TRANSITIONAL CARE IN SCHIZOPHRENIA: A CONCEPT ANALYSIS

Sri Wahyuni
Department of Mental Health and Community Health Nursing
School of Nursing, Riau University
Pekanbaru-Indonesia
Email: uyun_wahyuni12@yahoo.com

Abstract

Little is known about the transitional care for patients with mental illness, particularly schizophrenia. The purpose of this paper is to illustrate the concept of transitional care which is applied to schizophrenia patients. Walker and Avant's concept analysis were used to analyze the concept of transition care in schizophrenia patient. Data were collected from a review of Web of Knowledge, Pub Med, CINAHL, Cohcrane, and Google scholar databases using "transitional care", "transitional care in schizophrenia", "transitional care in mental illness" , and "transitional care in psychiatric" as keywords. Articles written in the English language, with an abstract, published between 1998 and 2012 were considered. The search yielded 8 articles. Data were synthesized to identify attributes, antecedents and consequences of transitional care. The transitional care described as a smooth process moving patient from one level of care to another and involved the health care providers in each of the levels. The defining attributes of transitional care separate in period in hospital and post hospitalization. The primary antecedent of transitional care is readmission, which is caused by psychotic symptom and inadequate planning of the patient's discharge. Consequences of transitional care include decreasing the length of stay and reducing the readmission, improving quality of care and satisfaction with health care providers. The empirical referent of the concept is the Care Transitions Measure (CTM). Providing explanation about transitional care in schizophrenia will allow completion in the delivery of transitional care for schizophrenia people in hospital. These findings are useful for nursing intervention program, research, and making policy.

Keywords: concept analysis; transitional care; schizophrenia

BACKGROUND

Schizophrenia is one of a chronic and severe mental disorder that will likely get the hospitalized because of their psychotic symptoms. Patrick, Smith, Schleifer, Morris & McLennon (2006) conveys that various symptoms and inability to join the community made the patient more comfortable living in the hospital. Besides that, the extending of the duration of hospitalization, relapsing for schizophrenia patient impedes the discharge as well. Patients without a job, with severe symptoms, more medication side effects, and a poorer attitude about treatment at the time of discharge were more likely to have a relapse during the year after discharge (Schennach et al., 2012), ancillary factors that continuity of care after discharge (Mgutshini, 2010; Lin, Cheng, Shih, Chu, & Tjung, 2012).

Transitional care have been used and succeed to handle other high risk-population with physical illness for improvement outcomes such as the number of readmission, quality of life, severity of symptoms, and medication adherence (Coleman, Parry, Chalmers, & Min, 2006;

Parrish, O'Malley, Adams, Adams, & Coleman, 2009). The transitional care as a set of design to establish continuity of care and coordination between health provider to transfer patient between different location, or different levels of care within the same location (Parry, Coleman, Smith, Frank, & Kramer, 2003). Nevertheless, it is just a little found about the transitional care for patients with mental illness, particularly schizophrenia (Reynolds et al., 2003; Forchuk, Reynolds, Sharkey, Martin, & Jensen, 2007; Price, 2007; Rose, Gerson, & Carbo, 2007; Sarakan, Thapinta, Panuthai, & Kennedy, 2012), but the literature still did not present a definition and structures of concept of transitional care in schizophrenia. There is one literature (Sarakan et al., 2012) that explained about transitional concepts but only discussed about one structure of transitional concept, it is nursing therapeutic, that was used in the practice situation. It is necessary to make it clear because the definition and structures of concept can help nurse and researcher to understand and to develop a guideline about transitional care in schizophrenia.

Based on the articles, it became clear that further delineation of the concept of transitional care in schizophrenia is needed to clarify. What transitional care in schizophrenia refers to and how it differs from transitional care for physical or another mental illness concepts. This analysis of the concept of transitional care is guided by the conceptual framework developed by Walker and Avant (2005).

The purpose of this study is to illustrate the concept of transitional care which is applied to schizophrenia patients.

METHODS

Walker and Avant's (2005) method of concept analysis were used. The key element of this concept analysis consists of attributes, antecedents, empirical referents and consequences. The meaning of transitional care was grounded in the research literature of nursing and health care. Searches were carried out using Web of Knowledge, Pub Med, CINAHL, Cohcrane, Google scholar and reference list of related journal articles with a timeline of 1998 to 2012. All the searches were limited to English document. The term is used in searching literature such "transitional care", "continuity of care", "transitional care in schizophrenia", "transitional care in mental illness" , and "transitional care in psychiatric". The term "continuity of care" did not proceed further because it term had different meaning and denoted part of transitional care.

RESULTS

Step 1 entails the selection of a concept of interest, and step 2 focuses on determination of the aim of the analysis.

Step 3: Identifying uses of the concept

On this step Walker and Avant's method involved an analysis of the uses of transitional care concepts. Chick and Meleis (1986 as cited in Meleis, 2010) mentioned that transition word came from the Latin verb "transire", meaning to go across. According to Merriam-Webster dictionary (2013) the word "transition" refers to "(1) passage from one state, stage, subject, or place to another; (2) a movement, development, or evolution from one form, stage, or style to another". On this concepts analysis author discuss further about transition care in nursing practice situation in schizophrenia patient.

A literature review showed that the term of "transitional" is used by nursing area in complex medical needs, primarily older patients. From geriatric nursing perspective the term "care transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness (Coleman, 2003). Parry et al. (2003) defined transitional care as "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location".

From all perspectives of transitional care described as a smooth process moving patient from one level of care to another involved the health care providers in each of the level. For schizophrenia patient, the first level might be started at the hospital to the community such as to primary health care and patient's home or the other treatment place in the community.

Step 4: Determining the defining attributes

Walker and Avant (2005) identify defining attribute as a cluster most frequently associated with the concept, which help differentiate the concept from other similar or related to it. The defining attributes of transition in the literature include the period in the hospital/hospitalization, and post hospitalizations or home follow up. Besides that, the nurse's roles as care provider need to be included in each period.

Period in the hospital

Transitional care for patients is started from hospital. Some literature explained to prevent health complication and rehospitalizations of cronically ill,

elderly patients by providing comprehensive discharge planning (Price, 2007; Reynolds et al., 2003; Rose et al., 2007). Coleman et al. (2006) established the transitional care based on 4 pillars, or conceptual domains; and 2 pillars of the task should do in the hospital. There are (1) assistance with medication self management, (2) the note that in a patient-centered form managed by the patient to facilitate cross-site information transfer. Furthermore, in the hospitalization period nurse carry out the assessment of readiness; preparation for transition; role suplementation for family caregiver (Sarakan et al., 2012). Sarakan et al. (2012) illuminated in the hospital care the nurse building the relationship, recording patient health's condition, arranging a home visit and discussing with the caregiver how to treat the patient.

All of the nurse interventions above supported the transitional care in the hospital. The nurse in hospital (1) conduct a comprehensive assessment of the patient's health status, behaviors, community support, and goal (2) develops an individual plan of care consistent with the guidelines included competence in medication review and reconciliation, experience in helping patients communicate their needs to different health care professionals (3) conduct daily patients visits, focused on optimizing patient health at discharge.

Period in Post hospitalization

To provide continuity across settings and to ensure that the patient's needs in transitional care, home visits and telephone is the key of attribute (Sarakan et al., 2012). Timely follow-up with primary or specialty care, and a list of "red flags" indicative of a worsening condition and instructions on how to respond to them are the other from 4 pillars that nurse should provide in post hospitalization (Coleman et al., 2006; Parry, Min, Chugh, Chalmers, & Coleman, 2009). A main goal of the home visit was to adjust all of the patient's medication regimens (eg, prehospitalization and posthospitalization medications, over-the counter medications, and medications prescribed to someone else that the patient was taking) using the Medication Discrepancy Tool. After doing home visit, maintenance patient through the telephone is needed to set whether the patient received appropriate services, and the progress of the patient after home visit (Parry et al., 2003; Coleman et al., 2006).

Nurse job along home visit and phone contacts are indentifying changes patient's health; managing and/or preventing health problems,including making any adjusments in therapy as

physician's collaboration; and accompanying the patient to the next care level after discharge to ensure effective communication.

Step 5: Constructing a model case

The following is an exemplar of transitional care in schizophrenia because it demonstrates all the defining attributes of the concept.

Mr. W (33 years-old) was admitted to a rehabilitation care ward after getting the treatment at psychiatric intensive care unit. The admitting nurse was expecting Mr. W when he arrived and escorted him to private room. The primary nurse had received a report from the room prior to Mr. W's arrival and was aware of the medical circumstances surrounding his need to move for rehabilitation room. During the initial assessment, the nurse inquired about Mr. W's awareness of his diagnosis, medication, hallucination condition, socialization with the health worker and other patients, ability to cope the hallucination and doing activity daily living. Mr. W explained that he was good in handling the hallucination and mentioned the step to reduce the hearing voices of the hallucination, enjoyed talking with nurses and patients; however, he expressed low self esteem with all the condition after he realized that he was schizophrenia. He is ashamed to go back to home and don't want to meet his neighborhood. The nurse sat by his bedside and listened while Mr. Trent described the feeling. The nurse encouraged him to participate in Cognitive Behavior Therapy group.

After initial assessment, the primary nurse calls the assistant nurse who is responsible with the group activity and talk about the nursing plan for Mr. W. Furthermore, the primary nurse discuss to the physician about Mr. W's medicine and planning the discharge. The primary nurse tries to contact the family of patient to make appointment about the family therapy and make sure the primary care unit in their community. The nurse introduces Miss. U as the community mental health nurse (CMHN) which stays in the community to handling the patient as long as the transition cares to establish the rapport. The next two days, Mr. W come back to his home and doing activity daily living as usual. After 48 hours after discharge, Miss. U visit Mr. W's home to reconcile all of the Mr. W medication regimens. Furthermore, during a 28 day post hospitalization Miss. U continues of care by telephoning 3 times. Miss U does not call the Mr. W after feeling certain that he was good in his self management toward his health.

This case illustrates all the attributes of transitional care in schizophrenia at

inpatient room from admission until stay at their home. Moreover, in this case describe that communication among the nurse and between nurses with other health provider running well. In every step of the phase nurse had a clear roles and being therapeutic for the patients.

Step 6: Constructing borderline and contrary cases

The borderline case is an example containing most, but not all, of the defining attributes. The contrary case is an example identifying none of the defining attributes of the present concept (Walker and Avant, 2005)

Borderline case

Mrs. N, 53 years-old, schizophrenia, being inpatient since three weeks ago. She is prior to patient's discharge from an area hospital. Informational letter sent to the hospital discharge planner requesting a conference prior to the patient's discharge. The patient was discharged from hospital before the nurse arranges the meeting. Nurse Family was explained to bring patient to a primary health center upper on for patient. Patient cognitively intact but exhibits poor judgment and refuses higher level of care. After Mrs. N come back to her home, the community mental health nurse coming once to make sure about the medication.

This case describes that patient did not ready yet to go back to the community, because the psychotic symptom still severe. In other hand, the family did not involve directly in the treatment, only should find the next level for treatment.

Contrary case

The following case does not reflect transitional care because it contains none of the defining attributes of the concept.

Mr. L, 2 months ago had severe mental illness, and right now he can control the symptom of the hallucination. He can do activity daily living and go to the rehabilitation center in the community to follow some group therapy. He never knows when he would come back to his home. As long as in hospital, primary nurse only asked about her progress through the nurse assistance that treated him every day. Sometimes Mr. L asked about the date that he would go out from hospital, the nurse answered that he have to wait his family visiting in hospital and after his physician give some judgment for him.

This instance showed that the transitional care of patient did not clear; poor communication nurse-patient. The case described that the conversation between the nurses with the physician did

not clear and indirect, so that the nurse did not prepare transitional care for patient.

Step 7: Identifying antecedents and consequences

Walker and Avant (2005) described antecedents as an event that occurs prior to the concept. Without the antecedents, nurses will not be able to provide transitional care effectively. The main antecedent in transitional care in schizophrenia is readmission. Transitional care approaches have been shown to reduce hospital admission. The most frequent reasons given for readmission were ongoing the psychotic symptom, advanced age, higher rating of one's own capabilities in daily living, medication adjustment, behavior stabilization, and discharge planning (Ishikawa & Okamura, 2008; Kelly, Watson, Raboud, & Bilsker, 1998). Furthermore, inadequate patient assessment by health professionals resulting in problems such as poor knowledge of the patient's social circumstances, poor organization of post-discharge health and social care; and poor communication between the hospital care giver, follow-up care and community service providers due to an inadequate planning of the patient's discharge (Watts & Gardner, 2007; Martin, et al., 2007).

The consequences are events that occur as a result of the concept (Walker & Avant, 2005). Consequences in transitional care in schizophrenia are decreasing the length of stay and readmission for inpatient care; improved quality of care; and patient' satisfaction with health care providers.

Step 8: Defining empirical referents

Empirical referents are described by Walker and Avant (2005) as groups of actual phenomena that demonstrate the occurrence of the concept. Transitional care is typically measured from the perspective of the patient receiving care. The only currently nationally endorsed measure of transitional care quality is the Care Transitions Measure (CTM), which is a 15-item survey for administration to patients after discharge from the hospital. The measure also exists as a 3-item survey (Coleman, 2003). Coleman and his team developed as an intervention designed to improve patient outcomes during transitions.

CONCLUSION

This article described the concept of transitional care in schizophrenia by presenting the relevant concept, its defining attributes, antecedents, consequences, empirical referent and a model, borderline and contrary case. Providing explication

about transitional care in schizophrenia will allow for completion in the delivery of transitional care in schizophrenia in a mental hospital. By synthesizing the attributes derived from the literature base in transitional care process, a new guideline has been developed. Using the empirical referents to measure the practice of transitional care is the key to validating that transitional care has a positive effect on health outcomes.

The implications of these findings are useful for program development, research and policy making. After developing the model, nurses or the other provider's health care can conduct an intervention program to know effective transitional care for schizophrenia patient.

REFERENCES

Coleman, E. (2003).Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. *Journal of the American Geriatrics Society, 51*(4), 549–555.

Coleman, E. A., Parry, C., Chalmers, S., & Min, S. J. (2006). The care transitions intervention: results of a randomized controlled trial. *Archive Internal Medicine, 166*(17), 1822-1828.

Forchuk, C., Reynolds, W., Sharkey, S., Martin, M. L., & Jensen, E. (2007). Transitional discharge based on therapeutic relationships: state of the art. *Archives of Psychiatric Nursing, 21*(2), 80-86.

Hunter, T., Nelson, J. R., & Birmingham, J. (2013). Preventing Readmissions Through Comprehensive Discharge Planning. *Professional Case Management, 18*(2), 56-63.

Huycke, L., & All, A. C. (2000). Quality in health care and ethical principles. *Journal of Advanced Nursing, 32*, 562-571

Ishikawa, Y., & Okamura, H. (2008). Factors that impede the discharge of long-term schizophrenic inpatients. *Scandinavian Journal of Occupational Therapy, 15*(4), 230-235.

Kelly, A., Watson, D., Raboud, J., & Bilsker, D. (1998). Factors in delays in discharge from acute-care psychiatry. *Canadian Journal of Psychiatry, 43*(5), 496-501.

Lin, J. C., Cheng, J.S, Shih, C.S, Chu, H.C, & Tjung, J.J. (2012). Discharge planning. *International Journal of Gerontology, 5*, 237-240.

Meleis, I, A. (2010). *Transition theory: Middle-range and situation-spesific theories in nursing research and*

practice. New York, NY: Springer Publishing Company, LLC

Merriam-Webster Dictionary. (2013). *Transitional*. Retrieved from http://www.merriam-webster.com/dictionary/transition?show=0&t=1376214871

Mgutshini, T. (2010). Risk factors for psychiatric re-hospitalization: An Exploration. *International Journal of Mental Health Nursing, 19*, 257-267.

Oxford Dictionaries online. *Transitional*. Retrieved July, 18, 2013, from http://oxforddictionaries.com/definition/english/discharge?q=discharge

Parrish, M. M., O'Malley, K., Adams, R. I., Adams, S. R., & Coleman, E. A. (2009). Implementation of the care transitions intervention: sustainability and lessons learned. *Professional Case Management, 14*(6), 282-293.

Parry, C., Coleman, E. A., Smith, J. D., Frank, J., & Kramer, A. M. (2003). The care transitions intervention: a patient-centered approach to ensuring effective transfers between sites of geriatric care. *Home Health Care Service Quarterly, 22*(3), 1-17.

Parry, C., Min, S. J., Chugh, A., Chalmers, S., & Coleman, E. A. (2009). Further application of the care transitions intervention: results of a randomized controlled trial conducted in a fee-for-service setting. *Home Health Care Service Quarterly, 28*(2-3), 84-99.

Patrick, V., Smith, R. C., Schleifer, S. J., Morris, M. E., & McLennon, K. (2006). Facilitating discharge in state psychiatric institutions: a group intervention strategy. *Psychiatric Rehabilitation Journal, 29*(3), 183-188.

Price, L. M. (2007). Transition to Community: a program to help clients with schizophrenia move from inpatient to community care; a pilot study. *Archive Psychiatric Nursing, 21*(6), 336-344.

Reynolds, W., Lauder, W., Sharkey, S., Maciver, S., Veitch, T., & Cameron, D. (2003). The effects of a transitional discharge model for psychiatric patients. *Journal of Psychiatric and Mental Health Nursing, 11*, 82–88.

Rose, L. E., Gerson, L., & Carbo, C. (2007). Transitional care for seriously mentally ill persons: a pilot study. *Archive Psychiatric of Nursing, 21*(6), 297-308.

Sarakan, K., Thapinta, D., Panuthai, S., & Kennedy, M. (2012). Effectiveness

of a transitional care program for persons with schizophrenia. *Chiang May University. Journal of Natural Science, 11*(1), 43-60.

Schennach, R., Obermeier, M., Meyer, S., Jager, M., Schmauss, M., Laux, G., . . . Riedel, M. (2012). Predictors of relapse in the year after hospital discharge among patients with schizophrenia. *Psychiatric Service Journal, 63*(1), 87-90.

Walker, L. O., & Avant, K. C. (2005). *Strategies for theory contruction in nursing* (4th ed). Upper Saddle River, NJ: Prentice Hall.

Watts, R., & Gardner, H. (2005). Nurses' perceptions of discharge planning. *Nursing and Health Sciences,*7, 175–183