies mainly focus on the utilisation of care as ED use, LOS, QoL, costs, and outpatient resource use. This indicates a quality focus on efficiency and effectiveness, although results of transitional care interventions on these outcomes are often poor or lacking. Although QoL was used as an outcome measure in some studies, no impact on quality of life was mentioned in the reviews between 2008 and 2022.

In the period after 2016, better outcomes are reported on the reduction of mortality, ED visits and re-admissions within three months of discharge in high-intensity transitional care interventions. This might indicate a shift in the past decade towards more high intensity interventions.

Many reviews have shown that transitional care appears to focus mainly on the 'youngest' old and the 'middle' old. Eleven of the twenty-three reviews included patients above 65 years old: four studies before 2017 and seven studies from 2017. It is notable that RCT studies tend to leave the most vulnerable as well as the oldest patients out of scope, and sometimes exclude patients with cognitive problems or patients who are expected to die within one year. This means that insights into the effectiveness of transitional care programmes for the oldest patients are lacking.

Only two reviews specifically addressed the experiences of the patient and their carers (Allen et al., 2017; Hestevik et al., 2019). The perspectives of professionals were only specifically addressed in the review by Allen et al. (2017). This review reveals practice cultures that insufficiently support questioning and discussion of the needs of older people and their carers for independence in transitions (Allen et al., 2017).

3.5. Discussion

Transitional care for older adults is not an episodic event, but rather a longitudinal process, especially for older adults, as they are not only recovering from their acute illness, but also experience a transient period of generalised risk for a wide range of adverse health events (Werner et al., 2019). After discharge, older adults are often required to take on a new care regimen alongside re-integrating and coping at home (Krumholz, 2013; Liebzeit et al., 2021; Murray et al., 2019; Werner et al., 2019). Werner et al. (2019) state that patients may be sent home without adequate means to address their post-discharge reality.

Although in time the target group of research studies shifted toward older adults aged over 65, the age groups of the middle-old (75-85) and the oldest-old (over 85) still seem to be understudied in transitional care research. This lack of knowledge on the effectiveness of transitional care programmes and the perspectives of the middle–old and oldest-old on their care is noteworthy, as most of these older adults nowadays stay in their own home as they get older. Policies focus on ageing at home, which is called 'ageing in place' . More transitional care approaches are needed that address older patients who are well above 65 years old, and more knowledge is needed on the individual components of transitional care that explicitly address the needs and characteristics of these patients, as well as research that clarifies what varying intensity is needed (Mabire et al., 2016; O'Donnell et al., 2021). Based on the definition of transitional care used in this study, transitional care should promote recovery, restore independence and confidence at the interface between home and the acute services (Sezgin et al., 2020). Independence is, however, poorly researched in the transitional programmes (Allen et al., 2017). Self-management interventions aimed at enhancing independence are often mentioned, but rarely described, in transitional care programmes and, even if mentioned, it is often unclear how they are supposed to work.

Overall, the focus of the research, as it comes to the macro-, meso- and micro-levels, as explored in Chapter 2, seems to focus on the micro-/patient level. Figure 3.2 below shows the elements mentioned at all levels in the literature review. The micro-level is the largest, as it encompasses more elements than the meso- and macro-levels. This emphasis on the micro-level is noteworthy, since desired outcomes on the clinical level also require interventions targeted at the meso-level (organisational) and macro-level (policy) (Briggs et al., 2018). Examining only one level, neglects the complex interrelationships between these levels (Valentijn et al., 2013). The diagram below visualises how the elements mentioned in this literature review are located on the macro-, meso- and micro-levels.

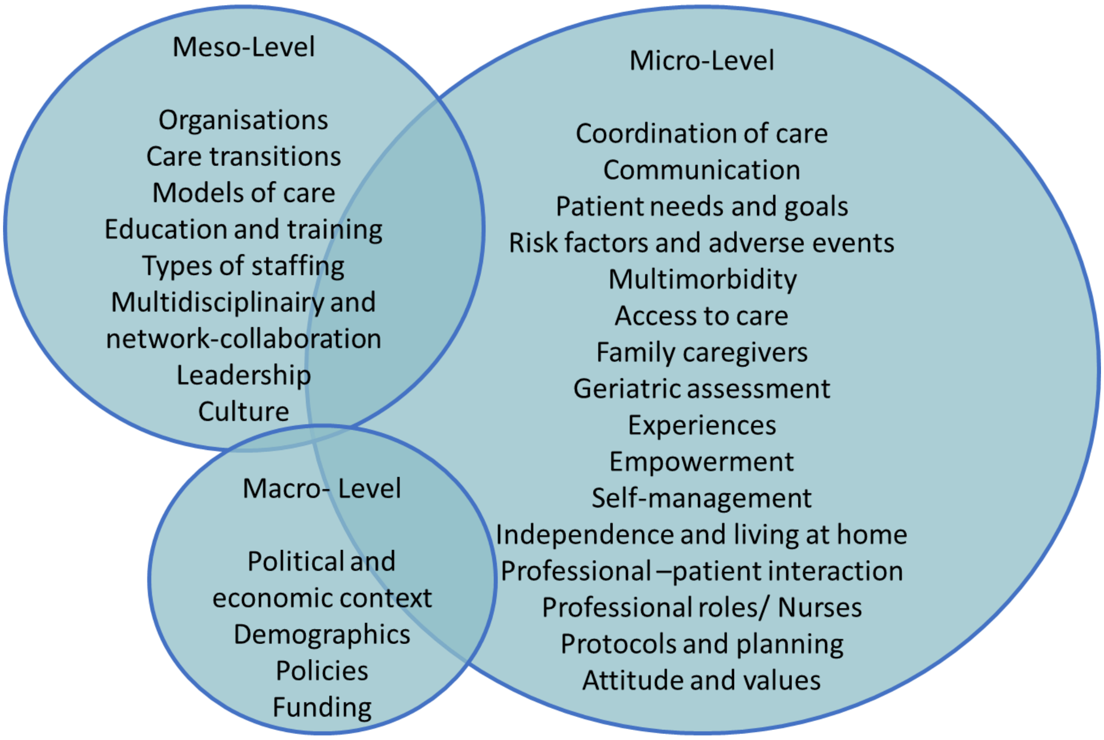


Figure 3.2. Elements in the literature review on micro-, meso- and macro-levels

Although in the past decade the focus of policies has been on ageing in place, it is noteworthy that there is a lack of inclusion of the functional status, as a key indicator to develop policies. None of the studies included in this literature review mention the emergence of restorative and re-ablement approaches. Restorative home care interventions encompass occupational therapy, physical therapy, social rehabilitation, and health education. Re-ablement refers to intensive and time-limited multidisciplinary home care service interventions, which have been developed for people with poor physical and/or mental health, to help them learn or re-learn the skills necessary to manage their illness and to maximally participate in everyday activities. “Such approaches aim to go beyond traditional home care goals of ‘maintenance’ and ‘support’ towards improvements in functional status and quality of life” (Ryburn et al., 2009, p.225; Tuntland et al., 2015). However, within these approaches there is uncertainty about which components are most beneficial to which clients (Aspinal et al., 2016; Cochrane et al., 2016).

The differences in outcome measures not only make meta-analysis impossible, but also reflect conflicting agendas across practice settings due to the impact of which outcomes are valued. Interventions for the ‘middle’ old and ‘oldest’ old need to be developed to support older adults and their informal caregivers in the transition period after discharge. Impact and process evaluations are needed to add to the current body of knowledge on transitions from hospital to home for the ‘middle’ old and ‘oldest’ old.

This literature review shows it is still difficult to know what works and for whom (Pawson et al., 2005). Changing paradigms seem necessary to challenge outdated public perceptions, political priorities, policy models and research approaches, in order to avoid a crisis in the provision of health and social services for the ageing population (Lloyd-Sherlock et al., 2012).

3.6. Conclusion and implications for this study

The literature review reveals there is a knowledge deficit on the effectiveness and efficiency of transitional care programmes for the ‘average’ and the ‘oldest’ old, and furthermore, on their perspectives of their transitional care. Therefore, the aim of this study is to evaluate a high intensity transitional care programme for the average and the oldest adults, focusing on the outcomes and the perspectives and experiences of the oldest adults and their professionals and informal care givers. As will be shown in the remainder of this thesis, this study, with its focus on a transitional care programme and involving several collaborating organisations, addresses the micro-, as well as the meso- and the macro-level. In the general discussion (Chapter 8), the findings of this study will be compared to the literature published before and after 2016 and the implications will be discussed on the different levels.

3.7. Summary

The building blocks of successful transitional care interventions share similar features. Although better outcomes are reported in comparison to usual care, there is an abundance of outcome measures, which makes comparison of studies difficult. Many similar outcome measures focus on efficiency and effectiveness. Significant results were, for a long time, poor or lacking. After 2016, better outcomes are reported, probably due to more high-intensity transitional care interventions. Although older adults nowadays tend to age at home, as policies focus on living longer at home, many transitional care programmes focus on the 'youngest' old and the 'middle' old and independence and functional status remains poorly researched. In research RCTs, which is still the most dominant methodology, these tend to leave the most vulnerable and oldest patients out of scope. Impact and process evaluations are needed for the age groups: 'middle' old (75-85) and 'oldest' old (over 85) in terms of transitional care.

CHAPTER 4 METHODOLOGY AND METHODS

4.1. Introduction

This chapter will highlight the theoretical underpinnings of this study and explain the particular design chosen for the study.

The subject of this study is the transitional care programme for older adults with multimorbidity moving from a general hospital to home. This can be considered a complex intervention, as it includes several interacting components, both on an individual as well as on an organisational level (Campbell et al., 2007; Craig et al., 2008; Moore et al., 2015). The evaluation of this programme focuses on the design, piloting and implementation of a programme. This is a longitudinal study consisting of many stages conducted over time. Based on the research questions and the complexity of the intervention being evaluated, which included both quantitative and qualitative data, this study required a multi-stage mixed methods evaluation design (Creswell et al., 2011; Plowright, 2011).

The mixed methods approach was used to provide a more complete understanding of the delivery of the transitional care programme in practice and to reveal the underlying patterns which influenced the effectiveness of the programme (Campbell et al., 2007; Mannell & Davis, 2019; Möhler et al., 2015; Pawson et al., 2005). The aim was to explore different types of data: descriptive data from the analysis of standardised measures, as well as the lived experiences of professionals during delivery of the programme and the experiences of patients enrolled on the programme. Findings were integrated and interpretations drawn, based on the combined strengths of both sets of data to understand the research problems (Creswell et al., 2011; Shneerson & Gale, 2015).

The reasons for combining quantitative and qualitative methods in this study are: complementarity - to integrate two different but connected answers to a research question; completeness - to gain a greater understanding of the phenomenon under investigation by merging qualitative and quantitative findings; and compensation - to compensate for the weaknesses of one strand of a study by means of integrating methods (Fiorini et al., 2016). Integrating methods offer a better understanding of the links between theory and empirical findings, challenges theoretical assumptions and develops new theory (Creswell, 2021; Creswell et al., 2011; Östlund et al., 2011; Shneerson & Gale, 2015). For this study, I used the widely accepted definition of mixed methods of Creswell & Clark (Creswell & Clark, 2019).

> A research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and the analysis of data and the mixture of quantitative and qualitative approaches in many phases in the research process. As a method, it focuses on collecting, analysing and mixing both quantitative and qualitative data in a single or series of studies. Its central premise is that

> the use of quantitative or qualitative approaches in combination provide a better understanding of the research problem than either approach alone.
> (Creswell & Clark, 2019, p.5)

Combining both types of data helped to reveal the underlying patterns and provided insight into why and in what way the intervention did or did not work, with a particular focus in this study on the oldest adults. Both the convergence of results and the divergence or dissimilarity of information from different sources was important in this triangulation. This helped to provide a greater insight into the complex aspects under study (Teddlie & Tashakkori, 2010).

4.2. Theoretical perspectives

The philosophical underpinnings of a study create the foundation of the methodological design and methods. The word ‘paradigm’ is used in various ways in research. A paradigm can be looked upon as a worldview or as all-encompassing ways of experiencing and thinking about the world, including beliefs about morals, values, and aesthetics (Kuhn, 1962; Musgrave & Kuhn, 1970). Epistemological stances are also addressed as paradigms, which are belief systems that influence how research questions are answered (Braun & Clarke, 2013 and 2021; Cronje, 2014; Denzin & Lincoln, 2011) . For this study, I follow the view that a research paradigm contains three elements: ontology, epistemology and methodology (Crotty, 2020; Houghton et al., 2012).

Two paradigms, with their own ontology, epistemology and methodology, come together in this study:

- Critical realism
- Pragmatism

In recent years Pragmatist Critical Realism has been proposed as a new paradigm. This paradigm combines pragmatism and critical realism, which share a similar purpose as a ‘third way’ between positivism and interpretivism (Heeks et al., 2019). Heeks et al. (2019, p. 3) define Pragmatist Critical Realism as “a research paradigm based on our socially-constructed experience of the manifestations of an external, independent reality that aims to provide practical and emancipatory solutions to problems of inequality”. It examines the causal mechanisms of the real domain to provide a stronger foundation for explanation of the practical outcomes observed from any intervention. Critical realists recognise that the open systems of social phenomena require qualitative empirical evidence to accurately identify and explain the structural mechanisms that generate social phenomena. Realist synthesis lends itself to the review of complex interventions, as it accounts for context, as well as outcomes in the process of systematically and transparently synthesising relevant literature (Okoli, 2015; Pawson et al., 2005). “While realist synthesis demands flexible thinking and the ability to deal with complexity, the rewards include the potential for more pragmatic conclusions than alternative approaches to systematic reviewing” (Rycroft-Malone et al., 2012, p. 1). In this pragmatic approach, reality is constantly re-negotiated; debated; and interpreted in light of its usefulness in new and unpredictable situations, and influenced by perceptions and experiences. The ontology, epistemology and methodology of this study are described in more depth after Table 4, which shows the ontology, epistemology and methodology of the two paradigms.

Paradigm	**Ontology** ***What is reality?***	**Epistemology** ***How can I know reality?***	**Methodology** ***How do you go about finding out?***
Critical realism	Reality is socially constructed. Much of reality exists and operates independently of our awareness or knowledge of it and can only be partially known.	Mapping social reality historically and perspectivally, inquiry into artifacts, culture, social structures, people, and what affects human action and interaction. By exploring the interacting mechanisms and the way they work, theories can be developed of the phenomena under study.	Methodological pluralism to reconstruct the complexity and heterogeneity of the social world through retroductive or abductive inferences, causation, structures and processes.
Pragmatism	Reality is socially constructed. Reality is constantly re-negotiated, debated, interpreted in the light of its usefulness in new and unpredictable situations and influenced by perceptions and experiences.	Knowledge is constructed from socially-shared experiences.	A methodology that best fits the research question. Often: Mixed methods research Design-based research Action research

Table 4.1. Ontology, epistemology and methodology of two paradigms

4.2.1. Ontology

The description of a researcher's ontology reveals how a researcher understands reality and whether a researcher thinks reality exists or cannot exist separate from human practices and understandings (Braun & Clarke, 2013, 2021; Creswell, 2021; Musgrave & Kuhn, 1970). The view where reality is completely independent and can be known is referred to as 'Positivism' or 'Realism'. The view where it totally depends on human interpretation and knowledge and, therefore, that multiply-constructed realities exist, is referred to as 'Interpretivism', 'Constructivism' or 'Relativism'. Post-positivism is more pragmatic, and recognises observations are influenced by perceptions and experiences. The philosophical background of qualitative research is considered to be Interpretivism or Constructivism. In Interpretivism and Constructivism, reality is socially constructed by and between the people who experience it, their views and it focusses on detailed information (Fiorini et al., 2016). This implies that reality is subjective and that multiple realities exist (Creswell, 2011; Leech & Onwuegbuzie, 2009). Authors such as Denscombe (2007), Johnson & Onwuegbuzie (2004 and 2014), and Tashakkori & Teddlie (2010), all champion the view that neither the Positivist quantitative paradigm nor the Interpretivist qualitative paradigm should be mutually exclusive, and that the approach chosen should be guided by what would best serve the research question at every stage of the research (Cronje, 2014; Denscombe, 2017; Johnson & Onwuegbuzie, 2004; Teddlie & Tashakkori, 2010).

In Critical Realism, as well as in Pragmatism, reality is not completely independent, nor is it purely subjective (Braun & Clarke, 2013, 2021). The ontological viewpoint of both is that reality is socially constructed. This implies that reality is subjective, and that multiple realities in different contexts exist, which should be considered in research or be identified by research (Creswell & Clark, 2019; Leech & Onwuegbuzie, 2009). Reality or truth in Critical Realism depends on the context and can differ from context to context, as the world is real and is driven by mechanisms that may function differently according to context. (Pynn, 2015). In Critical Realism, this means the world can only be partially known, based on the subjective and socially-located knowledge that a researcher can access (Braun & Clarke, 2013 and 2021). Critical Realism also offers mixed methods researchers a view that emphasises perspective-taking and empowering the voices of others while, at the same time, recognising that these perspectives can only be partial representations of reality (Leech & Onwuegbuzie, 2009; Maxwell & Mittapalli, 2010; Shannon-Baker, 2016).

Pragmatism, on the other hand, emphasises of practice or practices as the starting point and underscores that beliefs are justified or unjustified based upon the practical differences made in our experience of and interaction with the world (Long, 2002; Saunders et al., 2015; Turyahikayo, 2021).

4.2.2. Epistemology

Epistemology is about the nature of knowledge and addresses what is possible to know (Braun & Clarke, 2013 and 2021). Critical realists argue that the world is real and is constructed through our individual standpoints and perceptions. Critical Realism emphasises diversity and the relationships between people, events, and ideas. However, these mechanisms may function differently according to context (Creswell, 2011; Creswell et al., 2011; Ellaway et al., 2020; Shannon-Baker, 2016). As this study focused on the evaluation of a transitional care programme and explored what worked for whom in the specific context of this study, this also required a pragmatic approach. Pragmatism emphasises the importance of practice, and justifies or rejects beliefs based upon the practical difference made in experiences and interactions with the world (Long, 2002). In Pragmatism, beliefs can be immediately justified by their utility. Pragmatism values both objective and subjective knowledge, in terms of methodologies, focusing on what 'works' and is oriented towards studying real world problems, rather than the nature of knowledge (Hall, 2013).

4.2.3. Methodology

In both paradigms, multiple methodologies, which best fit the research question, can be used to re-construct the world. In the current study, two paradigms were brought together in a mixed methods design. In a mixed methods approach, the war between paradigms becomes apparent, as the philosophical underpinnings of quantitative and qualitative research come from different and opposing paradigms (Tashakkori & Creswell, 2007). Quantitative research is mainly based on Positivism or post-Positivism (Creswell, 2021). Qualitative research is often based on Interpretivism or Constructivism (Creswell, 2021). In mixed methods, the integration of the quantitative and qualitative research approaches can take place at any point in the research process, that is, during data collection, during data analysis or at the interpretive phase (Borglin, 2015; Creswell, 2011; Creswell et al., 2011). Healthcare and nursing research has shown a trend for conducting mixed methods research over the past 20 years (Leech & Onwuegbuzie, 2009; Östlund et al., 2011; Plano Clark, 2010). This happened at a time of increasing complexity in both the contextual environment and in the delivery of health care (Borglin, 2015).

The mixed methods approach in this study offered the opportunity to uncover the relationships between the treatment outcomes and the diverse perspectives of professionals and patients (Shorten & Smith, 2017). For this complex programme evaluation specifically, qualitative research provided empirical findings to explain why and how the effects of programmes varied in different contexts, as well as in the participants' perspectives (Pluye & Hong, 2014).

4.3. Design of the study

In this study, the context; the population; the different organisations working in collaboration; and the specific working and living contexts of professionals and patients, played an important role that had to be considered and reflected upon. This makes knowledge relative to this specific context. Therefore, this study required a pragmatic, as well as a critical approach, as it used multiple perspectives, and explored underlying structures to understand reality at a deeper level, with respect to what may have, must have, or could have caused them, and can explain the participants' behaviours and the outcome of their behaviours (Halcomb & Hickman, 2015). This study used different research design elements within an evaluation study approach, consisting of both qualitative and quantitative data. There are three basic mixed method designs: 1) A convergent parallel design, in which the researcher collects both qualitative and quantitative results and merges these two sets of data analyses with the purpose of comparing results. This design is also known as a concurrent triangulation design (Creswell, 2021; McBride et al., 2019). 2) An exploratory sequential design, in which the intent is first to gather quantitative data, and secondly to use qualitative methods to explain the quantitative results in more depth. 3) An explanatory sequential design first gathers qualitative data to explore the problem, and secondly uses these data in a quantitative phase to build an instrument or intervention. This instrument or intervention is used in a third phase for data collection (Creswell, 2021).

This study uses a convergent parallel design, as the quantitative and qualitative data are collected separately, analysed separately, and subsequently, compared in a second phase.

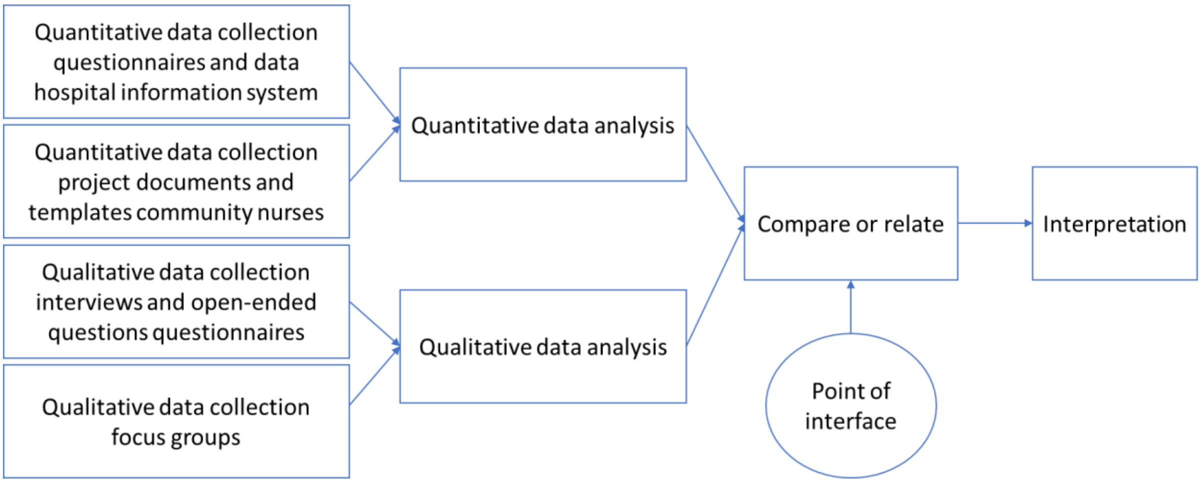


Figure 4.1. A Convergent parallel design, based on Creswell, 2021

The quantitative aspects involved survey methods within a prospective cohort study; data collection from the hospital information system; and templates of the visits of the CNs. Qualitative aspects in this study involved the gathering of data through semi-structured interviews with caregivers and patients; focus group interviews; gathering additional data by the open-ended questions in the surveys; and reflexive thematic content analysis (RTA) (Braun & Clarke, 2016 and 2021; DeSantis & Ugarriza, 2000). The choice for RTA is addressed in paragraph 4.8.2..

4.4. Study setting and participants

This study was performed in a 332-bed regional hospital in the Netherlands, in collaboration with six home care organisations. Before the implementation of the programme, this regional hospital had already collaborated for several years with home care organisations, general practitioners and the social services of local municipalities to improve care for the elderly in the area, in order to establish conditions for the elderly to live safely at home for as long as possible, and to provide care close to the home. As a result, a shared vision for elderly care and a transitional care pathway for vulnerable elderly people was developed. The implementation of the TCB was additional to this pathway and part of the national quality mark, funded by the healthcare insurers to become a senior-friendly hospital.

Three groups of participants were invited to take part in this study. Additionally, two focus group interviews were held. The recruitment and sample are shown in Figure 4.2.

Recruitment and sample

Patients	Professionals
Cohort study Control-group n=50 Intervention-group n=50	**Interviews nurses** Hospital nurses n=5 Community nurses n=4
Interviews patiënts Average old n=8 Oldest old n=5	**Focus group** Geriatic team n=6 Home care n=6

Figure 4.2. Recruitment and sample

Recruitment followed a pragmatic nature. In the cohort study, after the first 50 patients consented to participate in the control or intervention group, no further enrolment took place.

4.4.1. Patient's cohort study

In total, 100 patients were enrolled in this study, of which 50 patients followed the usual care path and 50 patients the transitional care path (figure 4.3.). Inclusion criteria were that patients were aged ≥70 years; who were admitted to the hospital for ≥48 hours; and were later discharged home. Patients were screened for risk of functional decline, using the Identification of Seniors at Risk - Hospitalised Patients (ISAR-HP). Patients with an ISAR-HP score of ≥2 were eligible for this study. Patients could be assessed for inclusion in the study if they exhibited frailty or cognitive problems during admission via the ED. Additionally, nurses and specialists could ask for consultation with the geriatric team if these problems subsequently became evident either during or after admission, even though the ISAR-HP had not initially indicated these issues.

Patients were excluded if they were living in a nursing home or were discharged to a nursing home; had advanced dementia as diagnosed by a geriatrician; and/or were not able to speak the Dutch language. Between August and December 2015, patients were included in this study following the usual care path. Between March and October 2016, patients were included in this study following the TCB-S intervention. Patients following both usual care and transitional care received a questionnaire before discharge and a follow-up questionnaire at 1 and 3 months post-discharge. In both the usual care path and the TCB path, eligible patients were invited to take part in the study, and all patients had to provide written informed consent.

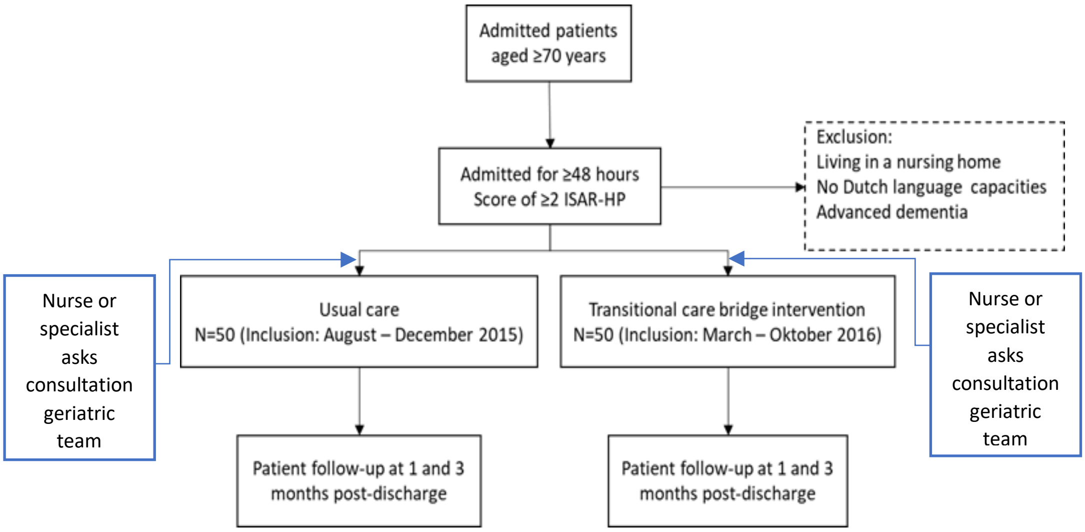


Figure 4.3. Flow chart of patient selection

As the statistical power will be influenced due to a small sample size, the focus in this study is on a global quantitative comparison between two groups, The ISAP-HP is the only instrument which is used for inclusion or exclusion in the programme, as well as the consultation of the geriatric team.

Other baseline characteristics, such as the number of comorbidities, were not explored before inclusion in the study, but were part of the data collection. Patients were visited by me during hospital admission and informed consent was obtained for participation in the study and to allow access to the patient's data from the hospital registry. Patients received help in completing the questionnaire during hospitalisation from the project team. After discharge patients in the usual care group were assisted by telephone to answer the questions on the questionnaires.

Patients in the TCB-S group received assistance from the CN, if necessary. The CNs received instruction during a training session, as well as written information around supporting patients in an objective way, only by reading the question out loud, repeating the question and by providing, if necessary, a pre-determined explanation on the items of the Patient Activation Measure (PAM) in case the patient did not understand the question (appendix 7).

4.4.2. Interviews with patients

Patients were eligible to participate in an interview if they received at least three out of the six visits from the community nurse. A sample of 13 patients participated, and were asked to participate in a semi-structured interview, including older adults aged both below and above 85 years old, both men and women, and who had received the transitional care programme. Participants were asked by the CN to take part, following the last visit by the CN in the TCB-S programme. The participants received an information leaflet from the CN, along with a consent form, which was returned to me. I made a telephone call within two weeks to verify that the patient still wanted to participate in the research, and I provided any additional information required, as well as making an appointment. Interviews were held at the homes of the participants and were recorded, either by myself or by a Masters student from the University of Amsterdam. At the start of the interview, patients were asked to give their consent for the recording. To gain an in-depth insight into the perspectives of the 'oldest' old (85+) in comparison to the 'average' old, a purposeful sample of 5 patients who were 85 years old or above were selected.

4.4.3. Interviews with nurses

A sample of registered nurses in the hospital (n=5) and CNs (n=4) were interviewed regarding their views on the programme and their experiences with the delivery of the programme. I either asked nurses face-to-face on different wards of the hospital if they would participate, or alternatively, I telephoned them. All the nurses agreed to participate after being asked, and gave their written consent to participate and to be recorded.

4.4.4. Focus group interviews

After the quantitative and qualitative data collection, additionally 2 multidisciplinary and multi-level groups, both from inside and outside the hospital, and both consisting of 6 professionals, were selected by purposive sampling by me, and they were asked to provide their perspectives on the preliminary findings of the quantitative and qualitative data.

For the selection of participants for the interviews with the professionals and the focus group meeting, I reached out to (community) nurses, members of the geriatric team, and managers of community nursing organisations I was familiar with. I approached nurses and community nurses who had a special focus in their work on the wards considering care for older adults, or were trained as a CN in the TCB programme.

4.5. Ethics

4.5.1. Researcher position

As the researcher in this study I was an active agent in acquiring information for recruitment and reaching out to participants. My background, gender and age, as described in Chapter 1, were of importance in the relationship between me and participants. As I was not active on the wards of the hospital as a professional, or in a community nursing organisation, my role, was more that of an observer, but not entirely from an outsider-position. Upon introducing myself in and outside the hospital, I mentioned my position in the hospital to patients, which gave me a position as an insider, but emphasised that I was not part of the multidisciplinary team of professionals in the programme. As I was a familiar face to professionals in and outside the hospital, although not closely related to their working context, I straddled a position between the emic and the etic perspectives. During the analysis and interpretation stage I leaned more towards an outsider position.

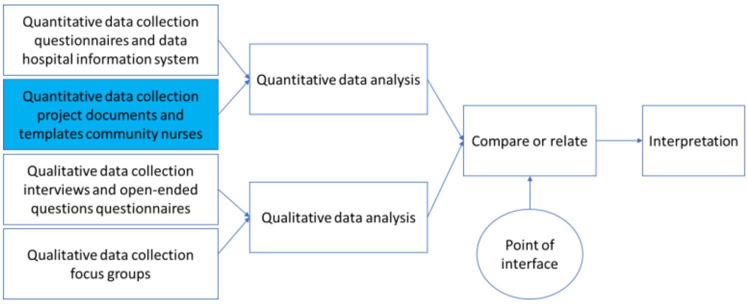
4.5.2. Ethical approval

Approval from the STEMH Ethics Committee of the School of Health Sciences at the University of Central Lancashire (UCLan) was granted on the research proposal (Reference Number: STEMH 654). Ethical approval of the study was obtained from the local ethics committee of the general hospital under study. The local ethics committee concluded on the 20th of February 2017, and this study was included under the Law on Medical Scientific Research involving Human Beings. Approval was based on the contents of the protocol, and the fact that the participants (patients) were correctly informed, according to laws that apply, such as, the Personal Data Protection Act, which was replaced in 2016 by the European General Data Protection Regulation (GDPR, 2016). Participants were asked to take part voluntarily and to give their informed consent in writing. Additionally, I obtained a certificate of conduct from the state secretary of the Ministry of Security and Justice in the Netherlands, which was required in order to demonstrate that I had not committed any criminal offences and that I was a trustworthy person.

For the cohort study, I visited the participants during their admission to the hospital to provide information about the research. The participants were informed on two occasions. First, they received information orally, as well as in writing, by leaving an information sheet. Secondly, prior to conducting the interviews I again explained my role and the purpose and aim of the study. Participants were told what was expected of them; the amount of time likely to be required for participation; the risks and benefits; the fact that participation was voluntary and that one could withdraw at any time with no negative repercussions; how confidentiality was to be protected; and the name and contact information of the investigator who could be contacted regarding any questions or problems they may have related to the research. Consent from the participants was obtained in writing prior to the interviews.

Copies of the hospital's ethical approval, UCLan's ethical approval, consent form and information leaflets are provided in the appendices.

4.6. Quantitative data collection



Fifty older patients (recruited before the start of the programme from June 2015 to December 2015 and after the start of the programme from June 2016 to December 2016) were asked to fill out a questionnaire on the day before discharge (or within 48 hours of discharge), and at one and three months after discharge.

The questionnaires measured morbidity; functional limitations; emotional well-being; cognitive functioning; social functioning; self-perceived health; and self-perceived quality of life. This questionnaire was based on The Older Persons and Informal Caregivers Survey Minimal Dataset

(TOPICS-MDS) questionnaire (Hofman et al., 2014). TOPICS is a compilation of validated instruments measuring physiological, psychological and social health and wellbeing (Lutomski et al., 2013). These instruments are described in Section 4.6.1. The effect of the programme on self-management abilities was measured by the CN using the (Dutch) Self Sufficiency Matrices questionnaire (Fassaert et al., 2014). Patients were asked to report their self-management skills and their sense of confidence in their ability to manage their chronic conditions using the Dutch Patient Activation Measure (PAM) (Rademakers et al., 2012).[2] Data from the two age-groups, namely, 70 to 84 years old and older than 85 years (the 'oldest' old) were compared.

This research study did not include a comprehensive health economic evaluation. However, it does provide data on the differences in mortality rates; the number of GP visits, ED visits and hospital re-admissions; and the use of care homes between both the intervention and the control group. This provided insights into the effects of the TCB-S at a general hospital, compared to the TCB-A in the AMC hospital in Amsterdam. The process of evaluation in practice included an assessment of the integrity of the delivery of the TCB-S programme, by assessing project documentation on the delivery in practice and the templates of the visits of the CN.

4.6.1. Measurements

Using The Older Persons and Informal Caregivers Survey Minimal Dataset's (TOPICS-MDS) questionnaire, relevant outcomes were measured for elderly people on the physical and mental health and well-being of older adults in over 60 research projects of this programme (Hofman et al., 2014; Lutomski et al., 2013). Based on the TOPICS-MDS, self-rated health and quality of life was assessed with a numerical value from 0 to 10, scoring '0' for 'very poor health or totally unhappy with', and '10' for 'completely healthy or happy with'. Self-evaluations of health have proven to be sensitive predictors of morbidity and mortality (Bailis et al., 2003; Mossey & Shapiro, 1982). Although a range of measurements are available for quality of life, the TOPICS-MDS use a subjective quality of life measurement by asking individuals to rate their own happiness from 0 to 10. This differs from other measurements that use a visual numeric scale of 0 to 100.

As many data as possible were retrieved from the hospital register, in order to limit the number of questions participants would have to answer during their hospital admission. This baseline assessment included the following:

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[2] This instrument was used with the consent of Insignia Health.

- Summary of the CGA, including visual and hearing impairment, admission diagnosis and co-morbidities.
- The ISAR-HP at the ED.
- Risk of falling (one question - relating to the number of falls in the last 6 months).
- The Short Nutritional Assessment Questionnaire (SNAQ) (a three-item questionnaire to check the risk for or existence of malnutrition (Kruizenga et al., 2005). The range of the score is 0 to 7. Patients with < 2 points were classified as well-nourished. At 2, the patient is moderately malnourished. At 3 and above, the patient is classed as severely malnourished.
- The risk of delirium (3 one-point questions, one and above being a positive indicator for being at risk).
- Physical restrictions in ADL (6-item Katz Index of Independence in Activities of Daily Living), on a 0 to 6 scale, with higher scores indicating more dependence. Patients with < 2 points are considered independent. At 2, the patient is at risk, at 4, the patient is moderately dependent, and at 6, the patient is completely dependent.
- Triage for the geriatric team using a self-assessment questionnaire.
- Length of hospital stay (calculated from the day of admission to the day of discharge).

The first questionnaire at the baseline included items related to socio-demographics (for example, age, gender, marital status, living situation), items regarding the extent of home care and informal care, self-rated health and self-rated quality of life. The follow-up questionnaires at one and three months after discharge included questions on everyday living, number of visits to the GP, visits to the ED, re-hospitalisation, admission to care home, changes in living situation and formal and informal care, self-rated health and self-rated quality of life. Mortality information within one and three months of discharge from hospital was retrieved from the hospital register. The risk of functional decline was assessed with the identification of seniors at risk - hospitalised (ISAR-HP) (Hoogerduijn et al., 2012). A score ≥ 2 on a scale of 0 to 5, with '5' being the highest risk, was considered to indicate a risk of functional decline.

As the TCB programme aims to enhance the self-management abilities of the patient, self-management was assessed by patients themselves with the Dutch Patient Activation Measure (PAM) at discharge, and in the group of patients who took part in the programme at one and three months after discharge (Rademakers et al., 2012). This self-assessment of self-management was not a part of the TCB-A study in Amsterdam. The Patient Activation Measure (PAM-13) measures individual patients' self-reported knowledge, skills and confidence in coping with their own health or illness (Hibbard et al., 2004). The PAM was developed in the United States and subsequently validated for use in the Netherlands (Rademakers et al., 2012). This questionnaire consists of 13 statements, which are rated on a 5-point Likert scale by the participant. For each of the 13 statements, participants say how much they agree or disagree, where ‘1’ represents ‘strongly disagree’, ‘4’ represents ‘strongly agree’. If a statement is not applicable, or an answer is missing, ‘0’ points are scored. A total score is generated where participants have answered at least 10 out of the 13 questions. The total score indicates the level of patient activation based on this instrument. At Level One, the patient is barely capable of self-management. Based on the PAM score, people can be classified into one of four ascending levels: from more passive patients, who experience little self-control (PAM 1); to active patients, who say they can and want to manage their illness and their care well (PAM 4). If patients did not fill out the entire form, the questionnaire was invalid.

To be able to compare the assessment of the patients with the assessment of the CNs, the CNs assessed the self-management abilities of the patients in the transitional care group at discharge, at one and at three months with the Dutch version of the Self Reliance matrix, developed by Vilans at the National Centre of Expertise for Long-term Care in the Netherlands (Vilans, 2013). Although inspired by the Self-Sufficiency Matrix (Fassaert et al., 2014) and altered for professionals who deliver care at home, this instrument was not yet validated by 2015. The self-reliance matrix distinguishes 10 areas of life (for example, daily activities, living situation and housekeeping, physical and cognitive functioning, social network, mobility, and financial situation). For each area of life, the client's self-reliance is assessed by the professional on a scale from ‘1’ (not self-reliant) to ‘4’ (completely self-reliant). An overview of all outcomes and measurement tools is provided in Table 4.2. below.

Outcome	**Source**	**Tool**	**Method of analysis**
Frailty (Hoogerduin, 2012)	Data Hospital Information System Questionnaires at 1 and 3 months	ISAR-HP Questions 1-3	t-test
Functional decline (Katz, 1983)	Data Hospital Information System Questionnaire at 1 and 3 months	KATZ-ADL Questions 10-15	t-test
Number of GP visits	Questionnaire at 1 and 3 months	Questions 16-18 about number of GP visits in previous month(s)	Descriptive statistics
Number of ED visits	Questionnaires at 1 and 3 months Data Hospital Information System	Question 19 about number of ED visits in previous month(s)	Descriptive statistics t-test

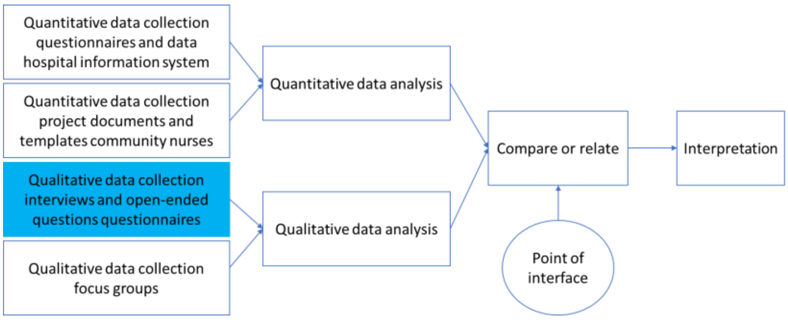
Number of re-admissions	Questionnaires at 1 and 3 months Data Hospital Information System	Question 20 about number of re-admissions in previous month(s)	Descriptive statistics
Number of admissions into care home	Questionnaires at 1 and 3 months	Question 21 about admissions in previous month(s)	Descriptive statistics
Hours of care received by CN	Questionnaires at discharge and at 1 and 3 months	Question 22 about hours of care provided by CN	Descriptive statistics
Hours of informal care	Questionnaires at discharge and at 1 and 3 months	Question 25-28 about hours of informal care provided by family members, friends and neighbours	Descriptive statistics
Self-rated health (Mossey, 1982; Meng 2014)	Questionnaires at discharge and at 1 and 3 months	Question 37 Scale for self-rated health	Descriptive statistics
Quality of life (Cummings, 2000)	Questionnaire at discharge and at 1 and 3 months	Question 38 Subjective numeric scale for quality of life	Descriptive statistics
Mortality within 3 months of discharge	Data from hospital information system	Kaplan-Meier survival analysis	Comparison
Self-management abilities (Rademakers, 2012; Fassaert, 2014)	Questionnaire at discharge and at 1 and 3 months Self-Sufficiency Matrix filled out by the CN at the time of discharge and at 1 and 3 months	Self-Sufficiency Matrix Patients filled out the Patient Activation Measure (PAM), Question 42	Descriptive statistics
Perspectives of patients	Questionnaires at discharge and at 1 and 3 months	Qualitative Questions 37-41 on self-rated health, quality of life, transition from hospital to home, and perspective on care provided	Reflexive thematic analysis

Tabel 4.2. Outcomes and measurment tools

4.6.2. Programme fidelity

During the implementation, programme data and project documents gave insight into the programme fidelity. Data were retrieved relating to numbers and outcomes of screening; numbers of consultations of the geriatric team; and numbers enrolling in the transitional care programme. The CNs recorded each visit of the participants in the transitional care group and returned the templates of these visits to the hospital. The fidelity of the programme was assessed based on predefined quality indicators and subjects to be discussed during the visits of the CNs.

4.7. Qualitative data collection



Qualitative data collection encompassed the open-ended questions in the three questionnaires at 0, 1 and 3 months, which addressed the patients' experiences of the hospital-to-home transition; their ability to cope at home; and their perceived quality of care at home (that is, did they receive sufficient care?). The main qualitative data were collected from the interviews in three groups of participants: patients, hospital nurses and CNs, plus two focus groups' interviews: one with the geriatric team, and one with the managers and CNs of the home care organisations.

Interviews with the registered nurses from the hospital took place in the different wards of the hospital. Interviews with the CNs took place at the different CN home care organisations. I invited participation from nurses on the several wards that were familiar with the programme, and had worked with the CNs, along with CNs from four different home care organisations who delivered the programme. All nurses who were invited were willing to participate.

Topics of these interviews were:

- Experiences in the delivery of the programme;
- Experiences in how the programme was received;
- Quality of care;
- Continuity of care; and
- Meeting the needs of the patients.

The CNs invited patients to be interviewed after the final CN visit. After a notification from a CN, I then contacted the patients within two weeks to make an appointment. Most patients were willing to participate, but due to fatigue and other physical problems, over 50% of the patients who were contacted declined or postponed the interview. In these cases, the interviews with the patients subsequently took place at their homes. Informal caregivers were present in the majority of these interviews.

Topics in these interviews were:

- Hospital to home transition;
- Information on the programme;
- Experience with the programme; and
- Needs of the patient.

Derived from these topics, an interview guide was developed for professionals, as well as patients, based on the Six Senses Framework (Nolan et al., 2006). This framework incorporates patient experiences, continuity and co-ordination of care, and patient empowerment. The concepts relate to: sense of security; sense of continuity; sense of belonging; sense of purpose; sense of fulfilment; and sense of significance. When examined together in a health service setting, each of these six senses contribute to a service which can be considered a good quality service. The interview guides can be found in Appendix 9.

Two focus group meetings took place at the hospital. At the start of the focus group, the health professionals or managers gave their written consent. Participants were asked to provide their perspectives regarding the quantitative and qualitative data from the questionnaires and interviews, by using the survey feedback approach. By using this approach, professionals were able to discuss the findings, as well as generate potential solutions. The survey feedback in an interactive group session entailed the active discussion and consensus of the group participants (Werkman & Boonstra, 2001).

4.8. Data Analysis

4.8.1. Quantitative data analysis

Quantitative data from the surveys and the hospital information system were stored and analysed via the Statistical Package for Social Sciences (SPSS v26). The baseline assessments and outcome parameters were summarised using simple descriptive statistics. The main analysis focused on a comparison between the usual care group and the transitional care group on the Katz ADL index score, mortality, and the use of care. A chi-square test of homogeneity (categorical) and an Independent-sample t-test (continuous) were conducted to test for differences between usual care patients and transitional care patients regarding the demographic characteristics. Descriptive statistics (mean and standard deviation (SD), median (IQR) and proportions) were used to determine the prevalence of: mortality; health care utilisation (for example, LoS, re-admissions, care home admissions, CN care, and informal care); and health outcomes (for example, frailty, functional outcome, risk delirium, and self-rated health).

4.8.2. Qualitative data analysis

Qualitative research is about meaning and viewing these meanings in relation to the context. Qualitative data analysis focusses on interpreting the stories and creating a truth from within the data. Several approaches in analysis are widely known and used, such as grounded theory (GT), interpretive phenomenological analysis (IPA), discourse analysis, content analysis and (reflexive) thematic analysis ((R)TA). These approaches show similarities when it comes to generating themes, but demonstrate differences when it comes to their methodologies or their aim to generate a theory. As this study focuses on the evaluation of a care programme and the perspectives of participants specifically on this programme, a TA or a GT approach could have been appropriate. In GT the objective is to develop theories (Charmaz, 2006). In TA, which has been updated by Braun and Clarke (2021) to RTA, the process is often driven by the research question and focuses on identifying patterns and themes, which are explained by existing theory, and applicable for this study**.** In reflexive thematic analysis (RTA), the approach is flexible and organic, and was therefore considered most appropriate for this mixed methods study, which aimed to focus on identifying, analysing and generating patterns or themes across datasets, whilst describing the data of the experiences of the participants in great detail.

4.8.2.1. Reflexive thematic analysis

Qualitative data from the open survey questions in the questionnaires, the interviews and the forms completed by the CNs were analysed using RTA (Braun & Clarke, 2021; Crowe et al., 2015; Vaismoradi & Snelgrove, 2019; Vaismoradi et al., 2013). Data from the interviews were coded by two researchers. The computer-assisted qualitative data analysis software Maxqda (Version 2020) was used to support the analysis of the interviews.

In this current study, interview participants came from three distinct groups: older patients, registered nurses from the wards in the hospital, and CNs. The RTA was conducted by me for each group of participants, as well as for the focus group interviews. The different perspectives and themes of the three groups and two focus groups were compared for similarities and variances. The RTA approach I used in this study follows the six-phase process developed by Braun & Clarke (2013, 2021): 1) data familiarisation and writing familiarisation notes; 2) systematic data coding; 3) generating initial themes from coded and collated data; 4) developing and reviewing themes; 5) refining, defining and naming themes; and 6) writing the report.

Texts were read repeatedly by me, coded and merged into themes. This process of coding and analysis is captured by Braun & Clark (2019) by the term 'organic'. This means the process of RTA was open, exploratory, flexible and had an iterative nature (Braun & Clarke, 2019).

1) Data familiarisation and writing familiarisation notes: I transcribed the semi-structured interviews verbatim and read the interviews several times, to become closely familiar with its content. I added notes and memos.

2) Systematic Data Coding: At the start, I used an inductive approach to identify significant features of the data with one other researcher, which enriched labels and codes assigned to the transcripts. Coding in the process occurred at two levels: semantic or manifest meaning, and latent or implicit meaning. This fine-grained coding captured diversity and nuance and provided a foundation for conceptualising potentially significant patterns (for research questions) of shared meaning.

3) Generating initial themes from coded and collated data: I further explored the data to identify patterns or possible themes. The themes were conceptualised as patterns of shared meaning across the data set underpinned or united by a core concept.

4) Developing and reviewing themes: I checked the potential themes by going back to the data and ensuring they represented the meaning of the participants and captured the central organising concept (Braun & Clarke, 2013, 2021; Braun et al., 2014).

5) Refining, defining and naming themes: I analysed each theme in greater detail, clarified each theme with a title and described each theme.

6) Writing the report: I wrote a detailed analysis, which I enriched with extracts from the data that underpinned the themes, and I contextualised each theme with references to relevant literature.

4.9. Research synthesis

The pragmatic realist synthesis of data from this mixed methods research can be classified as a parallel-results convergent synthesis design (Heyvaert et al., 2013; Hong et al., 2017). This means that qualitative and quantitative data were analysed and presented separately with integration occurring in the interpretation of the results in the discussion section, addressing the following research questions:

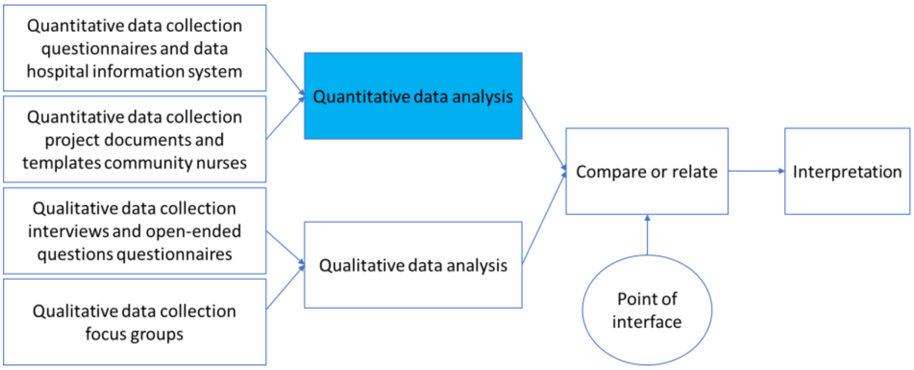
- Does patterning of similarities or discrepancies emerge from the effects of the interventions and the perceived experiences of the older patients?
- Does patterning of similarities or discrepancies emerge based on outcomes and perceived experiences of the different age groups of the elderly?
- What is it about this intervention that works, from whom, in what circumstances, in what respects, and why? (Pawson et al., 2005)
- Can patterns be expanded or explained based on the available scientific literature?

In the discussion chapter, themes from the qualitative data analysis are compared to the quantitative data and to scientific literature (Creswell, 2021; Creswell et al., 2011; Noyes et al., 2019; Östlund et al., 2011).

4.10. Summary

This study combines two paradigms: critical realism and pragmatism. This means the diversity and the relationships between people, events, and ideas were explored in the context, as well as what worked and for whom. A mixed methods convergent parallel study design was chosen as this offered the opportunity to uncover the relationships between the treatment outcomes and the diverse perspectives of professionals and patients. Combining both types of data helped to reveal the underlying patterns and provided insight into why, and in what way, the intervention did or did not work, with a particular focus in this study on the oldest adults. This study was performed in a 332-bed regional hospital in the Netherlands in collaboration with five home care organisations. In total, 100 patients were enrolled in a cohort study, whereby 50 patients followed the usual care path and 50 patients followed the TCB-S programme. Patients filled out three questionnaires over a period of three months' time. Three groups of participants were invited to take part in the interviews. Additionally, two focus group interviews were held. Measurements were mainly based on the TOPIC-MDS. Both descriptive and statistical analyses were used. A thematic reflective analysis was conducted for the interviews. Data were synthesised and discussed and compared to the literature.

CHAPTER 5 ANALYSIS AND DISCUSSION OF THE QUANTITATIVE DATA



5.1. Introduction

This chapter is presented in two parts. The first part provides a description of the total of 100 patients that were followed over a period of three months in the usual care group and the transitional care group. The second part reports on the result of the delivery of the programme in practice.

Before the implementation of the programme, the regional hospital involved had already been collaborating for several years with homecare organisations, general practitioners and social services of the local municipalities in order to improve care for elderly in the area; to establish conditions for the elderly to live at home safely for as long as possible; and to provide care close to home. A shared vision on care for the elderly, along with a transitional care pathway for the vulnerable elderly was developed. The implementation of the TCB was additional to this pathway and part of the national qualitygrade, which was funded by the healthcare insurers to become a senior-friendly hospital.

The implementation of the transitional care programme in the general hospital under study was supported by a programme manager during the first two years of the implementation. All wards of the hospital were included in the implementation. In the preparatory phase, a great deal of attention was paid to encouraging the employees and medical specialists involved in the transitional care programme. Professionals were informed and trained on the contents of the TCB programme and the effective elements of the programme were discussed. CNs, nurses on different wards of the hospital, and nurses working at GP practices were trained.

Initially, due to the geriatricians of the hospitals being anxious about whether they would be overwhelmed by the number of consultations for their department, the age for inclusion in the transitional care programme was set at 80 years but, within two month, this changed to 70 years. This differs from the group of the TCB-A study. Additionally, to limit the influx of patients, the geriatricians developed a self-assessment questionnaire, that patients had to fill out on the ED, if their ISAR-HP score was ‘2’ or more. This questionnaire included 26 questions on physical and mental conditions and everyday living, could be answered with ‘Yes’ or ‘No’, and was considered a minimal comprehensive geriatric assessment (CGA) (Appendix 8). Patients were eligible for consultation from the geriatric team if five questions of this questionnaire were answered with a ‘Yes’, or if there was a positive answer to one of the five key questions. These question were: 1) Do you consume an average of 3 or more units of alcohol per day?; 2) Do you have Parkinson's disease?; 3) Have you had (some) memory problems for a long period of time?; 4) Have you ever become suddenly confused either now or in the past?; 5) Is this an unplanned re-admission within 30 days of discharge?

Additionally, nurses and specialists could also request a consultation from the geriatric team, if patients were identified by the nurses themselves as vulnerable, or if patients developed signs of cognitive decline during hospitalisation.

5.2. Participants’ characteristics

During the inclusion period of the usual care group and the transitional care group, additional patients were asked to participate in the programme until 50 participants were found for each group. In the control group, the number of patients who did not agree to participate was less than 10%. In the intervention group, the number of patients who did not agree to participate was over 25%. Patients in this group often mentioned that they were too tired to take part.

The mean age of patients in the transitional care group and the usual care group were 84.0 (SD 4.8) and 84.6 (SD 6.1) years respectively, with 74.0% and 62.0% respectively being female (Table 8). In the transitional care group, 74% of the patients normally lived alone, compared to 58% in the usual care group. The majority of patients had secondary or tertiary education (70.0% in the transitional care group and 72.0% in the usual care group).

In the transitional care group, 66% of the patients had 3 or more co-morbidities, compared to 52% in the usual care group. In both groups, lung problems, such as dyspnoea, pneumonia or exacerbation of existing problems, seemed to be highly prevalent (24% in the usual care group and 30% in the transitional care group). Examples of co-morbid conditions were: heart disease, vascular disease, lung disease, neurological disease, kidney disease, diabetes mellitus, obesity, gastro-intestinal disorders, osteoporosis, dementia and cognitive disorders, psychiatric disorder (for example, depression), joint or back problems, arthritis or rheumatic problems, and various forms of cancer.

Characteristics	Usual care	Transitional care	p-value
Participants, n (%)	50 (50.0%)	50 (50.0%)	
Gender, n (%)			0.198
Male	19 (38.0%)	13 (26.0%)	
Female	31 (62.0%)	37 (74.0%)	
Age, mean (SD)	84.6 (6.1)	84.0 (4.8)	0.610
Age, n (%)			0.315
70-84 years	25 (50.0%)	30 (60.0%)	
≥85 years	25 (50.0%)	20 (40.0%)	
Marital status, n (%)			0.091
Living with a partner	21 (42.0%)	13 (26.0%)	
Living alone	29 (58.0%)	37 (74.0%)	
Education[a]			0.784
Primary education	14 (28.0%)	12 (24.0%)	
Secondary/tertiary education	36 (72.0%)	35 (70.0%)	
Co-morbidity status [a]			0.232
1-2 co-morbidities	22 (44.0%)	17 (34.0%)	
3 or more co-morbidities	26 (52.0%)	33 (66.0%)	
[a] 2 (4.0 %) missing values in usual care group (no hospital registry report on co-morbidities)			

Table 5.1. Patient characteristics

The reasons for principal diagnosis for admission were often not described as diseases in the hospital register, but as conditions, such as, collapse, dehydration and general malaise, and were prevalent in 14% of the usual care group and in 12% of the transitional care group. These diagnoses reflect the complex and often fragile condition of the patients, who are vulnerable to considerable decompensation when confronted by even small perturbations, such as a fall or a mild infection (McIntyre, 2013). In the usual care group, 14% suffered from intestinal problems. Other infectious diseases were also prevalent in 12% of the usual care group and 14% of the transitional care group of the cases, and cardiovascular diseases in 10% and 6% respectively.

5.3. Clinical outcomes

5.3.1. Mortality

The mortality rate within three months of discharge was lower in the transitional care group (6.4%), compared to the usual care group (12.8%), although this was not statistically significant (p 0.293).

Mortality	Usual care	Transitional care	p-value
Within one month of discharge [a]	3 (6.4%)	2 (4.3%)	0.646
Within three months of discharge [a]	6 (12.8%)	3 (6.4%)	0.293
[a] 3 missing values in the usual care group and 3 missing in the transitional care group			

Table 5.2. Mortality in usual care group and TCB-S group

5.3.2. Health care utilisation

Patients with usual care had a mean hospital stay of 10.0 (SD 6.4) days, compared to 9.1 (SD 3.9) days for patients following transitional care. More patients in the transitional care group had a hospital stay longer than 8 days (70.0%), compared to patients with usual care (52.0%). Nearly a quarter of all the patients had a re-admission to hospital within 3 months (21.7% in the transitional care group and 24.4% in the usual care group). The majority of patients visited the GP at least once within 3 months of discharge, and half of all the patients (48.8% in the usual care group and 51.2% in the transitional care group) visited the GP more than 3 times. After three months, 80% of the patients in the transitional care group and 52.9% of the patients in the usual care group received care from a CN. There were no statistically significant differences in the healthcare utilisation between the transitional care and the usual care group. In both groups, the percentage of patients receiving informal care, consisting of help from family members, friends or neighbours, was high. Three months after discharge, informal care in the transitional care group was higher than in the usual care group, though again not statistically significant.

Healthcare use	**Usual care**	**Transitional care**	**p-value**
Median (IQR) hospital length of stay	8.0 (6.0-12.0)	8.0 (6.75-11.0)	0.368
Hospital length of stay, n (%)			0.099
3 - 7 days	23 (46.0%)	15 (30.0%)	
≥8 days	26 (52.0%)	35 (70.0%)	
Healthcare use within 3 months of discharge, n (%)			
ED visit [a]	6 (13.0%)	11 (23.9%)	0.179
Hospital re-admission [b]	11 (24.4%)	10 (21.7%)	0.795
Admission to care home [c]	8 (17.8%)	10 (21.3%)	0.672
Visits to GP [d]	32 (78%) [d]	32 (74.4%)	0.696
≥ 3 visits to GP	21 (48.8%)	22 (51.2%)	0.894
Help from Community Nurse [e]	18 (52.9%)	24 (80%)	0.467
Informal care [f]	30 (81.1%)	29 (87.9%)	0.435

IQR= Inter-Quartile Range

[a] 4 missing in the usual care group and 4 missing in the transitional care group

[b] 5 missing in the usual care group and 4 missing in the transitional care group

[c] 5 missing in the usual care group and 3 missing in the transitional care group

[d] 9 missing in the usual care group and 7 missing in the transitional care group

[e] 16 missing in the usual care group and 20 missing in the transitional care group

[f] 13 missing in the usual care group and 17 missing in the transitional care group

Table 5.3. Healthcare utilisation in the usual care group and the TCB-S group

5.3.3. Health outcomes

Based upon the cut-off point for the Katz-adl ≥ ‘4’ at the baseline, more patients in the usual care group were dependent in ADL, compared to the transitional care group. The percentage of those being dependent rose within three months of discharge from 36% in the usual care group to 47.1%, and in the transitional care group being dependent rose from 20.4% to 36.7% (p=0.401). Although the indicator of ‘seniors at risk’ was developed for the hospital environment, this indicator showed a rise of patients being at risk (ISAR-HP ≥2) in both groups over a three-month period. The increase in the transitional care group particularly stands out as, at three months, 93.3% of the patients were at risk of functional decline. Patients self-rated their health and their quality of life at three points in time. Both groups show similar results over time, although the ratings of the transitional care group seem slightly poorer.

	Usual care group			**TCB group**		
Health outcomes	Hospital	1 month	3 months	Hospital	1 month	3 months
Dependent in ADL, n (%)	18 (36.0%)[a]	14 (37.8)[b]	16 (47.1%)[c]	10 (20.4%)[a]	16 (44.4%)[b]	11 (36.7%)[c]
At risk of delirium, n (%)	29 (58.0)	16 (50.0)[d]	17 (56.7)[e]	34 (68.0%)	26 (78.8%)[d]	23 (76.7%)[e]
Risk of malnutrition, n (%)	15 (30.0%)	14 (43.8%)[g]	6 (19.4%)[h]	17 (34.7%)[f]	11 (30.6%)[g]	5 (16.7%)[h]
Self-rated health, mean (SD)	5.4 (1.4)[i]	6.4 (1.3)[j]	6.6 (1.6)[k]	5.7 (1.3)	6.0 (1.4)[j]	5.9 (1.6)[k]
Quality of life, mean (SD)	6.4 (1.9)[l]	7.0 (1.5)[m]	6.4 (2.0)[n]	6.3 (1.6)	6.3 (1.6)[m]	5.9 (1.7)[n]

SD= Standard Deviation

[a] 1 (2.0%) missing in the TCB group

[b] 13 (26.0 %) missing in the usual care group and 14 (28.0 %) missing in the TCB group

[c] 16 (32.0 %) missing in the usual care group and 20 (40.0 %) missing in the TCB group

[d] 16 (32.0 %) missing in the usual care group and 14 (28.0 %) missing in the TCB group

[e] 18 (36.0 %) missing in the usual care group and 20 (40.0 %) missing in the TCB group

[f] 1 (2.0 %) missing in the TCB group

[g] 17 (34.0 %) missing in the usual care group and 14 (28.0 %) missing in the TCB group

[h] 17 (34.0 %) missing in the usual care group and 20 (40.0 %) missing in the TCB group

[i] 1 (2.0 %) missing in the usual care group

[j] 12 (24.0 %) missing in the usual care group and 14 (28.0 %) missing in the TCB group

[k] 16 (32.0 %) missing in the usual care group and 20 (40.0 %) missing in the TCB group

[l] 1 (2.0 %) missing in the usual care group

[m] 12 (24.0 %) missing in the usual care group and 14 (28.0 %) missing in the TCB group

[n] 17 (34.0 %) missing in the usual care group and 21 (42.0 %) missing in the TCB group

Table 5.4. Health outcomes in the usual care group and the TCB-S group

5.4. Self-management

Self-management was assessed by patients in the baseline questionnaire with the Patient Activation Measure (PAM) before discharge. In the transitional care group, patients also assessed their self-management with the PAM at one and three months after discharge, with the assistance of the CN. In the usual care group, a considerable number of patients were unable or unwilling to answer these questions to make a comparison between both groups at one and three months.

For this study, PAM levels 1 and 2 and PAM levels 3 and 4 were merged. At discharge, the levels of patient activation were comparable for the usual care group and the transitional care group. In the usual care group, 66.7% of the patients experienced little or no self-reliance in terms of managing their health, compared to 71.1% in the transitional care group. In the transitional care group, this percentage dropped by the three-month stage to 60.9%.

PAM	**At discharge**	**1 month**	**3 months**
Transitional care			
PAM level 1-2	32 (71.1%)	18 (78.3%)	14 (60.9%)
PAM level 3-4	13 (28.9%)	5 (21.7%)	9 (39.1%)
Usual care			
PAM level 1-2	30 (66.7%)	*(extensive missing data)*	*(extensive missing data)*
PAM level 3-4	15 (33.3%)	*(extensive missing data)*	*(extensive missing data)*

Table 5.5. Patient Activation Measure levels

For the 23 patients in the transitional care group with follow-up data at both 1 and 3 months, the number of patients with a PAM level of ‘3’ or ‘4’ increased from ‘5’ (21.7%) at 1 month to ‘9’ (39.1%) at 3 months after discharge.

To compare the views of the patients and the CNs, the CNs assessed the self-management abilities of the patients in the transitional care group at discharge, and at one and three months after discharge in ten areas of their life, using the Dutch version of the Self Sufficiency matrix (SSM). These ten areas are: daily activities; living situation; physical-, psychological- and cognitive functioning; housekeeping; ADL skills; social network; mobility; and financial situation. For each of the ten areas of life, the client's self-reliance was assessed by the CN on a scale from ‘not at all’ (1) to ‘completely’ (4). To gain an insight into the development of the self-management abilities, an overall score was added and compared at one and three months after discharge to the score prior to discharge. The inter-item consistency of this instrument varied between 0.796 and 0.831, which is considered as a good consistency (Gliem & Gliem, 2003). Therefore, if one or two items were missing, the mean of the overall score of the filled-out items was imputed. If three or more items were missing, the entire score was rated as invalid and missing.

The SSM total score increased significantly from 26.8 at discharge to 29.1 at 3 months after discharge (p=0.007).

SSM	**At discharge**	**1 month**	**3 months**
Transitional care			
SSM total score (SD)	26.8 (5.3)	28.2 (4.8)	29.1 (5.2)
Only includes patients with complete follow-up (n=26) SSM=self-sufficiency matrix			

Table 5.6. Self Sufficiency Matrix total score (SD) in TCB-S group

5.5. Programme fidelity

Project data showed that in the first year of the transitional care programme, 268 patients were reported to the geriatric team, of which 150 patients were enrolled in the programme (56%). Screening at the ED of the ISAR-HP took place in 91% (85% being the quality indicator), and the self-assessment questionnaire for triage for the geriatric team was filled out in 65% (90% being the quality indicator). The four main reasons for not enrolling in the programme were: a change of plan to discharge a patient to a care home, rather than to their own home; too little notice to be able to arrange a visit by a CN before discharge; the patient's choice of a care organisation which was not trained in the transitional care programme; or that the patient's family did not give their consent. In 59.6%, the CN visited the patient within 48 hours of discharge (90% being the quality indicator). On average, the CN visited the patients three times at home. In 70%, the CN contacted the GP at the end of the programme (90% being the quality indicator). Delays, or even not enrolling in the programme, occurred when screening at the ED was incomplete and nurses on the wards had to finish this screening, and/or consultation of the geriatric team was not requested. Additionally, sometimes it was clear that even though a patient was vulnerable and eligible for the transitional care programme, CNs observed that they were still not always enrolled in the programme. During the holiday periods, for example, capacity problems occurred in the transfer agency of the hospital, and the CNs' organisations. Some CNs refused to start the transitional care programme if the patient was already receiving usual care from the CN.

During the first year of the programme, the CNs were asked to return the filled-out templates of their visits. The six collaborating home care organisations in total returned the templates of 55 patients of the 150 included patients (37%), ranging from 3 to 17 templates per organisation. The average number of visits was 3.8 ranging from one to six visits. Of these patients, 22% were admitted to the geriatric ward, 34% to wards of internal medicine, and 12% to the pulmonary diseases ward. Only 7% of the included patients were admitted to surgical wards. In 94% of the second visits by the CN, medication was discussed with the patients. During the third visit, in 82.5% of cases, the aims of the patients were discussed. Informal caregivers were invited to attend the visits of the CN. In 65.5% of the trajectories, the informal caregiver was present in one or more of the visits. During the first visit of the CN in the hospital, 41.8% of the informal caregivers were present. Based on the templates that were returned, 10% of the patients received all six visits from the CNs. Reasons for prematurely ending the programme, besides admissions to care homes (11%), were that patients or CNs no longer saw the value of the visits, or that patients already had homecare and, therefore, the care was handed over to them.

5.6. Differences between routes of patient inclusion

In the usual care group (n=9) and in the TCB group (n=9), patients were included based on the advocacy of nurses or specialists, by asking for consultation by the geriatric team. In both groups, levels of dependence in ADL were low. Of the 9 patients in the TCB group, 8 patients had high frailty scores at 1 month, ranging from 2 to 5. In the usual care group, this increase in frailty after one month was not found. Both groups of these patients had a higher LoS (usual care group mean 11.33 and TCB group mean 9.44) compared to the entire usual care or TCB group. None of these patients in both groups were re-admitted or died within 3 months of discharge.

5.7. Differences between the ‘’average’ old and the ‘oldest’ old

In this section, the outcomes and differences between the ‘average’ old,’ (75-85 years old), and the ‘oldest’ old (85 years old and older) will be described. In the TCB-S group, 40% of the patients were 85 years old or older, of which 60% had three or more comorbidities. The percentage of patients with three or more comorbidities in the TCB-S group, for both age groups, were considerably higher when compared to the usual care groups.

In the ‘average old’ age groups, the difference in mortality stands out after three months, as this percentage is 12.5% in the usual care group and 3.6% in the TCB-S group. Also the mortality in the ‘oldest old’ age group is slightly lower in the TCB-S group.

Both age groups in the TCB-S group showed considerably higher levels of ED visits and admissions to care homes after discharge. It is especially noteworthy that the percentage of admissions into care homes after discharge is 27.8% in the ‘oldest old’ age group of the TCB-S group.

The levels of being dependent in ADL one month after discharge are very similar for the usual care group and TCB-S group in both age groups. After three months, the level of being dependent drops in the oldest age group of the TCB-S group (40%), compared to the oldest old in the usual care group (58.8%).

	Usual care 70-85	**Usual care 85 +**	**TCB-S group 70-85**	**TCB-S group 85+**
Characteristics				
Participants, n (%)	25 (50.0%)	25 (50.0%)	30 (60.0%)	20 (40.0%)
Comorbidity status				
1-2 comorbidities	9 (36.0%)	10 (40.0%)	9 (30.0%)	3 (15.0%)
3 or more comorbidities	11 (44.0%)	8 (32.0%)	19 (63.3%)	12 (60.0%)
Mortality				
Within one month of discharge	1 (4.2%)	2 (8.7 %)	2 (3.6%)	1 (5.3%)
Within three months of discharge	3 (12.5%)	3 (13.0%)	1 (3.6%)	2 (10.5%)
Healthcare use				
Median (IQR) hospital LoS	8.0 (6.0-15.75)	8.0 (5.5-11.00)	8.0 (6.00-11.00)	9.0 (8.00-11.75)
Health care use within 3 months of discharge, n (%)				
ED visit	3 (12.5%)	3 (13.6%)	7 (25.0%)	4 (22.2%)
Hospital re-admission	6 (25.0%)	5 (23.8%)	8 (26.7%)	2 (11.1%)
Admission to care home	4 (16.7%)	4 (19.0%)	5 (17.2%)	5 (27.8%)
Visits to GP	22 (88%)	19 (76%)	27 (90.0%)	16 (90.0%)
≥ 2 visits to GP	4 (18.2%)	6 (31.6%)	8 (29.6%)	7 (43.8%)
Help from Community Nurse	6 (35.3%)	12 (70.6%)	17 (56.6%)	7 (70.0%)
Informal care	14 (73.7%)	16 (88.9%)	19 (86.4%)	10 (90.9%)
Health outcomes one month after discharge				
Dependent in ADL, n (%)	6 (40.0%)	8 (47.0%)	9 (42.8%)	7 (46.6%)
ISAR-HP ≥2, n (%)	19 (95.0%)	18 (90.0%)	20 (86.9%)	15 (100.0%)
Health outcomes three months after discharge				
Dependent in ADL, n (%)	6 (35.3%)	10 (58.8%)	7 (35.0%)	4 (40.0%)
ISAR-HP ≥2, n (%)	14 (77.7%)	16 (88.9%)	18 (90.0%)	10 (100.0%)

Table 5.7. Outcomes of the ‘average’ old and the ‘oldest’ old

5.8. Discussion

In the original RCT study in Amsterdam, the TCB-A, the reduction in mortality after one and six months was statistically significant. In comparison to the TCB-A, during the implementation in the regional hospital under study, patients were included who were over 70, as opposed to over 65 years in the

TCB-A, and the intervention was implemented in the entire hospital as, in the TCB-A, only the internal medical wards were included. Results of patient outcomes in the regional hospital under study are similar to the results in the TCB-A. It is noteworthy that both studies do not show a reduction in functional decline after hospitalisation. Whereas the recommendation of the TCB-A study was to measure outcomes sooner after hospital discharge, the current study followed patient outcomes in the first three months of hospital discharge (Buurman et al., 2016).

Although in the present study the number of participants is too low to show statistical differences, the drop in mortality in the transitional care group at three months after discharge is noteworthy. Furthermore, this study does not show other differences with regards to health outcomes and care utilisation in both groups. It is, however, apparent that the transitional care group in this study had higher levels of comorbidity than the usual care group and also appeared more frail at three months after discharge. The results did not show any significant differences on the effect of TCB-S on the prevention of functional decline and other health outcomes in the vulnerable period after hospital discharge, although some small differences were found. The literature shows one-quarter to one-third of re-hospitalisations in older adults are believed to be preventable (Occelli et al., 2016). This study, however, does not show a drop in re-hospitalisations in patients following the TCB-S programme, compared to those following the usual care route. While the patients following the TCB-S programme already appeared more frail at inclusion into the programme compared to those in the group following usual care, the lack of difference in re-hospitalisations and the lower mortality rates do indicate the effectiveness of the programme. As mortality dropped in this group and there was no increase in re-admissions, this might indicate that the transitional care programme was working. Part of the usual care in this study already included screening at the ED for functional decline, a CGA within 48 hours of admission, and a care and treatment plan from the geriatric team. Therefore, the question arises that, in comparison to the TCB-A study, as to whether the in-hospital component was already better in the hospital under study, than in the hospital in the original TCB-A study, which sheds a favourable light on the outcomes of this programme, in terms of health outcomes.

The apparently more frail transitional care group may be due to the fact that the geriatricians added a threshold by adding a triage questionnaire for geriatric consultation at the ED. Although in the programme only patients would be included with an ISAR-HP ≥2, some patients with a lower score were included in the programme. This indicates the professional autonomy to deviate from protocol. In both groups of the study, patients who were advocated for by the nurses or specialists, and who received consultation by the geriatric team, and in the TCB arm included in the TCB programme, seemed, over time, eventually less frail than other patients. It seems that the circumstances leading to a longer admission to hospital might have been a reason for specialists or nurses to ask for a geriatric consultation. As none of these patients were readmitted or died within three months after discharge, this might have influenced the outcomes in both groups.

Based on the project documents and the monitoring during implementation, it is apparent that the programme's fidelity, despite the efforts during implementation, seemed limited. Capacity problems in the geriatric team and in the CN team may have influenced the programme's fidelity, and possibly the preferences of the professionals to alter the programme and make other choices. This raises the question on the shared vision of all stakeholders during the implementation of this innovation.

Another underlying assumption of the dissemination and implementation of this innovation seemed to be the assumption that the innovation was better than what has gone before, although it was already apparent in the study setting of the TCB-A in Amsterdam that, apart from the reduction in mortality, there were no significant results in preventing functional decline (Buurman et al., 2016; Greenhalgh et al., 2004). The data gathered by the hospital and the collaborating home care organisations during the implementation show the changes made by the implementers to better fit the innovation in their own organisations. This reflects the necessity to alter the innovation in order for it to be transferable to another context and setting, until an innovation-system fit is reached and which shows that the diffusion of an innovation is a highly organic and adaptive process in which the organisation adapts to the innovation, as well as the innovation adapting to the organisation (Greenhalgh et al., 2004).

In this study, the capacity of the geriatric team and the CN team required such an alteration. Additionally, as in the Netherlands, and also internationally, people remain working until 67 years of age or older, it seems prudent that the programme inclusion criteria of 65 years and older was changed to 70 years and older. The setting also differed from the TCB-A, as the regional hospital wanted to make the innovation accessible for all older patients, not only patients on internal medicial wards. Although there was an evidence base for the TCB-A programme, during dissemination and implementation elsewhere, such a practice is continually interpreted and reframed in accordance with local context and priorities. This also includes power struggles between various groups of professionals (Greenhalgh et al., 2004). "As in complex organisations the users are often not the choosers of the innovations", and other methods of research are needed in order to address the motivation to use or sabotage an innovation and the perspectives of the diverse stakeholders on the innovation (Dearing & Cox, 2018, p. 186).

5.8. Conclusions

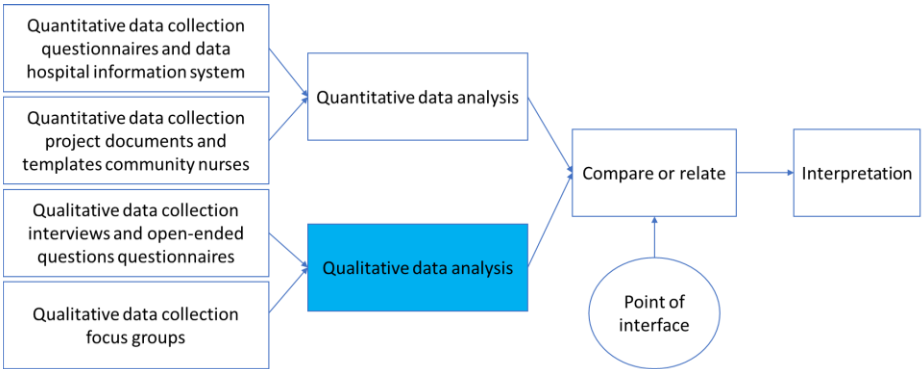
This 'before and after' study regarding the outcomes at one and three months after discharge demonstrate no significant effect of the intervention on ADL, mortality rates and re-hospitalisation.

However, the lower mortality rates, especially in the 'average' old age group in the TCB-S participants, stands out as well as the lack of difference in the number of hospitalisations. However, these outcomes might indicate the effectiveness of the programme shortly after discharge. Further studies in small scale settings are needed to confirm these results. This study did not address the in-hospital component of the programme, which was the same for the usual care group and the TCB-S group, except for the first visit of the CN. Compared to the TCB-A study, which implemented and evaluated the in-hospital component as well, the similar outcomes of this study compared to the TCB-A shed a favourable light on the outcomes of this programme. Adaption of the programme to another context, as in this study, has led to the inclusion of more patients in the TCB-S programme than was initially anticipated. Outcomes indicate challenges in programme fidelity, which may have influenced patient outcomes. To address these outcomes and programme fidelity additional qualitative research is needed on the perspectives of healthcare professionals and patients in the delivery of the programme and its effectiveness. These outcomes are addressed in the next chapter.

5.9. Summary

In total, 50 patients followed the TBC programme, and 50 patients followed 'usual' care. While no significant differences were found, the lower mortality rates, especially with the 'average' old age group in the TCB-S participants, stand out. Additionally, the lack of difference in the numbers of re-hospitalisations do indicate that the programme could be effective in reducing the mortality of older adults, especially as the patients following the TCB-S programme were more frail at the time of their inclusion. This frailty in the TCB-S group may be due to the fact that the geriatricians added a threshold for inclusion. Especially in the 'oldest' old group of the TCB-S group, the percentage of 3 or more co-morbidities was almost twice as high when compared to the 'oldest' old group of the 'usual' care group. In this group, the admissions into a care home after discharge home was considerably higher compared to the 'usual' care group. In comparison with the initial TCB-A study in Amsterdam, changes were made and, similarly, challenges during the implementation of the transitional care programme might have influenced the apparent limited fidelity of the programme. Programme fidelity shows only 10% of the patients in the TCB-S group received all six visits by the CN. This lack of fidelity may have influenced patient outcomes. The contributions of these findings are the insights into the adaptation of the transitional care programme in another context and the apparent challenges during the implementation and delivery of such a programme in a multidisciplinary setting. This chapter provides one of the first studies' insights into the differences of (health) outcomes between the 'average' and the 'oldest' old age groups, as well as on the effectiveness of a transitional care programme shortly after patients' discharge.

Chapter 6 ANALYSIS AND DISCUSSION OF THE QUALITATIVE DATA



6.1. Introduction

In this chapter, I present my analysis of the perspectives from the three distinct groups of interviewees: hospital nurses, CNs and patients on the TCB-S programme, as well as the analysis of two focus group meetings: one with the geriatric team of the hospital, and the other with the managers and CNs of the home care organisations. The data reveal their experiences in providing or receiving care, as intended by the programme. The coding process is outlined, and credibility is increased by using the participants' actual words to illustrate and underpin themes constructed during the coding process.

As described in the methodology chapter, at the start of the coding process, I used line-by-line coding and writing memos, followed by mind mapping. One of the supervisors participated in simultaneous coding, which led to a more substantial approach (Vaismoradi et al., 2016). Mind maps of the three groups were discussed with the three supervisors to clarify the emerging themes. During the process of mind mapping, additional codes were added. If new codes, or if more common ways of describing an experience were identified, interviews were read again to check if other participants had also described their experience in a similar way. The process of re-reading the interviews was continued until all codes were exhausted. The process of constructing the final themes was challenging, especially the phase where I had to merge codes into concepts, and I had to interpret the interrelatedness of these concepts.

In this chapter, the next section presents the overall findings and then goes on to categories and themes. The themes identified in the data of the three groups of participants and the focus groups are presented within a framework. Each theme is supported with quotes from participants. Themes are described and the interrelatedness between the themes is reflected upon. As might be expected, there is some overlap of themes across the findings. The theme of the delivery of the care programme is not addressed separately, as it is interwoven into all the other themes. By using RTA from a pragmatic critical realist approach, experiences and meaning are interpreted by the researcher and bias is acknowledged (Vaismoradi et al., 2016). In the discussion section of this chapter, the outcomes are compared to existing literature.

6.2. Overall findings from the qualitative data

Two main findings were identified from my analysis of the qualitative data, which I entitled: *value of the programme* and *different worlds*.

Value of the programme

Based upon the analysis of the interviews, it became clear that the TCB-S programme is valued, but there are major issues concerning the delivery of the programme. During the implementation of the TCB-S programme, care for older adults became more of a priority for health professionals, as well as there being a greater focus for the entire hospital. Many elements of the programme, such as screening and geriatric assessment, became common practice and collaboration between the hospital and the home care organisations improved.

Different worlds

The overall sentiment is that professionals still remain working within their silos. This working in silos reflects the overall finding of this study that, collaboration between units within the hospital organisation, or between organisations, did not bridge the gap between the different worlds of hospital and home, despite the extensive collaboration and joint training during implementation. It appears that the contexts, or working environments, of the hospital nurses and the CNs still remain unfamiliar to each other. Additionally, during the implementation of the TCB-S programme, these worlds changed for nursing roles, policies and funding. In the Netherlands, the role of the CN shifted in 2016 towards bridging and being the central pin between medical and social care. CNs with education level 6 became responsible for the assessment of care, and guiding patients towards more self-efficacy, self-management and independence (Rosendal, 2019). In addition,, in 2016, based on conversations with the insurers during the process of the TCB-S programme, the TCB as an intervention received structural funding by the insurers.

The overall findings contain nine themes, four of which: ‘expertise’, ‘doing the right thing’, ‘support’, and ‘building relationship’ relate to the *value of the programme*. The themes ‘expectations’, ‘staying motivated over time’ and ‘world becomes smaller’ relate to the concept of *different worlds*. Two themes, ‘reluctance in accepting help’ and ‘sharing care’ relate to both overall findings. The nine themes identified in the qualitative data reflect three categories: quality of care, motivation and relationships. Each category is briefly described in the sections below. In Table 6.1, an overview is given of the categories and themes that were constructed during the analysis. A brief description of each theme is provided in the table.

6.3. Categories and themes

Quality of care

Professionals want to provide the best care for patients, based on their expertise and values. Patients benefit from this and, therefore, experience support. In a recent concept analysis, health care quality is defined as *"the assessment and provision of effective and safe care, reflected in a culture of excellence, resulting in the attainment of optimal or desired health"* (Allen-Duck et al., 2017, p. 1.). In the current study, this also means engaging and involving the patient and family as partners in their care.

Motivation

The motivation of professionals and patients can be affected by individual perceptions of barriers to success and expectations about the outcomes. Motivation can be defined as *"an individual's degree of willingness to exert and maintain an effort towards goals and can be influenced at many levels: the individual, organisation, health sector, and the community"* (Franco et al., 2002, p. 1255). Expectations of each other and expectations of the programme influence motivation of the professionals and the willingness of patients to participate in the programme.

Relationships

Different relationships are identified in the provision of care and in the lives of the patients. Building relationships is essential for interprofessional collaboration, and collaboration with patients and families. These relationships are interdependent and have an influence on the quality of care (Bartunek, 2011; Lee & Doran, 2017). Relationships within the lifeworld of patients are essential to wellbeing.

Categories	**Themes**	**Description of the theme**
Quality of care	Expertise *(CNs)*	Using professional training, skills and experience.
	Doing the right thing *(hospital nurses)*	Getting to know a person and customise the care to the person's needs.
	Support *(patients)*	Support patients' experience from professionals and informal caregivers.
Motivation	Expectations *(CNs)*	Expecting results from the programme and a positive professional attitude; Information about what patients can expect.
	Staying motivated over time *(hospital nurses)*	Working with a team on the quality of care and getting feedback on the impact.

	Reluctance in accepting help *(patients)*	Not wanting to be a burden and trying to cope on your own.
Relationships	Building relationship *(CNs)*	Developing strong relationships with patients and families.
	Sharing care *(CNs)*	Collaborating with other providers in the care of a patient and their family.
	World becomes smaller *(patients)*	Losing functional and cognitive abilities and losing loved ones.

Table 6.1. Categories and themes

Each category consists of three themes. The nine themes come from the three different groups of participants. ‘Doing the right thing’ and ‘Staying motivated over time’ for the hospital nurses: ‘Building relationship’, ‘Sharing the care’, ‘Expectations’ and ‘Expertise’ for the CN; and ‘Support’, ‘Reluctance in accepting help’ and ‘World becomes smaller’ for the patients.

By putting each theme in the middle of the visualisation of themes and concepts and grouping the others around this central theme, I explored which case in every theme was related to a central theme. This can be considered as an axial coding process (Corbin & Strauss, 1990; Vollstedt & Rezat, 2019). This process is needed to investigate the relationships between concepts and categories that have been developed in the open coding process. How the themes and categories are related is reflected in Figure 6.1. Even if some themes did not emerge in a group, nevertheless, every theme is connected or intertwined with other themes.

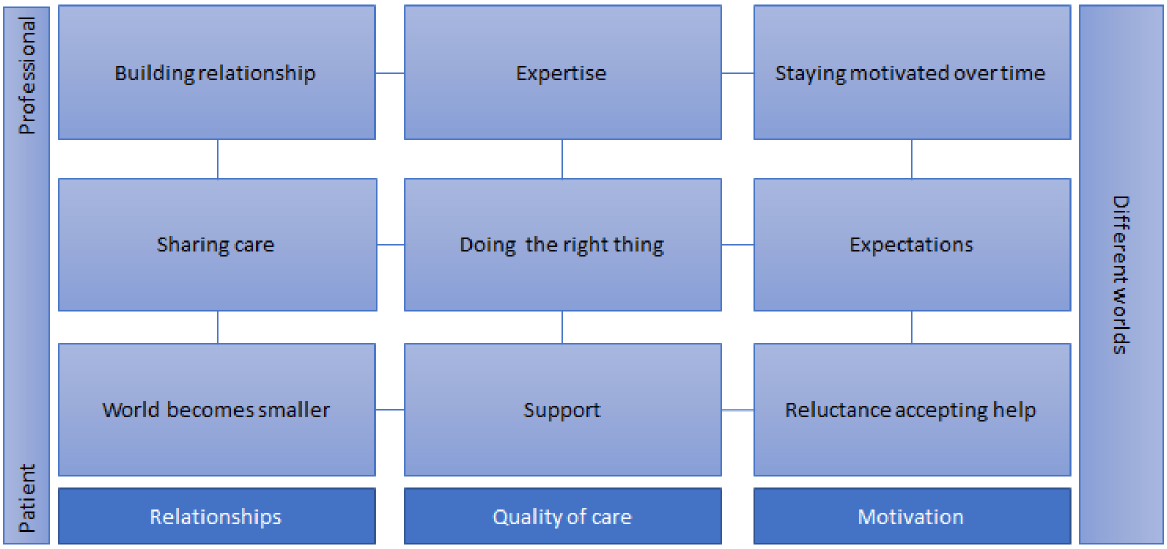


Figure 6.1. Themes and concepts

Doing the right thing is the central theme, and bridges the world of *expertise* and the world of *expectations*. The worlds of expertise and expectations appear to be separate and nurses often seem to struggle between these two concepts. *Doing the right thing* is connected to *sharing care* with other professionals and family members and is valued and experienced as *support*.

Other themes are also intertwined. *Building relationships* is a part of professional expertise and is a requirement for *sharing care*. Expertise and expectations are the key-drivers for *staying motivated over time*. In addition, *expectations* influence whether help is accepted or whether patients feel *reluctance accepting help*. What patients expect and how they perceive their support is also influenced by the *world becoming smaller* for patients.

Below, I address the findings of each group in turn and provide illustrative extracts from my data, accompanied by my analysis. In some instances, I show words in square brackets [example] to clarify the participants' meaning or the context.

6.4. Findings and analysis participant groups

In total, 22 interviews were held with 5 hospital nurses, 4 CNs and 13 patients, sometimes accompanied by their family members. Additionally, two focus group meetings were held with the hospital geriatric team and with a group that represented the collaborating homecare organisations.

6.4.1. Group 1: Hospital nurses

A nurse was interviewed from each of the five different wards of the hospital about the delivery of and their experiences with the TCB-S programme. The two themes which emerged from the RTA of the interviews were 'Doing the right thing' and 'Staying motivated over time'.

6.4.1.1. Doing the right thing

'Doing the right thing' for nurses means getting to know the person you are caring for and customising your care to the needs of this specific patient and his or her family. This entails gaining an insight into the story of the patient, in addition to the figures and assessment scores, by listening to how someone was managing at home and by getting additional information from family members.

> *"Often you heard the worries of family members. They were often very open to the transitional care programme"* (geriatric ward nurse).

Within the transitional care programme, collaboration within the hospital is essential. As the programme starts at the ED screening, information transfer starts from the ED and continues on to the wards or directly to the geriatric team. Thus, the wards and the geriatric team act upon the screening and information from the ED. Nurses stated that the value of the programme is that screening for frailty and for the risk of delirium has become common practice during the triage at the ED.

> *"The TCB programme has had a very positive influence (…) That is a major benefit of the programme. This contributes to a better information transfer (…) and insight in why you do something"* (ED nurse).

The information transfer to the CN is also considered a key element. Contact with the CN was especially valued by the hospital nurses.

> *"The information transfer and speaking to the CN yourself was very nice, especially for patients who were hesitant to accept help; this programme offered something else than solely physical care"* (geriatric ward nurse).

> *"It gives a feeling of satisfaction, to make sure patients' transition from hospital to home is safe, and home care knows what they can expect and have to attend to (…). Patients are sent home with more support according to their wishes"* (cardiac ward nurse).

The visits of the CN to the hospital were still considered challenging, because CNs had to fit the visit into their existing schedule and, in the hospital wards, certain times during the day were too busy for hospital nurses to talk to the CN. In addition, on many occasions, no room was available to talk in private with patients, family and the CN.

Based upon frailty scores alone, some patients were not eligible for inclusion in the programme, but nurses on various wards advocated, and succeeded, in getting inclusion into the programme for their patients, even though sometimes this was against the advice of the geriatric team. Most of the wards did not have a multidisciplinary team meeting. This means, as nurses stated, that good care is sometimes dependent on one person.

> *"Sometimes you have to defend your patient, because someone else does not see the point to start the programme (…). You should discuss more in a multidisciplinary team what you see and what someone else sees and share your worries"* (surgical ward nurse).

Nurses thought that the TCB-S programme would also be very beneficial for patients who did not have a high frailty score, or for those patients who were younger. The group that was eligible for inclusion was considered too frail. Many patients who were included in the programme were already receiving some kind of care at home from homecare organisations.

> *"If you see someone is vulnerable in some sort of way, not depending on age, you should be able to start the programme. I think you would gain so much by this"* (geriatric ward nurse).

> *"It would be nice if you would be at liberty to start the programme for other patients. The concept is very good"* (pulmonary ward nurse).

6.4.1.2. Staying motivated over time

'Staying motivated over time' meant for nurses working in a team with colleagues who continued to contribute to the programme and, as such, to the quality of care, and by getting feedback in both statistics and stories on the trajectories of the patients; the impact on their lives; and insights into how well the programme was being delivered.

According to the nurses, not everyone contributed to the same extent in the delivery of the programme.. Some screening tools were poorly applied or forgotten at the ED or in the pre-operative trajectories, which caused more work for the nurses on the wards, as well as a delay in the start of the appropriate geriatric care. Nurses said that this was due to time constraints and a high turnover of patients, but that it also addressed the attitude of colleagues.

> *"One colleague finds it more important than the other. Sometimes you have to survive and go with the flow. I find that difficult (…). Some nurses always complain of a lack of time. Busy, busy…what is busy?"* (surgical ward nurse).

> *"If something new starts, it is often considered as a burden (…). I worry about that (…) people saying it is going well as it is. It isn't (...). Apparently we have our own views on what we consider important. That seems something people hold on to and is not easy to change"* (pulmonary ward nurse).

For some nurses, the programme was proof that the needs of older patients were finally being recognised, but there was also recognition of their own work and their efforts to care for the elderly in the hospital. More hospital nurses felt that they were part of a team working with the ED, the geriatric team and with physiotherapists. However, they also missed information on the trajectory of the patients, as they only contributed to a small part of the programme.

> *"I feel part of a team, but also an outsider (...). I still miss knowledge and there are concepts I know nothing about (…). I fall short"* (ED nurse).

> *"We still focus on the specific task ahead of us"* (pulmonary ward nurse).

Nurses did not feel part of a team with the CNs, because they did not often encounter the same CN.

> *"It would be nice if one day you would have a regular CN, it would be nice to know each other's name and you would recognise each other. That is something I have not experienced yet"* (pulmonary ward nurse).

Nurses said this would improve helping and supporting each other and inquiring about a patient who was included in the programme. Nurses did not contact the CN after discharge and the CN did not contact hospital nurses after information transfer, although they had each other's phone numbers.

What motivated nurses was hearing how many patients were included in the programme, and how each ward was contributing to the programme. Quality care process metrics helped to discuss what was going well or not.

> *"It became a sport to make sure everything was filled out properly"* (ED nurse).

This type of information declined after a while and nurses missed the information as to how patients were doing at home.

> *"The implementation process was very good but sticking to it in the long run is difficult"* (pulmonary ward nurse).

> *"I think results could be made more available regularly in a newsletter and presentations to keep everyone involved"* (surgical ward nurse).

> *"This would create a feeling of doing something successful. Now you have no idea"* (pulmonary ward nurse).

Family members were involved in arranging care after discharge. Many family members were enthusiastic regarding the transitional care programme. They were supposed to be included in all of the visits from the CN, as well as the visit of the CN before discharge, but nurses commented that family members were often not given enough notice to attend or were not able to be present. How family members experienced the programme at home was not clear to the hospital nurses.

> *"I want patients to go home safely. I treat everyone like my own parents. I wish everyone to be able to stay at home safely for as long as possible (…), that they can manage at home"* (surgical ward nurse).

6.4.2. Group 2: Community nurses

The hospital collaborated with four major home care organisations in the delivery of the transitional care programme, as well as with two smaller organisations. One CN from each of the four major organisations was interviewed. The themes identified from the RTA of these interviews were 'Building relationships', 'Sharing the care', 'Expectations' and 'Expertise'.

6.4.2.1 Building relationship

'Building relationships' for the CNs meant developing strong relationships with patients and their family members during which time trust can be built.

Patients

After a while, patients start to share more information about themselves, and CNs felt that they had more time to get to know their patients and to gain their trust. Since the same CN came to visit and there was more time, patients would begin to reveal more about what they really thought was important.

> *"During the first visit they don't know you and the conversation is superficial. In Visit 3, patients tell you things they could have told you before, but that has to do with trust"* (CN2).

> *"The value is the trust that grows, so underlying problems can surface. Because you already visited during hospitalisation, you are a familiar face"* (CN 1).

> *"People keep their cards close to their chest (…). It is an art of asking the right questions. You just get to know someone. It depends on how much someone wants to expose and tell (...). With social problems people have feelings of shame. They won't tell the CN the first time they have problems with debts or alcohol"* (CN 1).

In the TCB-S, the CNs could monitor a patient for a longer period of time, even after a patient was physically independent, and could confirm with a patient if everything was still going according to plan. This is something that is not possible in usual care, and patients in usual care have to manage independently at an earlier point in time..

> *"In usual care, I don't visit every patient every three weeks. Now you are forced to plan these visits and I think quality of care and quality of life improve because of that"* (CN 2).

> *"So people gain more confidence by those visits. Someone is monitored until someone is confident enough and recovered enough to go to activities (…). Then you can stop the programme with peace of mind"* (CN 3).

> *"I think it is great when people start telling you what they want. Perhaps they want day-care, but they think that is nice, but you have to pay for it. You can also see if you can do something with a neighbour. I think it is great if this succeeds"* (CN 2).

Family

In addition, when family members are present, they can express their worries and also discuss possible solutions with the CN, so everyone could feel safer.

> *"I had more time to support the informal care giver, especially in the period her husband was deteriorating and she didn't know how to handle this (…). This is very valuable providing care to the informal caregiver. In usual care this is not possible"* (CN 1).

Hospital nurses

The CNs mentioned very little about building relationships with the nurses on the several wards of the hospital. They rarely met the same nurse, and added that the nurses they encountered on the wards were often not the nurse who took care of the patient in the previous couple of days. CNs felt that they were not able to engage with anyone from the hospital when they attended the hospital and could not have a good conversation with a nurse who knew the patient well.

> *"Often you have to look for the nurse on the ward [although an appointment was made] (…). In some cases, nurses didn't even know the patient. If there is an appointment, I expect you to prepare for this meeting"* (CN 3).

6.4.2.2. Sharing the care

For CNs, 'sharing the care' meant collaboration with other care providers in the TCB-S programme, as well as sharing the care for a patient with family members.

Family engagement

Part of the programme entailed involving the family from the start. Family members were supposed to be invited to every visit with the CN, including the visit before discharge from the hospital. Yet, almost every CN, said that family members were often not present on the first visit and it appeared as though the hospital nurses were not aware of the fact they should have invited the family. However, the presence of and the contact with the family was very valued by the CNs. The CNs suggested that, if family members were present, you could inform them about the topics that would be discussed over time and, in this way, family members became part of the care team.

> *"In usual care you don't have a lot of contact with the family (...). The family is often in the background and doesn't get involved. Now they become active and more informed (…). Sometimes they don't know what they can do or what we expect of them. It becomes more clear for everyone involved"* (CN 2).

This sharing of care with family members was often not the case in usual care situations, due to the lack of encounters with family members. Likewise, in usual care situations, the CN, as a co-ordinator, only gets involved in complex situations, and when the time to invite the family is often too short to organise. The value of the programme expressed by the CN was the frequency of the visits and the structure of the programme. The programme provided more time to discuss things with the patient, as well as with the primary informal caregiver at home.

Collaboration with care providers

CNs experienced an improvement in the collaboration with the hospital, but also expressed that there was still a long way to go. CNs did not feel part of the transitional care team. It appeared to them as though everyone was still working in their own silo and did not communicate with each other.

> *"I think we are not done. It is a road to progress for collaboration between hospital and community care. It is a first step (...), contact, knowing each other's role, the hospital is still not fully informed of what we can do as CNs"* (CN 4).

As a result, not every CN felt part of a team. CNs were never contacted by the hospital nurses when a patient was admitted about how things had been going at home, and whether a patient's home would be suitable regarding care after their discharge.

> *"The extra information and co-operation during information transfer is lacking (…). I don't feel part of a team. I have tasks as a CN within the TCB programme. And so does the geriatrician and nurse on the ward. But it is not a coherent organisation"* (CN 1).

After the programme was terminated, the CNs handed the patients over to the usual nursing team or to the general practitioner (GP). However, they did not feel the GP was part of the programme, and the GP was often not especially interested in the information handover from the CNs.

6.4.2.3. Expectations

'Expectations' for CNs included expecting results from the programme and expecting a professional attitude from the other team members, along with information about what patients could expect of the programme. In addition, according to the CNs, the goals for patients were poorly defined by the hospital team. This meant that the CNs had to do a new assessment in order to reach the same point as their colleagues from the hospital. This was considered a burden for patients. It was not always clear why someone was included in the programme, and CNs often encountered nurses on the ward who did not know anything about the programme.

> *"…so is the goal [e.g.] medication-safety, or to reduce social isolation or loneliness (…). I think this was discussed during hospitalisation, otherwise patients would not have been included"* (CN 2).

> *"9 out of 10 times, nurses did not know anything about the transitional care programme, and I had to inform them"* (CN 3).

According to the CNs, patients often did not remember very well what they had been told about the programme during hospitalisation as a result of their illness and their sudden transfer to hospital,. Some patients did not know what the programme was about or did not know why they were included.

> *"I think patients don't retain the message about the programme (…). They get the information during hospitalisation (…), but at home it seems like they hear it for the first time"* (CN 1).

> *"They just don't know what the programme is about. They did not receive a good explanation about the TCB programme"* (CN 3).

> *"If it has nothing to do with physical care, patients wonder why you come in the first place, because they can manage themselves. They don't realise they can also get support for their financial situation, and they can be redirected to other organisations or social services"* (CN 1).

The information handover was considered sufficient, although the information transfer from the geriatric team changed over time from a sufficient information transfer to a list with tick boxes. During information transfer in the hospital, a ward nurse was supposed to be present, but this was often not the case. Therefore, the difference between an information transfer for the TCB-S programme and for usual care was not very clear.

The fact that the geriatric team and the hospital wards did not clearly explain what they expected from the CNs during the programme, made it harder for patients and families to understand what they could expect. The amount of homecare requested by the hospital was sometimes considered too much and sometimes not enough. For the CNs, this suggested that the nurses on the wards were not aware of the patient's home situation, and often, as a result, did not consider the practical implications. A conversation to discuss this during the first visit by the CN before the patient's discharge with a nurse on the ward was often absent, despite the CN having made an appointment with the ward.

> *"I think, that is a conversation for us within the TCB programme, don't arrange it beforehand (...). Afterwards we have to defend ourselves with the family that we have to alter things, or things are not feasible(…). You have got to have this conversation together"* (CN 4).

After discharge, and after a while, many patients did not consider that the visits were valuable any longer or else they considered it to be meddling. Sometimes, patients wanted to stop the programme, often after 2 or 3 visits to their home. CNs commented that they never reached the full potential of the programme.

> *"After three visits we were done, we didn't know what to talk about anymore. Then I handed it over to the GP"* (CN 2).

> *"This is not very satisfying for me, because you never reach the point you intend to"* (CN 1).

> *"You don't make progress (…). You ask about relationships with others, and what someone wants, you talk about addictions, but you get stuck. They don't see you that way as a CN. It is a bottleneck how you should present yourself as a CN in that way. That is challenging"* (CN 1).

Although CNs were dissatisfied by the delivery of the programme, at some points, they still considered the programme to be valuable. The first four visits were considered to be essential in making sure that everything was arranged well in order for good care to be received.

> *"During assessment in usual care [as a co-ordinator] your focus is on physical care. Other issues are handed over to other colleagues. In the transitional care programme everything sticks with us. The one who starts the programme continues the entire trajectory (…). You are the one who keeps an eye on things"* (CN 3).

Because many patients who were included in the programme already received usual care at home, CNs stopped the programme earlier than intended by the programme.

6.4.2.4. Expertise

'Expertise' for CNs meant using their training, skills and their experience.

The CNs stated that the educational level of the CN, which, in the Netherlands, is Educational Level 4 or 5, and, in the European qualification framework (EFQ), is Level 4 to 6, contributes to the improvement of the self-management of the patients. In usual care, professionals are mostly at Educational Level 2 or 3 in order to take care of patients.

> *"I think if you have more professionals on this level [Level 4 ,5], it is more expensive, but if you have more professionals at Level 4, you need less of these kinds of conversations (…). But it has to become more clear which patients in the neighbourhood need this kind of attention. You need to think about the educational level you specifically assign to which patient. I think this would be helpful"* (CN 2).

As there was more time available and conversations had specific topics, CNs could really 'hear' the stories of the patients and what they really wanted and, as a result, the CNs learned from this experience.

> *"Normally, I want to arrange everything. In these conversations you have to let go, and look what someone really wants. So your questions have to be open, and sometimes you just have to be silent to hear what someone thinks and how someone's life has been (…). I already figured out a solution for someone, but then you see things turn out to be very different than you expect. You learn to be not-directive in your conversation"* (CN 2).

CNs thought the programme would be very beneficial for patients without home care, since there is much to gain by this group. CNs also see a role for themselves in preventing hospital admissions for the elderly, although in the current financial system, there is no flexibility to visit patients without home care assessment.

> *"It is a pity (…). How would it be to have these conversations with patients without homecare, (…) that would be an entirely new dimension (…). More patients after discharge could benefit from a visit of the CN (…), most people are insecure"* (CN 4).

> *"Where is the time I could just do things as a CN to prevent things, without anyone asking me to? That time is gone"* (CN 3).

6.4.3. Group 3: Patients

A few weeks after the CNs visited the patients for the last time, thirteen patients were visited for an interview. Eight patients were aged between 75 and 85 years old; five patients were 85 years old or older. On four occasions, a family member, partner and/or children were present. The patients had stayed on different wards in the hospital and were visited by different home care organisations. The three themes from the RTA of the interviews were ‘Support’, ‘Reluctance to accept help’, and ‘World becomes smaller’.

6.4.3.1 Support

Support for patients means the support they experienced from their professional and informal caregivers.

Many patients did not know their care was part of this programme. Patients did not remember the information about the TCB-S, nor did they remember who initiated their enrolment in the programme. They said they were very tired and got a great deal of information during discharge. Patients who already had homecare considered the visits of the CN as the normal homecare. They said that the home care nurses arranged everything. They did not know what to expect of the programme and they often did not remember what the CN discussed during the visits.

> *“I know she* [CN] *sat there on the couch. But those conversations (…), I was unable to follow them”* (Patient 11).

All patients appeared pleased with the help they got after discharge. They all considered the professionals kind and willing to help. The role of the CN was considered as informative and supportive, and that they were able to arrange everything. Patients and informal carers were reassured that everything was arranged well. Some patients did remember the first visits, regarding topics, such as, medication and care. Only a few patients mentioned other topics being discussed, such as, volunteering or getting back to activities.

> *“It is a kind of support, because you ask yourself how are we going to manage. And he* [the CN] *opens doors. That was really great (…). Before we knew everything was well arranged”* (Patient 5).

Patients and family members were very pleased that the CN regularly asked how things were going.

> *“That gives confidence, especially at the start when we were insecure how we were going to cope with everything (…). So it is very nice if someone ask regularly how things are”* (Patient 5).

> *“We could talk about everything with her. She took care of everything (…), if necessary she phoned the GP. That was great. Our experience with her was very good (…). If it wasn’t for her I would not have known where to start (…), it is a huge transition from hospital to home (…). You have some longer conversations in this programme. After that, things run smoothly”* (Patient 11).

> *"In fact she is a top coordinator (…), it was very supportive. You don't have to do everything yourself. Besides practical support, you could also call it moral support"* (Patient 12).

Patients were very pleased with all the help from family members, neighbours and professionals, and were also very pleased that they could stay at home.

> *"I don't want to leave this house. I have lived here for over 51 years and I have said I am only leaving in a box"* (Patient 8).

> *"I am very glad being able to stay in my own home. Going to a nursing home that would be awful"* (Patient 9).

However, support from the GP after discharge was lacking. Many patients said the GP did not visit or did not phone to listen to how someone was doing. In the few cases where the GP did visit the patients, this was very valued.

6.4.3.2. Reluctance accepting help

For patients, 'reluctance in accepting help' meant not wanting to be a burden and trying to cope on their own as soon as possible.

Although patients felt greatly supported, they said that they did not tell their family members or their professional care provider everything. They did not want to become a burden and did not want to complain. Many patients got help from family members. Although family and neighbours offered their help, patients said they were reluctant to ask for help. They felt that everyone has their own life to live and that you cannot ask for too much help. Help from professionals was only considered when it was a necessity, and most patients used as little care as possible.

> *"Before they* [the CNs] *leave, they ask if there is something else they can do for me (…), but I never say anything"* (Patient 8).

> *"I liked the visits. I could talk very well with her* [CN]. *But the result in the end (…), I did not use the things she offered"* (Patient 9).

> *"My family is willing to help me with everything, but I want to be a burden to as few people as possible"* (Patient 9).

> *"I have some lovely daughters who are always willing to drive me everywhere, but you feel troubled (…). Do I have to ask this again?"* (Patient 11).

The only thing patients complained about was not knowing exactly what time their professional carer would turn up and, therefore, this was giving up their privacy.

> *"In fact it is a privacy violation (…). You accept it because it is necessary"* (Patient 12).

6.4.3.3. World becomes smaller

The 'world becomes smaller' represents loss for patients, including the loss of people around them, and the loss of feeling able to do certain tasks or enjoy certain things.

After discharge, most patients said that it took two weeks before they could go out or were able to prepare a meal for themselves. Most of them felt worn out and complained about fatigue. Many patients got help from family members during the first weeks after discharge.

> *"They already warned me in the hospital (...), you are going to feel miserable. Well, that came true. The first weeks I did not leave my house. After that I started to go out, but had to stop after 150 meters"* (Patient 9).

Patients longed for other activities, or being able to resume activities they used to do, but considered themselves too tired.

> *"Everything is so exhausting, that's the main problem (…). I don't want to complain (…). My children, they don't know about me feeling so tired (...). I used to do three things at the same time, now I already get tired just thinking about it".* (Patient 1)

> *"From my point of view I am a healthy dude, only I can't get anything done"* (Patient 2).

During rehabilitation after discharge, some patients, especially those who had been admitted to the cardiac ward, took part in activities in a group or with a physiotherapist. They missed the regular activities after they stopped. Most patients said they could only do one activity per day.

> *"So then you enter a void, which you have to fill. That's where I stand now"* (Patient 3).

> *"I would like to have more structural things (…), like going to a club. Things like that. More structure (…). That's what I would like, going out more (…), but I am too old, nearly 88. It is hard to get new acquaintances"* (Patient 7).

> *"There is so much I want to do (…), but it is not possible anymore"* (Patient 8).

> *"A day to the beach, making a ride (…), those are things I still intend to do (…) if it is ever going to happen (…). I have always been very active, going everywhere. It does not interest me anymore (…), I am done"* (Patient 9).

> *"It is boring during the day, if nobody visits you (…), sometimes you get fed up"* (Patient 13).

Every patient told stories about losing loved ones, a spouse or children, or friends and neighbours. The world becomes smaller.

> *"I want more, but I am less mobile, that is the point. You know, when you are older you lose a lot of people around you, I recently lost two friends (…), that's the disadvantage of getting old (…). It's not the point of getting old, but what's happening around you. I lose a lot of people"* (Patient 7).

> *"I am glad things turn out this way, but there are moments when you wonder what is the point. Those moments keep coming. That feeling (…)"* (Patient 8).

6.4.4. Focus groups

Based on preliminary results of the study in two focus group meetings, both quantitative and qualitative findings were addressed. One of these focus groups was with the hospital geriatric team, the other focus group was with managers and CNs of four involved home care organisations.

6.4.4.1. Geriatric team

In the focus group meeting with the geriatric team, the most important issue was the focus of the entire hospital to discharge patients as soon as possible, in order to increase efficiency. In the year that the TCB-S group was followed, it was the policy of the hospital to reduce LoS. This had a huge impact on providing the right geriatric care. Visits of the geriatric team were often too late to start the TCB-S programme and/or to notify the CN. In the future, the geriatric team wishes the responsibility of elderly care could be shared more with other specialists and wards.

> *"What I see is there is a lack of time. Wards and medical interns are pushed, pushed, pushed to discharge patients home because they need an empty bed. That's something we can't compete with"* (hospital geriatric team member).

On the other hand, although many patients already had some home care support when they were previously at home, the TCB-S programme was used as an intervention to try to extend living at home' somewhat longer. Often, the geriatric team felt some patients were eligible for admission into a nursing home, but often, with the support of the patient's family, the geriatric team were comfortable in trying to support the patient at home. Families were often more enthusiastic about this than the patients themselves. Goals were not always very clear on enrolment into the TCB-S programme, and sometimes, these goals were too ambitious.

> *"You know it is tight. You talk to everyone, you think (…) we'll give it a try. Sometimes it doesn't work out"* (hospital geriatric team member).

Patients being re-admitted was especially discouraging for some of the geriatricians. They missed the stories where it did work out, and some geriatricians even became emotional over stories where patients and families were very satisfied. The geriatric team struggled with the dilemma that patients who already had usual care at home, also wanted to start on the TCB-S programme as well. It seems that typically patients do not remember what the professional tells them about the programme, and they do not understand the difference between usual homecare and that delivered by a CN on the programme.

6.4.4.2. Managers and CN home care organisations

The accomplishment of the programme was improved collaboration in integrated care and within a positive atmosphere. However, in the focus group meeting with the managers and the CNs from the home care organisations, the overall sentiment was disappointment, as the programme did not reduce the number of re-admissions and nursing home admissions.

> *"On the project level we were a team. But in the provision of care it was difficult to even find a nurse on a ward. And often they did not know anything about a patient and did not know why we were there. There is, however, a willingness to collaborate and talk to each other"* (CN - during focus group meeting).

The programme got a great deal of attention in the local region, and also beyond, in the Netherlands as a whole. Despite all the efforts put into the implementation of the programme, such as education of nurses, meetings and adaptation of the programme, the outcomes seemed poor.

> *"This shows the complexity of the problem" (…). "What we did accomplish is more patient satisfaction and more work satisfaction of the CN. Their work was more profound"* (Manager - during focus group meeting).

The focus of the hospital regarding care after discharge often relates to physical care, for example, help with self-care, such as, putting on stockings, etc., rather than what is wrong with someone in other areas of their life. There seems to be a lack of awareness on why someone is frail and, during hospitalisation, nurses do not seem to act on that frailty. On the other hand, patients were included who were in the terminal stage of their disease.

> *"(...) the hospital nurse thinks (…) I don't want to be criticised, let's include this patient in the TCB programme"(…). "It seems like the information handover of the geriatric team does not cover this"* (CN - during focus group meeting).

It was regarded as a value of the programme that a CN does not enter someone's home without prior information, but that the CN is able to act more quickly and provide the GP with the right information immediately.

> *"As home care organisations, we say if the nurses of the wards have a feeling of insecurity for discharging someone home, this should be enough to take a look as a CN"(…). "This group was the tip of the iceberg. If we wanted to take care of the entire iceberg, we would not have had the capacity (…). During the process patients fell off the iceberg and they got usual care"* (Manager - during focus group meeting).

As previously mentioned, patients often did not remember the information regarding the programme. They tended to resist other professionals in their home and believed they could manage on their own after a while. Due to the rigid structure of the programme, a patient could only be included if the CN could visit the patient before discharge. However, if the structure of the programme was less rigid, many other patients could have benefited from the programme.

During the delivery of the programme, some community nursing organisations could only provide the programme if they were familiar with the patient. Capacity problems were recognised by all organisations. This resulted in the inclusion of very frail patients, of whom 20% were admitted into a nursing home during the programme. Nevertheless, nurses were still very happy they could quickly provide the right care when things went wrong.

> *"Sometimes I could* [as a CN] *not prevent discharge from hospital, although I was very worried. But I knew what I was up to and could arrange an admission in a nursing home very quickly"* (CN - during focus group meeting).

On the other hand, because usual care at home was also involved, CNs and patients stopped the programme prematurely. As a result of this, the value of the programme remained underexposed.

> *"The pitfall of starting with usual care from the CN at home is this is not likely to ever end. People get used to it. The goal is of making patients independent and enhancing their self-management (…). The entire healthcare system has the financial incentive to keep patients under your care. I don't get rewarded if, after three months, someone is independent again"* (CN - during focus group meeting).

During the delivery of the programme, appointments were made to involve social services if this was applicable to the goals of a patient. However, the CNs rarely made contact with social services and during the focus group one CN said she was not aware of this addition to the programme. On the other hand, nurses who tried to reach social services got lost in the bureaucracy and the waiting lists of social services. An additional pitfall was the overlap with the usual nursing care that patients already received at home.

> *"If you, as a patient, remain under our care after the programme ends, we tend to neglect to ask other professionals outside our profession on their point of view. This is a problem for the entire home care organisation sector"* (CN - during focus group meeting).

During the period of the study, changes to usual care processes evolved and they increasingly started to resemble the TCB-S programme. This happened due to a number of factors, amongst others, the structural funding of the TCB-S programme by the insurers. Home care organisations also started to provide this kind of care for other hospitals in the region. On the other hand, due to legislation in the Netherlands, the role of the CN shifted toward more preventative measures, and to focus on self-management and collaboration within communities (Kwaliteitskader wijkverpleging [Quality framework community nurses, in Dutch], 2018).

> *"During this programme, the world has changed. The CN got another role [legislation] in establishing the home care assessment. Their role changed"* (Manager - during focus group meeting).

6.5. Analysis findings open-ended questions questionnaires

The open-ended questions of the questionnaires at one and three months after discharge contained questions on how patients experienced the transition from hospital to home; what care was arranged; and if this care was sufficient. Patients were asked for additional remarks and advice about the programme. Many patients did not use the opportunity to make additional comments in the open-ended questions. Most patients in the usual care group and the TCB-S group were satisfied with their transition to home and the care provided at home. More patients in the TCB-S group pointed out that they were very happy to be home again.

The transition from hospital to home was considered difficult in both groups. In both groups the same number of patients (n=3) said that their discharge was too soon. In the TCB-S group, more patients (n=12) at the three months' point in time commented that they were not doing well, compared to the usual care group (n=8). Especially in the TCB-S group, a number of patients wrote that they suffered from lack of energy and depression, and they felt dependent and isolated due to mobility problems (n=13), compared to the usual care group (n=4). Although in both groups, patients said their care was adequate, in the usual care group, patients (n=7) pointed out they had to rely on family members and that these family members had to advocate for their care. Alternatively, no patient in the TCB-S group addressed this topic. In the TCB-S group, some patients mentioned how pleased they were with the support from the CN.

Three patients in the usual care group and two patients in the TCB-S group shared feelings about loss of purpose. In the usual care group, these patients were over 85 years old. One person in the usual care group suggested it would have been better if they had received a follow-up phone call from a caregiver shortly after discharge. Although the question was not asked about the GP, six patients in the usual care group and one patient in the TCB-S group mentioned the lack of attention from the GP after discharge.

Several patients in the usual care group who received a phone call about filling out the questionnaire mentioned they did not want to be called back after three months.

6.7. Discussion

There were a number of different reasons why patients did not want to continue taking part in the programme, for instance, not wanting to be a burden, loss of privacy or feeling a lack of control. This reluctance to accept support needed to have been addressed during the programme, since, by prematurely ending their participation in the programme, some needs were unmet (Lindquist et al., 2018). This could be counterproductive in light of supporting people to stay at home for as long as possible. One of the main reasons appears to be the expectations that patients have towards the CN, and their perception of the role of the CN. Although the TCB-A programme was developed to enhance self-management, participation and prevention, patients often terminated the CN visits as soon as their main physical problems had ceased. This might indicate that expert judgements and patients' needs or preferences are not always congruent. During implementation, the needs and expectations of patients need to be taken into account to achieve more acceptance and satisfaction (Juhnke & Mühlbacher, 2013). Patients revealed in their interviews that they experienced extreme fatigue after hospitalisation. After a few weeks, their longing for more social activities and structure during the week became stronger. Some of the patients said they missed their rehabilitation activities and exercise group activities after their discharge. This suggests that an understanding of the life world of the patient should provide the direction of the care. Although this was incorporated in the TCB-S programme, patients hardly ever discussed issues regarding their well-being with the CNs. On the one hand, this might be due to the way patients perceive the CNs, as the patients seem to think that the

CNs are only concerned about their physical well-being. On the other hand, this shows the difficult process the CNs have to go through in order to incorporate discussing the well-being of their patient as part of their daily work. It appears that the care given by the CNs, although patient-led or patient-centered, has still not enough focus on the lifeworld of the patient and their deeper existential issues (Dahlberg et al., 2009).

Although other studies show the value of a more proactive and preventive care approach (Bleijenberg et al., 2013), the CNs stated that their work was not rewarded when it came to prevention. The financial incentive is to keep patients under professional care, rather than getting patients independent again. On the other hand, the CN's knowledge, and the practical knowledge of how things run in home situations, along with the assessment of the amount and type of care needed, could be better used by the hospital for other patients who are discharged home. This is contradictory to the changing role of CNs in the Netherlands since 2016, as well as the role the CNs had in the TCB-S programme. In the Netherlands, the role of the CN has shifted towards bridging and, therefore, being the central pin between medical and social care. CNs with Education Level 6 (EFQ) became responsible for the assessment of care, and of guiding patients towards more self-efficacy, self-management and independence (Rosendal, 2019). When it comes to the work environment, both groups of nurses (in hospital and in the community) expressed the boundaries of capacity they have to work in and the different attitudes they encounter with colleagues when it comes to doing the right thing, such as including a suitable patient in the programme. Receiving the right care, as they stated, is sometimes the responsibility of one person. This is related to autonomy, as professionals can act according their knowledge and judgment (Weston, 2010). Autonomy and control over nursing practice contributes to a healthy work environment, including nursing satisfaction and the quality and safety of patient outcomes (Weston, 2010). Being able to provide the right type of care by nurses at a higher education level would be beneficial to improve patients' self-management. The CNs stated that they would then need fewer of these types of conversations than with professionals of a lower level of education. This view is supported by the research of Mark, Lindley and Jones (2009), who state that a positive work environment, including higher levels of autonomy, is not associated with increased nursing costs (Mark et al., 2009).

Providing nursing care within the full scope of practice, as defined by existing professional, regulatory, and organisational rules, is related to the nursing process and clinical reasoning. The abilities required to effectively meet the healthcare needs of the people served are reflected in six professional roles in the CanMEDS-model (Canadian Medical Education Directions for Specialists). In Europe, this model was used to develop 'the European core competence framework for health and social care professionals working with older people' (Dijkman et al., 2017). The seven roles for professionals in health and social care, and services working with older people are defined as: Expert;

Communicator; Collaborator; Organiser; Health and Welfare Advocate; Scholar; and Professional. The major difference between these frameworks is an autonomous understanding of the role of the expert. In the European model, 'expert' is described as profession-specific competences. Based on the analysis in this study, it is especially the role of the professional, as the expert, that needs reflecting upon, as well as the positioning of the specific profession in the different contexts.

6.8. Conclusions

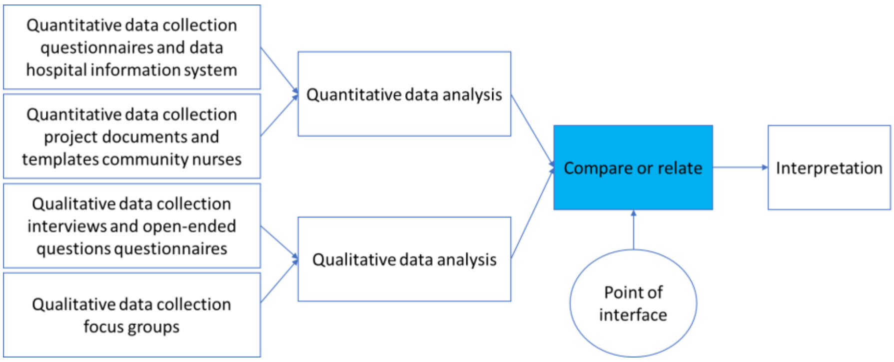
Many patients did not remember why they were enrolled in the programme or were not aware that the TCB-S programme was something different from usual care. This could be due to the fact that patients were overwhelmed by their admission into hospital and/or that they had difficulties remembering information, but the analysis also shows that many nurses on the wards were not familiar with the programme, and the criteria for enrolment in the programme were often unclear. The fact that patients did not always realise they were in a programme apparently has influenced the expectations of the patients, and which has resulted in patients prematurely withdrawing from the programme. As patients in many instances did not realise the programme's aim was to prevent future hospitalisations and to enhance their self-management skills, so they could live at home for longer, patients tended to end the programme after their physical problems diminished. This suggests that patients did not realise the full extent of what the CNs could offer. The real value of the programme was not entirely fulfilled and this influenced the documented outcomes of the programme.

Additionally, enrolment in the programme was hindered by the strict boundaries, including the focus on early discharge from hospital care and the capacity of the home care organisations. Not everyone seemed motivated to the same extent, so enrolment was often dependent on one person 'doing the right thing'. Many patients who were included in the TCB-S programme often had some form of homecare and were already known by the CNs. Although CNs still considered the programme valuable, they often decided to terminate the programme early, and refer the patient to their usual carers. This was often done based on capacity problems, although the CN's were well aware of the difference between the TCB-S programme and the usual care.

6.9. Summary

From my reflexive thematic analysis, nine themes were identified in the three different groups of participants. 'Doing the right thing' and 'Staying motivated over time' for the hospital nurses; 'Building relationships', 'Sharing the care', 'Expectations' and 'Expertise' for the CNs; and 'Support', 'Reluctance accepting help' and 'World becomes smaller' for the patients. These themes are intertwined and reflect three categories: quality of care, motivation and relationships. The TCB-S programme is valued by patients, family members and professionals, but there are major issues concerning the delivery of the programme. The findings in the focus groups with the geriatric team and the managers, and the CN of the homecare organisations show similarities with the individual interviews, but gave more insight into the overall sentiment that professionals still remain working within their silos. Findings revealed that the programme was not always understood well by the patients, raising questions as to how the programme was introduced. Patients tended to end the programme prematurely, as they did not want to be a burden, and they also wished to be independent. Several needs of patients remained unmet, such as, the extreme fatigue experienced shortly after discharge, as well as the desire to resume their normal activities. Alternatively, the CNs tended to end the programme prematurely due to capacity problems. The CNs felt their role in the entire continuum of care could be more profound, and that their work is not rewarded when it comes to prevention. This is noteworthy in light of the changing role of CNs.

Chapter 7 SYNTHESIS OF THE FINDINGS



7.1. Introduction

In this study, I set out to assess the outcomes of a transitional care programme for older patients, especially for the 'average' and the 'oldest' old, who are discharged home after hospitalisation. The study also aims to assess the patients' and healthcare providers' perspectives on the care provided.

A mixed methods research study was conducted, using a convergent parallel design to combine the strengths of the qualitative and quantitative data. The data was collected via three questionnaires to two groups of 50 patients who did (n = 50) and who did not (n = 50) receive the programme: before discharge, one month after discharge and three months after discharge. Data from the hospital registry was used to identify the characteristics of the patients. The perceptions of the patients, their informal caregivers, and the healthcare professionals were obtained regarding the care provided within the transitional care programme by means of semi-structured interviews and focus group meetings. The quantitative data was analysed statistically and the qualitative data by RTA. In addition, the delivery of the programme in practice was explored. It was hoped that this study would help to enhance the self-rated health, self-management skills, and quality of life of patients, while reducing the number of GP visits, ED visits and re-admissions. The aim of this synthesis chapter is to reconstruct the meaning, importance and relevance of the data in relation to the literature in order to answer the research question: *What is known about transitional care programmes for older adults, discharged from hospital to home, the working elements of these programmes, the outcomes, and the experiences of professionals and patients?*

In this chapter, I will discuss how my findings go beyond the existing theories of transitional care. By combining and linking the findings, I will examine the data from a new perspective and provide interpretive insight that goes beyond the explanations provided for only the quantitative part or qualitative part of the study. This approach reflects the pragmatist critical realist approach of this study. In addition to the practicality of the pragmatic ontological component, this chapter will also provide insights into the inherent values and guidance about the explanation and implications of the findings, in other words, the critical realist ontological component (Heeks, 2019). The data collection for this study took place in 2015 and 2016. Therefore, in this chapter, I will discuss the findings from my research in the light of relevant literature written before and after this period.

7.2. Compare and relate

In contrast to the expected outcomes, the outcomes of the quantitative part of the study did not show any significant results on the effect of TCB-S on the prevention of functional decline, health care utilisation and other health outcomes, especially in the first month after discharge, which is regarded as the vulnerable period after hospital discharge. However, some small differences were found.

The study did not show a drop in re-hospitalisations for patients following the TCB-S programme as compared to those following usual care. However, the patients included in the TCB-S programme already seemed more frail and had more co-morbidities at inclusion compared to those in the group following usual care. This suggests that the lack of difference in re-hospitalisations and the lower mortality rate may indicate some effectiveness of the programme. Both groups of patients showed similar results in their self-rated health and self-rated quality of life scores, although the ratings of the TCB-S group appeared to be slightly poorer. In the TCB-S group, the patient activation level (PAM) increased over a period of three months, which was consistent with the views of the CNs in this group, as their scores in the Self Sufficiency Matrix showed an increase in self-management abilities. Project documents showed the patients in the TCB-S group were visited at home on average three times by the CN. Of all patients enrolled in the TCB-S programme, only 10% received all six recommended visits from the CN. Possible reasons for these findings will be discussed below.

The findings of the qualitative part of the study show that the TCB-S programme was valued, but there were major issues concerning the delivery of the programme. The themes identified in the data from the three groups of participants reflect three categories: quality of care, motivation and relationships. Each category consisted of three themes. The nine themes came from the three different groups of participants. These themes were ‘Doing the right thing’ and ‘Staying motivated over time’ for the hospital nurses; ‘Building relationships’, ‘Sharing the care’, ‘Expectations’ and ‘Expertise’ for the CNs; and ‘Support’, ‘Reluctance accepting help’ and ‘World becomes smaller’ for the patients. The findings of the two focus groups show the challenges in capacity to deliver the care as intended and, although the programme accomplished a better collaboration of professionals inside and outside of the hospital, findings reflect that professionals still remain working within their own silos.

Many patients did not remember why they were enrolled in the programme, or were not aware the TCB-S programme was something different than usual care. This apparently has influenced the expectations of the patients and has resulted in patients prematurely withdrawing from the programme. Familiarity with the programme was an issue for hospital nurses as well. The criteria for enrolment in the programme was often unclear. CNs struggled with the poorly defined goals for the patient at the point of information handover. Family members were often not invited or not present during the visits of the CN to the hospital. Those family members who were familiar with and included in the programme felt supported by the CN.

Although CNs considered the programme valuable, they often decided to terminate the programme for a patient earlier than planned, and referred the patient to their usual carers, as many of the patients already had some type of homecare. During the implementation of the TCB-S programme, care for older adults became the focus for the professionals and the entire hospital. Many elements of the programme, such as screening and geriatric assessment became common practice, and collaboration between the hospital and the home care organisations improved. Professionals, however, seemed to struggle with their motivation. Hospital re-admissions were very discouraging for the geriatric team. The hospital nurses, on the other hand, found it difficult to stay motivated, as they did not get any feedback on how a patient was doing at home. The CNs felt frustrated by the poor information handover and felt their expertise was not valued enough. The overall sentiment was, especially in the focus group meetings, that professionals still remained working within their silos and there was still a gap between the different worlds of hospital and home.

7.3. Synthesis of the findings

My synthesis of the findings of the qualitative part of the study and the results of the quantitative part of the study show the value of the combination data and give an insight into how each source supports the central question of this study into the effectiveness of the TCB-S programme, in terms of which outcomes improved for whom and how valuable the programme is in what respect. A synthesis of the findings is shown in Figure 7.1 below. In the figure, ‘black’ is considered ‘neutral’, ‘green’ is ‘positive’, and ‘orange’ is ‘negative’.

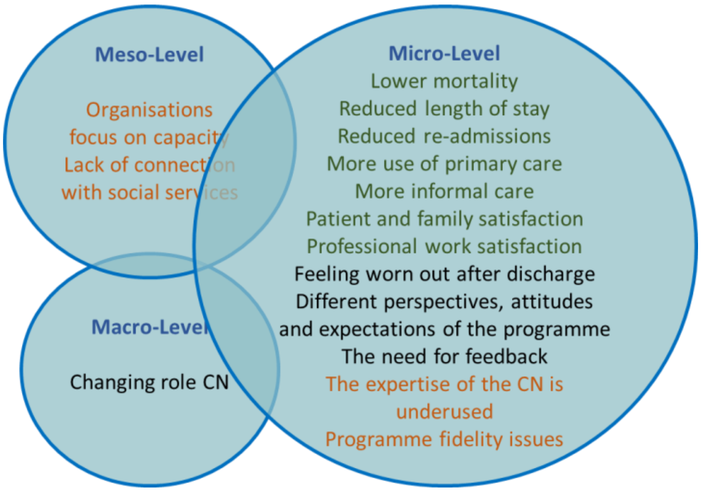


Figure 7.1. Findings and results on micro-, meso- and macro-levels

A finding such as 'feeling worn out after discharge' is considered neutral, as it is already known that older patients in general experience these feelings after discharge (van Seben et al., 2019).

The quantitative data provide some differences in the results between the usual care and the TCB-S group, although these differences are not statistically significant. This lack in significance is due to the small numbers in the study and is also influenced by missing data. Insight into the reasons for the lack of significance in the results mainly comes from the qualitative part of the study, as well as insights into the reasons why many patients only received part of the programme. In the qualitative part of the study, it became clear that the high number of patients who were admitted to a nursing home after their discharge was because the geriatric team tried to give as many older adults as possible the chance to return home instead of sending them to a nursing home strait away. Both parts of the study showed that the patients included in the programme were frail, and the patients enrolled in the TCB-S programme were even more frail, when compared to the patients in the usual care group.

The findings in the qualitative part of the study add new insights into the process of implementation, which would have otherwise remained underexposed. In this part of the study, it became clear that nurses experienced strict boundaries for enrolling the patients in the hospital's usual geriatric care. These boundaries became even stricter after the implementation of the programme, as the geriatric team added an additional threshold for geriatric assessment to be implemented by the geriatric team. This geriatric team questionnaire was based upon the insights and theoretical background of the geriatric team. In practice, this questionnaire did what it was supposed to do, namely select the most frail older adults.

According to the main aim of the programme, which was to reduce functional decline, the findings in the quantitative part of the study do not show significant outcomes. In the qualitative part of the study, however, patients stated that after a few weeks of feeling worn out after discharge, they started to recover and, sometimes, even ended the care from the CN. An underlying factor of a patient ending the programme seemed to be a lack of clarity of the goals for including a patient in the TCB-S programme in the first place. This lack of clarity was underscored by the patients. Sometimes the goals stated by the geriatric team were considered by the CN to be overly ambitious. This desire of the geriatric team to 'give it a try' to discharge a patient back to their home, resulted in several care home admissions very soon after discharge. In these cases, the admissions into care homes after discharge were not regarded by the CNs as a negative outcome, but as a value of the programme. As the CN already got to know the patient during hospital admission and did not enter the patient's home without any prior knowledge the CN was able to act right away. This might indicate that reducing functional decline in a group of older adults, who are already at high risk of functional decline, may not reflect the most important needs of the most frail patients.

The protocol of the programme was to include the family or informal caregiver in all the visits with the CN. This was only delivered for 40% of the patients who were enrolled in the TCB-S programme. As many of the patients included in the programme were frail, most of the patients receiving usual care or the TCB-S programme already received some form of nursing homecare. This, combined with the unclear aims for inclusion in the TCB-S programme, seemed to have several consequences during the process. As patients did not have a clear view of the value and aims of the programme and they already received another form of care, they tended to end the programme prematurely. This view was supported by many CNs who stated that the patients ended the programme and that their care was handed over to usual professional caregivers as soon as the patient had recovered well enough. CNs seemed to be driven to make the choice to terminate the programme by the lack of capacity of their own organisations. Although they stated that they valued the time in getting to know the patient and, in due course, after gaining the patient's trust, the CNs rarely heard what the needs and desires of the patient were. Due to this practice, the CNs could not reach the full potential of the programme. For the quantitative part of the study, this meant there was also a loss of follow up data during the study period, due to these early terminations of the programme, which might have otherwise influenced the outcomes.

The quantitative and qualitative findings indicate how far the aims of the TCB-S programme were met. The data from the quantitative phase of the study produced data to access the differences between the usual care group and the TCB-S group on functional decline, health care utilisation and health outcomes in the vulnerable period after hospital discharge. The data from the qualitative part of the study produced data on the personalised aims and experiences of the patient during the transitional period after discharge. Aims were supposed to be discussed with the patient by the geriatric team during hospitalisation and were supposed to be described in the information handover to the CNs. Patients and family members, however, did not mention reducing their healthcare utilisation as a goal, but mentioned goals such as recovery, being able to take care of yourself, building structure in the day, and resuming daily activities.

There is a huge gap between and differences in the expectations of the programme in the findings of both groups of data. As stated in the paragraph above, the expectations of the programme in the quantitative part of the study was to enhance the self-rated health; the self-management skills; and the quality of life of the patient while, at the same time, reducing the number of GP visits, ED visits, and re-admissions. In the qualitative part of the study, it became clear that these expectations were shared by the geriatric team. As these outcomes did not improve, the team became discouraged. However, the nurses and patients appeared to have different expectations of the programme. The hospital nurses expected the programme to provide a smooth transition for patients and continuity of care. Patients, on the other hand, seemed to have no expectations whatsoever of the programme, as they often did not receive or else did not comprehend this information. It seems that the expectations of the patients mainly focused on being supported in order to cope physically, as many patients withdrew from the programme after they started to recover from their physical problems. Most patients were very satisfied with their care. On the other hand, family members who were involved from the start stated that their expectations were exceeded, as they felt very supported by the care of the CN, and expressed the view that they would not have known how they would have coped without this support. In addition to the finding that the expectations of family members were exceeded, the expectations of the professionals were also exceeded. This was especially the case for the CNs, who experienced more time to provide or arrange the necessary care for the patients, they experienced more time to work together and take care of family members, and they were also able to anticipate the patients' needs more quickly after the discharge from hospital.

Neither the quantitative nor qualitative findings provide insight into how well the in-hospital component of the programme was delivered (Steps 1 to 3 of the programme, see Figure 1.1), since it was considered part of usual care in this study. The in-hospital part of the programme was not within the focus of this study. The data of the qualitative part of the programme, however, shed some light on this part of the care for older adults during hospitalisation. It revealed some major concerns regarding the familiarity of the usual care programme for older adults among the hospital professionals, highlighting issues relating to the professionals' attitudes in adhering to the elements of usual care delivery as implemented, and the capacity problems of the geriatric team and hospital nurses.

The impact of the programme was also observed and mentioned during and since the study period. At the micro-level, the impact observed was:

1) the validity of the assessment questionnaire of the geriatric team as a selective instrument for the most frail patients;
2) the programme being adapted to the context;
3) more awareness for the care for older adults;
4) more family involvement;
5) increased autonomy to include patients in the TCB-S programme.

The observed impact at the meso-level was:
1) an agreement by the hospital and home care organisations to work together;
2) improved collaboration between organisations;
3) the TCB-S becoming usual care.

At the macro-level, the outcome of the impact was:
1) the scaling up of the TCB-S programme to other hospitals in the region;
2) the structural funding by insurers for the TCB as a product.

7.4. Relation to the literature

In the literature published up to 2016, the focus of transitional care programmes was on health-outcomes, specifically on reducing health care utilisation. The components of high intensity complex interventions in transitional care reflect the emphasis on the role of the professional, as the main components are early geriatric assessment; education and training; a transfer nurse or assigning a nurse as the clinical manager or leader of the care; discharge planning; medication reconciliation; a discharge letter; patient awareness and empowerment; and in-person home visits to discharged patients (Boling, 2009; Laugaland et al., 2012). Up to 2016, there is little evidence in the literature that CN-led transitional care improves patient and health outcomes (Bryant-Lukosius et al., 2015). The current study adds to that body of knowledge.

The transitional care interventions before 2016 differed widely in intensity and duration, as well as in time, but mainly, after 2016, transitional care interventions began to focus on high intensity transitional care interventions. The findings in this study, however, indicate that this high intensity TCB-S programme does not reduce healthcare utilisation, but it does add to other outcomes, which were not considered at the start of this study, such as, the work satisfaction of professionals; the satisfaction of informal caregivers; the innovation adapted to the context; improved collaboration;

structural funding from the insurers; and more emphasis on and awareness of the care for older adults. It also shows an added perspective on outcomes such as re-admission, which is in line with Liebzeit (2021), who states that in some cases, re-admission may not be a negative outcome, but instead, a rational choice to prevent other adverse outcomes including death, quality of life, and psychological wellbeing.

Until 2016, the literature shows that patient and family satisfaction was addressed in some of the literature, but other outcomes reflecting patient and family perspectives were limited. In addition, even after 2016, the literature is still lacking or absent in terms of the patients and their family or other caregiver involvement. Although the TCB-S programme was specifically targeted at the patient, his or her needs and goals, and included family members or informal caregivers in the programme, the experiences of the patients reveal that they did not often feel involved in their own care plan. This raises questions about the in-hospital component of the care programme, which was part of usual care. Hestevik et al. (2019) found similar results in their review of the literature. They state that, although healthcare professionals believe that they consider the needs of their patients, in reality, they do not actively engage with the patient in terms of questioning, discussion and information-seeking, and additionally, the healthcare professionals tend to overestimate the person's understanding of the post-discharge treatment plan (Hestevik et al., 2019). According to Hestevik et al. (2019), feeling uninvolved in your own care leads patients to act autonomously, creating the potential to cause harm. In our current study, these outcomes are confirmed as patients tended to terminate their care programme prematurely. In many transitional care interventions, nurses were the primary caregivers. However, until 2016, there is limited research investigating the role of nurses. This study sheds light on this role and the challenges that hospital nurses and CNs encounter. The CNs, especially, thought that with their knowledge and experience they could add more value to the discharge process from hospital for every older adult. Both groups of nurses thought that the TCB-S programme could be beneficial to more older adults. This reflects the strict inclusion criteria of the programme. Many of the literature reviews on transitional care from 2008 to 2016 mentioned that studies they had included also had strict inclusion criteria as well, and left the most vulnerable patients out of scope (Piraino et al., 2012).

The findings show that professionals see things they want to improve, but they do not communicate this with each other. In general, professionals see improvements in collaboration, but also mention that they still tend to remain working in their silos. At the start of the emergence of transitional care programmes, Coleman (2004) stated that many of the professionals involved in transitional care had never practiced in the setting into which they were sending patients. Accordingly, they were often unfamiliar with the capacity of these settings for delivering care and may have transferred patients inappropriately (Coleman, 2004, p.533-534). The literature after 2016 still seems to confirm these findings. In research questions after 2016, more attention arises for reflection on multidisciplinary approaches, education and communication between health professionals, but the outcomes still show a lack of dialogue and a lack of understanding of the roles of others, which are barriers to communication in transitional care for older adults (Allen et al., 2017; McGilton et al., 2021).

The findings raise major concerns about programme fidelity. The TCB-S programme, as a goal-oriented intervention, was compromised by the flaws in the discussion of goals with the patient and family and in the information handover of these goals to the CN. In the literature after 2016, there is more awareness of the lack of studies that examine implementation, or address intervention fidelity, which might hinder the assessment of the lack of positive impact (O'Donnell et al., 2021). The current study does, however, shed light on this subject. The findings of this study reflect outcomes on all of the five aspects of programme fidelity: adherence to an intervention; exposure; quality of delivery; participant responsiveness; and programme differentiation (Carroll et al., 2007). The hospital nurses' perspectives especially showed that 'doing the right thing' was often left up to one professional. The focus on programme fidelity, which was also apparent in the focus group meetings, does reflect a certain view on quality, as the elements of intervention quality or interventionist-participant interactions are not considered. The qualitative part of this study sheds light on the intervention quality and the interactions between professionals and patients.

7.5. Summary

In contrast to the expected outcomes, the outcomes of the quantitative part of the study did not show any significant results on the effect of the TCB-S programme on the prevention of functional decline, health care utilisation and other health outcomes. Of all patients enrolled in the TCB-S programme, only 10% received all six visits from the CN. Despite the fact that patients, as well as professionals, were often not familiar with or aware of the programme, nevertheless, the overall programme was valued by patients, family members and professionals. The familiarity with the programme and the personal attitudes may have influenced expectations and outcomes. Patients, as well as professionals, tended to terminate the programme prematurely. Many patients enrolled in the programme were already very frail and already received some kind of home care, which led to referral to the usual carers. Professionals in the different organisations struggled with motivation towards the programme and felt they still remained working within their silos, which reveals there is still a gap between the different worlds of hospital and home.

Chapter 8 GENERAL DISCUSSION AND CONCLUSIONS

8.1. Introduction

This study set out to explore *what is known about transitional care programmes for older adults, discharged from hospital to home, the working elements of these programmes, the outcomes, and the experiences of professionals and patients.*

For me, as the researcher, it was apparent from the start that additional research was needed that provided insights into the experiences of the patients and the professionals. It is the value of the mixed methods approach of this study that other points of view and other outcomes were revealed that target the micro-, meso- and macro-levels. Some of these outcomes and successes were unexpected, which makes it clear that research methodologies are required that continually document what happens during the implementation process (Willis et al., 2016). As I used a pragmatic realist approach, in this general discussion I will explore the causal mechanisms of the findings to provide a stronger foundation for explanation of the practical outcomes and open ‘the black box’ of what happened during the implementation. The micro-, meso- and macro-level of the quantitative and the qualitative outcomes will be discussed, as well as their interrelatedness (Figure 8.1.).

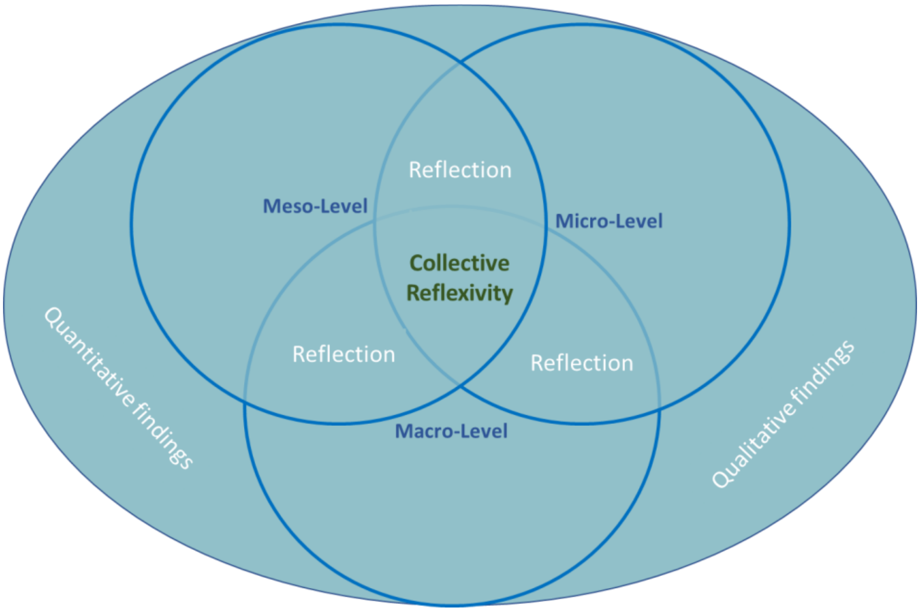
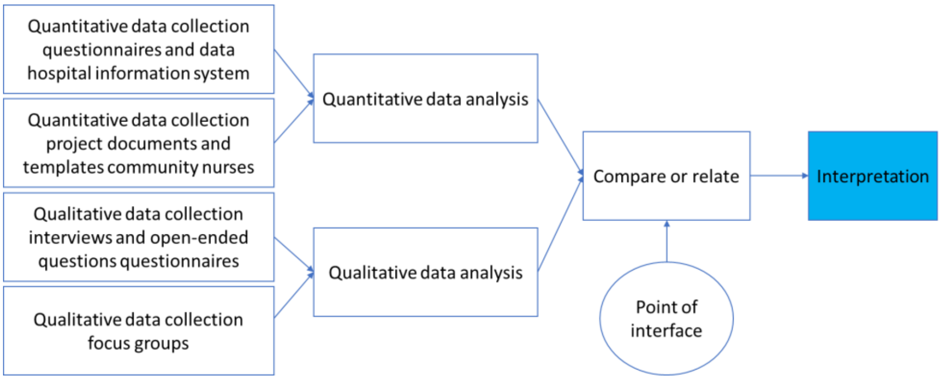


Figure 8.1. Reflection on micro-, meso- and macro-levels

8.2. Interpretation



8.2.1. Discussion of findings at the micro-level

The quantitative phase of this convergent parallel design study showed no statistically significant differences in health outcomes and healthcare utilisation between the usual care group and the TCB-S group. Findings do, however, indicate some effectiveness on mortality, reduced LoS, and reduced re-admissions. As the TCB-S group showed more signs of frailty and a decline in functional status over a three-month period, it is noteworthy that the health outcomes of this group did not decline, and the utilisation of health care did not increase. These finding are considered to be favourable outcomes of the programme. Mortality, which was the only statistically significant finding in the TCB-A study in Amsterdam, was, therefore, of interest to this study. The mortality rates in the usual care group (12.8%) and the TCB group (6.4%) are both lower than the percentages found in other literature, although mortality is not often measured at the three-month point after discharge (Martin et al., 2019). In the study by Buurman et al. into the TCB-A mortality rate at the six-month point after discharge, this was 25.2% in the TCB-A group and 30.9% in the usual care group. The reliance on mortality as an indicator for success can be contested, as functional status and quality of life appear to be more appropriate to focus on, when considering ‘ageing in place’ and ‘valuing the perspectives and needs’ of the oldest patients. Furthermore, the outcomes showed an increase in the use of primary care services. This is in line with the findings of Weeks et al. (2018) and, in addition, demonstrates that transitional care has a favourable impact on preventive care.

The results of the qualitative phase of the study reveal improved patient, family and work satisfaction; more awareness in the care of older adults; and improved collaboration. Although at the start of the programme needs were assessed by the geriatric team and during the programme needs were assessed by the CNs, the needs of patients seemed only to be partially recognised and addressed. In Chapter 2, I described research by Stafford & Gulwadi (2020) who state there is a lack of understanding of the coping strategies during the ‘ageing-in-place’ experience. The qualitative findings of this study provide important insights into the perspectives of patients on nursing care, such as, not wanting to be a burden; trying to cope on your own; and a broad shared desire for structure and activities.

To some extent, the professional needs assessment fails to recognise the needs of those who should benefit from healthcare (van Meijel et al., 2004). The outcomes of this study raise the question as to what extent the client's perspective was an intrinsic and essential part of the problem analysis before the development of the programme. Kaehne (2022) addressed the question of the design principles of integrated care interventions, pointing out the difference between patient outcomes and patient experience (Kaehne, 2022). In many studies, patient experience is narrowly defined as 'satisfaction'. However, the patient perspective, their stories and their journeys are often not an integral part of the service planning or of managing health organisations. This apparently has led to outcome measures that reflect organisational interests more than patients' interests. If the focus is on optimising older people's intrinsic capacity and healthy ageing at home, a different set of outcome indicators is needed (de Carvalho et al., 2017). At the start of the programme, the focus of the TCB-S was on the predetermined outcomes. During implementation, these outcomes remained poorly evidenced and feedback was lacking. Also, as Hudson et al.'s (2014) research shows, some nurses feel frustration with the lack of feedback from outside agencies for their discharge planning efforts (Hudson et al., 2014). Without this interagency-communication, it is difficult to know what works. This might have influenced the motivation and influenced the attitude to steer away from risk for their own professional organisation, by limiting resources, efforts and capacity.

Although improved multi-professional communication reduces rates of re-admission and LoS (Allen et al., 2013), what the outcomes show is a lack of dialogue and a lack of understanding of others' roles, which are barriers to communication in transitional care. Professionals and organisations seem to make choices based upon their own interests, benefits, motivation, views and capacity. This is reflected in the differences in attitudes and in the choices professionals made, as highlighted by the hospital nurses and the CNs. During the implementation of the TCB-S programme, the CNs stated that, at their visit before the patient's discharge, they often could not discuss the information handover with a nurse who was familiar with the patient. The CNs did not ask for clarification of unclear goals for the patient nor reacted upon insufficient information handover of the geriatric team. Likewise, the CNs did not contact the geriatric team to discuss their intention to stop the programme. These findings show that, although the professional attitude towards clients is cognitive, affective and behavioural (Keulemans & Van de Walle, 2020), the environmental circumstances and organisational factors seem to influence professional attitudes more than patient experience (Kieft et al., 2014).

The personal dimension of change for staff is rarely investigated, although it is at this level that quality improvement occurs (Kaehne, 2022). As this study shows, changing practices brings cognitive and emotional problems, as they appear to test judgments on long held beliefs and practices. The premise during the implementation of the TCB-S programme, as well as in the literature I reviewed, appears to be that working together is beneficial for everyone, especially patients. As organisations developed the structural framework for transitional care integration, it was the individual members of staff who were supposed to make it work. The outcomes show, however, that the professionals seemed more defined by their organisations and established practices, which were regulated by those very organisations. This study reveals the tension between being bound to your institution as a professional, regulations and professional autonomy.

The lack of awareness of the programme among patients, but also by the hospital nurses as well, raises the question as to what extent professionals understood the information regarding the programme and, subsequently, were able, as well as willing and motivated to communicate with the patients according to this information. Unawareness by the professionals may be due to implementation issues, as not every nurse could be reached with the training and this would also be affected by the turn-over of staff. Beside the fact that typically patients were tired, and had a lot of information to process, the provision of information by professionals may have been hampered by the motivation or lack of awareness by the professionals.

8.2.2. Discussion of findings at the meso-level

The qualitative as well as the quantitative outcomes reflect a focus on the micro-level for every organisation, but not on the entire network at the meso-level as a whole. At the start of the programme, collaborating organisations discussed and signed a shared vision and agreement. At the professional level, organisations collaborated in knowledge transfer about the care of older adults, and professionals from different organisations were trained together on the delivery of the programme. From time to time, professionals from different organisations came together to discuss the implementation of the programme and the barriers they had encountered, and the programme was adapted if found necessary. The TCB-S programme and the evaluation research began based on the shared goals of organisations to improve the quality of transitional care by integrating services. In our study, the assertion was that once organisations started to integrate their services, patients would move smoothly from one service to another in terms of the integration of care for the elderly and the transitional care services. The underlying idea or premise was that working together in a transitional care network for older adults would improve the quality of care and would lead to better outcomes.

The findings show some improvements inside the hospital, as professionals from the ED, the different wards and the geriatric team collaborated on the TCB-S programme. There is also some indication of better collaboration between the CNs and the hospital nurses on the wards. These findings also demonstrate the view of Greenhalgh (2004, p.588), as previously described in 2004:

> *"Professionals seek innovations, experiment with them, evaluate them, find (or fail to find) meaning in them, develop feelings (positive or negative) about them, challenge them, worry about them, complain about them, 'work around' them, gain experience with them, modify them to fit particular tasks, and try to improve or redesign them - often through dialogue with other users"* (Greenhalgh et al., 2004).

In practice, the findings of this study show that, despite all the implementation efforts, many professionals were unaware, unable or unwilling to adhere to the programme. This means that organisations tended to operate in parallel rather than in partnership with each other and this demonstrates a relative lack of strategies at the meso-level to reflect collectively on the process during the implementation. These findings are similar to the findings of Mur-Veenman et al. (2001) who already by 2001 had stated that professionals often act in ways that defend or enhance their own interests (Mur-Veeman et al., 2001). As shared care, integrated care or, in this study, transitional care goes beyond the traditional division of labour, it threatens the professional's discretion and autonomy (Mur-Veeman et al., 2001). Silos, as Kaehne (2022, p.88) states, make work bearable and protects professionals from information overload. This evaluation research shows that at a meso-level little attention has been given to power dynamics within and between organisations, and the interests of organisations. As the integration of services is a liberal enterprise, the agreement of supposed shared values and practice goals can change during implementation. This raises the question of how we should translate our collaborative agreements into the internal policy and practice of every organisation. This reflects what Kaehne (2020a, p, 312) states that "what we do in practice and why we do it only seem tenuously linked". This tension is reflected in the network of the hospital and the collaborating home care organisations under study. The qualitative part of the mixed methods approach of this study sheds light on these tensions and the process of the transitional care integration. The interviews with the CNs, the hospital nurses and the focus group interviews especially, indicate that professionals still remain working within their own silos. The findings show that professionals in practice and organisations seem to make choices that had an impact on programme fidelity, although at the start of the programme collaborating organisations made an agreement, which was evaluated every six months with members of the boards.

8.2.3. Discussion of findings between the micro- and meso-level

This study shows that the role of the professional is predominantly defined by organisations and established practices. In transitional and integrated care services, professionals from different wards and organisations have to work together, which reveals heterogeneity and fragmentation within the professional fields. As described in Chapter 6, it is especially the role of the professional, as the expert, that needs reflecting upon, as well as the positioning of the specific professions in the different contexts. Reflection most of the time is individual. Being reflective means that professionals do not simply look back and contemplate, but rather they consider their contributions to the construction of meanings and the re-interpretation of their actions in light of newly constructed meaning (Hunt, 2021; Koshy et al., 2017). The findings show that professionals can no longer isolate themselves, and reflection is necessary between the professionals of the different organisations, affecting the micro- as well as the meso-level (Adams et al., 2020; Noordegraaf, 2020). Reflection is necessary regarding the basic needs of professionals, such as, autonomy, relatedness and competence (Deci et al., 2017). This reflection should not only address how services are planned and delivered in collaboration, but also on how well these services support the patient. If actions are not beneficial for patients, professionals should not integrate care (Kaehne, 2022, p.87). Without putting the patient first, professionals are destined to replicate and reproduce the boundaries that are essential for silos (Keahne, 2022).

8.2.4. Discussion of findings at the macro-level

The implementation of the TCB programme in the regional hospital under study was part of the upscaling in the Netherlands of the TCB-A intervention, with the focus on the same outcome measures as the original study in Amsterdam. The programme focused on working together without barriers as collaborating professionals both in and outside of the hospital; the reduction of costs by reducing health care utilisation; and improving the quality of patient care. The adoption of the intervention, as especially shown in the qualitative findings of this study, had to take place on several wards, in several organisations, and on multiple levels. This might have been an important source of variation between the different hospital wards and between the different home care organisations. What this study started out to measure was predominantly based on how well services were integrated in transitional care and the impact of this integration on effectiveness and efficiency. In addition, in the literature after 2016, there remains a strong methodological focus on health and care utilisation outcomes, which reflects a focus on the integration of services. This focus on identifying outcomes of integration results mainly in positivistic research approaches in transitional care in the past two decades, although in integrated care research, the focus on the process, using implementation science, is emerging

(Kaehne, 2020a).

The reasons for integrating transitional care services, as also in this study, seem highly based upon policies and funding. In the Netherlands, policies aim at the integration of transitional care services as outlined in Chapter 2. Based on the policy practices of the health insurers, the TCB-A programme was adopted and funding was granted by The Netherlands Organisation for Health Research and Development (ZonMw) for the implementation of this programme in regional hospitals.

8.2.5. Discussion of findings between the micro- and macro-level

Although the focus of the programme was intended to be on functions at the micro-level, involving activities to support patients to age well at home, this study reveals that the actual focus relates more to the forms, regulations, structure and arrangements between organisations. “What is often overlooked is that the effectiveness of programmes cannot surpass the skill levels of the people implementing them” (Cross & West, 2011, p. 1), and how the programme was implemented, or the implementer fidelity, has an impact on the programme fidelity. Mur-Veenman et al. (2008) describe the delivery of integrated care in different counties. The Netherlands is seen as a progressive country, as are the UK and the Nordic countries. Dutch healthcare managers and professionals, as they themselves describe, would never consider integrated care delivery as the implementation of national policy, as is the case in England. Instead, they consider it to be dependent on their own motivation, initiatives, ideas, goals, and hard work (Mur-Veeman et al., 2008). The findings of this study indeed show that the professional behaviour strongly impacts the outcomes of the transitional care initiatives. It is, however, not the professionals’ attitude, but foremost it is the regulations, routines and boundaries of professionals’ own organisations, which impact and challenge their boundaries of autonomy and, as a result, patient outcomes. As such, the integration of services seem policy-driven and rarely happens bottom up from the micro-level (Kaehne, 2022).

8.2.6. Discussion of findings between the meso- and the macro-level

The findings raise the question as to what organisations and policies value in transitional care. The TCB-S programme claims to be patient- and family-centred. These values are also embraced by the collaborating organisations in this study and by national policies. Making significant strides towards a health system that is more responsive to patients' preferences, needs, and values will require substantially more attention to learning about these preferences from the patient's perspective (Davis et al., 2005). More needs to be learned about how patients view the care they receive from their health care professionals, how well that care is addressing their concerns, and what changes in practice would be most effective in achieving patient-centred care (Davis et al., 2005). This way, the micro-level will begin the change at the meso- and the macro-levels, instead of the other way round. It is not only about the shared values organisations claim to have as a network, but about enhancing the value as a network and how organisations create mutual value in a process of co-creation, and thus with more valuable co-created experiental outcomes (Ramaswamy & Ozcan, 2020).

8.2.7. Discussion on the interconnectedness of the levels

In the paragraphs above, different views on quality are reflected, which I addressed in several articles as (co)author on quality paradigms in integrated care (van der Vlegel-Brouwer et al., 2020; van Kemenade et al., 2021). The findings reflect the empirical paradigm and the reference paradigm. The empirical paradigm tends to measure focuses on performance indicators, values accountability, and aims to predict and control. The reference paradigm tends to develop models, protocols, and pathways to demonstrate how to achieve quality. It values improvement and aims to understand and reconstruct. These two paradigms, however, fit best in circumstances that are certain or can be planned, which does not apply to the complex environment of transitional care. Two other quality paradigms: the reflective paradigm and the emergence paradigm, fit best in circumstances which are uncertain and cannot be planned. The reflective paradigm encourages professionals to reflect individually as well as with colleagues, to agree on aims and quality indicators to transform practice. Its values are wisdom and professionalism. In the emergence paradigm, a collective of stakeholders, including patients and/or citizens, explore and co-create new solutions. The values in this paradigm are willingness to change and flexibility. In the current study, it appears that the reference paradigm seems dominant, which might have been influenced by the prerequisites for starting this research project, including the detailed planning. “Very often, researchers are not granted the flexibility to *not* rigorously plan or to allow for emergent and evolving results, or indeed recognise that interventions necessarily must vary to suit the unique contexts in which they are implemented” (van der Vlegel-Brouwer et al., 2020, p.2). Being reflective together with others is referred to as ‘collective reflexivity’. This means the extent to which group members overtly reflect on, and communicate about the group’s objectives, strategies (decision making) and processes (communication), and adapt these to current or anticipated circumstances (Van Kemenade et al., 2022). The findings show that reflexivity, especially between the micro- and the meso-level, has been lacking and this might have influenced organisations and professionals to choose their own strategy.

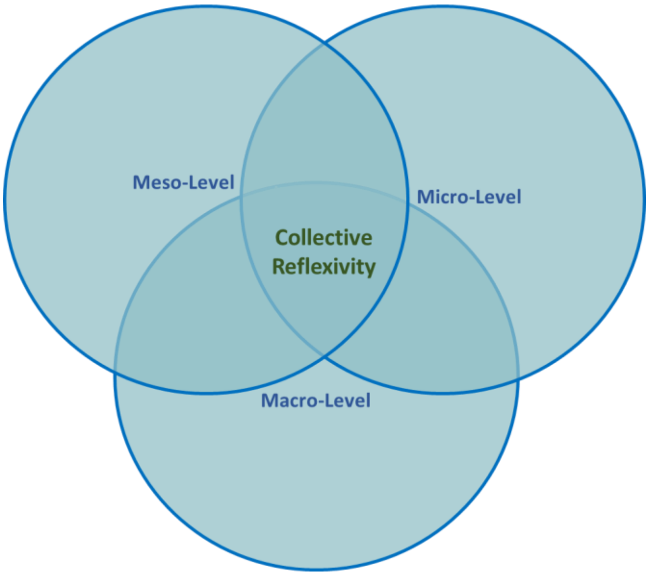


Figure 8.2. Collective reflexivity on micro-, meso- and macro-level

Shared mental models of transitional care are needed to create an inter-organisational and inter-professional space, or collaborative environment, that facilitates the delivery of transitional care. The level of connectedness between the stakeholders defines the complexity of the network and the level of development (van der Vlegel-Brouwer, 2013). In this study, the focus was mainly on the implementation of the transitional care programme in the hospital, but to a lesser extent on how the programme was implemented in the different nursing homecare organisations. Mental models, norms and values, however, seemed to differ locally. This requires the network to be examined as a unified whole, considering the important role of (each) organisational context (Anderson & McDaniel Jr., 2000; Plsek, 2001). The performance of a given network depends on its connectedness, that is, its structural ability to facilitate interactions among its components and its consistency or the extent to which there is a sharing of interests between the network's goals and its components' goals (Ramaswamy & Ozcan, 2020). The findings show that at the patient level users' needs are often complex and unforeseen and require a more flexible approach. Meeting a person's health and social care needs is by necessity a joint activity between the service providers and that specific user (Edgren, 2008; Naylor et al., 2013).

8.3. Conclusions

The conclusions that I have drawn from my research suggest that:

- Support for older adults at risk of functional decline during the first few weeks of the transition period is valued by patients and family, as well as by professionals.

- The TCB-S programme has a favourable impact on the health outcomes of the most frail older adults, as well as on preventative care.
- Findings from the qualitative part of the study reveal that the professional initial needs assessment does not sufficiently explore the needs of patients which may change over time, leading to different expectations from the programme.
- The provision of healthcare at the patient level is influenced more by the focus of the organisational structures and forms, than by what patients need.
- Although organisations, professionals and patients seem to have the same values when it comes to person-centred care, patients, professionals and managers have different views on what good quality transitional care should look like, and professionals tend to remain working within their own silos.
- A lack of feedback and reflexivity within and between the micro-, meso- and macro-levels has influenced motivation, strategies of organisations and outcomes for patients.

8.4. Strengths and limitation of the study

The study contributes to an increased understanding of the experiences of professionals and patients during the process of giving or receiving transitional care. The strength of this study is the inclusion of all admitted vulnerable patients, from every ward of the hospital, with a high risk of functional decline. It is noteworthy that data were used from a relatively small, regional hospital, as traditionally, smaller organisations have less experience and tradition in gaining funding and undertaking research projects. This study provides valuable information on the feasibility and effect of a transitional care programme in a smaller setting. The hospital in the study was one of the first hospitals in the Netherlands to introduce screening for older patients at risk of functional decline at the ED, and it was one of the first hospitals in the dissemination of the TCB programme. Presenting preliminary results of this study in the region inspired other hospitals in their care for older adults. The programme turned out to be very supportive for informal caregivers. This is something that would not have been revealed by quantitative research alone. This means that the strength of this study is the mixed methods approach, and the interviews and focus group meetings also proved to be a valuable approach to data collection.

The pragmatic critical realist approach to address the findings proved to be a valuable approach to examining the causal mechanisms and the context, and provided a strong foundation for the explanation of the findings at the micro-, meso- and macro-level. However, in addition, it is also a limitation, since, as a researcher, I interpret the socially constructed reality based upon my own beliefs, values and assumptions. This might have been interpreted differently by another researcher.

There are several other limitations to this study. First, as the study was performed in a relatively small hospital, the number of included patients was limited. The fact that the numbers of participants in both the usual care group and the transitional care group were small (n=50) has influenced the outcomes. Additionally, the baseline characteristics varied slightly between the TCB and the usual care group as, for example, more patients in the TCB group lived alone and more patients had 3 or more co-morbidities. This might have influenced the outcomes. Considering the baseline differences, a randomised group may have had an impact on the outcomes, as well as inclusion based only on the ISAR-HP. However, the small numbers would have complicated the statistically significant findings.

Secondly, the relatively small sample size and the lack of follow up has limited the statistical power of this study. For future studies on the TCB programme, it would be valuable to include a larger patient population in smaller settings, and to take into consideration the lack of follow-up in this older population due to mortality and admissions to care homes. Despite the efforts to complete the follow-up assessments, data was still missing from 'at home' patients, along with missing follow-up data from patients who were re-admitted to hospital or were admitted to a care home. Likewise, data was missing as not every questionnaire was returned, some patients could not be contacted anymore, and sometimes, patients decided to terminate their participation in the programme. Thirdly, community nurses, although instructed to assist patients in a neutral way to provide assistance in completing the questionnaires in the TCB group, they may have influenced the findings, since some patients were reliant on them for their care. This is, however, a small risk, as most questions required only 'tick-box' type answers, and, additionally, the open-ended questions of the questionnaires reflect the same findings as the patient interviews.

Considering the recruitment of participants, my 'in-between' status as both an insider and an outsider might have impacted the process and the outcomes, although my position was as a neutral observer and patients did not know me beforehand. A further limitation of the study was the limited insights collected by the interviews and the focus group meetings. A different and more broad composition of the focus groups might have enriched the insights. The chosen approach limited the opportunity for collective reflexivity among all stakeholders and might have limited the insights on what works, for whom and in what respect.

The data only gave a limited view on the implementation of the programme in home care organisations. In addition, a gap in the findings remains, as the CNs could not provide all the visits that were planned for every patient, and it remains unclear as to how the programme reliability of delivering all the planned visits by the CNs would have influenced the quantitative as well as the qualitative outcomes.

The effectiveness of the programme on self-management was measured by patients as well as the CNs. Although this was innovative as an approach, no comparison could be made to the usual care group.

8.5. Recommendations for practice

Patients' needs and perspectives

The needs of patients and informal caregivers should be assessed and addressed from the start. As in transitional care measuring dependence in ADL is not sufficient to address the needs of older adults, programmes or interventions should be co-created together with the patients in order to address their needs for support during the period shortly after hospital discharge. This should encompass the need to build structure into their daily routines; the thresholds they experience to resume activities; and their need for exercise. As social wellbeing is a major issue for patients during their transition from hospital to home, other stakeholders, such as, social services, occupational therapists, physiotherapists, and sports and exercise advisors, should be considered as well to broaden the whole system approach to ageing well at home.

Inclusion and information about the programme

Patients who are at high risk of functional decline or who are very old should not be excluded from programmes of transitional care. Regarding the target group, this should not only be limited to the most frail patients. Functional status could also be used, not only as an outcome measure, but as a predictive instrument for the need of support in the transition period after discharge. As the age group of older adults ranges from 60 to 100 years old, more flexible programmes should be developed, which could include informal caregivers or family as a primary target of the intervention.

As the aim of transitional programmes after discharge from hospital to home is not only to prevent new hospitalisation, but is also about being able to remain at home for longer, it should also be considered for patients who develop signs of frailty during their hospitalisation. The goal of the programme should be clearly explained to the patients and informal caregivers from the start, both in writing, as well as orally.

New role of the CN

The new role of the CN should be more clearly explained, since the CN is the link pin between healthcare and social services, and has a major role in prevention and health promotion. The positioning of CNs in the different contexts needs reflecting upon at different levels. This requires a move from disease- and task-oriented care towards relationship-focused care, enabling the identification of older people's individual expectations and their involvement in the care processes, resulting in more holistic and collaborative care.

Implementation

Implementation comes with several challenges. Special attention should be paid to the personal dimension of a change of staff member, as changing practices can trigger cognitive and emotional problems. Professionals should be incorporated to a greater extent in designing innovations, implementing them, and modifying them for specific environments. Methods of evaluation should be chosen, together with the professionals to address these.

Reflective practices

If the lifeworld of the patient provides the direction for care, more reflective and emergent practices are necessary, that address the readiness of the patient for discharge, whether there is reluctance to accept support, and which addresses the wellbeing of the patient. Reflective practices should be developed as a competence within and between all involved organisations of transitional care. Long-term commitment from stakeholders providing transitional care jointly should be addressed from the start and should address the system's readiness for innovation (Greenhalgh et al., 2004). Programmes should only be launched, given the disruptive and costly impact on staff and organisations, if it is clear that the programme will improve patient care. Before the start of collaborative practices, shared values should be discussed between stakeholders, as well as the value the collective of stakeholders wants to be added to integrated care. Implications should be assessed at the start, and during implementation, they should be reflected upon at the micro-, meso- and macro-levels.

8.6. Recommendations for policy

Focus on prevention

Since policies focus on reduced institutionalisation of older adults, policies should focus more on ageing well at home, as well as the prevention of institutionalisation. More preventative approaches are needed before, or at the first signs of, functional decline. Patients should be the starting point to develop and apply more preventive care, more support and more re-ablement approaches in the Netherlands. Policies that focus mainly on care for the most frail in society should be adapted to their needs.

Patient perspective as the starting point of policy

When policies are developed in reflective and emerging ways that address the challenges of an ageing population, practices can differentiate more. This means bringing the patient back into the picture during the development of new and flexible practices, so the micro-level can influence the macro-level and the other way around. The patients' perspectives should define the aims and objectives of any service changes.

Re-allocation of resources

Policymakers need to be aware of their responsibility to support home care organisations and social services, by allocating sufficient resources to enable preventive practices. Some form of coercion from policies is necessary to make collaborative practices shift from organisational interests towards patient-driven outcomes that reflect what patients value most during their journey.

8.7. Recommendations for research

Reflective and emergent research approaches

The mainstream scientific methodologies are often poorly equipped to deal with complex sustainability problems. Research approaches should be consistent with the complex environments and conditions encountered in integrated care. Research should navigate from pre-determined patient outcome measures, as proving a link between service changes and service outcomes is often problematic. More reflective and emergent research approaches are needed on the process of implementation at the meso- and macro-levels and to investigate how care outcomes are influenced by various components that are part of the wider service delivery environment. At the micro-level, more research is needed with regards to the personal dimensions of change for staff and the socio-psychological dimensions of change, during and after the implementation of an innovation. Co-creative and participatory practices with patients and informal caregivers can bridge the gap in knowledge by not only focusing on the patient's health conditions, but also on psycho-social, environmental, and community issues.

Include the 'average' and 'oldest' old

More research is needed on the needs, experiences and preferences of the 'average' old and the 'oldest' old in transitional care, and the 'oldest' old should be brought back into the scope of the research. Further research should address the extent of the frailty of this group and the level at which care and support is required.

Implementation of research in smaller settings

Conducting research into programme implementation in a regional hospital comes with its challenges. The experience in and funding for implementation research in a small hospital is limited and the context is often complex and rapidly changing. More research is needed that addresses the results of implemented programmes in smaller research settings. It is recommended for further research of the need to make the link between the mechanisms of the intervention and the outcomes explicit, as well as to illustrate the process of implementation in specific contexts. Due to the reciprocal interaction between the context and the programme, any research should engage with both the professionals and the patients. The personal dimension of the changes for staff should be part of the implementation, as well as for the research. As transitional care programmes encompass different organisations, implementation and evaluation research should address every setting in evaluative research programmes and should investigate issues of conflicting or disparate interests.

Funding

Funding for research should change the practice of prerequisites for research projects that include detailed planning and focus on predetermined hypotheses and outcomes. Research approaches are needed that grant the flexibility to *not* rigorously plan or to allow for emergent and evolving results, or indeed recognise that interventions necessarily must vary to suit the unique contexts in which they are implemented (van der Vlegel-Brouwer et al., 2020). Health researchers should be invited to engage with policy researchers in order to assure the uptake of each other’s research results in longitudinal studies, in which both types of researchers collaborate, reflect together and inform each other (Al-Riyami, 2010; Kaehne, 2020b; Martens & Roos, 2005; Smith & Kawachi, 2020). This may lead to more robust and sustainable transitional care policies, and practices relating to ageing well at home, and these policies can inform new research practices that connect research in both policy and practice at the micro-, meso- and macro-levels.

8.8. Interconnectedness of practice, policy and research

Policy, practice and research also appear to be ‘different worlds’. Public health researchers and practitioners are more accustomed to the passive diffusion of data through peer-reviewed journals or presentations, than positioning their own work so that policymakers and legislators can use this information and turn it into action (Smith & Kawachi, 2020). It is apparent that policymakers pay more attention to research findings if they have invested their own funds (Martens & Roos, 2005). Martens and Roos (2005) state that researchers should make efforts in building relationships with policymakers and to communicate in simple terms by means of short policy briefs, revealing the real meaning of their results. In addition, the drivers of public health, when it comes to prevention and ageing well at home, often lie outside the domain of public health and healthcare. Health professionals need to develop a deeper understanding of how other sectors work and develop effective collaboration with colleagues from other sectors, who may be better positioned to identify and change potential policy issues (Smith & Kawachi, 2020).

8.9. Summary

The micro-, meso- and macro-levels of the quantitative and the qualitative outcomes were discussed as well as their interrelatedness. The results of the qualitative phase show improved patient and family satisfaction, as well as improved work satisfaction for the professionals and more awareness of the care for older adults, along with improved collaboration. Patients' needs, to some extent, remain under-recognised. If the focus is on optimising older people's intrinsic capacity, as well as ageing well at home, different approaches and indicators are needed. Professional collaboration still shows a lack of communication and feedback, which results in a lack of understanding how the programme works and for whom. Organisational circumstances and personal attitudes seem to have influenced the delivery of the programme. Especially the lack of reflection between the micro-, meso- and macro-levels have caused organisations to operate in parallel rather than in partnership.

The findings at the micro-level can begin to change policies at the meso- and macro-levels in an emergent and reflective way, providing professionals learn more about the patient's perspectives on their care, and how well that care is addressing their needs. A pragmatic critical realist approach is valuable for future research in that it examines the network as a unified whole and co-creates together with patients. Transitional care interventions should be redeveloped for and with the oldest adults and their informal caregivers and should address their needs during the period shortly after discharge, and should help them build structure into their daily routines, and enable them to resume activities and exercise. Reflective practices on shared values, implications and outcomes should be developed as a competence within and between all involved organisations of transitional care. More reflective and emergent research approaches are needed to steer away from pre-determined patient outcome measures and to focus more on the process of implementation. Policies can be informed by healthcare research and should focus more on ageing well in place and health prevention.

Chapter 9 FINAL REFLECTIONS

At the end of writing my thesis, I want to look back at my journey over the past few years and also to look ahead, as I realise my journey as a researcher has just begun.

9.1. Introduction

At the start of my professional doctorate study, I was employed as a policy advisor on integrated care in a general hospital. Up to that point, I had worked as a nurse, and as a manager. Already from an early point in my career, I had been interested in integrated care and care for older adults and I developed several pathways and trajectories throughout the hospital, and also, in collaboration with other professionals outside the hospital. It was particularly in doing the Master's degree in Integrated Care Design at the University of Applied Sciences in Utrecht, which revealed my fondness for research, and provided me with the necessary skills and insights to develop care from the patient's or citizen's perspective. After obtaining my Master's degree, I was challenged by Marlou de Kuiper, the director of studies of this Master's degree, to continue the road of research, and I began to prepare myself for a professional doctorate trajectory. Marlou, along with colleagues at the University of Applied Sciences in Utrecht, developed a 'Leadership in Complex Change' course for those students, who already had a Master's degree, and who wanted to become a professional doctorate student. After finishing this leadership course, I then signed up for a doctoral degree at the University of Central Lancashire, in Preston.

9.2. Experience of my study

I set out to evaluate a transitional care programme for older adults during my period as a policy advisor on integrated care in a general hospital. The opportunity to be part of the upscaling of this programme in the Netherlands, along with my desire to start a professional doctorate degree came together in this period. From the start, the request from the The Netherlands Organisation for Health Research and Development (ZonMw), who partly funded the implementation, was to participate in an evaluation based on the TOPICS MDS, focusing on health outcomes and health utilisation.

Although from the start, I realised that I should also conduct qualitative research, during this period my main hope was being able to demonstrate the effectiveness of the programme on the quantitative outcomes. Looking back, I realise it was not only my environment and the policies which were focusing on these outcomes, but, as an emerging researcher at the start of my professional doctorate, my focus was also on my own paradigm, which was particularly influenced by the positivistic paradigm.

To evaluate the programme in full, I had to address the perspectives and experiences of everyone involved. Initially, my research skills in terms of qualitative research were limited and I followed several courses in qualitative analysis, in addition to working with Maxqda at Evers Research & Training in the Netherlands. It was especially this part of my research that provided me with many new skills and insights. Seeing the themes in my qualitative data was an extensive and challenging process, but which also gave me great pleasure. My supervisors encouraged me tremendously, as I immersed myself in the data and really let the voices of my participants speak. The themes I identified in the findings and the insights in the context of the participant shed a bright light on the outcomes of the quantitative part of the study and the challenges of its implementation.

9.3. My development as a researcher

During my professional doctorate, I had to interrupt my studies for an extended period of time, due to being overwhelmed and being unable to combine work and studies. However, I found my confidence to start again during this period in my life, especially through writing several articles with Everard van Kemenade and my daughter Marjolein, on quality paradigms and integrated care. During this period, my research skills developed and my epistemological stance shifted. For my professional doctorate study, this required that I embraced the pragmatic critical realist paradigm. For my career, this led to a shift towards being a participatory action researcher and trainer.

I feel there is still a great deal of work to be done in practice and research to work towards a more integrated care paradigm. Bridging the world of research and practice and contributing to the transformation towards more patient- and citizen-inclusive practices appears to be what I should be doing and I look forward to the road ahead.

REFERENCES

Abebe, F., Schneider, M., Asrat, B., & Ambaw, F. (2020). Multimorbidity of chronic non-communicable diseases in low-and middle-income countries: a scoping review. *Journal of comorbidity*, *10*, 2235042X20961919.

Adams, K., & Corrigan, J. M. (2003). Priority areas for quality improvement. *Priority areas for national action: transforming health care quality*.

Adams, T. L., Kirkpatrick, I., Tolbert, P. S., & Waring, J. (2020). From protective to connective professionalism: Quo Vadis professional exclusivity? *Journal of Professions and Organization*, *7*(2), 234-245.

Al-Riyami, A. (2010). Health researchers and policy makers: a need to strengthen relationship. *Oman medical journal*, *25*(4), 251.

Allen-Duck, A., Robinson, J. C., & Stewart, M. W. (2017, October). Healthcare quality: a concept analysis. In *Nursing forum* (Vol. 52, No. 4, pp. 377-386).

Allen, J., Hutchinson, A. M., Brown, R., & Livingston, P. M. (2014). Quality care outcomes following transitional care interventions for older people from hospital to home: a systematic review. *BMC Health Serv Res*, *14*, 346. https://doi.org/10.1186/1472-6963-14-346

Allen, J., Hutchinson, A. M., Brown, R., & Livingston, P. M. (2017). User Experience and Care Integration in Transitional Care for Older People From Hospital to Home: A Meta-Synthesis. *Qual Health Res*, *27*(1), 24-36. https://doi.org/10.1177/1049732316658267

Allen, J., Ottmann, G., & Roberts, G. (2013). Multi-professional communication for older people in transitional care: a review of the literature. *Int J Older People Nurs*, *8*(4), 253-269. https://doi.org/10.1111/j.1748-3743.2012.00314.x

Ament, B. H., de Vugt, M. E., Koomen, F. M., Jansen, M. W., Verhey, F. R., & Kempen, G. I. (2012). Resources as a protective factor for negative outcomes of frailty in elderly people. *Gerontology*, *58*(5), 391-397. https://doi.org/10.1159/000336041

Anderson, R. A., & McDaniel Jr, R. R. (2000). Managing health care organizations: where professionalism meets complexity science. *Health care management review*, 83-92.

Andreasen, J., Lund, H., Aadahl, M., & Sørensen, E. E. (2015). The experience of daily life of acutely admitted frail elderly patients one week after discharge from the hospital. *International journal of qualitative studies on health and well-being*, *10*(1), 27370.

Aromataris E, Fernandez R, Godfrey C, Holly C, Kahlil H, Tungpunkom P. Summarizing systematic reviews: methodological development, conduct and reporting of an Umbrella review approach. *Int J Evid Based Healthc.* 2015;13(3):132-40.

Asogwa, O. A., Boateng, D., Marzà-Florensa, A., Peters, S., Levitt, N., van Olmen, J., & Klipstein-Grobusch, K. (2022). Multimorbidity of non-communicable diseases in low-income and middle-income countries: a systematic review and meta-analysis. *BMJ Open*, *12*(1), e049133.

Aspinal, F., Glasby, J., Rostgaard, T., Tuntland, H., & Westendorp, R. G. (2016). New horizons: Reablement - supporting older people towards independence. *Age Ageing*, *45*(5), 572-576. https://doi.org/10.1093/ageing/afw094

Bailis, D. S., Segall, A., & Chipperfield, J. G. (2003). Two views of self-rated general health status. *Soc Sci Med*, *56*(2), 203-217. https://doi.org/10.1016/s0277-9536(02)00020-5

Bartunek, J. M. (2011). Intergroup relationships and quality improvement in healthcare. *BMJ Qual Saf*, *20 Suppl 1*(Suppl_1), i62-66. https://doi.org/10.1136/bmjqs.2010.046169

Bleijenberg, N., Ten Dam, V. H., Steunenberg, B., Drubbel, I., Numans, M. E., De Wit, N. J., & Schuurmans, M. J. (2013). Exploring the expectations, needs and experiences of general practitioners and nurses towards a proactive and structured care programme for frail older patients: a mixed-methods study. *J Adv Nurs*, *69*(10), 2262-2273. https://doi.org/10.1111/jan.12110

Boling, P. A. (2009). Care transitions and home health care. *Clin Geriatr Med*, *25*(1), 135-148, viii. https://doi.org/10.1016/j.cger.2008.11.005

Borglin, G. (2015). The value of mixed methods for researching complex interventions. In *Complex Interventions in Health* (pp. 55-71). Routledge.

Braet, A., Weltens, C., & Vleugels, A. (2012). Effectiveness of discharge interventions from hospital to home to reduce readmissions: a systematic review. *JBI Evidence Synthesis*, *10*(28), 1-13. https://doi.org/10.11124/jbisrir-2012-310

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Braun, V., & Clarke, V. (2016). (Mis) conceptualising themes, thematic analysis, and other problems with Fugard and Potts'(2015) sample-size tool for thematic analysis. *International Journal of social research methodology*, *19*(6), 739-743.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589-597.

Braun, V., & Clarke, V. (2021). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*.

Braun, V., Clarke, V., & Rance, N. (2014). How to use thematic analysis with interview data (process research).

Breaz, M. A. (2015). Changes characteristics to elderly persons. . *Agora Psycho-Pragmatica*, *9*(1), 203-210.

Briggs, A. M., Valentijn, P. P., Thiyagarajan, J. A., & de Carvalho, I. A. (2018). Elements of integrated care approaches for older people: a review of reviews. *BMJ Open*, *8*(4), e021194.

Bryant-Lukosius, D., Carter, N., Reid, K., Donald, F., Martin-Misener, R., Kilpatrick, K., . . . DiCenso, A. (2015). The clinical effectiveness and cost-effectiveness of clinical nurse specialist-led hospital to home transitional care: a systematic review. *J Eval Clin Pract*, *21*(5), 763-781. https://doi.org/10.1111/jep.12401

Buccheri, R. K., & Sharifi, C. (2017). Critical appraisal tools and reporting guidelines for evidence-based practice. *Worldviews on Evidence-Based Nursing*, *14*(6), 463-472.

Buurman, B. M., Parlevliet, J. L., Allore, H. G., Blok, W., van Deelen, B. A., Moll van Charante, E. P., . . . de Rooij, S. E. (2016). Comprehensive Geriatric Assessment and Transitional Care in Acutely Hospitalized Patients: The Transitional Care Bridge Randomized Clinical Trial. *JAMA Intern Med*, *176*(3), 302-309. https://doi.org/10.1001/jamainternmed.2015.8042

Buurman, B. M., Parlevliet, J. L., van Deelen, B. A. J., de Haan, R. J., & de Rooij, S. E. (2010). A randomised clinical trial on a comprehensive geriatric assessment and intensive home follow-up after hospital discharge: the Transitional Care Bridge. *BMC health services research*, *10*(1), 296.

Buurman, B. M., van Munster, B. C., Korevaar, J. C., de Haan, R. J., & de Rooij, S. E. (2011). Variability in measuring (instrumental) activities of daily living functioning and functional decline in hospitalized older medical patients: a systematic review. *J Clin Epidemiol*, *64*(6), 619-627. https://doi.org/10.1016/j.jclinepi.2010.07.005

Calderón-Larrañaga, A., Vetrano, D. L., Ferrucci, L., Mercer, S., Marengoni, A., Onder, G., . . . Fratiglioni, L. (2019). Multimorbidity and functional impairment–bidirectional interplay, synergistic effects and common pathways. *Journal of internal medicine*, *285*(3), 255-271.

Campbell, N. C., Murray, E., Darbyshire, J., Emery, J., Farmer, A., Griffiths, F., . . . Kinmonth, A. L. (2007). Designing and evaluating complex interventions to improve health care. *Bmj*, *334*(7591), 455-459.

Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implementation Science*, *2*(1), 40. https://doi.org/10.1186/1748-5908-2-40

CASP. (2021). *Critical Appraisal Skills Programme*. CASP. https://casp-uk.net/casp-tools-checklists/

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.

Cochrane, A., Furlong, M., McGilloway, S., Molloy, D. W., Stevenson, M., & Donnelly, M. (2016). Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. *Cochrane Database Syst Rev*, *10*(10), Cd010825. https://doi.org/10.1002/14651858.CD010825.pub2

Coleman, E. A. (2003). Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. *J Am Geriatr Soc*, *51*(4), 549-555. https://doi.org/10.1046/j.1532-5415.2003.51185.x

Coleman, E. A., & Berenson, R. A. (2004). Lost in transition: challenges and opportunities for improving the quality of transitional care. *Annals of internal medicine*, *141*(7), 533-536.

Coleman, E. A., & Boult, C. (2003). Improving the quality of transitional care for persons with complex care needs. *Journal of the American Geriatrics Society*, *51*(4), 556-557.

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative sociology*, *13*(1), 3-21.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *Bmj*, *337*.

Creswell, J. W. (2011). Controversies in mixed methods research. *The Sage handbook of qualitative research*, *4*, 269-284.

Creswell, J. W. (2021). *A concise introduction to mixed methods research*. SAGE publications.

Creswell, J. W., & Clark, P. (2019). VL (2007). Designing and conducting mixed methods research. Thousand Oaks, CA: Sage IOP Conf. Series: Earth and Environmental Science,

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). Best practices for mixed methods research in the health sciences. *Bethesda (Maryland): National Institutes of Health*, *2013*, 541-545.

Cronje, F. (2014). Research design and research paradigms should be led by research questions: a mixed method approach.

Cross, W., & West, J. (2011). Examining implementer fidelity: Conceptualising and measuring adherence and competence. *Journal of children's services*.

Crotty, M. (2020). *The foundations of social research: Meaning and perspective in the research process*. Routledge.

Crowe, M., Inder, M., & Porter, R. (2015). Conducting qualitative research in mental health: Thematic and content analyses. *Australian & New Zealand Journal of Psychiatry*, *49*(7), 616-623.

Dahlberg, K., Todres, L., & Galvin, K. (2009). Lifeworld-led healthcare is more than patient-led care: an existential view of well-being. *Med Health Care Philos*, *12*(3), 265-271. https://doi.org/10.1007/s11019-008-9174-7

Davis, K., Schoenbaum, S. C., & Audet, A.-M. (2005). A 2020 vision of patient-centered primary care. *Journal of general internal medicine*, *20*(10), 953-957.

Dearing, J. W., & Cox, J. G. (2018). Diffusion of innovations theory, principles, and practice. *Health affairs*, *37*(2), 183-190.

de Carvalho, I. A., Epping-Jordan, J., Pot, A. M., Kelley, E., Toro, N., Thiyagarajan, J. A., & Beard, J. R. (2017). Organizing integrated health-care services to meet older people's needs. *Bulletin of the World Health Organization*, *95*(11), 756.

De Klerk, M., Verbeek-Oudijk, D., Plaisier, I., & Den Draak, M. (2019). *Zorg voor thuiswonende ouderen [Taking care of elderly living at home]* https://www.scp.nl/binaries/scp/documenten/publicaties/2019/04/17/zorgen-voor-thuiswonende-ouderen/Zorgen+voor+thuiswonende+ouderen.pdf

Deci, E. L., Olafsen, A. H., & Ryan, R. M. (2017). Self-determination theory in work organizations: The state of a science. *Annual review of organizational psychology and organizational behavior*, *4*, 19-43.

Denscombe, M. (2017). *EBOOK: The Good Research Guide: For Small-Scale Social Research Projects*. McGraw-Hill Education (UK).

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research*. sage.

DeSantis, L., & Ugarriza, D. N. (2000). The concept of theme as used in qualitative nursing research. *Western journal of nursing research*, *22*(3), 351-372.

Dijkman, B., Reehuis, L., & Roodbol, P. (2017). Competences for working with older people: The development and verification of the European core competence framework for health and social care professionals working with older people. *Educational Gerontology*, *43*(10), 483-497.

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse researcher*, *13*(3).

Duggleby, W., Hicks, D., Nekolaichuk, C., Holtslander, L., Williams, A., Chambers, T., & Eby, J. (2012). Hope, older adults, and chronic illness: a metasynthesis of qualitative research. *J Adv Nurs*, *68*(6), 1211-1223. https://doi.org/10.1111/j.1365-2648.2011.05919.x

Dutch Ministry of Health. (2018). *Programma langer thuis, samen aan de slag, plan van aanpak 2018-2021 [Programme longer at home 2018-2021]. [In Dutch].* Retrieved from https://www.rijksoverheid.nl/onderwerpen/zorg-en-ondersteuning-thuis/documenten/rapporten/2018/11/05/programma-langer-thuis-samen-aan-de-slag-plan-van-aanpak-2018-2021

Edgren, L. (2008). The meaning of integrated care: a systems approach. *International journal of integrated care*, *8*.

Ellaway, R. H., Kehoe, A., & Illing, J. (2020). Critical realism and realist inquiry in medical education. *Academic Medicine*, *95*(7), 984-988.

Ellis, G., & Langhorne, P. (2005). Comprehensive geriatric assessment for older hospital patients. *British medical bulletin*, *71*(1), 45-59.

Evans, J. M., & Baker, G. R. (2012). Shared mental models of integrated care: aligning multiple stakeholder perspectives. *Journal of health organization and management*.

Fakha, A., Groenvynck, L., de Boer, B., van Achterberg, T., Hamers, J., & Verbeek, H. (2021). A myriad of factors influencing the implementation of transitional care innovations: a scoping review. *Implement Sci*, *16*(1), 21. https://doi.org/10.1186/s13012-021-01087-2

Fassaert, T., Lauriks, S., van de Weerd, S., Theunissen, J., Kikkert, M., Dekker, J., . . . de Wit, M. (2014). Psychometric properties of the Dutch version of the self-sufficiency matrix (SSM-D). *Community Mental Health Journal*, *50*(5), 583-590.

Fiorini, L., Griffiths, A., & Houdmont, J. (2016). Mixed methods research in the health sciences: A review.

Fønss Rasmussen, L., Grode, L. B., Lange, J., Barat, I., & Gregersen, M. (2021). Impact of transitional care interventions on hospital readmissions in older medical patients: a systematic review. *BMJ Open*, *11*(1), e040057. https://doi.org/10.1136/bmjopen-2020-040057

Fortin, M., Lapointe, L., Hudon, C., Vanasse, A., Ntetu, A. L., & Maltais, D. (2004). Multimorbidity and quality of life in primary care: a systematic review. *Health Qual Life Outcomes*, *2*, 51. https://doi.org/10.1186/1477-7525-2-51

Franco, L. M., Bennett, S., & Kanfer, R. (2002). Health sector reform and public sector health worker motivation: a conceptual framework. *Soc Sci Med*, *54*(8), 1255-1266. https://doi.org/10.1016/s0277-9536(01)00094-6

General data protection regulation (GDPR), (2016). https://gdpr.eu/

Gliem, J. A., & Gliem, R. R. (2003). Calculating, interpreting, and reporting Cronbach's alpha reliability coefficient for Likert-type scales.

Goodwin, N. (2016). Understanding integrated care. *International journal of integrated care*, *16*(4).

Grant, M. J., & Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Info Libr J*, *26*(2), 91-108. https://doi.org/10.1111/j.1471-1842.2009.00848.x

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Q*, *82*(4), 581-629. https://doi.org/10.1111/j.0887-378X.2004.00325.x

Halcomb, E. J., & Hickman, L. (2015). Mixed methods research. Faculty of Science. *Medicine, and Health–Papers*.

Hall, R. (2013). Mixed methods: In search of a paradigm. *Conducting research in a changing and challenging world*, 71-78.

Heeks, R., Ospina, A. V., & Wall, P. J. (2019). Combining pragmatism and critical realism in ICT4D research: an e-Resilience Case Example. In *Information and Communication Technologies for Development. Strengthening Southern-Driven Cooperation as a Catalyst for ICT4D: 15th IFIP WG 9.4 International Conference on Social Implications of Computers in Developing Countries, ICT4D 2019, Dar es Salaam, Tanzania, May 1–3, 2019, Proceedings, Part II 15* (pp. 14-25). Springer International Publishing.

Hestevik, C. H., Molin, M., Debesay, J., Bergland, A., & Bye, A. (2019). Older persons' experiences of adapting to daily life at home after hospital discharge: a qualitative metasummary. *BMC Health Serv Res*, *19*(1), 224. https://doi.org/10.1186/s12913-019-4035-z

Heyvaert, M., Maes, B., & Onghena, P. (2013). Mixed methods research synthesis: definition, framework, and potential. *Quality & Quantity*, *47*(2), 659-676.

Hibbard, J. H., Stockard, J., Mahoney, E. R., & Tusler, M. (2004). Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers. *Health services research*, *39*(4p1), 1005-1026.

Higgs, P., & Gilleard, C. (2014). Frailty, abjection and the 'othering'of the fourth age. *Health Sociology Review*, *23*(1), 10-19.

Hofman, C. S., Makai, P., Boter, H., Buurman, B. M., de Craen, A. J., Olde Rikkert, M. G., . . . Melis, R. J. (2014). Establishing a composite endpoint for measuring the effectiveness of geriatric interventions based on older persons' and informal caregivers' preference weights: a vignette study. *BMC Geriatr*, *14*, 51. https://doi.org/10.1186/1471-2318-14-51

Holm, A. L., & Severinsson, E. (2013). A qualitative systematic review of older persons' perceptions of health, ill health, and their community health care needs. *Nurs Res Pract*, *2013*, 672702. https://doi.org/10.1155/2013/672702

Hong, Q. N., Pluye, P., Bujold, M., & Wassef, M. (2017). Convergent and sequential synthesis designs: implications for conducting and reporting systematic reviews of qualitative and quantitative evidence. *Systematic reviews*, *6*(1), 1-14.

Hoogerduijn, J. G., Buurman, B. M., Korevaar, J. C., Grobbee, D. E., de Rooij, S. E., & Schuurmans, M. J. (2012). The prediction of functional decline in older hospitalised patients. *Age Ageing*, *41*(3), 381-387. https://doi.org/10.1093/ageing/afs015

Hoogerduijn, J. G., Schuurmans, M. J., Korevaar, J. C., Buurman, B. M., & De Rooij, S. E. (2010). Identification of older hospitalised patients at risk for functional decline, a study to compare the predictive values of three screening instruments. *Journal of clinical nursing*, *19*(9-10), 1219-1225.

Houghton, C., Hunter, A., & Meskell, P. (2012). Linking aims, paradigm and method in nursing research. *Nurse researcher*, *20*(2).

Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., . . . Smid, H. (2011). How should we define health? *Bmj*, *343*, d4163. https://doi.org/10.1136/bmj.d4163

Hudson, R., Comer, L., & Whichello, R. (2014). Transitions in a wicked environment. *J Nurs Manag*, *22*(2), 201-210. https://doi.org/10.1111/j.1365-2834.2012.1478.x

Hunt, C. (2021). Understanding Reflective Practice. In *Critical Reflection, Spirituality and Professional Practice* (pp. 29-62). Springer.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational researcher*, *33*(7), 14-26.

Jordan, J., & Wright, J. (1997). Making sense of health needs assessment. *The British Journal of General Practice*, *47*(424), 695.

Juhnke, C., & Mühlbacher, A. C. (2013). Patient-centredness in integrated healthcare delivery systems - needs, expectations and priorities for organised healthcare systems. *Int J Integr Care*, *13*, e051.

Kaehne, A. (2020a). Reconciling practice, research and reality of integrated care. Critical reflections on the state of a discipline. *Journal of Integrated Care*.

Kaehne, A. (2020b). Why is integrated care not a'policy'? *Journal of Integrated Care*, *28*(2), 49.

Kaehne, A. (2022). Integrated Care: Reflections on Change in Health Services. Emerald Group Publishing.

Keulemans, S., & Van de Walle, S. (2020). Understanding street-level bureaucrats’ attitude towards clients: Towards a measurement instrument. *Public Policy and Administration*, *35*(1), 84-113.

Kieft, R. A., de Brouwer, B. B., Francke, A. L., & Delnoij, D. M. (2014). How nurses and their work environment affect patient experiences of the quality of care: a qualitative study. *BMC health services research*, *14*(1), 1-10.

Koshy, K., Limb, C., Gundogan, B., Whitehurst, K., & Jafree, D. J. (2017). Reflective practice in health care and how to reflect effectively. *International journal of surgery. Oncology*, *2*(6), e20.

Kruizenga, H., Seidell, J., de Vet, H. C., & Wierdsma, N. (2005). Development and validation of a hospital screening tool for malnutrition: the short nutritional assessment questionnaire (SNAQ©). *Clinical Nutrition*, *24*(1), 75-82.

Krumholz, H. M. (2013). Post-hospital syndrome–a condition of generalized risk. *The New England journal of medicine*, *368*(2), 100.

Kuhn, T. S. (1962). Historical Structure of Scientific Discovery: To the historian discovery is seldom a unit event attributable to some particular man, time, and place. *Science*, *136*(3518), 760-764.

Kwaliteitskader wijkverpleging [Quality framework community nurses, in Dutch]. (2018). https://www.zorginzicht.nl/binaries/content/assets/zorginzicht/kwaliteitsinstrumenten/Kwaliteitskader+wijkverpleging+%28versie+1%29.pdf

Larsson, A., Haglund, L., & Hagberg, J. E. (2009). Doing everyday life--experiences of the oldest old. *Scand J Occup Ther*, *16*(2), 99-109. https://doi.org/10.1080/11038120802409762

Laugaland, K., Aase, K., & Barach, P. (2012). Interventions to improve patient safety in transitional care--a review of the evidence. *Work*, *41 Suppl 1*, 2915-2924. https://doi.org/10.3233/wor-2012-0544-2915

Le Berre, M., Maimon, G., Sourial, N., Guériton, M., & Vedel, I. (2017). Impact of Transitional Care Services for Chronically Ill Older Patients: A Systematic Evidence Review. *J Am Geriatr Soc*, *65*(7), 1597-1608. https://doi.org/10.1111/jgs.14828

Le Reste, J. Y., Nabbe, P., Manceau, B., Lygidakis, C., Doerr, C., Lingner, H., . . . Claveria, A. (2013). The European General Practice Research Network presents a comprehensive definition of multimorbidity in family medicine and long term care, following a systematic review of relevant literature. *Journal of the American Medical Directors Association*, *14*(5), 319-325.

Lee, C. T., & Doran, D. M. (2017). The Role of Interpersonal Relations in Healthcare Team Communication and Patient Safety: A Proposed Model of Interpersonal Process in Teamwork. *Can J Nurs Res*, *49*(2), 75-93. https://doi.org/10.1177/0844562117699349

Lee, J. Y., Yang, Y. S., & Cho, E. (2022). Transitional care from hospital to home for frail older adults: A systematic review and meta-analysis. *Geriatr Nurs*, *43*, 64-76. https://doi.org/10.1016/j.gerinurse.2021.11.003

Lee, S. B., Oh, J. H., Park, J. H., Choi, S. P., & Wee, J. H. (2018). Differences in youngest-old, middle-old, and oldest-old patients who visit the emergency department. *Clin Exp Emerg Med*, *5*(4), 249-255. https://doi.org/10.15441/ceem.17.261

Leech, N. L., & Onwuegbuzie, A. J. (2009). A typology of mixed methods research designs. *Quality & Quantity*, *43*(2), 265-275.

Liebzeit, D., Rutkowski, R., Arbaje, A. I., Fields, B., & Werner, N. E. (2021). A scoping review of interventions for older adults transitioning from hospital to home. *J Am Geriatr Soc*, *69*(10), 2950-2962. https://doi.org/10.1111/jgs.17323

Lindquist, L. A., Ramirez-Zohfeld, V., Forcucci, C., Sunkara, P., & Cameron, K. A. (2018). Overcoming Reluctance to Accept Home-Based Support from an Older Adult Perspective. *J Am Geriatr Soc*, *66*(9), 1796-1799. https://doi.org/10.1111/jgs.15526

Lloyd-Sherlock, P., McKee, M., Ebrahim, S., Gorman, M., Greengross, S., Prince, M., . . . O'Neill, D. (2012). Population ageing and health. *The Lancet*, *379*(9823), 1295-1296.

Löffler, C., Kaduszkiewicz, H., Stolzenbach, C. O., Streich, W., Fuchs, A., van den Bussche, H., . . . Altiner, A. (2012). Coping with multimorbidity in old age--a qualitative study. *BMC Fam Pract*, *13*, 45. https://doi.org/10.1186/1471-2296-13-45

Long, J. W. (2002). Who's a pragmatist: Distinguishing epistemic pragmatism and contextualism. *The Journal of Speculative Philosophy*, *16*(1), 39-49.

Lutomski, J. E., Baars, M. A., Schalk, B. W., Boter, H., Buurman, B. M., den Elzen, W. P., . . . Melis, R. J. (2013). The development of the Older Persons and Informal Caregivers Survey Minimum DataSet (TOPICS-MDS): a large-scale data sharing initiative. *PLoS One*, *8*(12), e81673. https://doi.org/10.1371/journal.pone.0081673 Lutomski, J. E., Baars, M. A., Schalk, B. W., Boter, H., Buurman, B. M., den Elzen, W. P., Jansen, A.P.D., Kempen, G.I., Stuenenberg, B., Steyerberg, E.W., Olde Rikkert, M.G.M.Melis, R. J. (2013). The development of the Older Persons and Informal Caregivers Survey Minimum DataSet (TOPICS-MDS): a large-scale data sharing initiative. *PLoS One*, *8*(12), e81673. https://doi.org/10.1371/journal.pone.0081673

Mabire, C., Dwyer, A., Garnier, A., & Pellet, J. (2016). Effectiveness of nursing discharge planning interventions on health-related outcomes in discharged elderly inpatients: a systematic review. *JBI Database System Rev Implement Rep*, *14*(9), 217-260. https://doi.org/10.11124/jbisrir-2016-003085

Mannell, J., & Davis, K. (2019). Evaluating Complex Health Interventions With Randomized Controlled Trials: How Do We Improve the Use of Qualitative Methods? *Qual Health Res*, *29*(5), 623-631. https://doi.org/10.1177/1049732319831032

Marengoni, A., Angleman, S., Melis, R., Mangialasche, F., Karp, A., Garmen, A., . . . Fratiglioni, L. (2011). Aging with multimorbidity: a systematic review of the literature. *Ageing research reviews*, *10*(4), 430-439.

Mark, B. A., Lindley, L., & Jones, C. B. (2009). Nurse working conditions and nursing unit costs. *Policy Polit Nurs Pract*, *10*(2), 120-128. https://doi.org/10.1177/1527154409336200

Markle-Reid, M., Valaitis, R., Bartholomew, A., Fisher, K., Fleck, R., Ploeg, J., & Salerno, J. (2020). An integrated hospital-to-home transitional care intervention for older adults with stroke and multimorbidity: A feasibility study. *Journal of comorbidity*, *10*, 2235042X19900451.

Martens, P. J., & Roos, N. P. (2005). When health services researchers and policy makers interact: tales from the tectonic plates. *Healthcare Policy*, *1*(1), 72.

Martín, J., Padierna, A., Anton-Ladislao, A., Moro, I., & Quintana, J. M. (2019). Predictors of mortality during hospitalization and 3 months after discharge in elderly people with and without dementia. *Aging & mental health*, *23*(8), 1057-1065.

Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. *Handbook of mixed methods in social & behavioral research*, *2*, 145-168.

McBride, K. A., MacMillan, F., George, E. S., & Steiner, G. Z. (2019). The use of mixed methods in research.

McGilton, K. S., Vellani, S., Krassikova, A., Robertson, S., Irwin, C., Cumal, A., . . . Sidani, S. (2021). Understanding transitional care programs for older adults who experience delayed discharge: a scoping review. *BMC Geriatr*, *21*(1), 210. https://doi.org/10.1186/s12877-021-02099-9

McIntyre, R. S. (2013). Using measurement strategies to identify and monitor residual symptoms. *J Clin Psychiatry*, *74 Suppl 2*, 14-18. https://doi.org/10.4088/JCP.12084su1c.03

Merten, H., Zegers, M., De Bruijne, M. C., & Wagner, C. (2013). Scale, nature, preventability and causes of adverse events in hospitalised older patients. *Age and ageing*, *42*(1), 87-93.

Meulenbroeks, I., Epp, J., & Schroeder, L. (2021). The value of caregiver inclusive practices in geriatric transitions of care: A systematic review. *Health Policy*, *125*(7), 888-898. https://doi.org/10.1016/j.healthpol.2021.05.001

Möhler, R., Köpke, S., & Meyer, G. (2015). Criteria for Reporting the Development and Evaluation of Complex Interventions in healthcare: revised guideline (CReDECI 2). *Trials*, *16*, 204. https://doi.org/10.1186/s13063-015-0709-y

Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., . . . Baird, J. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *Bmj*, *350*, h1258. https://doi.org/10.1136/bmj.h1258

Mora, K., Dorrejo, X. M., Carreon, K. M., & Butt, S. (2017). Nurse practitioner-led transitional care interventions: An integrative review. *J Am Assoc Nurse Pract*, *29*(12), 773-790. https://doi.org/10.1002/2327-6924.12509

Morkisch, N., Upegui-Arango, L. D., Cardona, M. I., van den Heuvel, D., Rimmele, M., Sieber, C. C., & Freiberger, E. (2020). Components of the transitional care model (TCM) to reduce readmission in geriatric patients: a systematic review. *BMC Geriatr*, *20*(1), 345. https://doi.org/10.1186/s12877-020-01747-w

Mossey, J. M., & Shapiro, E. (1982). Self-rated health: a predictor of mortality among the elderly. *American journal of public health*, *72*(8), 800-808.

Mur-Veeman, I., Van Raak, A., & Paulus, A. (2008). Comparing integrated care policy in Europe: does policy matter? *Health Policy*, *85*(2), 172-183.

Mur-Veeman, I., Eijkelberg, I., & Spreeuwenberg, C. (2001). How to manage the implementation of shared care-A discussion of the role of power, culture and structure in the development of shared care arrangements. *Journal of management in medicine*.

Murray, J., Hardicre, N., Birks, Y., O'Hara, J., & Lawton, R. (2019). How older people enact care involvement during transition from hospital to home: A systematic review and model. *Health Expect*, *22*(5), 883-893. https://doi.org/10.1111/hex.12930

Musgrave, A., & Kuhn, T. (1970). *Criticism and the Growth of Knowledge: Volume 4: Proceedings of the International Colloquium in the Philosophy of Science, London, 1965* (Vol. 4). Cambridge University Press.

Naylor. (2012). Advancing high value transitional care: the central role of nursing and its leadership. *Nursing administration quarterly*, *36*(2), 115-126.

Naylor, M. D. (2002). Transitional care of older adults. *Annual review of nursing research*, *20*(1), 127-147.

Naylor, M. D. (2004). Transitional care for older adults: a cost-effective model.

Naylor, M. D., Feldman, P. H., Keating, S., Koren, M. J., Kurtzman, E. T., Maccoy, M. C., & Krakauer, R. (2009). Translating research into practice: transitional care for older adults. *J Eval Clin Pract*, *15*(6), 1164-1170. https://doi.org/10.1111/j.1365-2753.2009.01308.x

Naylor, M. D., Hirschman, K. B., O'Connor, M., Barg, R., & Pauly, M. V. (2013). Engaging older adults in their transitional care: what more needs to be done? *J Comp Eff Res*, *2*(5), 457-468. https://doi.org/10.2217/cer.13.58

Naylor, M. D., & Keating, S. A. (2008). Transitiaonal care. *Journal of Social Work Education*, *44*, 65-73.

Naylor, M. D., & Sochalski, J. A. (2010). Scaling up: bringing the transitional care model into the mainstream. *Issue Brief (Commonw Fund)*, *103*(11), 1-12.

Noble, H., & Smith, J. (2018). Reviewing the literature: choosing a review design. *Evid Based Nurs*, *21*(2), 39-41. https://doi.org/10.1136/eb-2018-102895

Nolan, M., Davies, S., & Brown, J. (2006). Transitions in care homes: Towards relationship-centred care using the ‘Senses Framework’. *Quality in Ageing and Older Adults*.

Noordegraaf, M. (2020). Protective or connective professionalism? How connected professionals can (still) act as autonomous and authoritative experts. *Journal of Professions and Organization*, *7*(2), 205-223.

Noyes, J., Booth, A., Moore, G., Flemming, K., Tunçalp, Ö., & Shakibazadeh, E. (2019). Synthesising quantitative and qualitative evidence to inform guidelines on complex interventions: clarifying the purposes, designs and outlining some methods. *BMJ Glob Health*, *4*(Suppl 1), e000893. https://doi.org/10.1136/bmjgh-2018-000893

O'Donnell, R., Savaglio, M., Skouteris, H., Banaszak-Holl, J., Moranl, C., Morris, H., . . . Ayton, D. (2021). The Effectiveness of Transition Interventions to Support Older Patients From Hospital to Home: A Systematic Scoping Review. *J Appl Gerontol*, *40*(11), 1628-1636. https://doi.org/10.1177/0733464820968712

Occelli, P., Touzet, S., Rabilloud, M., Ganne, C., Poupon Bourdy, S., Galamand, B., . . . Bonnefoy, M. (2016). Impact of a transition nurse program on the prevention of thirty-day hospital readmissions of elderly patients discharged from short-stay units: study protocol of the

PROUST stepped-wedge cluster randomised trial. *BMC Geriatr*, *16*, 57. https://doi.org/10.1186/s12877-016-0233-2

Occelli, P., Touzet, S., Rabilloud, M., Ganne, C., Poupon Bourdy, S., Galamand, B., , Debray, M, Dartiguepeyrou, A., Chuzeville, M., Comte, B., Turkie, B,. Tardy, M., Luiggi, J.S., Jacquet-Francillon, T., Gilbert, T., Bonnefoy, M. (2016). Impact of a transition nurse program on the prevention of thirty-day hospital readmissions of elderly patients discharged from short-stay units: study protocol of the PROUST stepped-wedge cluster randomised trial. *BMC Geriatr*, *16*, 57. https://doi.org/10.1186/s12877-016-0233-2

OECD. (2021). *Elderly population.* https://doi.org/doi:https://doi.org/10.1787/8d805ea1-en

Okoli, C. (2015). Critical realist considerations for literature reviews. *Available at SSRN 2700524*.

Östlund, U., Kidd, L., Wengström, Y., & Rowa-Dewar, N. (2011). Combining qualitative and quantitative research within mixed method research designs: a methodological review. *Int J Nurs Stud*, *48*(3), 369-383. https://doi.org/10.1016/j.ijnurstu.2010.10.005

Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2005). Realist review--a new method of systematic review designed for complex policy interventions. *J Health Serv Res Policy*, *10 Suppl 1*, 21-34. https://doi.org/10.1258/1355819054308530

Piraino, E., Heckman, G., Glenny, C., & Stolee, P. (2012). Transitional care programs: who is left behind? A systematic review. *Int J Integr Care*, *12*, e132. https://doi.org/10.5334/ijic.805

Plano Clark, V. L. (2010). The adoption and practice of mixed methods: US trends in federally funded health-related research. *Qualitative Inquiry*, *16*(6), 428-440.

Plowright, D. (2011). *Using mixed methods: Frameworks for an integrated methodology*. Sage publications.

Plsek, P. (2001). Appendix B: Redesigning health care with insights from the science of complex adaptive systems. *Crossing the quality chasm: A new health system for the 21st century*, *2001*, 309-322.

Pluye, P., & Hong, Q. N. (2014). Combining the power of stories and the power of numbers: mixed methods research and mixed studies reviews. *Annu Rev Public Health*, *35*, 29-45. https://doi.org/10.1146/annurev-publhealth-032013-182440

Pynn, G. (2015). Contextualism in epistemology.

Rademakers, J., Nijman, J., van der Hoek, L., Heijmans, M., & Rijken, M. (2012). Measuring patient activation in The Netherlands: translation and validation of the American short form Patient Activation Measure (PAM13). *BMC public health*, *12*, 577. https://doi.org/10.1186/1471-2458-12-577

Ramaswamy, V., & Ozcan, K. (2020). *The co-creation paradigm*. Stanford University Press.

Reich, A. J., Claunch, K. D., Verdeja, M. A., Dungan, M. T., Anderson, S., Clayton, C. K., . . . Thacker, E. L. (2020). What Does "Successful Aging" Mean to you? - Systematic Review and Cross-Cultural Comparison of Lay Perspectives of Older Adults in 13 Countries, 2010-2020. *J Cross Cult Gerontol*, *35*(4), 455-478. https://doi.org/10.1007/s10823-020-09416-6

RIVM. (2014). *Public Health Status and Foresight Report*. [The Dutch National Institute for Public Health and Environment]. http://www.eengezondernederland.nl/en/English_version

Rosendal, H. (2019). *Expertisegebied wijkverpleegkundige [Community Nurses area of expertise]*. V&VN.

Rousseau, D. M., Manning, J., & Denyer, D. (2008). 11 Evidence in management and organizational science: assembling the field’s full weight of scientific knowledge through syntheses. *Academy of Management Annals*, *2*(1), 475-515.

Rudnicka, E., Napierała, P., Podfigurna, A., Męczekalski, B., Smolarczyk, R., & Grymowicz, M. (2020). The World Health Organization (WHO) approach to healthy ageing. *Maturitas*, *139*, 6-11.

Ryburn, B., Wells, Y., & Foreman, P. (2009). Enabling independence: restorative approaches to home care provision for frail older adults. *Health Soc Care Community*, *17*(3), 225-234. https://doi.org/10.1111/j.1365-2524.2008.00809.x

Rycroft-Malone, J., McCormack, B., Hutchinson, A. M., DeCorby, K., Bucknall, T. K., Kent, B., . . . Wilson, V. (2012). Realist synthesis: illustrating the method for implementation research. *Implement Sci*, *7*, 33. https://doi.org/10.1186/1748-5908-7-33

Saunders, M., Bristow, A., Lewis, P., & Thornhill, A. (2015). Research methods for business students (Chapter 4). *Understanding research philosophy and approaches to theory development*.

Sezgin, D., O'Caoimh, R., Liew, A., O'Donovan, M. R., Illario, M., Salem, M. A., . . . Hendry, A. (2020). The effectiveness of intermediate care including transitional care interventions on function, healthcare utilisation and costs: a scoping review. *Eur Geriatr Med*, *11*(6), 961-974. https://doi.org/10.1007/s41999-020-00365-4

Shahsavari, H., Zarei, M., & Mamaghani, J. A. (2019). Transitional care: Concept analysis using Rodgers’ evolutionary approach. *International journal of nursing studies*, *99*, 103387.

Shannon-Baker, P. (2016). Making paradigms meaningful in mixed methods research. *Journal of mixed methods research*, *10*(4), 319-334.

Shneerson, C. L., & Gale, N. K. (2015). Using mixed methods to identify and answer clinically relevant research questions. *Qual Health Res*, *25*(6), 845-856. https://doi.org/10.1177/1049732315580107

Shorten, A., & Smith, J. (2017). Mixed methods research: expanding the evidence base. *Evid Based Nurs*, *20*(3), 74-75. https://doi.org/10.1136/eb-2017-102699

Siu, C., & Comerasamy, H. (2013). Doing a Research Project in Nursing and Midwifery: A Basic Guide to Research Using the Literature Review Methodology.

Smith, L., & Kawachi, I. (2020). Translating evidence to policy. *Oxford Handbook of Public Health Practice 4e*, 312.

Smith, S. M., Soubhi, H., Fortin, M., Hudon, C., & O'Dowd, T. (2012). Managing patients with multimorbidity: systematic review of interventions in primary care and community settings. *Bmj*, *345*.

Sorrell, J. M. (2011). Mental health of the oldest-old. *J Psychosoc Nurs Ment Health Serv*, *49*(5), 21-24. https://doi.org/10.3928/02793695-20110329-04

Souza, M. T., Silva, M. D., & Carvalho, R. (2010). Integrative review: what is it? How to do it? *Einstein (Sao Paulo)*, *8*(1), 102-106. https://doi.org/10.1590/s1679-45082010rw1134

Stafford, G. E., & Gulwadi, G. B. (2020). Exploring aging in place inquiry through the lens of resilience theory. *Housing and Society*, *47*(1), 42-62.

Statistics Netherlands [CBS]. (2022). *Woonsituatie van personen van 70 jaar of ouder, 2018-2022* [Living situation of persons 70 years and older] [In Dutch]. https://www.cbs.nl/nl-nl/maatwerk/2020/51/woonsituatie-van-personen-van-70-jaar-of-ouder-2018-2022

Sturmberg, J. P. (2014). Multimorbidity and chronic disease: an emergent perspective. *J Eval Clin Pract*, *20*(4), 508-512. https://doi.org/10.1111/jep.12126

Tarrant, C., Windridge, K., Baker, R., Freeman, G., & Boulton, M. (2015). 'Falling through gaps': primary care patients' accounts of breakdowns in experienced continuity of care. *Family practice*, *32*(1), 82-87.

Tashakkori, A., & Creswell, J. W. (2007). The new era of mixed methods. In (Vol. 1, pp. 3-7): Sage Publications.

Tavassoli, N., Piau, A., Berbon, C., De Kerimel, J., Lafont, C., De Souto Barreto, P., . . . Angioni, D. (2021). Framework implementation of the INSPIRE ICOPE-CARE program in collaboration with the World Health Organization (WHO) in the Occitania Region. *The Journal of Frailty & Aging*, *10*, 103-109.

Teddlie, C., & Tashakkori, A. (2010). Overview of contemporary issues in mixed methods research. *Handbook of mixed methods in social and behavioral research*, *2*(2010), 1-41.

Threapleton, D. E., Chung, R. Y., Wong, S. Y., Wong, E., Chau, P., Woo, J., . . . Yeoh, E.-K. (2017). Integrated care for older populations and its implementation facilitators and barriers: A rapid scoping review. *International Journal for Quality in Health Care*, *29*(3), 327-334.

Tomassini, C. (2005). The demographic characteristics of the oldest old in the United Kingdom. *Popul Trends*(120), 15-22.

Tsoi, C. S., Chow, J. Y., Choi, K. S., Li, H. W., Nie, J. X., Tracy, C. S., . . . Upshur, R. E. (2014). Medical characteristics of the oldest old: retrospective chart review of patients aged 85+ in an academic primary care centre. *BMC Res Notes*, *7*, 340. https://doi.org/10.1186/1756-0500-7-340

Tuntland, H., Aaslund, M. K., Espehaug, B., Førland, O., & Kjeken, I. (2015). Reablement in community-dwelling older adults: a randomised controlled trial. *BMC Geriatr*, *15*, 145. https://doi.org/10.1186/s12877-015-0142-9

Turyahikayo, E. (2021). Philosophical paradigms as the bases for knowledge management research and practice. *Knowledge Management & E-Learning: An International Journal*, *13*(2), 209-224.

Vaismoradi, M., Jones, J., Turunen, H., & Snelgrove, S. (2016). Theme development in qualitative content analysis and thematic analysis.

Vaismoradi, M., & Snelgrove, S. (2019). Theme in Qualitative Content Analysis and Thematic Analysis. Forum Qualitative Sozialforschung/Forum: Qualitative Social Research,

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nurs Health Sci*, *15*(3), 398-405. https://doi.org/10.1111/nhs.12048

Valentijn, P. P., Schepman, S. M., Opheij, W., & Bruijnzeels, M. A. (2013). Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. *International journal of integrated care*, *13*.

Van Campen, C. (2011). Frail older persons in the Netherlands.

Van der Ven, M., Schoon, Y., & Olde Rikkert, M. (2015). Ongeplande heropnames bij kwetsbare ouderen. Retrospectieve analyse van opnames in een academisch ziekenhuis. [Unplanned readmissions with vulnerable elderly, in Dutch]. *Ned Tijdschr Geneeskd*, *159*, A9211.

van der Vlegel-Brouwer, W. (2013). Integrated healthcare for chronically ill. Reflections on the gap between science and practice and how to bridge the gap. *International journal of integrated care*, *13*.

Van der Vlegel-Brouwer, W. (2016). Which factors enable older adults with multimorbidity to adapt and self-manage to increase health? A narrative literature review. *International journal of integrated care*, *16*(6).

van der Vlegel-Brouwer, W., van Kemenade, E., Goodwin, N., & Miller, R. (2020). Research in Integrated Care: The Need for More Emergent, People-Centred Approaches. *International journal of integrated care*, *20*(4).

van Dyk, S. (2016). The othering of old age: Insights from Postcolonial Studies. *J Aging Stud*, *39*, 109-120. https://doi.org/10.1016/j.jaging.2016.06.005

Van Kemenade, E., de Kuiper, M., Booij, M., & Minkman, M. (2022). How Different Quality Paradigms Undermine a Shared Value Base for Integrated Care: The Need for Collective Reflexivity. *International journal of integrated care*, *22*(1).

Van Kemenade, E., & van der Vlegel-Brouwer, W. (2019). Integrated care: a definition from the perspective of the four quality paradigms. *Journal of Integrated Care*.

van Kemenade, E., van der Vlegel-Brouwer, W., & van der Vlegel, M. (2021). Exploring the quality paradigms in Integrated Care: the need for emergence and reflection. *International journal of integrated care*, *21*(2).

van Meijel, v. B., Gamel, C., van Swieten-Duijfjes, B., & Grypdonck, M. (2004). The development of evidence-based nursing interventions: methodological considerations. *Journal of advanced nursing*, *48*(1), 84-92.

Van Oostrom, S. H., Picavet, H. S. J., Van Gelder, B. M., Lemmens, L. C., Hoeymans, N., Van Dijk, C. E., . . . Baan, C. A. (2012). Multimorbidity and comorbidity in the Dutch population–data from general practices. *BMC public health*, *12*(1), 1-9.

van Seben, R., Reichardt, L., Buurman, B., & Smorenburg, S. (2016). *Interventies gericht op het verbeteren van de (transmurale) ziekenhuiszorg voor kwetsbare ouderen [Interventrions aimed at the improvement of transitional hospital care for frail elderly] [In Dutch]*. http://www.bensajetcentrum.nl/assets/wbb-publications/345/Interventies%20gericht%20op%20het%20verbeteren%20van%20de%20(transmurale)%20ziekenhuiszorg%20voor%20kwetsbare%20ouderen%2020160312.pdf

van Seben, R., Reichardt, L. A., Essink, D. R., van Munster, B. C., Bosch, J. A., & Buurman, B. M. (2019). "I Feel Worn Out, as if I Neglected Myself": Older Patients' Perspectives on Post-hospital Symptoms After Acute Hospitalization. *Gerontologist*, *59*(2), 315-326. https://doi.org/10.1093/geront/gnx192

van Walraven, C., Jennings, A., & Forster, A. J. (2012). A meta-analysis of hospital 30-day avoidable readmission rates. *Journal of evaluation in clinical practice*, *18*(6), 1211-1218.

Verhaegh, K. J., MacNeil-Vroomen, J. L., Eslami, S., Geerlings, S. E., de Rooij, S. E., & Buurman, B. M. (2014). Transitional care interventions prevent hospital readmissions for adults with chronic illnesses. *Health Aff (Millwood)*, *33*(9), 1531-1539. https://doi.org/10.1377/hlthaff.2014.0160

Vilans. (2013). *Self-sufficiency matrix [Zelfredzaamheidsmeter, in Dutch]*. https://www.vilans.nl/vilans/media/documents/producten/zelfredzaamheidsmeter.pdf

VMS, [Dutch National Patient Safety Programme]. (2009). Praktijkgids Kwetsare Ouderen.[Practical guide frail older adults]. *Den Haag: VMW Veiligheidsprogramma.* https://www.vmszorg.nl/wp-content/uploads/2017/11/web_2009.0104_praktijkgids_kwetsbare_ouderen.pdf

Vollstedt, M., & Rezat, S. (2019). An introduction to grounded theory with a special focus on axial coding and the coding paradigm. *Compendium for early career researchers in mathematics education*, *13*, 81-100.

Weeks, L. E., Macdonald, M., Martin-Misener, R., Helwig, M., Bishop, A., Iduye, D. F., & Moody, E. (2018). The impact of transitional care programs on health services utilization in community-dwelling older adults: a systematic review. *JBI Database System Rev Implement Rep*, *16*(2), 345-384. https://doi.org/10.11124/jbisrir-2017-003486

Wehrens, R., Oldenhof, L., Verweij, L., Francke, A., & Bal, R. (2017). Experimenteel sturen in netwerken: een evaluatie van proces en structuur van het Nationaal Programma Ouderenzorg.

Werkman, R., & Boonstra, J. (2001). Lessons in Survey Feedback: interactive reflection, sense making and learning in organizational change processes. In: University of Amsterdam, Amsterdam.

Werner, N. E., Tong, M., Borkenhagen, A., & Holden, R. J. (2019). Performance-shaping factors affecting older adults' hospital-to-home transition success: a systems approach. *The Gerontologist*, *59*(2), 303-314.

Weston, M. J. (2010). Strategies for enhancing autonomy and control over nursing practice. *Online J Issues Nurs*, *15*(1).

WHO. (2015). *World report on ageing and health*. (9241565047). World Health Organization

WHO. (2016a). *Framework on integrated, people-centred health services*. Geneva: World Health Organization

WHO. (2016b). *Report on the public consultation to inform development of the Framework on integrated people-centred health services*. World Health Organization

WHO. (2020). *Decade of healthy ageing: baseline report*. (9240017909). World Health Organisation

WHO. (2022). *Ageing and Health*. World Health Organisation. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

Willis, C. D., Riley, B. L., Stockton, L., Abramowicz, A., Zummach, D., Wong, G., . . . Best, A. (2016). Scaling up complex interventions: insights from a realist synthesis. *Health research policy and systems*, *14*(1), 1-16.

Appendix 1 Scholary outputs during this thesis

Published articles

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van der Vlegel-Brouwer, W. (2013). Integrated healthcare for chronically ill. Reflections on the gap between science and practice and how to bridge the gap. *International Journal of Integrated Care*, *13*.

Van Kemenade, E., & van der Vlegel-Brouwer, W. (2019). Integrated care: a definition from the perspective of the four quality paradigms. *Journal of Integrated Care*.

van Kemenade, E., van der Vlegel-Brouwer, W., & van der Vlegel, M. (2021). Exploring the quality paradigms in Integrated Care: the need for emergence and reflection. *International Journal of Integrated Care*, *21*(2).

van der Vlegel-Brouwer, W., Everard van Kemenade, K. Stein, V., Goodwin, N., & Miller, R. (2020). Research in Integrated Care: The Need for More Emergent, People-Centred Approaches. *International Journal of Integrated Care*, *20*(4).

van der Vlegel-Brouwer, W., van der Vlegel, M., Duckworth, J. E., Partington, H., & de Jong, A. (2023). Evaluating a transitional care program for the oldest adults: results from the quantitative phase of a mixed-methods study. *Quality in Ageing and Older Adults*.

Van Eijk, C., Van der Vlegel-Brouwer, W., & Bussemaker, J. (2023). Healthy and Happy Citizens: The Opportunities and Challenges of Co-Producing Citizens' Health and Well-Being in Vulnerable Neighborhoods. *Administrative Sciences*, *13*(2), 46.

Published Book chapter

Van der Vlegel-Brouwer, W. & Bussemaker, M. (2021). [Happiness and health, a co-creation process with citizens of the Hague] [In Dutch]. Geluk en gezondheid, een co-creatieproces met bewoners in Den Haag. *Momentum voor de menselijke maat*, *hoofdstuk 3*. Available from: https://www.movisie.nl/sites/movisie.nl/files/2021-06/Momentum%20voor%20de%20menselijke%20maat.pdf

Published Book review

van der Vlegel-Brouwer, W., & Miller, R. (2021). How to Deliver Integrated Care. *International Journal of Integrated Care*, *21*(3).

Published abstracts

Which factors enable older adults with multimorbidity to adapt and self-manage to increase health? A narrative literature review (2016). Available from: https://www.ijic.org/articles/abstract/10.5334/ijic.2751/

Evaluation of a transitional care programme for frail older adults and the effectiveness for the oldest old (2017). Available from: https://www.ijic.org/articles/abstract/10.5334/ijic.3561/

Exploring the quality paradigms in integrated care: The need for emergence and reflection (2021). Available from : https://www.ijic.org/articles/10.5334/ijic.ICIC2025/

Conference oral presentations

International Conference on Integrated Care 2020
Title: Exploring the quality paradigms in Integrated Care: the need for emergence and reflection.

IIAS Study Group ‘Co-production of Public Services’, Haifa Israel (digital conference), 10th of November 2020. Titel: Healthy and happy citizens: how co-production contributes to the health and well- being of citizens and what leadership can facilitate.

International Conference on Integrated Care 2021
Title: Evaluating a transitional care programme for the average and the oldest old: results from the quantitative phase of a mixed methods study.

International Conference on Integrated Care 2021
Title: Participatory action research as a driver for change on health and wellbeing in a deprived neighbourhood in The Hague: a quest towards regaining trust, sustainable citizen participation and co-creation.

International Conference on Integrated Care 2022
Title: A Participatory Action Research as a driver for change for prevention and health promotion: A co-creation process between professionals and citizens in two deprived neighbourhoods in The Hague.

Conference (oral) posters presentations

16th International Conference on Integrated Care, Barcelona 23-25 May 2016
Title: Factors that enable olde adult to adapt and self-manage.

UClan 3rd International Health and Wellbeing with Real Impact Conference, Preston UK.
Title: An evaluation of a trastional care programme for older adults.

17th International Conference on Integrated Care, Dublin 8-10 May 2017
Title: An evaluation of a transtional care programme for older adults and the effectiveness for the oldest old at the Dutch IJsselland hospital.

International Forum on Quality and Safety in Healthcare, Amsterdam, 2-4 May 2018
Title: An evaluation of a transtional care programme for older adults and the effectiveness for the oldest old at the Dutch IJsselland hospital.

18th International Conference on Integrated Care, Utrecht 23-25 May 2018
Title: A quasi experimental before and after study of a transitional care programme for older adults in the area of the IJsselland Hospital (2018). Available from:
https://www.ijic.org/articles/abstract/10.5334/ijic.s2196/

22th International Conference on Integrated Care, Odense Denmark, 23-25 May 2022
Title: Evaluating a transitional care programme for the average and the oldest old: results from the qualitative phase of a mixed methods study.

Awards

2022 Runner up Integrated Care award at ICIC22 conference in Denmark for the abstract A Participatory Action Research as a driver for change for prevention and health promotion: A co-creation process between professionals and citizens in two deprived neighbourhoods in The Hague.

Appendix 2a Proof Reader Declaration

Declaration of Proofreading Services

Confirmatory Statement of Acceptance

Name of Candidate:	Wilma van der Vlegel-Brouwer
Award:	Professional Doctorate in Health
I declare that I have read, understood, and have adhered to UCLan's Proofreading Policy (Appendix 1) when proofreading the above candidate's research degree thesis.	
Signature of Proofreader:	V. Hulse
Print name of Proofreader:	Vikki Hulse
Name of Company:	Academic Proof-Reading Service
Proof-reader's Contact Details: **Phone:** **Email:**	 07947 512223 aprsvh@gmail.com

Appendix 2b Approval local ethics committee IJsselland hospital

afdeling Stafafdeling Raad van Bestuur
doorkiesnr. 010 - 258 5389
datum 9 november 2017
uw ref.
onze ref. SWO-jz-br-17-37
betreft **Nader besluit uitvoeringstoestemming**

ijssel land
ziekenhuis

Mw. Van der Vlegel, Beleidsadviseur ketenzorg
E1.041

Protocoltitel:
An evaluation of an integrated care programme for older adults in the IJsselland hospital

Geachte mevrouw Van der Vlegel,

Hierbij zend ik u het nader besluit van de Lokale Toetsingscommissie inzake wijzigingen behorende bij het protocol getiteld: 'An evaluation of an integrated care programme for older adults in the IJsselland hospital'.
De lokale toetsingscommissie heeft het amendement op het bovenvermeld onderzoeksvoorstel ontvangen op 3 oktober 2017 jl.

De Lokale Toetsingscommissie verleent haar goedkeuring aan genoemde wijzigingen die betrekking hebben op het onderzoeken van de perceptie van professionals in het IJsselland Ziekenhuis en experts in het zorgprogramma.

Patiënten werden reeds op correcte wijze, volgens vigerende wetten als de Wbp, geïnformeerd en naar vrijwillige deelname gevraagd. Deze toestemming wordt schriftelijk vastgelegd. De aanvullende informatie van de professional m.b.t. de procesevaluatie en zijn/haar perceptie hebben geen consequenties voor de lokale haalbaarheid.

Met vriendelijke groet,

Namens de Lokale Toetsingscommissie

Mw. J.G.M. Zwanink- in 't Veld
Secretaris Lokale Toetsingscommissie wetenschappelijk onderzoek

postadres
IJsselland Ziekenhuis
Postbus 690
2900 AR Capelle a/d IJssel

bezoekadressen
IJsselland Ziekenhuis
Prins Constantijnweg 2
2906 ZC Capelle a/d IJssel
tel. 010 - 258 5000

IVLU 1.2 swo-jz-17-09
Buitenpolikliniek Nesselande
Cypruslaan 410
3059 XA Rotterdam
tel. 010 - 258 5700

Buitenpolikliniek Krimpen
Groenendaal 1
2922 CJ Krimpen a/d IJssel
tel. 010 - 258 3400

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ijssel land
ziekenhuis

To whom it may concern,

The Daily Board of the Local Ethics Committee IJsselland Hospital of Capelle aan den IJssel, The Netherlands, confirmed that it has reviewed the above mentioned research proposal. As a result of this review, the Committee informs you that the rules laid down in the Medical Reseach Involving Human Subjects Act (also known by its Dutch abbreviation WMO), do not apply to this research proposal.

Yours sincerely,
On behalf of the Local Ethiscs Committee IJsselland Hospital

Mrs. J.G.M. Zwanink- in 't Veld
Secretary of the Local Committee

Appendix 2c Addendum approval local ethics committee

afdeling Stafafdeling Raad van Bestuur
doorkiesnr. 010 - 258 5389
datum 9 november 2017
uw ref.
onze ref. SWO-jz-br-17-37
betreft **Nader besluit uitvoeringstoestemming**

ijssel land
ziekenhuis

Mw. Van der Vlegel, Beleidsadviseur ketenzorg
E1.041

Protocoltitel:
An evaluation of an integrated care programme for older adults in the IJsselland hospital

Geachte mevrouw Van der Vlegel,

Hierbij zend ik u het nader besluit van de Lokale Toetsingscommissie inzake wijzigingen behorende bij het protocol getiteld: 'An evaluation of an integrated care programme for older adults in the IJsselland hospital'.
De lokale toetsingscommissie heeft het amendement op het bovenvermeld onderzoeksvoorstel ontvangen op 3 oktober 2017 jl.

De Lokale Toetsingscommissie verleent haar goedkeuring aan genoemde wijzigingen die betrekking hebben op het onderzoeken van de perceptie van professionals in het IJsselland Ziekenhuis en experts in het zorgprogramma.

Patiënten werden reeds op correcte wijze, volgens vigerende wetten als de Wbp, geïnformeerd en naar vrijwillige deelname gevraagd. Deze toestemming wordt schriftelijk vastgelegd. De aanvullende informatie van de professional m.b.t. de procesevaluatie en zijn/haar perceptie hebben geen consequenties voor de lokale haalbaarheid.

Met vriendelijke groet,
Namens de Lokale Toetsingscommissie

Mw. J.G.M. Zwanink- in 't Veld
Secretaris Lokale Toetsingscommissie wetenschappelijk onderzoek

Appendix 2d Translation local ethics committe IJsselland hospital

Mrs. Van der Vlegel, policy advisor on integrated care

Titel protocol:

An evaluation of an integrated care programme for older adults in the IJsselland hospital

Dear mrs. Van der Vlegel,

The local ethics committee has received the protocol mentioned above on the 16th of February 2017, to establish if this study is under the Law on Medical Scientific Research involving Human Beings (WMO).

The local ethics committee has concluded that this protocol is not under this law. Therefore, the committee concludes that:

-This protocol has a medical scientific research question

-The participants are not subjected to interventions or conduct, as mentioned both in the Law on Medical Scientific Research.

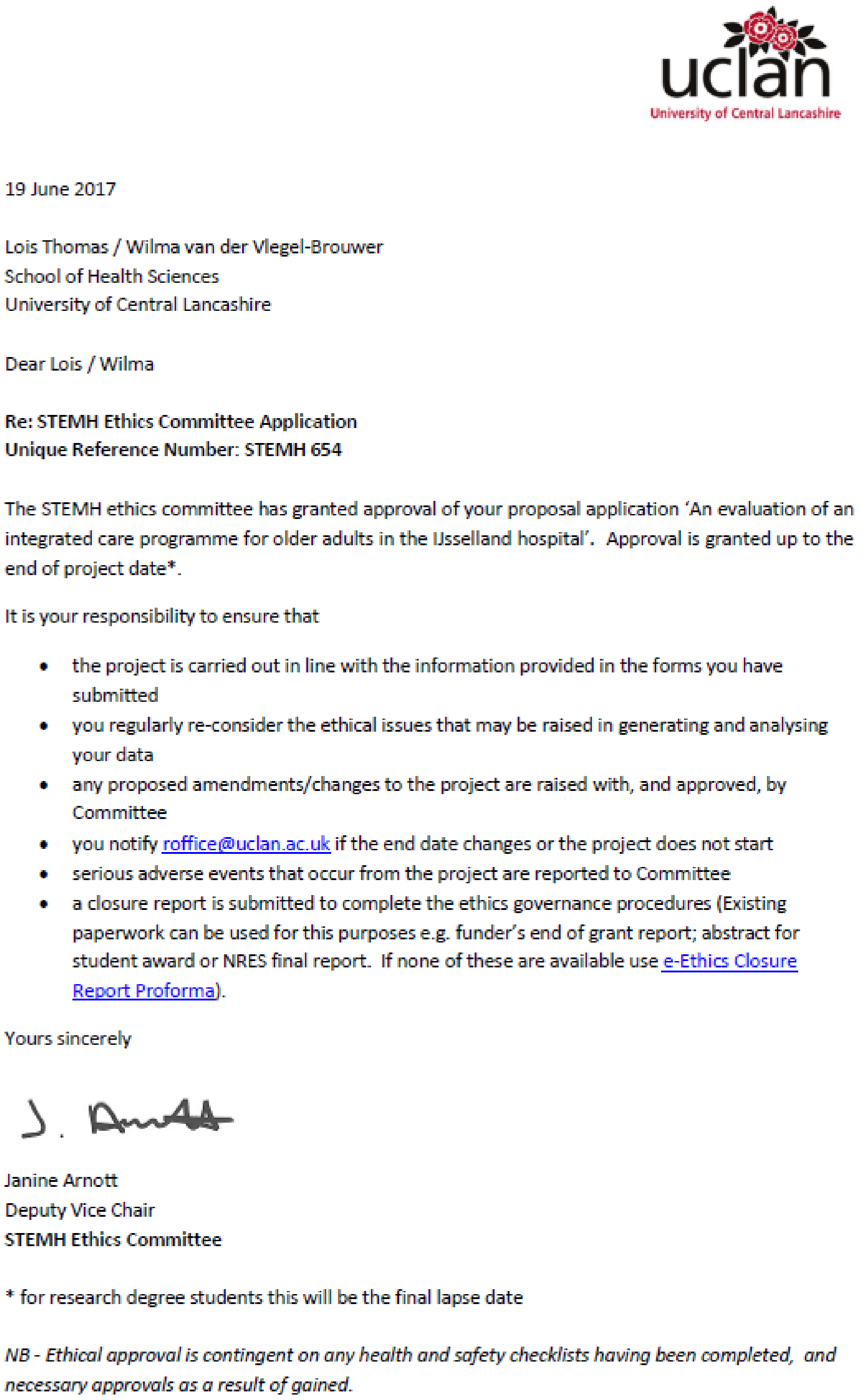
Because one of the condition to be subjected to the the Law on Medical Scientific Research does not apply, the The local ethics committee has decided on the 20th of February 2017 the protocol mentioned above is not under the Law on Medical Scientific Research.

Additionally, the contents of the protocol were reviewed. Participants (patients) are informed correctly, according to laws that apply like the personal data protection act, and they are asked to participate voluntarily. Informed consent is given in writing.

Kind regards,

On behalf of the local ethics committee.

Appendix 2e Ethical approval STEMH committee UClan



uclan
University of Central Lancashire

19 June 2017

Lois Thomas / Wilma van der Vlegel-Brouwer
School of Health Sciences
University of Central Lancashire

Dear Lois / Wilma

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 654

The STEMH ethics committee has granted approval of your proposal application 'An evaluation of an integrated care programme for older adults in the IJsselland hospital'. Approval is granted up to the end of project date*.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely

J. Arnott

Janine Arnott
Deputy Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

Appendix 2f Ethical approval addendum STEMH committee UClan

04 December 2017

Lois Thomas / Wilma van der Vlegel-Brouwer
School of Health Sciences
University of Central Lancashire

Dear Lois / Wilma

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 654 amendment 06_11_17

The STEMH Ethics Committee has approved your proposed amendment to your application ‘An evaluation of an integrated care programme for older adults in the IJsselland hospital’.

Yours sincerely

Julie Cook
Deputy Vice-Chair
STEMH Ethics Committee

Appendix 3 Search strings literature review

Search string for databases Pubmed, Cinahl, Cochrane, Embase started with:

((transitional care) AND ((older adults) OR (older)) AND (hospital to home))

If necessary search terms were added or change into:

Pubmed/ Cinahl/ Embase
(((older adults) OR (elderly) OR (older persons)) AND ((discharge hospital) OR (hospital to home)) AND (hospitalisation) AND ((transitional care) OR (transition*)))

Chochrane

(((older adults) OR (elderly) OR (older persons)) AND ((independence) OR (self-management) OR (longer at home)))

To find qualitative reviews 'AND (experiences)' was added.

For the web search engine Google scholar and the grey literature search was conducted using the terms: transitional care, older adults, home, hospitalisation

If necessary search terms were added or change into:

Elderly
Discharge home
Hospital to home
Self-management
Independence
Transition
Experiences

Inclusion criteria literature review
Transitional care programme or intervention with at least a post-discharge component
Hospital to home
Older hospitalised adults ≥60 years old
Multiple health conditions
Reviews
Qualitative and quantitative studies
Studies reported in English, German or Dutch
Published after 2004

Appendix 4a Participant information sheet patient

Evaluation of the transitional care programme at the IJsselland hospital

Introduction and Purpose

My name is Wilma van der Vlegel. I am a policy advisor on integrated care in the IJsselland hospital and a professional doctorate student at the University of Central Lancashire in the UK. This research is supervised by Dr. Lois Thomas, Dr. L. Macphail, and Dr. P. Breman. This study has received ethical approval from the local Medical Ethical Committee of the IJsselland hospital and the University of Central Lancashire STEMH Ethics Committee.

I would like to invite you to take part in my research study, which concerns the evaluation of the care you received one day before discharge from the IJsselland hospital and the following weeks from the community nurse.

Participation in the study is entirely voluntary and you are free to withdraw from the study at any time without giving a reason. Taking part, or not taking part in the study will not affect the care you receive. The following information about the study is provided to enable you to be confident about giving informed consent if you decide to take part.

Aims of the study

We would like your views on the transitional care programme to help us improve the care for older persons who have been admitted to the IJsselland hospital and return home.

What will I be asked to do?

If you agree to participate in my research, I will conduct an interview with you at a time and location of your choice 2-4 weeks after your transitional care programme finished. It should last about one hour. I will ask you questions about what you liked about the programme, what could be improved, and your views on the care you received.

With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide, and will be used for transcription purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable at any time during the interview, I can turn off the recorder at your request. If you don't wish to continue, you can stop the interview at any time.

What are the risks or benefits of taking part

Participating in an interview should be a positive experience. The research provides you with an opportunity to contribute to a process of sharing your experiences of health and healthcare. The findings will help in the development of health care in the IJsselland Hospital.

Talking about your health and healthcare may make you uncomfortable or upset. You are free to decline to answer any questions you don't wish to. Every care will be taken to ensure that you are comfortable with the content and process of the interview.

Anonymity and confidentiality of data

If you decide to take part in the research, all the information you supply in the interview will be anonymous in nature and it will not be possible to identify you or the health care providers you mention. Some comments you provide in the interview may be quoted directly in the study report and subsequent publications. These will be put into open quotation marks and attributed to a 'participant' to ensure complete anonymity.

Data from the interviews will be stored securely on the password-protected IJsselland Hospital server and will be accessible only to the researcher. The recorded and transcribed interview will be kept in a locked cabinet at the IJsselland Hospital in a secure place.

The professional doctorate supervisors will be the only other people who will see the anonymised interview transcripts. The recorded interviews will be destroyed after transcription.

Contact details for further questions

If you have any questions about this research, please feel free to contact me: Wilma van der Vlegel, wvdvlegel@ysl.nl, (0031) 010-2583161 or (0031) 06-47023163. If you have any questions about your rights or treatment as a research participant in this study, please contact the Local Medical Ethical Committee of the IJsselland Hospital: Joyce Zwanink, jzwanink@ysl.nl, (0031) 010-2585000.

Appendix 4b Participant information sheet (community) nurses and geriatric team

Evaluation of the transitional care programme at the IJsselland hospital

Introduction and Purpose

My name is Wilma van der Vlegel. I am a policy advisor on integrated care in the IJsselland hospital and a professional doctorate student at the University of Central Lancashire in the UK. This research is supervised by Dr. Lois Thomas, Dr. Lyndsey Macphail, and Dr. Paul. Breman. This study has received ethical approval from the local Medical Ethical Committee of the IJsselland hospital and the University of Central Lancashire STEMH Ethics Committee.

I would like to invite you to take part in my research study, which concerns the evaluation of the transitional care programme for older people at the IJsselland hospital

Participation in the study is entirely voluntary and you are free to withdraw from the study at any time without giving a reason. The following information about the study is provided to enable you to be confident about giving informed consent if you decide to take part.

Aims of the study

We would like to evaluate the transitional care programme at the IJsselland hospital. This programme aims to improve the care of older people in the transition from hospital to their own home.

What will I be asked to do?

If you agree to participate in my research, I will conduct an interview with you at a time and location of your choice in the hospital. The interview will last about 30 minutes. The interview will involve questions about what you think the programme does well and what aspects of the programme could be improved.

With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide, and will be used for transcription purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable about this at any time during the interview, I can turn off the recorder. If you don't wish to continue with the interview you can stop at any time.

Anonymity and confidentiality of data

If you decide to take part in the research, all the information you supply in the interview will be transcribes anonymous and it will not be possible to identify the origins of the thoughts or views. There will be no identification possible of you or the healthcare providers you mention in the final report.

Some comments you provide in the interview may be quoted directly in the dissertation and any subsequent publications. These will be put into open quotation marks and attributed to a 'participant' to ensure complete anonymity.

The voice file and transcript of the interview will be stored securely on the password-protected UCLan server and will be accessible only to the researcher.

The professional doctorate supervisory team will be the only other persons to see the anonymised interview transcript. The recorded interviews will be deleted after transcription. When we publish the results, care will be taken to ensure that no participants are identifiable.

Contact details for further questions

If you have any questions about this research, please feel free to contact me: Wilma van der Vlegel, wvdvlegel@ysl.nl, (0031) 010-2583161 or (0031) 06-47023163

If you have any questions about your rights or treatment as a research participant in this study, please contact the Local Medical Ethical Committee of the IJsselland hospital: Joyce Zwanink, jzwanink@ysl.nl, (0031) 010-2585000.

Appendix 4c Participant information sheet focus group

Evaluation of the transitional care programme at the IJsselland hospital

Introduction and Purpose

My name is Wilma van der Vlegel. I am a policy advisor on integrated care in the IJsselland hospital and a professional doctorate student at the University of Central Lancashire in the UK. This research is supervised by Dr. Lois Thomas, Dr. L. Macphail, and Dr. P. Breman. This study has received ethical approval from the local Medical Ethical Committee of the IJsselland hospital and the University of Central Lancashire STEMH Ethics Committee.

I would like to invite you to take part in my research study, which concerns the evaluation of the transitional care programme for older people at the IJsselland hospital.

Participation in the study is entirely voluntary and you are free to withdraw from the study at any time without giving a reason. The following information about the study is provided to enable you to be confident about giving informed consent if you decide to take part.

Aims of the study

We would like to evaluate the transitional care programme at the IJsselland hospital. This programme aims to improve the care of older people in the transition from hospital to their own home.

What will I be asked to do?

If you agree to participate in my research, you will be invited to a focus group meeting at the IJsselland hospital. The focus group meeting should last about two hours. The focus group meeting will start with a presentation of the findings from the prospective cohort study and interviews with healthcare providers and patients. In the cohort study, we compared two groups of 50 patients, one group received and the other group did not receive the transmural care programme. During the cohort study data were gathered during three months on ADL functioning, self-management skills, self-related health and quality of life, and use of informal and healthcare services. The presentation will also provide an analysis of on the data of the interviews with healthcare providers and patients on their experiences with the programme.

Questions will focus on what you think went well during the programme and what aspects could be improved.

With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide, and will be used for transcription purposes only.

What are the risks or benefits of taking part

Participating in a focusgroup interview should be a positive experience. The research provides you with an opportunity to contribute to a process of sharing your experiences of providing health and healthcare for older persons. The findings will help in the development of health care around the IJsselland Hospital.

You are free to decline to answer any questions you do not wish to answer. Every care will be taken to ensure that you are comfortable with the content of the interview.

Anonymity and confidentiality of data

If you decide to take part in the research, all the information you supply in the interview will be anonymous in nature and it will not be possible to identify the origins of the thoughts or views. There will be no identification of you or the healthcare providers you mention in the final report.

Some comments you provide in the interview may be quoted directly in the dissertation and any subsequent publications. These will be put into open quotation marks and attributed to a 'participant' to ensure complete anonymity.

The voice file and transcript of the interview will be stored securely on the password-protected UCLan server and will be accessible only to the researcher.

The professional doctorate supervisory team will be the only other people who will see the anonymised interview transcript. The recorded and transcribed interviews will be kept for 5 years and then destroyed. When we publish the results, care will be taken to ensure that no participants are identifiable.

Contact details for further questions

If you have any questions about this research, please feel free to contact me: Wilma van der Vlegel, wvdvlegel@ysl.nl, (0031) 010-2583161 or (0031) 06-47023163

If you have any questions about your rights or treatment as a research participant in this study, please contact the Local Medical Ethical Committee of the IJsselland hospital: Joyce Zwanink, jzwanink@ysl.nl, (0031) 010-2585000.

Appendix 5 Consent form

ijssel land
ziekenhuis

uclan

Research study: **Evaluation of the transitional care programme of the IJsselland Hospital**
June 2017

Participant's name --

	Initials participant
1. I confirm that I have received and read the information sheet of research on the transitional care programme for older adults of the IJsselland Hospital.	
2. I confirm that I could raise any question and my questions were answered satisfactorily.	
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	
4. I agree to: Take part in an interview Allow the interview to be audio-taped	
Allow the information I supply to be used anonymously in reports, publications or for teaching purposes	
5. I would like a summary of the results of the study when it is completed.	

I agree to take part in this study

____ _______________________________

Signature Date

____ _______________________________

Signature of researcher Date

You will be given a copy of this consent form to keep for your own records.

Appendix 6 Questionnaire patients at one and three months

ijssel land
ziekenhuis

Questionnaire care pathway older adult
Transmural Care Bridge

Questionnaire 1 month and 3 months after discharge from hospital

Name, date of birth patient

Date of response

				2	**0**		
d	d	m	m	y	y	y	y

Living circumstances

Have your living circumstances changed since your last hospital admission? ☐ Yes ☐ No

Are your living circumstances satisfactory? ☐ Yes ☐ No

If not, can you explain why ……

……

Personal care

1. Do you need assistance for IADL (e.g., assistance in housekeeping, preparing meals, shopping, etc.) on a regular basis?	☐ No ☐ Yes	
2. Do you use a walking device (e.g., a cane, rollator, walking frame, crutches, etc.)?	☐ No ☐ Yes	
3. Do you need assistance for traveling?	☐ No ☐ Yes	
4. Did you fall in the previous month?	☐ No ☐ Yes	_____time(s)
5. Did you lose weight in the previous month unintentionally?	☐ No ☐ Yes	_____kilo
6. Did you have less appetite in the previous month?	☐ No ☐ Yes	
7. Did you use additional nutrition drink in the previous month?	☐ No ☐ Yes	
8. Do you experience problems with your memory?	☐ No ☐ Yes	
9. Did you need help in the last 24 hours to take care of yourself?	☐ No ☐ Yes	
10. Do you need help bathing or taking a shower?	☐ No ☐ Yes	
11. Do you need help getting dressed?	☐ No ☐ Yes	
12. Do you need help visiting the toilet?	☐ No ☐ Yes	
13. Do you use incontinence materials?	☐ No ☐ Yes	
14. Do you need help standing up from a chair?	☐ No ☐ Yes	
15. Do you need help eating?	☐ No ☐ Yes	

Use of healthcare

These questions address the care you received in the previous month after your discharge from hospital. If you don't know the exact number of hours or times, please try to make an estimation.

After your discharge from hospital in the previous month(s)……….

16. Did you visit your GP?	☐ No ☐ Yes	_____ times
17. Did the GP visit you at home?	☐ No ☐ Yes	_____ times
18. Did you visit a GP during evenings, nights or weekend?	☐ No ☐ Yes	_____ times
19. Did you visit the Emergency Room?	☐ No ☐ Yes	_____ times
20. Were you admitted to hospital?	☐ No ☐ Yes	_____ times _____ days in total
21. Were you admitted in a nursing home/ care home?	☐ No ☐ Yes	_____ weeks
22. Did you receive care by Community nurse?	☐ No ☐ Yes	____ hours each week
23. Did someone professionally do your housekeeping?	☐ No ☐ Yes	____ hours each week
24. Did your visit day care?	☐ No ☐ Yes	____ days each week
25. Did you receive help from your spouse?	☐ No ☐ Yes	____ hours each week
26. Did you receive help from your children?	☐ No ☐ Yes	____ hours each week
27. Did you receive help from other family members?	☐ No ☐ Yes	____ hours each week
28. Did you receive help from neighbours/ friends/ volunteers?	☐ No ☐ Yes	____ hours each week
29. Did you receive meals?	☐ No ☐ Yes	
30. Do you have an alarmsystem in your home?	☐ No ☐ Yes	
31. Did you arrage pivate domestic help?	☐ No ☐ Yes	____days each week for ______________________
32. Did you receive treatment by psychologist, psychiatrist?	☐ No ☐ Yes	
33. Did you receive care by an occupational therapist?	☐ No ☐ Yes	_____times for …………. hours each week
34. Did you receive care by a dietician?	☐ No ☐ Yes	
35. Did you receive care other care/ help?	☐ No ☐ Yes	Clarify:___________ _____________________

36. What help did you receive from your informal caregiver (several answers possible)?

☐ Not relevant
☐ Housekeeping
☐ Shopping

- ☐ Cooking
- ☐ Transportation
- ☐ Finances
- ☐ Other, …………………………………………………………………………………….

Remarks

37. Self rated health

The following question are about your health. What you think about your health at this moment. Which report mark would you give your health at this moment on a scale from 1 (very poor health) to 10 (excellent health)?

0	1	2	3	4	5	6	7	8	9	10

Very poor health

Excellent health

38. Quality of live

The following question are about your 'quality of life'. This refers to what you think about your life. For example, whether you are satisfied with your life, whether you have enjoyment in your life and whether your life gives you satisfaction.

Which report mark would you give your life at this moment on a scale from 1 (very poor quality of life) to 10 (excellent quality of life)? ☐ Enter a figure between 0 and 10 here

Could you clarify your answer?

Experience after discharge

39. How did you experience the transition from hospital home?

40. What care was provided at home at the moment of discharge?

41. Did the care provided meet your needs?
    If no care was provided, did you experience a lack of care at home?

Additional remarks

42. Self-management

Patiënt activatie meetinstrument (PAM)

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think others want you to say. If the statement does not apply to you circle N/A.

1. When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2. Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3. I am confident I can help prevent or reduce problems associated with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4. I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

6. I am confident that I can tell a doctor concerns I have even when he or she does not ask	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7. I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8. I understand my health problems and what causes them	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9. I know what treatments are available for my health problems	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10. I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
11. I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
12. I am confident I can figure out solutions when new problems arise with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
13. I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

Appendix 7 Handout community nurses questionnaires

Introduction
By means of an evaluation study, the effects of the care pathway for the frail elderly with the Transitional Care Bridge will become measurable by comparing the situation without the TCB with the situation after the implementation of the TCB. The data collection of the group without the programme was already carried out last year. In both groups we follow 50 patients during 3 months.

The research
During the research, we look at the (informal) care use of the elderly, self-perceived health, quality of life and self-reliance. The research consists of several parts.

- A questionnaire during hospitalisation (or at home within 48 hours)
- A self-sufficiency matrix that is completed within 48 hours by the community nurse
- A questionnaire after 1 month and after 3 months, which is completed by the patient, if necessary with the help of the community nurse
- A self-sufficiency matrix that is completed by the community nurse after 1 and 3 months

Role of the CN in the study
When visiting the hospital, the CN receives an envelope with all the research papers for the entire period of 3 months. The CN asks during the first visit at home whether the patient still wants to participate. The questionnaire is filled out, including the Patient Activation Measure. The self-sufficiency-matrix is also completed during the first home visit. Both the questionnaire and the self-sufficiency matrix are also administered after 1 and 3 months. The research papers can be returned to the researcher via the enclosed return envelopes.

Guide during the study

- If the survey was completed together with the informal carer, please state this.
- Be objective when helping the patient filling out the questionnaire by not influencing the patient's answer, but repeat the question if necessary.
- Do not answer on behalf of the patient. If the patient is unable to answer leave the answer blank.
- Issues that the patient 'seems to mention' during filling out the questionnaire can be very relevant to the study. Therefore ask the patient to write these in the free space or write these down on behalf of the patient.
- If the patient indicates that he/she does not (any longer) wish to participate in the study, acknowledge this. This is the patient's right.
- Thank the patient for participating in the study.

PAM
Since we will be supporting the completion of the questionnaires with several persons, it is wise to work with a common language and level of explanation. If the items of the PAM are too difficult to answer provide the patient with the explanations below.

We could explain the 5 different response categories as follows:
You can disagree in two ways: Simply: I disagree. In the questionnaire this is called: disagree
Or even stronger: I think that is complete nonsense, how can you think of it, ridiculous idea. In the questionnaire this is called: strongly disagree.
And vice versa: You just agree with something. In the questionnaire this is called: agree
Or even stronger: That is rather obvious, of course, that goes without saying. In the questionnaire this is called: completely agree.

Question 1: **Ultimately, I am responsible for my health.**
Explanation: If I do not pay attention to my health, then it is also my own fault if I become ill. If I don't feel well and I don't get the doctor to come, it's also my own fault if it gets worse. If I don't do what the doctor says, it's also my own fault if I keep getting worse. My health is just like my bicycle or moped; If I don't look after it, it's my own fault if it starts showing flaws.

Question 2: **Taking an active role in caring for my health has the most impact on my health.**
Explanation: What applies to your home also applies to your health. If you take good care of it, it will last the longest. If you take good care of your health every day, you will stay healthy longer. You are the boss of your own health, so you should also actively interfere with it.

Question 3: **I am confident that I can contribute to preventing or reducing problems with my health.**
Explanation: You believe that you are largely in control of your health. You believe that you can do a lot yourself to prevent problems with your health. You are able to manage your own health problems. You believe that you can do a lot yourself to ensure that your health does not deteriorate.

Question 4: **I know what each of my prescription medications does.**
Explanation: You know what your meds are for. You know what your medicines are for. You know what happens when you don't take your meds.

Question 5: **I am confident that I can judge whether I should go to the doctor or whether I can handle a health problem myself.**
Explanation: If something is wrong with you, you know whether you should go to the doctor or whether you can solve it yourself. If you don't feel well, you know whether you can solve it yourself or whether you have to go to the doctor. They don't have to tell you to go to the doctor, that's up to you.

Question 6: **I feel confident in telling my doctor my concerns, even if he/she doesn't ask.**
Explanation: When you're at the doctor's, don't hesitate to tell everything, even spontaneously if he doesn't ask. You are used to telling the doctor everything, you keep nothing secret about your health. At the doctor you tell everything, you don't hold anything back. At the doctor you have no problem telling everything.

Question 7: **I am confident that I can manage medical treatments that I have to do at home.**

Explanation: If the doctor tells me to do certain things at home, for example exercise, take medication, clean and bandage a wound, eat differently, etc., then I have no problem with that. If the doctor tells me to do certain things at home myself, then I know that I can manage it. I still feel quite independent, so if the doctor makes me do certain things at home, that's no problem for me.

Question 8: **I understand my health problems and their causes.**
Explanation: I know what's wrong with me and why. I know why I am (was) in the hospital and why. I'm not a doctor, but I really understand what I have and how got it.

Question 9: **I know what treatments there are for my health problems.**

Explanation: I know what needs to be done to me to get rid of my health problems. I do know what it takes to get over it. I know what awaits me to get my health back in order.

Question10: **I have been able to maintain changes in my lifestyle such as exercise and healthy eating.**
Explanation: I have followed the doctor's order to do some things differently (e.g. eat, exercise) to this day. The doctor told me to start living differently, and I totally succeeded.

Question 11: **I know how to prevent health problems.**
Explanation: I am well aware of the things I should and should not do in order not to get into trouble with my health. I do know what I have to do and not do to stay healthy as long as possible.

Question 12: **I am confident that I can come up with solutions for new problems with my health.**
Explanation: If I'm not well again, I think I know what I have to do and not, to get back on track or to make sure it doesn't get worse. If I have some problems again, I think I can figure out what I need to do to ensure that it is resolved. If I get a problem with my health again, I think I know what I should do and not do to prevent it from getting worse.

Question 13: **I am confident that I can maintain lifestyle changes (such as healthy eating and exercise), even in times of stress.**
Explanation: If the doctor tells me to start living differently (eat, drink, exercise), then I feel strong enough to keep it up through everyting. If the doctor tells me to start living differently (eating, drinking, moving), then nothing will stop me from doing so.

Finally

We would like to thank you in advance for your efforts during this research.

We expect to be able to provide you with feedback on the results in the autumn.

If you have any questions or ambiguities, I would like to hear from you.

Yours sincerely,

Wilma van der Vlegel

Policy advisor on integrated care

Appendix 8 Questionnaire geriatric team ED

TRIAGE GERIATRIC TEAM

Name patient

Explanation:
To gain insight in how you (and your family member) were doing **before your current illness. Please cirkel the box that applies**.

Date: … / … / … Name (of person filling out this form): ………………………….

Relation with patient: ………………………

S1. Are you under regular check-ups in 2 or more of the following specialties: lung / cardiology / internal medicine / neurology?	Yes	No
S2. Do you use 7 or more different medications?	Yes	No
S3. Do you regularly forget taking your medication?	Yes	No
S4. Do you use sedetives or antidepressants?	Yes	No
S5. Do you use on average 3 or more alcohol consumption a day?	Yes	No
S6. Did you lose weight involuntairaly of is your weight to low?	Yes	No
S7. Do you have trouble swallowing and/ or do you have mouth problems?	Yes	No
S8. Do you have pain on a regular basis?	Yes	No
S9. Do you experience dissiness?	Yes	No
S10.Do you have Parkinsons disease?	Yes	No
P11 Do you experience memory problems for some time now?	Yes	No
P12 Did you ever experience sudden confusion ?	Yes	No
P13 During the past month, have you regularly felt sad or anxious?	Yes	No
P14 Have you been less interested in or enjoying things in the past month?	Yes	No
P15 Do you rate your quality of life sufficient?	Yes	No
F16 Are you normally depending on help for you selfcare?	Yes	No
F17 Do you regularly need help with household chores, shopping or cooking?	Yes	No
F18 Do you have trouble walking, with or without a walking aid?	Yes	No
F19 Can you walk independently outside the home (possibly with walking aid)?	Yes	No
F20 Do you have trouble seeing despite using glasses?	Yes	No
F21 Do you have trouble hearing despite using a hearing aid?	Yes	No
F22 Do you suffer from incontinence (urine and / or faeces)?	Yes	No
F22 Do you often have to go to the toilet (also at night)	Yes	No
U23 Do you live independently? (not in a care home or nursing home)	Yes	No
U25 Is the care proved to you inadequate? (home care and / or from your family)	Yes	No
U26 Is this an unplanned readmission within 30 days after discharge?	Yes	No

Instruction nurse: At a positive answer to question **S5; S10; P11; P12; U26** → Digital application geriatric team

Appendix 9a Topic list interviews

Patients

How did the patient experience the hospital-home transition?

How was the patient informed about the programme?

What is the experience with the care provided by the community nurse?

Did this programme meet the needs of the patients?

Health professionals

How did the health professionals experience delivering this programme?

How was the programme delivered?

How was the programme received by the patients?

For which patients did the programme meet the needs of the patients?

For which patients did the programme not meet the needs?

Which facilitators and barriers were encountered in delivery?

Focus group

Are the data from the prospective cohort study and the experiences of the community nurses clear?

What are the different perspectives on these findings?

Which facilitators and barriers in the delivery of the programme are recognised?

What should be alternative courses of action?

Experts

Are the data from the prospective cohort study and the experiences of the community nurses clear?

What is the perspective on these findings?

Which facilitators and barriers in the delivery of the programme are recognised?

What should be alternative courses of action?

Appendix 9b Interview guide nurses and geriatric team hospital

An evaluation of a transitional care programme for older adults in the IJsselland Hospital
Wilma van der Vlegel
6th of September 2017

Overview of interview

Consent will already have been asked by telephone and participants will have received the information letter and the consent form prior to the interview.

Before starting the interview the researcher will check that the person is still willing to participate and gives consent to be audio-recorded. The researcher will check if the participant understands the interview and will answer all questions.

After that the semi-structured interview will start based on the interview guide displayed below. These questions allow the researchers to cover the same topics. The schedule will be used as a guideline, but the sequence of questions can be altered.

The participant is free not to answer a question. If a participant appears reluctant to answer a question he or she will not be pressed to do so.

The person will then be thanked for agreeing to take part in the interview and told that taking part in the interview is valuable for improving healthcare and that the perspective of the participant is important and that they should feel free to be frank about the things they tell us and that we will assure their anonymity and confidentiality.

Broad topics

How did the health professionals experience delivering this programme?

How was the programme delivered?

How was the programme received by the patients?

For which patients did the programme meet the needs of the patients?

For which patients did the programme not meet the needs?

Interview guide

In collaboration with the researchers from the Acedemic Medical Centre in Amsterdam, for this interview guide the Six Senses Framework is chosen as an overarching framework (Nolan, 2006)[3]. This framework addresses (older) patient experiences, as well the experiences of professional caregivers and family.

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[3] Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. (2006). *The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice (GRiP) Report No 2.* Project Report. University of Sheffield. http://shura.shu.ac.uk/280/1/PDF_Senses_Framework_Report.pdf

Introduction

At the beginning of the interview the researcher will explain that she is interested in the experiences of delivering the programme, and remind the participant what the programme is.

Sense of security

1. How did you feel about delivering the programme?
   -what did it mean to you as a nurse/ part of the geriatric team?
   -were you able to deliver the programme like you wanted to? Why?

How did you experience support for your work as a nurse/ part of the geriatric team in the programme?

Sense of continuity

2. How did you experience the transition of care of patients at risk from Emergency department to the ward of the hospital?
3. How did you experience the involvement of the geriatric team?
4. How did you experience the transition of care of patients from hospital to home?

(Relational continuity)

1. How did you experience the collaboration with other care providers? What did they do?
2. How did you experience the combination of care? How did it fit together (collaboration)?

(Management continuity)

3. How did you experience the appointments made with you and the patients in the hospital, and at home?
4. What was your own role in arranging the meetings?
   -What difficulties did you encounter?

(Informational continuity)

5. How did you experience the communication with the care providers in the hospital? And with the CN?
6. Did you receive all relevant information from the GP or CN at admission in hospital?
   -did you experience difficulties in communication or information?

How did you provide all relevant information to the CN (and GP)?

Sense of belonging

7. Did you feel part of a team during delivering the programme? How?
8. Did you form new relationships with other care providers? With whom?

9. Did you feel valued in delivering the programme? By whom?

Sense of achievement (purpose/fulfilment)

10. Did you talk with the patient about goals to reach during recovery?
    -Can you tell me about these goals?
    -How did they feel about these goals? And you?
11. Are there other goals that were achieved by the programme?
12. Did you enjoy the programme? Why?

Which personal goals did you achieve?

Sense of significance

13. How did patients (and family) react on the programme?
14. How did patients (and family) react on your role as a nurse / part of the geriatric team?
15. How do you look back on this programme?
    -did this programme meet your expectations?
    -what could be improved?

Finishing the interview

These questions help to round-off the interview

1. What is the most important thing we should know about your experience of the programme?
2. Would you recommend this programme to older persons after discharge from hospital?
3. What could make the programme better?
4. Is there anything else you would like to tell?

Thank the participant for taking part.

Appendix 9c Interview guide community nurses

An evaluation of a transitional care programme for older adults in the IJsselland Hospital
Wilma van der Vlegel
21th of August 2017

Overview of the interview

Consent will already have been asked by telephone and participants will have received the information letter and the consent form prior to the interview.

Before starting the interview the researcher will check that the person is still willing to participate and gives consent to be audio-recorded. The researcher will check if the participant understands the interview and will answer all questions.

After that the semi-structured interview will start based on the interview guide displayed below. These questions allow the researchers to cover the same topics. The schedule will be used as a guideline, but the sequence of questions can be altered.

The participant is free not to answer a question. If a participant appears reluctant to answer a question he or she will not be pressed to do so.

The person will then be thanked for agreeing to take part in the interview and told that taking part in the interview is valuable for improving healthcare and that the perspective of the participant is important and that they should feel free to be frank about the things they tell us and that we will assure their anonymity and confidentiality.

Broad topics

How did the health professionals experience delivering this programme?

How was the programme delivered?

How was the programme received by the patients?

For which patients did the programme meet the needs of the patients?

For which patients did the programme not meet the needs?

Which facilitators and barriers were encountered in delivery?

Interview guide

In collaboration with the researchers from the Acedemic Medical Centre in Amsterdam, for this interview guide the Six Senses Framework is chosen as an overarching framework (Nolan, 2006)[4]. This framework addresses (older) patient experiences, as well the experiences of professional caregivers and family.

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[4] Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. (2006). *The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice (GRiP) Report No 2.* Project Report. University of Sheffield. http://shura.shu.ac.uk/280/1/PDF_Senses_Framework_Report.pdf

Introduction

At the beginning of the interview the researcher will explain that she is interested in the experiences of delivering the programme, and remind the participant what the programme is.

Sense of security

5. How did you feel about delivering the programme?
   -what did it mean to you as a Community nurse?
   -were you able to deliver the programme like you wanted to? Why?

How did you experience support for your work as a CN in the programme?

Sense of continuity

6. How did you experience the transition of care of patients from hospital to home?
7. How did you experience the transition of care after finishing the programme?

(Relational continuity)

16. Which other care providers were involved?
17. How did you experience the collaboration with other care providers? What did they do?
18. How did you experience the combination of care? How did it fit together (collaboration)?

(Management continuity)

19. How did you experience the appointments made with you and the patients in the hospital, and at home?
20. What was your own role in arranging the meetings?
    -What difficulties did you encounter?

(Informational continuity)

21. How did you experience the communication with the care providers in the hospital? And with the care providers at home?
22. Did you receive all relevant information from the hospital?
    -did you experience difficulties in communication or information?

Sense of belonging

23. Did you feel part of a team during delivering the programme?
24. Did you form new relationships with other care providers?
25. Did you feel valued in delivering the programme? By whom?

Sense of achievement (purpose/fulfilment)

26. Did you talk with the patient about goals to reach during recovery?
    -Can you tell me about these goals?
    -How did they feel about these goals? And you?
27. Are you content about the goals achieved by patients?
28. Are there other goals that were achieved by the programme?
29. Did you enjoy the programme? Why?
30. Which personal goals did you achieve?

Sense of significance

31. How did patients (and family) react on the programme?
32. How did patients (and family) react on your role as a CN?
33. How do you look back on this programme?
    -did this programme meet your expectations?
    -what could be improved?

Finishing the interview

These questions help to round-off the interview

1. What is the most important thing we should know about your experience of the programme?
2. Would you recommend this programme to older persons after discharge from hospital?
3. What could make the programme better?
4. Is there anything else you would like to tell?

Thank the participant for taking part.

Appendix 9d Interview guide patients

An evaluation of a transitional care programme for older adults in the IJsselland Hospital
Wilma van der Vlegel
7th of August 2017

Overview of the interview

Consent will already have been asked by telephone and participants will have received the information letter and the consent form prior to the interview.

Before starting the interview the researcher will check that the person is still willing to participate and gives consent to be audio-recorded. The researcher will check if the participant understands the interview and will answer all questions.

After that the semi-structured interview will start based on the interview guide displayed below. These questions allow the researchers to cover the same topics. The schedule will be used as a guideline, but the sequence of questions can be altered.

Because all participants are older adult the researcher will terminate the interview if a participant becomes too tired. If the participant wishes to continue later, either face to face or over the phone, this will be arranged by the researcher.

The participant is free not to answer a question. If a participant appears reluctant to answer a question he or she will not be pressed to do so.

The person will then be thanked for agreeing to take part in the interview and told that taking part in the interview is valuable for improving healthcare and that the perspective of the participant is important and that they should feel free to be frank about the things they tell us and that we will assure their anonymity and confidentiality.

Broad topics

How did the patient experience the hospital-home transition?
How was the patient informed about the programme?
What is the experience with the care provided by the community nurse?
Did this programme meet the needs of the patients?

Interview guide

In collaboration with the researchers from the Acedemic Medical Centre in Amsterdam, for this interview guide the Six Senses Framework is chosen as an overarching framework (Nolan, 2006)[5]. This framework addresses (older) patient experiences, as well as continuity and coordination of care.

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[5] Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. (2006). *The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice (GRiP) Report No 2.* Project Report. University of Sheffield. http://shura.shu.ac.uk/280/1/PDF_Senses_Framework_Report.pdf

Introduction

At the beginning of the interview the researcher will explain that she is interested in the experiences of receiving the programme, and remind the participant what the programme is.
If a participant doesn't remember being part of the programme, the researcher will ask what care was discussed and arranged before discharge.

1. How are you doing since discharge from hospital? What is happened since discharge?
2. How is it to be home again?

Sense of security

3. How did you feel when you came home from hospital?
   -what care did you need?
   -how was this care arranged?
4. What did you expect when you came home from hospital?

Sense of continuity

5. How did you experience the involvement of the Community Nurse (CN) in hospital and at home?
   -what did she/ he do?

(Relational continuity)

6. Which care providers were involved when you came home?
   -how did you experience the combination of their care? How did it fit together (collaboration)?
   -did you feel at ease with these persons? If yes, why, if no, why not?

(Management continuity)

7. How did you experience the role of the Community Nurse (CN) in arranging your care (coordination)?
   -what was your own role?

(Informational continuity)

8. How did you experience the communication between the care providers?
   -did they have all relevant information about you?
   -did you experience difficulties in communication or information? (like telling something twice)

Sense of belonging

9. What things in your social life changed after your admission in hospital? (Like people visiting your or going to visit someone, or going out?
   - how did (or did not) informal caregivers or the CN to support you in this?
   -how did you feel about that?

Sense of achievement (purpose/fulfilment)

10. Did you talk with the CN about goals you wanted to reach during recovery?
    -Can you tell me about these goals?
    -How did you feel about these goals?
11. Are you content about your recovery and the goals you have reached so far?
    -What could have been improved?
12. How did you experience your own role during discharge from hospital and after your discharge?

Sense of significance

13. How do you look back on this programme/ support from the CN?
    -did this programme/ this care meet your expectations?
    -what could be improved?

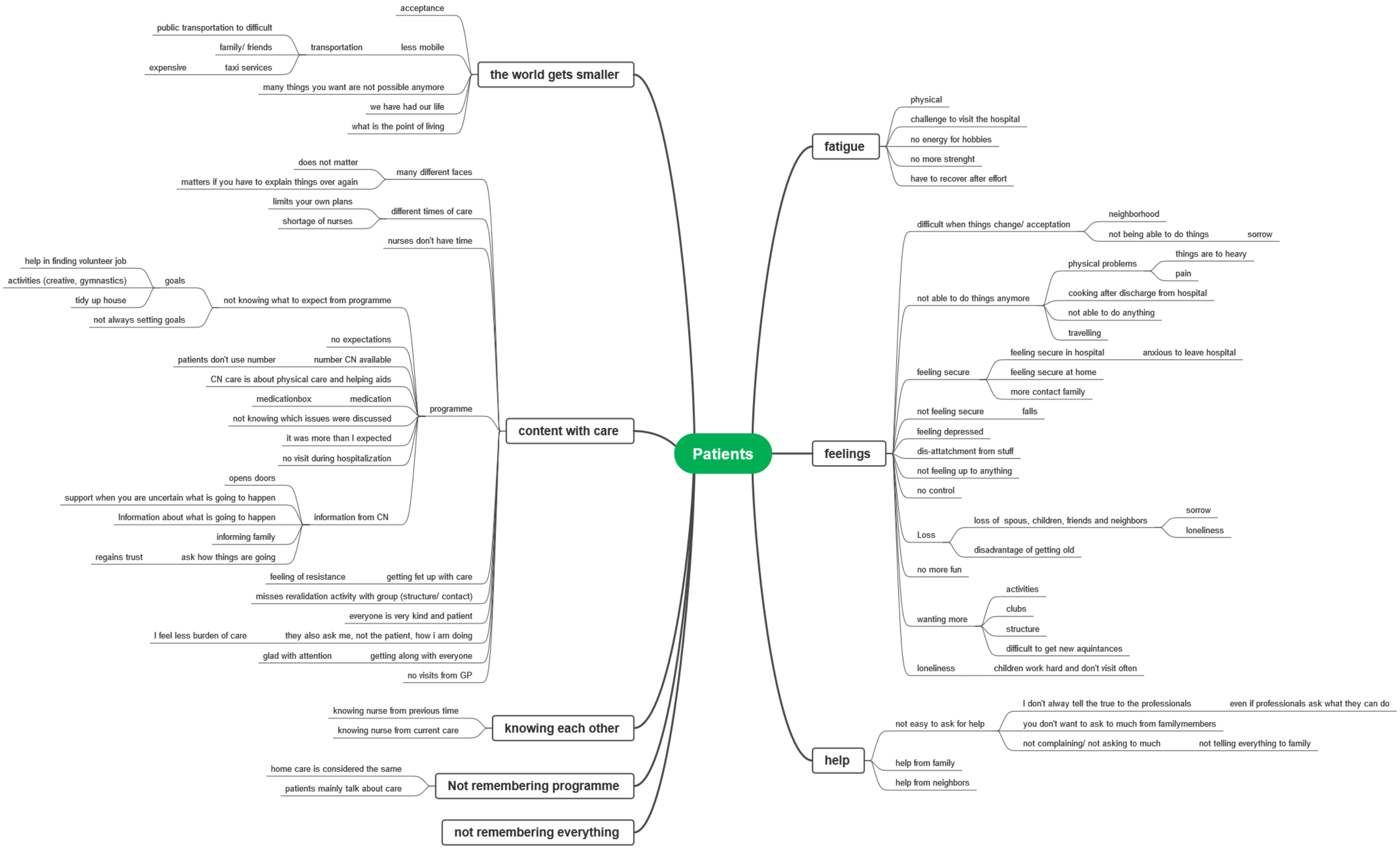
Finishing the interview

These questions help to round-off the interview

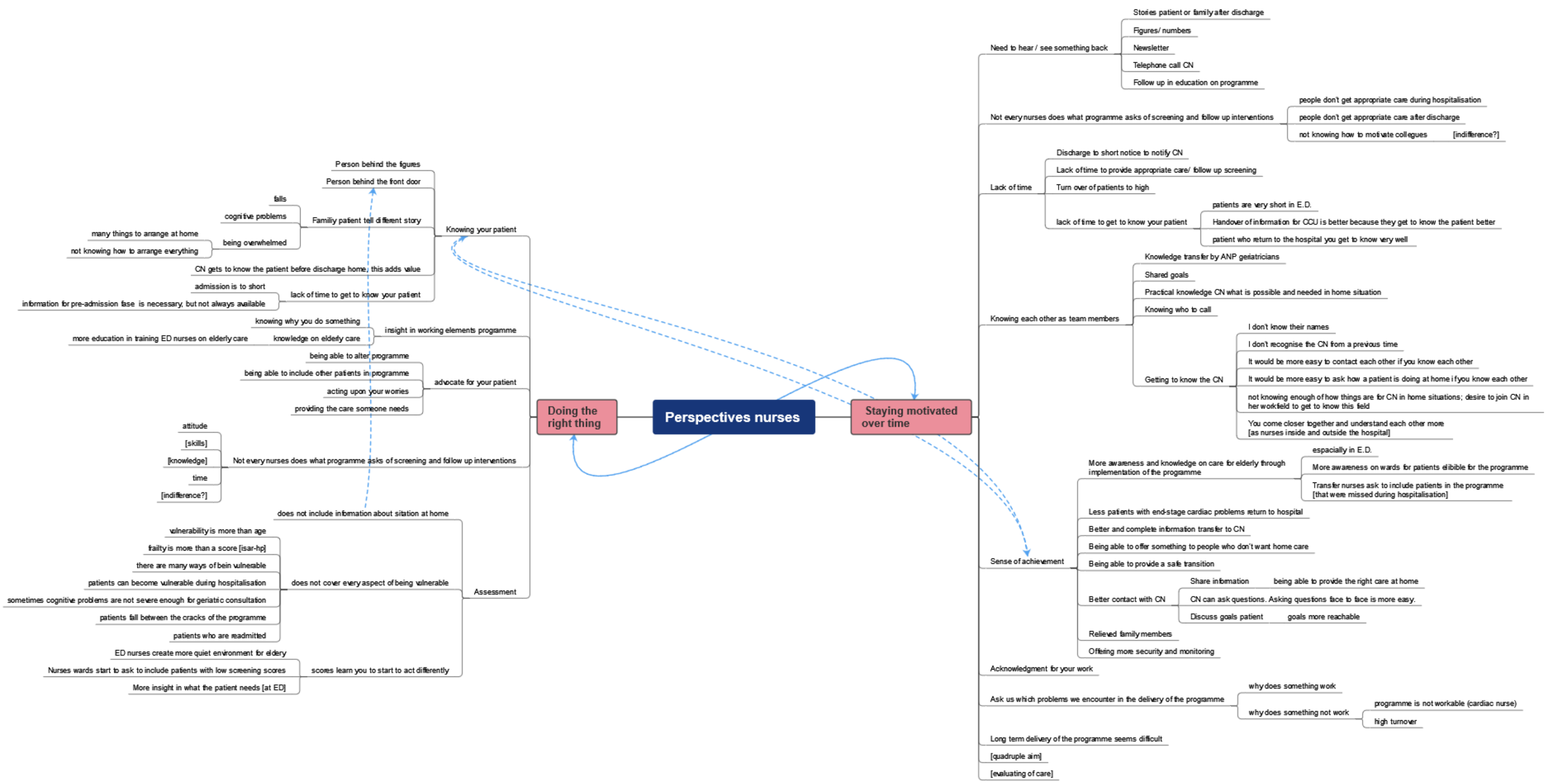
1. What is the most important thing we should know about your experience of the programme?
2. Would you recommend this programme to another older person after discharge from hospital?
3. What could make the programme better?
4. Is there anything else you would like to tell?

Thank the participant for taking part.

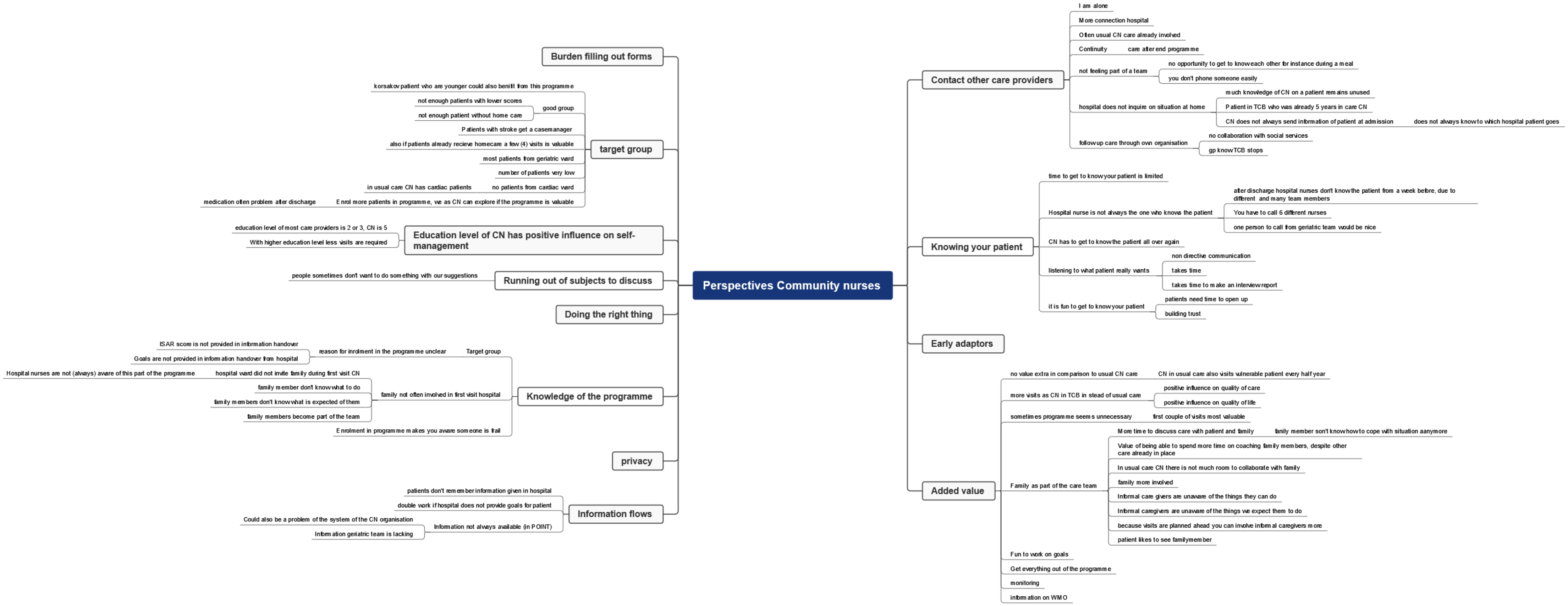
Appendix 10a Mindmap interviews patients



Appendix 10b Mindmap interviews hospital nurses



Appendix 10c Mindmap interviews community nurses



- **Perspectives Community nurses**
  - **Burden filling out forms**
  - **target group**
    - korsakov patient who are younger could also benifit from this programme
    - good group
      - not enough patients with lower scores
      - not enough patient without home care
    - Patients with stroke get a casemanager
    - also if patients already recieve homecare a few (4) visits is valuable
    - most patients from geriatric ward
    - number of patients very low
    - no patients from cardiac ward
      - in usual care CN has cardiac patients
    - Enrol more patients in programme, we as CN can explore if the programme is valuable
      - medication often problem after discharge
  - **Education level of CN has positive influence on self-management**
    - education level of most care providers is 2 or 3, CN is 5
    - With higher education level less visits are required
  - **Running out of subjects to discuss**
    - people sometimes don't want to do something with our suggestions
  - **Doing the right thing**
  - **Knowledge of the programme**
    - Target group
      - reason for inrolment in the programme unclear
        - ISAR score is not provided in information handover
        - Goals are not provided in information handover from hospital
    - family not often involved in first visit hospital
      - hospital ward did not invite family during first visit CN
        - Hospital nurses are not (always) aware of this part of the programme
      - family member don't know what to do
      - family members don't know what is expected of them
      - family members become part of the team
    - Enrolment in programme makes you aware someone is frail
  - **privacy**
  - **Information flows**
    - patients don't remember information given in hospital
    - double work if hospital does not provide goals for patient
    - Information not always available (in POINT)
      - Could also be a problem of the system of the CN organisation
      - Information geriatric team is lacking
  - **Contact other care providers**
    - I am alone
    - More connection hospital
    - Often usual CN care already involved
    - Continuity
      - care after end programme
    - not feeling part of a team
      - no opportunity to get to know each other for instance during a meal
      - you don't phone someone easily
    - hospital does not inquire on situation at home
      - much knowledge of CN on a patient remains unused
      - Patient in TCB who was already 5 years in care CN
      - CN does not always send information of patient at admission
        - does not always know to which hospital patient goes
    - followup care through own organisation
      - no collaboration with social services
      - gp know TCB stops
  - **Knowing your patient**
    - time to get to know your patient is limited
    - Hospital nurse is not always the one who knows the patient
      - after discharge hospital nurses don't know the patient from a week before, due to different and many team members
      - You have to call 6 different nurses
      - one person to call from geriatric team would be nice
    - CN has to get to know the patient all over again
    - listening to what patient really wants
      - non directive communication
      - takes time
      - takes time to make an interview report
    - it is fun to get to know your patient
      - patients need time to open up
      - building trust
  - **Early adaptors**
  - **Added value**
    - no value extra in comparison to usual CN care
      - CN in usual care also visits vulnerable patient every half year
    - more visits as CN in TCB in stead of usual care
      - positive influence on quality of care
      - positive influence on quality of life
    - sometimes programme seems unnecessary
      - first couple of visits most valuable
    - Family as part of the care team
      - More time to discuss care with patient and family
        - fanily member son't know how to cope with situation aanymore
      - Value of being able to spend more time on coaching family members, despite other care already in place
      - In usual care CN there is not much room to collaborate with family
      - family more involved
      - Informal care givers are unaware of the things they can do
      - Informal caregivers are unaware of the things we expect them to do
      - because visits are planned ahead you can involve informal caregivers more
      - patient likes to see familymember
    - Fun to work on goals
    - Get everything out of the programme
    - monitoring
    - information on WMO

Appendix 10d Mindmap focus groups