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Transition in Health Care and Clinical Leadership

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Abstract

This article is about transitions in life, more in particular the transitions in health and care that are related to these changes. We will focus on the awareness and the engagement that Meleis distinguished in the patient experience of transition. And how nurses can take clinical leadership to advance patient awareness and engagement and in this way promote self-management. We will focus on the question what the contribution of nurse practitioners may be in coordinating health professionals and promoting collaboration between stakeholders and between the health and the social domain. This is transitioning care.

Keywords: Awareness; Engagement; Transition; Clinical leadership; Nurse practitioners; Self-management; Self-efficacy

Introduction

This article is about transitions in a patient's life, especially those related to health and how nurses can adequately respond to them. In the life story of people transitions are a recurring phenomenon. Some concern developmental transitions: one phase in life makes place for another. Other transitions are situation bound changes in which people take up new social roles, for instance transitions in education or professional status, changes in family roles [1].

Tomlinson [2] defined transition as "a movement from one state to another that is accompanied by change in roles, relationships, or patterns of behavior" [3]. This applies also to someone becoming ill, developing a disorder or destabilization of health in some other way. Transitions in health can also be related to a new stage in the course a disease takes. This often concurs with changes in one's social roles and the delivery of received care [2-5]. Care transitions then may be necessary to guarantee optimal care for transitions in health. Care transitions must be distinguished from transitioning care.

Transitioning care is the overall organization of care by several care providers in more than one healthcare setting. Its

organization is even a special focus for accrediting agencies. The transition of care denotes the "movement of patients between healthcare practitioners, settings, and home as their condition and care needs change." [6]. It may be clear that the quality of transition of care often depends also on communication of care across settings.

According to Meleis et al. [7], and other researchers [8-11] transitions are complex and multi-dimensional. Meleis distinguished a number of essential aspects in the patient's experience of transition that together mirror this complexity and multidimensionality:

- Awareness
- Engagement
- Time span
- Critical points and events
- Change and difference

What do these essential qualities come down to in someone's life facing a health-illness transition?

A transition from being healthy to being ill can come about gradually, but can also happen fast due to crisis and sweeping life events. A change in someone's life situation can precede a transition in health, as is the case when for instance traumatic experiences lead to a post-traumatic stress disorder (PTSD), but the other way around is also possible, for instance when hospitalization becomes unavoidable by severe cognitive regression of an elderly person with dementia. Transition of health to illness demands from the patient and next to kin an awareness of options how to deal with the situation and active engagement in activities that promote one's directional powers and relative well-being. And not only at one moment but throughout the course of the disease and the treatment in following steps [3].

Transitions are often responsible for a break in someone's life. They can be turning-points in the course of someone's life or in his career as a patient. It is usually a temporary process during which meaningful changes with a large impact take place. This often causes a crisis with a lot of uncertainty and stress. Old routines and points of reference are often of no avail. One lacks a grip on the situation. A first phase in a process of transition is often the feeling of disconnectedness. When a crisis is overcome and the transition passed

successfully then a new balance comes into being. The change (with ill health this implies often a loss of vitality or perspective) has been integrated into daily life. Someone found his own answer to deal with the situation, a new balance has been struck and the self-image has been adapted. This adaptation of the self-image is often a continuous process of identity formation during which people build and mould their identity in an exchange with their social environment, thus creating their own subjectivity and making meaning of their lives. People need to tell their story again and again (and receive recognition for it from others), while its content is revised all the time (though only slightly most of the time) in order to create again a sense of connectedness, empowerment and 'wholeness'. Transition and meaning making of experiences in life are closely interconnected.

What does this all mean to nurses and what are the implications for nursing? In health care nurses focus on the consequences of transitions related to health and illness, rarely to the transition process itself. The factors related to the transition process as such tend to be recognized only for their share in eliciting a relapse or exacerbation of symptoms and are most of the time not addressed for their psychosocial impact on the patient and his social system.

Method and Purpose

In this article we will put forward the proposition that transitions in health and health care need a specific approach from professional nurses for which clinical leadership is necessary. Our argument is based on discursive thinking and the synthesis of diverse research findings. The overall direction will be that we move from the essential aspects of the transition experience to self-management and from there to the competencies nurses need to promote self-management. We will then consider these competencies in the context of clinical leadership and see how they relate to the demands posed by transitioning care, especially in primary and community care. Two cases will illustrate the role of nurse practitioners here.

Awareness and engagement constituting self-management

Awareness we describe as having knowledge of options how to deal with the situation and engagement as its active counterpart, namely as partaking in activities that promote one's directional powers and relative well-being. Together they are the two sides of the medal that is self-management. Self-management is the individual capacity of the patient to handle his health problem and to make necessary lifestyle changes or seen from the perspective of the nurse: it is the foundation of each nursing intervention to put patients in control of their health situation and to promote well-being [12]. Awareness will be necessary to learn what options there are for behavioral changes that often have to be sustained for a longer period of time, requiring that the patient is able to and motivated to engage in monitoring his health status and making decisions based on signs and symptoms. This is what

we identify as goal readiness: being able to formulate goals and engage in achieving these goals.

Meaning making

Both awareness and engagement are dependent on the way how people attribute meaning to their lives or in this case to transitions in their lives. This is often experienced as a sense of one's life having a purpose which is furthered by investing time and energy into the attainment of cherished goals [13,14]. According to Baumeister [15] the experience of meaning in life is contingent upon fulfilling four psychological needs: purpose, value, efficacy, and self-worth [14]. This comes down to: knowing what values matter in one's life, being able to translate them in purposeful working towards realizing them and having a realistic confidence in one's own possibilities and skills to do so (which is often conditional on self-worth). The development of purpose and its formulation plays an intermediary role, connecting values and meaning in life on one side with engagement in action, fulfillment, encounters with others and satisfaction over goal realization on the other side. Where values are distinct elements, purposefulness is more an overall sense that lends coherence to life. It need not necessarily be altogether rational and nicely formulated in language. It can also be an intuitive sense that is beyond a cognitive grasp to a certain degree, anyhow in the beginning before one becomes aware of it.

We will now have a closer look at how people develop purpose in life. Secondly how nurses can promote this purposefulness and in its wake self-efficacy.

Purpose in life

Kashdan et al. [16], defined purpose in life as:

"Purpose can be characterized as a central, self-organizing life aim. Central in that when present, purpose is a predominant theme of a person's identity. Self-organizing in that it provides a framework for systematic behavior patterns in everyday life. As a life aim, a purpose generates continual goals and targets for efforts to be devoted. A purpose provides a bedrock foundation that allows a person to be more resilient to obstacles, stress, and strain."

Kashdan et al. [16], distinguish three broad pathways in the development of purpose. The first process is proactive and involves an effort over time that only results in a purpose after gradual refinement and clarification. This is often a matter of years. The second process is reactive because a transition confronts the person with the necessity to respond. The transformative character of transitions may involve awareness and reformulation of purposes that adds clarity to the person's life. The third process is social learning- involving the formation of purpose through observation, imitation, and modeling. The two latter processes are particularly interesting to us as they can be influenced by therapeutic support, while the first one is mainly determined by temperament and personality aspects.

Where purpose in life is the bedrock foundation for more concrete goals or the formulation of the predominant theme of a person's identity, it implies that a person must (re-)discover who he/she really is, as it was the 'whole' person behind the patient. After the onset of a severe illness or any other serious health crisis a person will at first feel overwhelmed by the impact of this transition. Then what is needed first is to get a grip on the situation, which means that someone makes up for himself and can distinguish what the impact of the disease or disorder is and what can be accounted for by his normal healthy self. In mental health care for instance psychiatric or psychic problems pose a challenge to patients to learn and see who they are below the surface of being a patient and discern this identity from the impact of symptoms and the consequences of a mental disorder. Nurses can support this by recognizing and approaching the patient as a person and, when necessary, probe into someone's life story, strengths, ambitions and preferences. Or rather to create conditions that someone starts investigating this himself and becomes aware of them. For instance by using a life story interview or by a creative arts approach to visualize leading themes in someone's life which then become easier to narrate [17].

The Nurse Leader's Role

Awareness and engagement are crucial in promoting self-management. This means that on the part of care professionals there must be a keen understanding of what is needed to realize more awareness and engagement. They too must engage themselves, but engagement here means a form of interaction, instead of acting and performing the goals that one has set (as 'engagement' was used with patients). The professional's engagement is about interacting with the patient and his family in such a way that a therapeutic alliance is facilitated and patient and his family experience warmth, trust and hospitality. This furthers an active involvement between clients, family and caregivers and will enable the coordinated integrated care necessary to empower the patient and his family as per the Engagement Model by Sitvast [18]. By assessing needs and risks and adapt nursing interventions to a patient's individual profile (personalized care) nurses can support and coach patients in learning how to cope with symptoms of an disease and be able to adapt to disruptions, show resilience and maintain a balance (or re-establish this balance) physically, mentally and socially. This is in other words: self-management. So far these activities can be expected from all nursing professionals as part of their overall work as health promotor and health care provider.

Let us return now to transition. We defined transitioning care as the overall organization of care by several care providers in more than one healthcare setting. The transition of care denotes the "movement of patients between healthcare practitioners, settings, and home as their condition and care needs change." [6]. We recognized that the quality of transition of care often depends on communication of care across settings. It will be here that expert knowledge, directing care, coordination of other professionals is often needed.

These roles and tasks were traditionally assigned or attributed to one person, the leader. Today we consider clinical leadership as something that can be shared and is distributed over all clinicians where and when this is appropriate in a context that today is usually complex and highly interdependent. The idea has been taken up by the National Health Service (NHS) in the United Kingdom and was further developed in a Clinical Leadership Competency Framework (CLCF). It is based on the assumption that "Not everyone is necessarily a leader but everyone can contribute to the leadership process" [19]. To that aim, leadership behaviours are described in five core domains: demonstrating personal qualities, working with others, managing services, improving services, and setting direction (Figure 1).

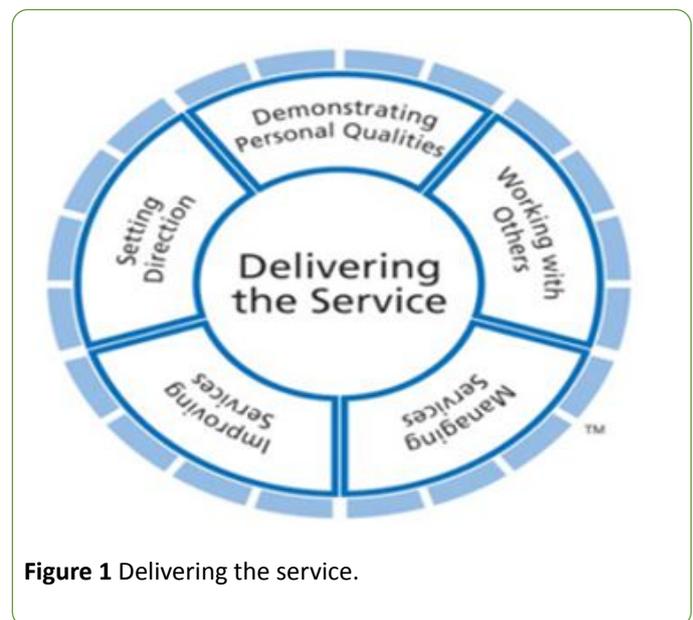


Figure 1 Delivering the service.

Although we recognize that clinical leadership behaviors and competences are demonstrated by nurses on all levels, we do argue that where comorbidity plays an increasingly larger role and communication between health care and welfare stakeholders in the social domain becomes more complex, then nurse practitioner may be needed. Where care and cure overlap each other (as often is the case in transitioning care) we rely on a professional who is positioned with enough autonomous discretionary power to act but can also stand next to the patient and be near. The nurse practitioner combines these qualities, being a clinical attendant, having the necessary expertise and yet being near the patient.

Since 2015 nurse practitioners are designated in the Netherlands by law as professionals with own discretionary and decisional powers in the treatment of patients, juxtaposed with medical specialists in this respect. A main condition for a safe and responsible care and cure has been fulfilled in the Netherlands: a clear definition of Advanced Nursing Practice, legal registration and credentialing. There are certain delimited substituted medical tasks which they act upon as clinical attendant with discretionary powers, but they remain nurses with a special eye to caring needs.

Findings from a systematic review into nurse-led clinics worldwide show a positive impact on patient outcomes, patient satisfaction, access to care and mixed results on cost-effectiveness [19]. A Cochrane review limited to primary health care services that provide first contact and ongoing care for patients with all types of health problems, excluding mental health problems, shows “that trained nurses, such as nurse practitioners, practice nurses and registered nurses, probably provide equal or possibly even better quality of care as primary care doctors and probably achieve equal or better health outcomes for patients” [20].

As different nurse roles/types of nurses were included within the study, it was impossible to disentangle the nurse practitioner role from other nursing levels. However, Van der Biezen [21], basing herself on a systematic review and meta-analysis by Martinez-Gonzales et al. [22], concludes that extant international research shows positive outcomes for care delivered by NPs.

Formulating a diagnosis upon assessment of needs and instigating a treatment is core business to the nurse practitioners, as is also the assigning of tasks to other disciplines and coordinating all therapeutic interventions and care. These tasks become more and more important as we move into an era of personalized health care with treatment ‘tailored’ to the specific individual needs of the patient. We postulated that in promoting self-management awareness and goal readiness were central issues and that professionals could contribute to them by:

- Keen understanding of what awareness and goal readiness takes
- Person-centred approach
- Narrative-orientation
- Being relation-oriented
- Assessing needs and risks
- Coaching skills (how to cope with a disease)

In every one of these competencies we recognize that they serve a treatment tailored to the specific individual needs of the patient. But also that they are not self-evident yet in health care and that there is still much work to do to embed them in care programs. Applying these competencies and approaches involves personal qualities on an advanced level, discretionary powers of setting direction, innovation for improving services, close collaboration with other disciplines and management and last but not least professionals being positioned in such a way that they can bridge the gap between the health care domain and the social domain. We think that nurse practitioners can answer the challenge mentioned here. Two cases will demonstrate our point of view.

We will present here two cases from nurse practitioners working in primary or community care. One of the areas in which nurse practitioners can make a difference is primary care and community care. The elderly and chronic ill do not necessarily have to enter specialized care and hospital care when their situation is stable. It is even better for them to stay independently and participate in society. Where transitions in health almost always imply social consequences they will be

more adequately handled in the community itself. This will also ultimately reduce medical cost and keep medical care financially sustainable. Coordinating the health services and the social domain will be asked for.

Case 1

As a nurse practitioner in primary healthcare I work with mostly elderly patients in different stages and situations of health. The patient population varies from someone who has 15 years COPD to someone just recently diagnosed with dementia. I’m working primarily with GP’s and home care nurses. GP’s and home care nurses refer to me if a patient becomes frail i.e., they start falling or having cognitive problems. But also for home visits for respiratory, musculoskeletal or skin problems.

Nurse practitioners treat patients at home or in a nearby community health center and are well-informed about the possibilities of formal and informal care that are available. This includes a solid collaboration with social workers. Keeping patients as healthy as possible in their own home and surroundings is what we aim at. The elderly patient sometimes sees different doctors or specialist because they can have multiple diseases. The nurse practitioner is the best person to coordinate this with the elderly because of his/her professional integration of medical and nursing care and cure. People have a lot of options in treatment and care. As a professional I align with the patient and respect their choices. Even if it’s not the best choice, it is still the patient’s choice. But then I always try to make patients reflect on their choices in a professional but unconvincing way. In relation to self-management this will help to make tailored goals with the patient, which will increase the awareness, motivation and rate of success (according to Boris Van Zalk).

Case 2

The population of elderly is growing worldwide. People are getting older and one of the reasons is that modern medicine has achieved so much in curing diseases. As the elderly gets older it is likely that they will get frail. Frailty can express itself physically, socially or as cognitive shortcomings. When an elderly gets frail the chances of functional decline, hospitalization and mortality increases. However, due to budget cuts in healthcare hospitalizations tend to be shorter and there is also a decrease in the number of nursing homes. The consequence of all this is that the complexity of care increasingly will be experienced more and more in the primary healthcare. The question is how does primary healthcare manage the care for this population and how can it contribute to Prevention of disability, functional decline and hospitalization? The key lies in the meaning of quality of life for the frail elderly. What does quality of life mean for the frail older people, living independently in the community? Care professionals must give special attention to the self-management of the elderly and the preservation of social connections. The social vulnerability has a great effect on the actual frailty, be it cognitive or physical. The resilience of the elderly stands or falls with good social support. The nurse

practitioner (NP) in the primary healthcare is in the position and has the skills to look after the frail elderly in a holistic way and to support the elderly in care, cure and social well-being.

I work as a nurse practitioner in the primary healthcare with frail elderly. A home care nurse called upon me when one of her patients felt depressed and had some memory problems. The family of the old man and the home care nurse thought of dementia. I investigated the case in different ways. With the doctor I looked into his medical history, his current pharmaceutical use and I performed some physical and mental tests to find the cause of his behavior. Being a nurse I evaluated the patient's environment, inquired after his family and history and spoke with his daughter. Beside some small ferritin decrease I found no physical problems. The reason why the patient felt lonely and depressed was that he felt that he had no purpose in life. Because of this problem he had almost no social contacts, did not leave the house, sat in his chair all day and had a lack of mental incentives. All ingredients for a depression and loneliness which can lead to frailty and functional decline were present. My aim was to prevent escalation of the depressed feelings and loneliness by detecting what a good quality of life meant for this patient. I listened to him to find out what his norms and values were and what purposes in life could be associated with them. Based on his story I asked the home nurse and the welfare organization to look for potential activities for the old man to engage in and, if possible, to find a buddy to accompany him. Eventually they found a buddy and the elderly man started to undertake more activities with a social purpose. He developed a more satisfactory social life, felt more purpose in life and was less lonely and depressed (according to Laura Klarenbeek).

Discussion and Conclusion

Transitions in health and transitioning care demand from health care professionals special skills in order to assist patients in developing purpose in life, self-efficacy and goal-readiness, being the outcome of patients' awareness and engagement and resulting in more self-management. Besides applying particular interventions in the realm of assessing the needs and risks, empowering people and strengthening their self-management these professionals must be able to take direction in coordinating health care services and take the lead in the collaboration between the health domain and the social domain. We think that nurse practitioners are best positioned to take up this challenge. The most important area in which this matter will be settled will be primary and community care.

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