

Hypothesis and Idea

Does the liaison Nurse have an Effective Role in Transitional Care Model?

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ABSTRACT:

Nurses play a pivotal role in the care of chronic patients. In consequence, innovations relating to the nursing practice as a liaison nurse and care for chronic patients are being implemented in many countries to produce new forms of health care model. These innovations often aim to break care gap and deliver long term after care for chronic patients. Long term after care means a shift of care givers responsibilities and tasks from hospital to patients home that qualitatively good care is provided by the most appropriate health care provider at the lowest cost level.

Implementing transitional care model show that it is indeed possible to decrease rates of re-hospitalization also duration of hospitalization of chronic patients. Patients and loved ones are better able to manage their care independently and their quality of life will be promoted.

Improved coordination of care leads to better communication and improved satisfaction ratings between patients and healthcare providers. Also improve quality of care and decrease health care costs.

In this paper author try to introduces a new model of nursing care, especially in patients with chronic diseases that will full care gap between hospital and home. Also the author suggests the positive and effective role of the liaison nurse in promote of quality of life of the patients with chronic diseases in this new model of care.

Keywords: Liaison Nurse; Transitional care model; Chronic patients; Long term care; Quality of life.

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1. INTRODUCTION

A growing body of science suggests that patients coping with multiple chronic conditions or complex therapies are particularly vulnerable to breakdowns in care. During the last four to five decades, the leading causes of death have changed from infectious and acute diseases to chronic and degenerative illnesses including cardiovascular diseases and cancer, respiratory diseases and injuries, diabetes and Alzheimer's disease .These conditions

also cause severe disability and is a common factor leading to the need for long-term aftercare(1).

Insufficient communication between providers in health care agencies and patients, inadequate patient education, poor continuity of care, and limited access to health services especially after discharge from the hospitals, are the major factors contributing to negative patient care quality and cost outcomes. Rehospitalization rates for these patients are very high and it is cause of burden cost for patient and hospital. Also, Since the 1960s there has been an

awareness of 'care-gap' when patients are transferred between hospital and home (2).

Today in reviewing of nursing services, we find increasing emphasis on the patient as a person and on hospitalization as only one phase in his total care. An acceptance of this concept extends responsibility for nursing services beyond the hospital in to the home and from the home to the hospital without any break in its continuity .in other words, nurses must deliver health care services, since early hospitalization of the patients and during the hospitalization, also deliver aftercare since discharge of the patients and referring to their homes. In the United Kingdom, attempts to improve continuity of care have included the development of the role of the hospital liaison nurse (3). The RCN (Royal College of Nursing) believes that the advanced nurse practitioner offers a complementary source of care to that offered by physicians and other health care professionals. Advanced nurse practitioners augment the care that a team can deliver (4).

Today, defines care transition as “the Movement of patients from one healthcare provider or setting to another as their condition and care requirements have changed in the course of an acute or chronic liaison nurse (5). According to research done by Forster and et al. (2004), 19 percent of individuals discharged from the hospital experienced at least one adverse event during their first three weeks at home (6). According to Dr. Mary Naylor, Professor in Gerontology and Director of the Center for Health Transitions at the University of Pennsylvania School of Nursing, (2005) “Home healthcare is the most important components of the healthcare industry best positioned to bridge gaps in care between hospitals and home, especially for high risk-groups such as older adults coping with multiple health problems. It is possible to achieve this goal by implementing the transitional care model by community liaison nurse that identifies patients to assist in the transition from hospital to their homes (7).

Regarding to liaison nurse role in a tertiary pediatric ICU, results of the Coffin and et al research (2006), showed: The year of the PICU liaison nurse trial (July 2004—June 2005), 1388 patients were discharged from PICU. Sixty-seven patients had unplanned readmission within 48 h. This readmission rate (4.8%) is lower than the readmission rate (5.4%) during the year prior to the implementation of the PICU liaison nurse. Staff and parents were surveyed at the end of the 12-month trial to evaluate the introduction of the liaison nurse role. The response from the surveys was very positive, 98.5% of staff believed the PICU liaison nurse to be beneficial and to have made a valuable impact on PICU—ward

transfers. Ninety-nine percent of surveyed parents agreed that the liaison nurse role is a good idea (8). Also the results of the research entitled "Impact of an ICU Liaison Nurse Service on major adverse events in patients recently discharged from ICU" done by Endacott and et al (2010),showed : A total of 165 major adverse events were identified in 129 patients. After controlling for all other potential predictors, patients who received the liaison nurse intervention were 1.82 times more likely to be transferred to a higher level of care ($P = 0.028$) and 2.11 times more likely to require a surgical procedure ($P = 0.006$). Surgical patients were 7.20 times as likely to require a surgical procedure ($P < 0.001$).these results support the claim that ICU liaison nurse has an important role in preventing adverse events (9,12).

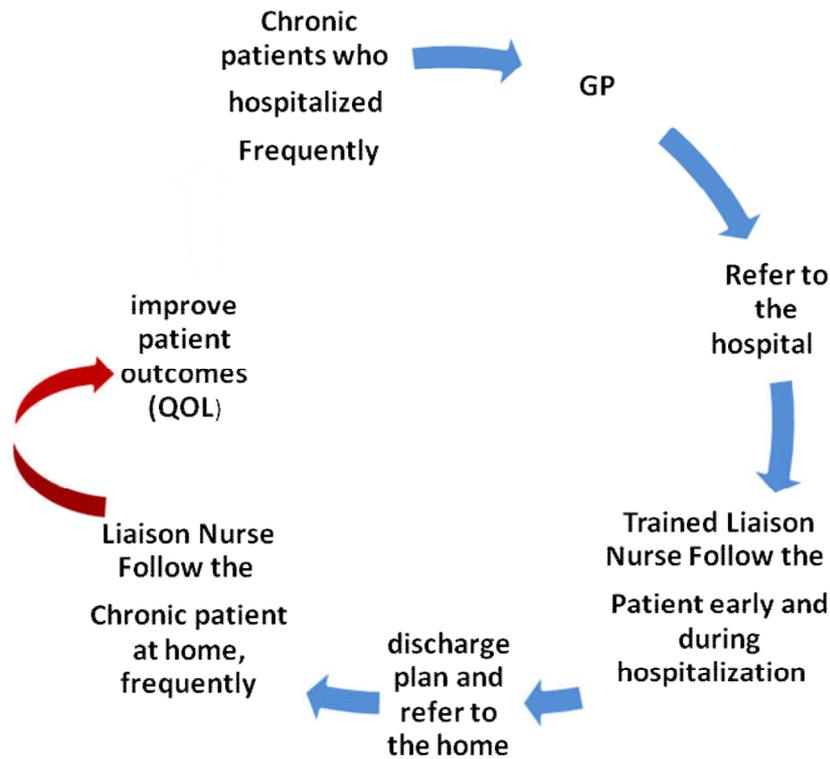
A research model utilized advanced practice nurses to follow patients from the acute care setting into homecare where they were responsible for streamlining medications, arranging subsequent physician appointments and setting up community services. As a result, the patients experienced improved quality outcomes, greater satisfaction, cost effectiveness treatment, decrease duration of hospitalization and decreased readmission rates (10, 11). Also, Dr. Naylor’s work follows on the heels of research conducted by Dr. Eric Coleman, Associate Professor of Medicine in the Divisions of Health Care Policy, University of Colorado Health Sciences Center, The care transition model is based on “four pillars,” including medication self-management, a patient-centered record, follow-up with a skilled nurse and knowledge of red flags or warning signs (7). Therefore, organization of nursing into hospital and home services as “liaison nurse” makes the smooth transition of care between hospital and home.

2. HYPOTHESIS

There is a growing body of evidence to suggest that nurses who work in general hospital setting do not generally consider themselves adequately prepared, skilled or experienced to care for patients with chronic disease or problems that need to aftercare at home. This issue not restricted to their skills or knowledge but also relates to their scope of practice. Instance, the research's results have shown that existence of the liaison nurse, as a new role, between hospital and patients home, have positive effects in patient outcomes. Therefore, regarding to the role of the liaison nurse in hospital, there is a hypothesis including: Patients with chronic diseases, who are hospitalized under the new model of care that will be delivered by liaison nurse, would be better experiences and clinical outcomes (improve quality of life) than they had during previous

hospitalizations prior to the implementation of the new model. The following diagram depicts the nurse

practitioner working as a liaison nurse in Transitional Care Model:



3. EVALUATION OF HYPOTHESIS

This quantitative experience study, after situational analysis and collection viewpoints of care givers and care takers about transitional care model and its necessity with use of two separate questionnaire, will be done with some ward nurses as a liaison nurse and patients with chronic diseases who readmitted to the hospital for treatment during the six-month study period, in selected hospitals.

After recognition of these patients we will divide them into two groups. Experience group and control group .experience group will be covered by liaison nurse care services in the hospital and after discharge, at their home. But control group will be delivered routine health care services during hospitalization and after discharge from the hospital. After six months, quality of life of the participants in two groups will be measured with a questionnaire and compare with each other. Also the researcher will done a cost effectiveness study for estimating the cost of this method for chronic patient care. In this study

sampling method is purposeful and the number of samples that researcher will consider is about 200 patients with chronic disease and needy to after care and their families. Ethical issues will be considered and patients will participate in the study voluntarily. Cultural background of the patients, their rituals and customs also age may be effect on the research results as confounders' variables that will be tried to matching the participants in two groups.

5. CONCLUSION

Results of this research will support the role of the Liaison Nurse in preventing adverse events, that patients with chronic disease will be faced with them after discharge. Also adequate patient education, continuity of care and access to health services especially after discharge from the hospitals will be delivered by LN in new nursing care model. However, existence of liaison nurse in hospital will reduce patient's rehospitalization rates and duration of hospitalization of these patients. This new model of nursing care will be cost benefit for both patient

and hospital. In this new nursing care model, patient's rights will be offered and quality of life will be promoted.

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