Building bridges from different settings to a common ground
Strengthening transitions for older patients with multiple chronic conditions

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INTRODUCTION
The population of older patients with multiple chronic conditions is increasing worldwide and the patients’ care transitions between hospital and home is often complicated by multiple contacts to the healthcare system. Transitional care nurses are employed in the Region of Zealand, Denmark, to ensure continuity in the older patients’ transitions and to reduce adverse events and re-admissions. However, the specific tasks and responsibilities of the transitional care nurses’ role is left undescribed, leaving the transitional care nurses with unprecise directions to perform their work.

AIM
The aim of this study was to explore and describe the transitional care nurses’ practices related to transitions between hospital and home of older patients with multiple chronic conditions, to gain insight into their experiences of their role and tasks, and how it could be strengthened.

METHODS
A qualitative constructivist design was used. Thirteen transitional care nurses employed in hospital and municipality settings participated in focused participant observations (n=12) and/or in two group interviews (n=5) in February 2021. Data were analysed using thematic analysis as described by Braun and Clarke.

BUILDING BRIDGES FROM DIFFERENT SETTINGS TO A COMMON GROUND

Practice depends on the setting
Employment settings determine daily practice
Securing transitional trajectories as a common goal

The transitional care nurses were employed in different positions and settings in hospital or municipality care. This entailed different responsibilities and work areas, and created differences in the transitional care nurses’ role, although they shared a common goal for transitional care.

Building external and internal bridges
External collaboration
Internal coordination

The transitional care nurses’ worked to improve patient transitions between hospital and home (external collaboration), as well as cooperating with other health professionals within their organizations (internal coordination).

Towards a common ground
Common prerequisites and competencies
Being different but similar
Strengthening communication

The transitional care nurses’ had a mutual understanding of how their role could be strengthened by becoming a specialist position employed by experienced nurses and by improving the collaborative communication.

Conclusions
In order for transitional care nurses to maintain and continue their goal of ensuring safe transitions for older patients with multiple chronic conditions, they recommend stronger external collaboration and communication between transitional care nurses working in hospital and municipality settings as well as an internal coordination with other health professionals.

IMPLICATIONS FOR APPLICABILITY
The findings from this study provides knowledge for clinical practice to support considerations of improving older patients’ transitions. Because the transitional care nurses already have positions within both settings, future implementation of recommendations from the transitional care nurses could be applicable for immediate use in clinical practice.