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Hospital discharge planning for older adults based on Afaf Meleis' theory: a theoretical reflection

Planejamento da alta hospitalar de idosos à luz de Afaf Meleis: uma reflexão teórica

Planificación del alta hospitalaria de ancianos a la luz de Afaf Meleis: una reflexión teórica

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ABSTRACT

Objective: to reflect on hospital discharge planning for older adults in light of Afaf Meleis's theory. **Content:** this is a theoretical-reflective study grounded in the Transitions Theory, also involving the authors' critical analysis of the application of this theory to the context of hospital discharge planning for older adults. Regarding the analytical dimensions, it addresses the continuity of care, particularly in the context of the hospital discharge of older adults, highlighting the importance of discharge planning and the role of nurses in this process, drawing on Afaf Meleis's Transitions Theory. **Final Considerations:** the application of the Transitions Theory in this context may contribute to an effective process, ensuring the safe transition and continuity of care, particularly with regard to the hospital discharge of older adults, with the nurse at the center of this process.
Descriptors: Nursing Theory; Health of the Elderly; Patient Discharge.

RESUMO

Objetivo: refletir acerca do planejamento da alta hospitalar de idosos à luz da teoria de Afaf Meleis. **Conteúdo:** trata-se de um estudo teórico-reflexivo, fundamentado na Teoria das Transições, envolvendo também a análise crítica dos autores, acerca da aplicação dessa teoria no contexto do planejamento da alta hospitalar de idosos. Quanto às dimensões analíticas, versa acerca da continuidade do cuidado, sobretudo no contexto da alta hospitalar de idosos, ressaltando a importância do planejamento da alta hospitalar e a atuação do enfermeiro nesse processo, tendo em vista a Teoria das Transições de Afaf Meleis. **Considerações finais:** a aplicação da Teoria das Transições no contexto pode contribuir para que este processo ocorra de forma efetiva, garantindo a transição e continuidade do cuidado de forma segura, sobretudo no que diz respeito à alta hospitalar da pessoa idosa, tendo o enfermeiro no centro desse processo.
Descritores: Teoria de Enfermagem; Saúde do Idoso; Alta do Paciente.

RESUMEN

Objetivo: reflexionar acerca de la planificación del alta hospitalaria de ancianos a la luz de la teoría de Afaf Meleis. **Contenido:** se trata de un estudio teórico-reflexivo, fundamentado en la Teoría de las Transiciones, que también incluye el análisis crítico de los autores acerca de la aplicación de dicha teoría en el contexto de la planificación del alta hospitalaria de ancianos. En cuanto a las dimensiones analíticas, aborda la continuidad del cuidado, especialmente en el contexto del alta hospitalaria de ancianos, destacando la importancia de la planificación del alta hospitalaria y la actuación del enfermero en este proceso, considerando la Teoría de las Transiciones de Afaf Meleis. **Consideraciones finales:** la aplicación de la Teoría de las Transiciones en este contexto puede contribuir a que este proceso ocurra de forma efectiva, garantizando la transición y continuidad del cuidado de manera segura, especialmente en lo que respecta al alta hospitalaria de la persona anciana, teniendo al enfermero en el centro de este proceso.
Descriptores: Teoría de Enfermería; Salud del Anciano; Alta del Paciente.

INTRODUCTION

From the earliest of times, the world has undergone constant transformations driven by a wide range of factors, political, social, economic, and health-related, that have led human beings through successive periods of transition, to which they may or may not successfully adapt[1].

In the case of the aging process, individuals face a range of limitations, physical, psychological, and related to illness, particularly in the context of chronic-degenerative diseases[2]. This stage of life is characterized by intrinsic demands that must be identified, examined, and addressed by qualified professionals[3].

The most recent Demographic Census indicates that the population of older adults residing in Brazil totaled 32,113,490 individuals, representing a 56% increase compared to the 2010 census[4]. The progressive growth of the older adult population calls for a shift in healthcare delivery patterns, highlighting the need for a more targeted approach to the care of this population[1].

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Therefore, health policies aimed at older adult care must account for the diverse demands of this population, as well as the particular characteristics of the healthcare system. The Política Nacional de Saúde da Pessoa Idosa (National Health Policy for Older Persons - PNSPI), for example, aims to ensure access to adequate healthcare services; however, many challenges remain in improving older adult healthcare in the country. One of the primary barriers is the lack of effective transitional care strategies[5].

Transition is a concept common to developmental theories as well as theories of stress and adaptation, encompassing both continuities and discontinuities. The transition experience begins when a change is anticipated, and the processes involved are numerous[1]. In the inpatient context, for example, and even after hospital discharge, older adults are particularly vulnerable to risks arising from comorbidities, possible frailties resulting from the hospitalization period, or from the aging process itself[6].

To this end, it is the nurse's role to assist patients and their families in coping with the various changes they face, which may require adaptation to the demands of long-term care[1]. Hospital discharge is one of the processes in which the nurse plays a particularly prominent role, acting as a facilitator of the hospital-to-home transition.

It is important to note that when the older adult's level of self-care changes, even without loss of functional capacity, assistance becomes necessary. While the hospital provides a team that delivers appropriate care, returning home involves a period of adjustment to a new routine. Demands may arise ranging from medication management and device care to wound dressing, among others[2]. Although the entire multidisciplinary team is involved in this process, nursing serves as a crucial agent by providing the necessary support, precise guidance, and promotion of autonomy whenever possible.

To this end, nursing professionals must be properly trained to deliver appropriate care to the older adult population, promoting quality of life and improved health outcomes[3]. It is essential to consider hospital discharge as a transition process that affects these individuals and to reflect on how they should be prepared to navigate it.

There is a notable lack of studies addressing the functional capacity of older adults, particularly in the context of the hospital-to-home transition. Research on this topic has the potential to guide health services toward adequate discharge planning, with actions that promote functional capacity and appropriate care for older adults[7].

It is therefore necessary to develop strategies to ensure continuity of care following hospital discharge[8]. The objective of this study is to reflect on hospital discharge planning for older adults in light of Afaf Meleis's theory.

To guide this reflection, the text is organized into the following sections: transition and continuity of care, healthcare networks and transitional care, care planning and discharge planning, and the role of the nurse in care transition and discharge planning, all considered in light of Afaf Meleis's Transitions Theory.

Theoretical framework

Human beings undergo various transition experiences throughout their lives. Particularly in the context of chronic illness and the ongoing pursuit of well-being, a series of transitions occurs that require nursing interventions at different stages[1].

Meleis dedicated her research to studying what occurred when individuals with chronic illnesses failed to achieve healthy transitions, as well as the nursing interventions used to prepare patients for an appropriate transition[1].

The application of the Transitions Theory takes into account the essence of transition and its particularities, which inform the planning and transition process based on the individual characteristics of the patient and their experience of the illness process[10].

Initially, the Theory focused on the interventions carried out; she subsequently began to reflect on the human experience of transitions and how individuals tend to interpret their own experiences. She thus came to conceptualize the transition experience itself as a theoretical construct, emphasizing that transition involves transformations of identity, roles, and behavioral patterns alike. Certain concepts were then defined, including: healthy transitions, unhealthy transitions, role insufficiency, and role supplementation. Healthy transitions are associated with the positive acquisition of new roles without the process becoming problematic. In the case of unhealthy transitions, the process unfolds ineffectively, leading to role insufficiency[1].

Role insufficiency refers to the potential difficulties that may arise when individuals are not adequately prepared to navigate the transition, encompassing both knowledge deficits and difficulty in assuming the new

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roles required. Role supplementation, in turn, refers to the therapeutic and preventive interventions designed to prepare individuals for this process[1].

In this context, it is possible to identify the relevance of this theory to the aging process, which is an inherent aspect of life. Over the years, the capacity to adapt to illness or to live autonomously gradually declines as a result of the slow and gradual changes associated with aging[2]. When reflecting on the hospital discharge process involving older adults, it becomes clear that achieving an appropriate hospital-to-home transition presents numerous challenges.

In her theory, Meleis identifies four main categories of transitions: developmental, situational, health-illness, and organizational. Developmental transitions address human development, such as the transformations associated with motherhood, as well as the changes linked to the aging process[1].

Situational transitions apply to geographic relocations, hospital discharge, and transfer to rehabilitation or long-term care facilities for older adults, commonly known as nursing homes. It is essential that patients be prepared for this transition, with particular emphasis on the nurse's role in the process. Situational transitions also encompass processes such as immigration and education, not only discharge and relocation[1].

Health-illness transitions involve aspects related to the illness process, applicable to the context of chronic diseases, for example, encompassing self-care, therapeutic interventions, and end-of-life care. Organizational transitions concern personal and professional development at the organizational level, as in the case of nurses, involving adaptation to changes in roles and contexts[1]. A clear connection can therefore be drawn between the aspects associated with the hospital discharge process and planning and the Transitions Theory, particularly in the context of the older adult's hospital discharge.

CONTENT

This study adopts a theoretical-reflective approach grounded in the Transitions Theory, also drawing on the authors' critical analysis. It focuses on hospital discharge planning for older adults and the application of Afaf Meleis's theory in this context, addressing the aspects inherent to preparation for the hospital-to-home transition.

Transition and continuity of care

Meleis presents the transitional care model as the preferred approach for older adult patients and individuals with chronic diseases. The establishment of favorable transition environments is the fundamental requirement of this process[1]. Gheno and other authors corroborate this view, emphasizing that care transition involves the multidisciplinary team's participation not only at the point of discharge but also throughout the hospitalization period, including health education activities[9].

Transitional care interventions are particularly effective for older adults, contributing to reductions in hospital readmissions and emergency department visits, improved medication adherence, enhanced functional capacity, decreased falls, and lower care-related costs[5]. To this end, the need for a discharge plan that addresses the individual's physical capacity has been identified[7].

It is essential to involve patients in decision-making when addressing their needs and to clarify their role in the health/illness process, which promotes a greater understanding of post-discharge care, thereby facilitating the transition[1,10,11].

Particular emphasis should be placed on the early inclusion of family members and/or caregivers in discharge planning and guidance, so as to prepare them to provide post-discharge patient care, enabling a smooth care transition[8,9]. Adequate preparation promotes a more positive perception of the entire process, thereby improving adaptation to the new reality[12].

A rapid systematic review found that the main strategies adopted for transitional care in older adults include telephone contact, home visits, and printed educational materials[5], as well as having a dedicated team to coordinate the discharge process[9].

It should be emphasized that ineffective communication, both within the multidisciplinary team and between the team, the patient, and their family members, constitutes a barrier to care transition[9]. Therefore, to effectively navigate the transition process, a qualified professional must provide appropriate guidance and follow up with the patient throughout, building confidence in the therapeutic treatment and supporting the patient in overcoming the challenges associated with self-care management[10].

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The multidisciplinary team plays an important role in empowering both the patient and their family member and/or caregiver by providing guidance during hospitalization and prior to discharge, so as to facilitate the transition process and contribute to self-care, health promotion, and autonomy for both the older adult patient and the family member/caregiver[9,12].

Healthcare networks and transitional care

One of the challenges of care transition is that access to the healthcare network is sometimes hindered, even due to weaknesses in meeting the population's demands, as well as the insufficiency of adequate public policies[9].

Linking the patient to healthcare networks is essential for an effective care transition process[9]. When health services provide effective care for older adults, this strengthens the hospital-to-home transition and positively impacts the satisfaction of family members and caregivers[12].

The organization of the Redes de Atenção à Saúde (Healthcare Networks - RAS) enables the implementation of strategies that make transitional care effective[5]. Appropriate referrals by the discharge management team to primary healthcare services, as well as patient monitoring carried out by home care services (Serviços de Atenção Domiciliar - SADs), can make this process possible[9].

To this end, several actions are suggested, including: improving cooperation among the health services that make up the RAS and provide care to older adults; the collaborative development of an individualized therapeutic plan during hospitalization and following discharge; shared family responsibility in older adult care; and training for transitional care provided by the multidisciplinary team[5].

It is therefore necessary to develop strategies for improving care transition, emphasizing the importance of communication and care planning, as well as better integration between the hospital and other points within the healthcare network, thereby ensuring continuity of care[8,9].

Care planning and discharge planning

Early preparation for a change facilitates the transition experience; conversely, the absence of such preparation can impair the process. Understanding what to expect during the transition and what strategies can be used is essential[6].

Care planning and hospital discharge planning must begin during hospitalization to ensure an effective hospital-to-home transition. This approach can reduce readmissions due to clinical deterioration and provide greater safety for those involved in the care provided in this context[1,6]. However, the development of an individualized care plan that ensures continuity of care is not yet a widespread reality in Brazil[11].

The need to develop strategies for effective hospital discharge, based on a protocol or systematized instrument for constructing an individualized discharge plan, has been identified[8]. Appropriate discharge planning and adequate preparation for health self-management promote a better care transition for the patient[11].

The multidisciplinary team must involve the patient and their family members or caregivers in developing the discharge plan, addressing the particularities of the hospital-to-home transition[8]. It is equally important for nursing to follow up on planning outcomes after discharge, maintain adequate communication with primary care, and coordinate a multidisciplinary team[6].

Role of the nurse in care transition and discharge planning

Care transition requires thoughtful planning: the facilitating and inhibiting conditions of this process must be understood, and the feedback patterns of older adult patients and their family members/caregivers must be assessed, so as to determine nursing responsibilities and the therapeutic interventions to be implemented in the process[12].

According to Meleis, during the transition period, the nurse is the professional best positioned to identify the patient's psychosocial demands and provide the essential interventions based on the patient's needs arising from role transition[1].

It is essential that both care planning and care transition occur collaboratively, involving the entire multidisciplinary team, the patient, and their family members, promoting adequate adaptation to the process[3,6].

Nursing, therefore, plays an indispensable role in hospital discharge planning, as well as in care management and continuity, contributing to patient safety, particularly in the case of older adults, and to the safety of the caregivers and family members involved in the care process[3,6].

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Health and illness processes, situational changes, and developmental phases all entail significant role changes[1]. As an active agent in this process, the nurse is directly involved in role change processes, including the loss or acquisition of new roles, directing strategies to support patient self-management based on the assessment of their actual needs[1,10].

After identifying the elements present in the transition process, the nurse can develop a therapeutic plan that encompasses the patient's individual experiences and the capabilities of family members, combining the resources available in the community environment, with the aim of achieving an appropriate transition and quality of life[12].

It is in this context that what Meleis calls role transition comes into play, requiring the individual to absorb new knowledge and modify their behavior, while also reshaping their understanding of their own role. Communication is the tool that enables the incorporation of strategies and supports role supplementation[1].

Guidance is provided continuously before the role transition occurs and at the onset of the transition process[1]. The individual then becomes capable of assuming the care that was previously provided by a professional, prepared to navigate the transition process and carry out self-care management[10].

Study limitations

This study has limitations in that it addressed only hospital discharge planning for older adults. It is important to recognize that the topic of hospital discharge planning encompasses a wide range of contexts and patient profiles. Furthermore, the limited number of studies addressing this topic was also a constraining factor.

FINAL CONSIDERATIONS

This reflection highlights how applying Afaf Meleis's Transitions Theory to hospital discharge planning can contribute to an effective process, ensuring a smooth transition and continuity of care—particularly for elderly patients. It offers a framework for developing protocols or guidelines to operationalize this process and foster appropriate care practices.

Thus, this reflection holds implications for the healthcare and nursing fields by addressing key aspects of hospital discharge, especially regarding effective and appropriate planning. Furthermore, it can contribute to providing adequate care for the elderly and promoting continuity of care, utilizing the Transitions Theory as a foundational basis for the process.

While the entire multidisciplinary team should be involved in this planning, nurses play a pivotal role, as it is essential to prepare the patient as well as the family members and/or caregivers involved. Therefore, this study can help strengthen the nurse's role as an active agent in discharge planning and promote continuity of care for the elderly during the transition from hospital to home.

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Authors contributions

Conceptualization, E.S.V.C. e Z.R.S.; methodology, E.S.V.C.; validation, E.S.V.C. e Z.R.S.; formal analysis, E.S.V.C.; investigation, E.S.V.C.; resources, E.S.V.C.; manuscript writing, E.S.V.C.; review and editing, E.S.V.C.; visualization, Z.R.S.; supervision, Z.R.S.; project administration, Z.R.S. All authors read and agreed with the published version of the manuscript.

Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "*Hospital discharge planning for older adults based on Afaf Meleis' theory: a theoretical reflection*".