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Introducing a new nursing care model for patients with chronic conditions

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Abstract

According to a world health organization (WHO) report, chronic diseases annually kill over 35 million people worldwide, and 80% of those chronic disease related deaths occur in low and middle income countries. Increased incidence of chronic disease in Iran is a cause of re-hospitalizations and economic burden. Using a new nursing care model for patients with chronic disease is a strategy to reduce re-hospitalization of these patients, increase patient satisfaction and improve the outcome for patients with specific conditions. The aim of this study was to review and introduce a transitional care model (TCM) as a new nursing care model for management of patients with chronic conditions. Innovations relating to the nursing practice and delivery of care as a transitional care model for patients with chronic conditions are being implemented in many countries, to produce new forms of health care models. The aim of these new care models is to reduce the after-care gap for patients with chronic conditions, and deliver long term care for them after discharge from the hospital.

Keywords: Chronic conditions, Long term care, Liaison nurse, Transitional care model

1. Introduction

Over the past few decades, the pattern of mortality has changed from infectious diseases to chronic and degenerative diseases such as cardiovascular disease, cancer, kidney disease and respiratory disorders (1). According to statistics released by the WHO, in recent years, the numbers of chronic diseases such as asthma and respiratory system (15%), kidney disease (40%) and cardiovascular disease (50%) have been increased in Iran. Additionally, an increase in the country's ageing population, together with an increase in the overall population rate, emphasized the necessary prospective planning to control their problems and deliver new nursing care models. In chronic illnesses, frequent readmission and re-hospitalization rate is very high. This is a huge financial burden for patients and hospitals as well (2). . Moreover, repeated hospitalization, can lead to financial burden for families, and consequent family disruption. Today, there is no emphasis on the patient as a person or on hospitalization process as a caring phase. Today, there is great emphasis on providing nursing services to patients, and extending it to the home. No doubt, providing nursing services after discharge from the hospital, especially in chronic patients, will reduce readmission to hospital and thus continuity of care (3, 4). Today, the concept of transitional care for patients transferring between hospitals or care centers has changed, and more emphasis is on the caring transfer from the arrival of the patient to the hospital, and to the patient's home (5). The results of 2004 study by Forrester showed, 19% of patients discharged from hospital experienced at least one adverse event during the first three weeks after discharge (6). Naylor (2005) said: "the best situation is delivering care at home, especially in the case of chronic diseases and health problems of the elderly, to bridge the care gap between hospital and home". With the implementation of a transitional care model by a liaison nurse we can achieve this aim (7). A 2006 study by Coffin et al. on the role of liaison nurses in the pediatric ICU, showed: As a result of activities of the PICU liaison nurse for one year, 1,388 patients were discharged. Sixty-seven patients were not referred after discharge. Readmission rate (4.8%) was lower than the rate of the readmissions (5.4%) during the years prior to the implementation of the PICU liaison nurse (8). Also, a 2014

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study by Tabanejad et al. regarding the role of liaison nurses on the improved patient outcome after discharge from ICU, showed: liaison nurses engender a reduced latency in patient discharge, effective discharge and a reduced readmission of patients (13). A 2014 study by Elliott and co-workers, showed that the liaison nurse has a vital role in the management of chronic patients and the improvement of their results (14). In this research, after all provision, patients who received care by the liaison nurse, 1.82 times, achieved a higher level of care (p = 0.028), and 2.11 percent were less likely to require surgery. (p = 0.006). These results support the claim that the ICU liaison nurse has an important role in the prevention of side effects (9, 12). As a result, in this new caring model, improvement of the quality of patients care, satisfaction of the patient, the cost-effective treatment, reduction in the length of hospital stay and thereby reduction in readmission rates are experienced (11,10).

2. The opinion

The evidence suggests that nurses are still in need of more preparation, skills and experience to care for patients with chronic diseases, and provide home care to them. This is not limited only to their skills or knowledge, but the main problem is the restriction on their performance area and job description. Several research projects have showed that the liaison nurse, as a new role for nurses, has a positive effect on the quality of a patient's outcome, from hospital admission to discharge and then at home. Also, chronic patients under the care of the liaison nurse have a better, more satisfying experience (15). Figure 1 shows the nurse practitioner working as a liaison nurse in transitional care model process.

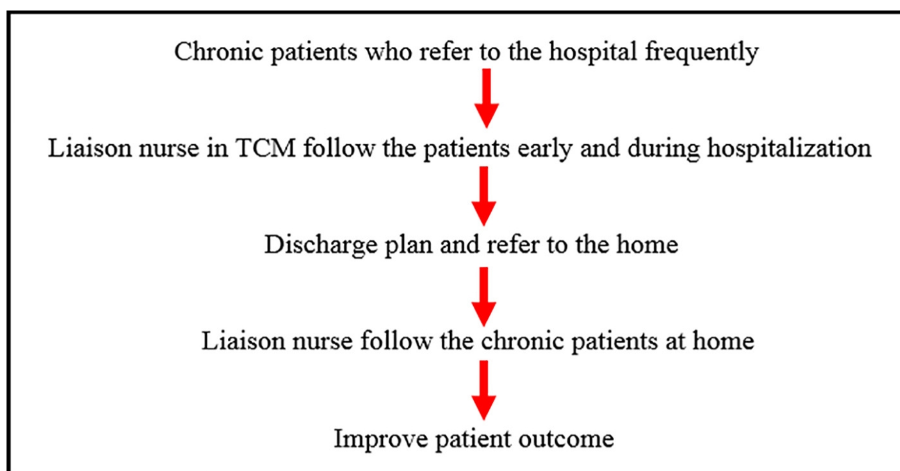

Figure 1. Transitional Care Model Process

3. Evaluation of Opinion

A research project will be conducted to evaluate opinion. After collecting the care givers and care takers' viewpoints about the transitional care model, through two separate questionnaires, nurses and a number of chronic disease patients who have been hospitalized for at least 6 months, will be interviewed. After determining, the patients will be divide into two groups. The examination group and the control group. The examination group will be cared for by the liaison nurse during hospitalization and after discharge from the hospital at home. And the control group at the same situation will be cared for as usual in hospital and at home. After six months, the quality of care in both participating groups will be measured by the quality of life questionnaire, and the results will be compared. On the occasion that the research shows that the new model of nursing care is cost effective, the cost efficiency of this model will be examined. Sampling method in this project is based on research target and the number of samples will be 200 patients with chronic conditions in accordance with sample size in similar studies. Patients will participate in the study voluntarily, and other ethical issues such as cultural background, values and religious and cultural beliefs of the patients will be considered.

4. Conclusions

Patients with chronic conditions will be faced with some complications after discharge from the hospital and the researchers believe that a new nursing care model (TCM) would reduce and indeed prevent these complications. Other specific roles of the liaison nurse are: empowerment of chronic patients, continuity of nursing care and patient advice, to access the health social services following discharge from the hospital. Increase in patient's satisfaction is another advantage of this new caring model. Also, a liaison nurse at the hospital will reduce re-admission rates and

length of the patients' hospital stay. The new model of care for both the patient and the hospital would be cost effective. In this new model of care, quality of life will be improved and patients' rights will be respected.

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Conflict of Interest:
There is no conflict of interest to be declared.

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