JAMDA 22 (2021) 351–356

JAMDA

journal homepage: www.jamda.com

Special Article

Toward a Partnership in the Transition from Home to a Nursing Home: The TRANSCIT Model

Lindsay Groenvynck MSc [a,b,*], Bram de Boer PhD [a], Jan P.H. Hamers PhD [a], Theo van Achterberg PhD [b], Erik van Rossum PhD [a,c], Hilde Verbeek PhD [a]

[a] Faculty of Health Medicine and Life Sciences, Department of Health Services Research, CAPHRI Care and Public Health Research Institute, Living Lab of Ageing and Long Term Care, Maastricht University, Maastricht, the Netherlands
[b] KU Leuven Department of Public Health and Primary Care, Academic Centre for Nursing and Midwifery, Leuven, Belgium
[c] Academy of Nursing, Research Centre on Community Care, Zuyd University of Applied Sciences, Heerlen, the Netherlands

Keywords:
Transitional care
nursing home
care needs
older people
informal caregivers

A B S T R A C T

The transition from home to a nursing home can be stressful and traumatic for both older persons and informal caregivers and is often associated with negative outcomes. Additionally, transitional care interventions often lack a comprehensive approach, possibly leading to fragmented care. To avoid this fragmentation and to optimize transitional care, a comprehensive and theory-based model is fundamental. It should include the needs of both older persons and informal caregivers. Therefore, this study, conducted within the European TRANS-SENIOR research consortium, proposes a model to optimize the transition from home to a nursing home, based on the experiences of older persons and informal caregivers. These experiences were captured by conducting a literature review with relevant literature retrieved from the databases CINAHL and PubMed. Studies were included if older persons and/or informal caregivers identified the experiences, needs, barriers, or facilitators during the transition from home to a nursing home. Subsequently, the data extracted from the included studies were mapped to the different stages of transition (pre-transition, mid-transition, and post-transition), creating the TRANSCIT-model. Finally, results were discussed with an expert panel, leading to a final proposed TRANSCIT model.

The TRANSCIT model identified that older people and informal caregivers expressed an overall need for partnership during the transition from home to a nursing home. Moreover, it identified 4 key components throughout the transition trajectory (ie, pre-, mid-, and post-transition): (1) support, (2) communication, (3) information, and (4) time.

The TRANSCIT model could advise policy makers, practitioners, and researchers on the development and evaluation of (future) transitional care interventions. It can be a guideline reckoning the needs of older people and their informal caregivers, emphasizing the need for a partnership, consequently reducing fragmentation in transitional care and optimizing the transition from home to a nursing home.

Transitional care is defined as the integration of a set of actions designed to ensure the coordination and continuity of care as a patient makes a transition within or between health care setting(s) or health care providers.[1,2] A common care transition experienced by older persons and informal caregivers is the relocation from home to a nursing home. This transition can be divided into 3 phases.[3] The first phase is the pre-transition phase in which a possible move to a nursing home is discussed, a transition decision is made, and a nursing home is chosen.[4–7] The mid-transition is the time on the waiting list of the chosen nursing home, which ends on the day the older person relocates.[6–8] The third phase is the post-transition phase, which focuses on the adjustment and acceptance of the new living situation.[4,6–8]

Despite this being a complex and precarious transitional pathway, interventions aiming at improving the transition from home to a nursing home often solely focus on one phase of the transition process.[9] Furthermore, recent evidence suggests that transitional care interventions and theories primarily concentrate on the transition from and to the hospital.[10,11]

This study was part of the TRANS-SENIOR project. This project has received funding from the European Union's Horizon 2020 research and innovation program under the Marie Sklodowska-Curie grant agreement no. 812656.

The authors declare no conflicts of interest.

* Address correspondence to Lindsay Groenvynck, MSc, Duboisdomein 30, 6229 GT Maastricht Postbus 616, 6200 MD Maastricht, the Netherlands.
E-mail address: l.groenvynck@maastrichtuniversity.nl (L. Groenvynck).

https://doi.org/10.1016/j.jamda.2020.09.041

A comprehensive and theory-based framework of the transition process from home to a nursing home is lacking, possibly leading to fragmented care. This has a significant impact on older persons and informal caregivers, who are the center of this transition.[12] For older persons, it can lead to complications such as deterioration of pre-existing conditions and falls.[10,13,14] Informal caregivers, conversely, are confronted with feelings of guilt, sadness, and failure.[15–17] Therefore, developing a comprehensive model is crucial. The model should identify key components to avoid fragmentation and optimize care. Additionally, it should include the care needs of older persons and informal caregivers as these are associated with better quality and active participation in transitional care.[18–20] Therefore, this article proposes a model to optimize transitional care from home to a nursing home.

Methods

Three steps were taken to construct the model: (1) a review of the literature; (2) mapping of identified needs; and (3) preliminarily validation of the model.

1. A literature review was performed based on 2 assumptions. First, studies were included that explored the experiences of older persons and/or informal caregivers, (in)advertently identifying their needs throughout the transition process. Second, these needs were formulated as barriers/facilitators or problems.[4] The assumptions guided the search string, which used the key terms *experiences*, *needs*, *barriers/problems*, *older person/dementia*, *transition*, (*nursing*) *home*, and synonyms hereof. The CINAHL and PubMed databases were used, and the bibliographies of the included articles were searched for additional references. Publications were included when published in 2000 or later and when they identified the needs of older persons and/or informal caregivers during the transition from home to a nursing home.
2. Articles matching the inclusion and exclusion criteria were thoroughly read and analyzed by the lead author and discussed within the research team. Each need cited in the included articles was extracted to a separate file, leading to a list of identified needs. The articles were read until no new needs were identified. Next, the list of needs was mapped onto the pre-, mid-, or post-transition phases. Second, per phase, the needs were categorized thematically focusing on commonalities between these needs. Based on these commonalities, the key components were identified. The whole process was conducted by the first author and verified by the second author. Finally, we looked at all the needs together to see if overall themes could be identified throughout the transition from home to a nursing home. As a result, the TRANSCIT model was developed. This whole process was regularly discussed and verified by the research team.
3. Experts in research and practice preliminarily validated the TRANSCIT model at 3 separate meetings. First, the model was presented to the research team encompassing a professor in care of older persons, a professor in long-term care environments, a professor in quality of care, a postdoctoral researcher in long-term care innovation, and an associate professor in health care and well-being. Moreover, approximately 15 researchers and (associate) professors in aging and long-term care, as well as around 20 PhD students and professors from an international transitional care network, preliminarily validated the model at a colloquium meeting. Finally, 16 experts in practice were found through the network of the research team. They were different professionals from care organizations, a coordinator of palliative care, a representative of the Dutch Alzheimer's Society, a patient representative, and a lecturer and a physician in geriatrics. Fidelity and recognizability were verified by probing questions of the first author (L.G.). For instance, "Do you recognize the key components and their persistence throughout each transition phase?" and "Are there components missing?" This led to a constructive discussion and the proposed TRANSCIT model.

Results

The proposed TRANSCIT model was developed to optimize the transition (Figure 1). TRANSCIT is the abbreviation for TRANsition Support, Communication, Information, and Time. The model, identifying the 4 key components and an overall need for a partnership throughout the transition process, is based on the thematic analysis of 20 articles (Supplementary Material 1). The final model was preliminarily validated and approved by the experts in research and practice, who agreed with the key components and the overall need identified.

The TRANSCIT Model

The TRANSCIT model was structured according to the 3 transition phases (pre-, mid-, and post-transition).[6–8] The model identified the overall need for a partnership throughout the transition process, which is reflected in all 4 key components identified: support, communication, information, and time. A detailed description of the TRANSCIT model is provided in Table 1.

Key Components

The 4 key components identified are interrelated and interdependent. For instance: effective communication is necessary to provide good information and offer support. However, effective communication and good information require an adequate amount of time.[4,21]

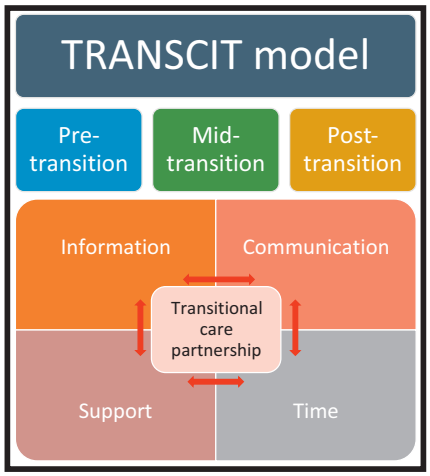

Fig. 1. TRANSCIT model. The model presents the 3 phases in transitional care (the pre-transition, mid-transition, and post-transition phase). Additionally, it identifies the interrelated and interdependent key components of information, communication, support, and time. Finally, the authors identified an overall need for a partnership throughout the transition from home to a nursing home.

Table 1
The Needs of Older Persons and Informal Caregivers Throughout the Transition From Home to a Nursing Home

Pre-transition Phase	
Key factors	There is an expressed need for …
Information	(In)formal and personalized information on the transition (decision) process.
	Information about the health care system and financing.
	Information on the dementia process and health declines of older persons.
	Information on the perspectives of family members and health care professionals to make a shared decision.
	Information on care alternatives/different nursing homes and how to access them.
	Recommendations and information on the future nursing home (eg, visiting nursing home).
	Information on the registration process of the nursing home.
Communication	Older persons, family, informal caregivers, and health care professionals to be included and involved in a shared decision process.
	A shared and constructive decision regarding the move.
	Older persons to feel in control and be involved in the transitional care plan. The older person needs autonomy.
	A health care professional to initiate and guide the transition process.
	Communication on expectations and perceptions of the transition.
	Communicating on the conflicting emotions and stigma surrounding an admission.
	Expressing insecurities and anxieties regarding the transition.
	Acknowledging/understanding the sense of loss and grief some patients experience with leaving their home.
	Older persons and informal caregivers to acquire communicative skills (eg, on assertive communication).
Support	Emotional support during the transition process.
	Older persons and informal caregivers to be supported by, ideally, a network (family and health care professionals).
	Older persons to be supported in the decision rather than making the decision.
	Support from family and health care professionals to make a shared decision to transition.
	Informal caregivers to receive confirmation a transition is necessary.
	Practical support with decision making.
	Informal caregivers to receive support taking on new roles: info seeking, advocating, navigating.
	Support to process insecurities.
Time	Timeliness
	A health care professional to coordinate care.
	To feel prepared and in control during the transition process.
	A care plan
	A timely transitional care plan.
	A crisis plan to be in place.
	To know the right time for placement.

Mid-transition	
Key factors	There is an expressed need for …
Information	Older person/informal caregivers ↔ Health care professional at a nursing home
	Information on the habits and course of life of the older person.
	Information on the needs of both the older person and informal caregivers.
	Information on the family situation of the older person.
	Information on the process of admission and the items required for the move.
	Detailed information on the habits and regulations of the nursing home.
	Nursing home ↔ Home care
	Information on the situation at home and medical information.
	Information on the profile of the older person, how he/she fits in the nursing home.
	Day of the move
	Information on what is needed to be prepared for the admission process.
	Information on what happens on moving day.
Communication	Communication between the different health care professionals involved to efficiently prepare for the move (a partnership between home care and nursing home care).
	To communicate and share experiences with peers.
	Communication on the negative feelings regarding the health care system.
	Older persons and informal caregivers to be included in the admission process.
	Day of the move
	Communication on the experience of the older person's first day in the nursing home.
	A formal introduction between the older person/informal caregivers and health care professionals/other residents.
Support	Informal caregivers to receive support in the adaptation to their new roles as advocates for the older person.
	Support during the grieving process.
	Support from friends or peers and family members who have had a similar experience.
	Support for informal caregivers when informing the older person on the planned move.
	Day of the move
	Support or help from family and friends on the day of the move.
	A warm welcome.
	The establishment of a sense of home for the older person.
	Immediate support on arrival at the nursing home.
Time	A transition plan
	A checklist to plan the actual transition.
	Timeliness
	Time to pack belongings.
	Updates regarding the place on the waiting list. The waiting time needs to be acceptable.
	Time to anticipate the move and accept the proposed place in the nursing home.
	To prepare and plan the admission procedure. Administrative work or other preparations should be done beforehand.
	Day of the move
	Time to unpack.
	Health care professionals to make time to offer support and information.

(*continued on next page*)

Table 1
(*continued*)

Post-transition	
Key factors	There is an expressed need for …
Information	Older person/informal caregivers ↔ Health care professionals
	Information on the role of the informal caregiver and the health care professional in the nursing home.
	Information on how to be active in the life and care of the older person.
	Information on the daily routine of the nursing home.
	Information on the routine, expectations, and preferences of the older person and informal caregivers.
	Informal caregivers to receive information on the daily life, routines, care, and health of the older person.
	Health care professionals ↔ Older person/informal caregivers
	Information on the habits and regulations of the nursing home.
	Nursing home ↔ Home care
	Information on the transition pathway and critical points of the care transition.
	General
	Navigating and self-care skills.
	Training to build a relationship with health care professionals.
Communication	Communication with the informal caregiver and staff about the experience of the older person living in the nursing home.
	Informal caregivers to be recognized as a care partner where each other's roles are clear and where they are encouraged to be involved in care.
	To be heard by health care professionals (questions, opinions, and expectations are taken seriously).
	Older persons to feel in control.
	Positive interaction and relationship with health care professionals.
	A regular contact person at the nursing home.
	Communication with the informal caregiver and health care professionals on the experience of transitional care.
	Communication of negative feelings regarding the nursing home and feelings of losing control.
	Communication skills to efficiently communicate with health care professionals.
Support	Support from a social environment.
	Informal caregivers to be supported when taking on different roles: quality monitor, lawyer, visitor, and link to the outside world.
	Informal caregivers to be supported by a health care professional to terminate home care but also to discuss insecurities or uncertainties.
	Older persons to receive support in creating their own space in the nursing home.
	Support to stay connected to the older person.
	Support from family, friends, and other residents residing in the nursing home.
Time	Contact with the outside via family/friends to create continuity of care.
	The creation of time by health care professionals to listen.
	To create continuity and to remain connected (eg, by regular visits, business as usual, and meaningful activities of the past).
	Informal caregivers to recreate continuity in their own lives.
	Flexibility for older persons to re-establish previous rituals and routines.

Support

(In)formal support was crucial in the transition process.[4,22] Older persons and informal caregivers defined support as continuous and easily accessible. It could range from emotional to practical support.[4,5,8] Some studies emphasized the desire for a supportive network (family, health care professionals, and peers).[4,16,18,23] Additionally, specific support should have been offered to informal caregivers taking on miscellaneous care roles (eg, advocating, expert, or a visitor role).[4,8,16,24]

In the pre-transition phase, older persons and informal caregivers preferred support from family and health care professionals to make a shared decision rather than them making that decision.[4,5,8,14,16,21,25] Studies, moreover, recommended the health care professional to confirm the necessity of this transition while also offering practical support.[4–6]

The mid-transition phase focused on the preparations and the actual move.[23] Here, older persons and informal caregivers communicated the importance of supportive peers who had already experienced the transition process.[7,23] They also expressed their need for support from health care professionals in packing belongings and saying farewell to their house.[7,23,26]

The literature showed that feeling at home is central in the post-transition phase.[25] The evidence indicated the need to feel supported and to receive compassion from health care professionals and peers.[6,8,21] More specifically, older persons needed support to adjust to the daily routine and to meet other residents.[7,25] Informal caregivers seek support to stay connected with the older person. They, therefore, should have been offered a place in the care team.[6,14,16,21,23]

Communication

Studies outlined the importance of an open, complete, and timely dialogue. This dialogue ideally, according to older persons and informal caregivers, should have been initiated by a health care professional.[6,22,24] These constructive discussions aimed to exchange knowledge, feelings, and expectations from all involved and they could be facilitated by acquiring the necessary communication skills.[3–7,14,16,18,22,24,27–29] Moreover, a health care professional should have coordinated the transition process and defined the responsibilities of those involved.[7,16,22,27,30]

There was an identified need for a shared transition decision in the pre-transition phase.[4,16,22,23] It was pivotal during these conversations that the older person felt in control and for his/her autonomy to be respected.[5,7,24–26] This need to feel in control entailed acknowledging conflicting emotions and feelings of bereavement associated with the move.[6,23,26–28]

In the mid-transition phase, communication between older persons, informal caregivers, and health care professionals was paramount.[7,22] This started with a formal introduction of the older person and informal caregivers to health care professionals and peers, and vice versa.[6,18] These interactions should be respectful, positive, and create mutual understanding.[4,6,7,23] Furthermore, research expressed the need to familiarize oneself with the future home by exchanging experiences with other residents and by exchanging knowledge and demands with health care professionals.[4,21,22]

In the post-transition phase, older persons and informal caregivers asked for contact moments with the assigned health care professional.[5,14,29] In these moments, opinions, expectations, and questions

should have been heard.[4,7,16,18,27] It allowed informal caregivers to start a partnership with the health care professional and for both to elaborate on their transition experience.[4,6,16,21,23,24,27]

Information

The studies analyzed highlighted the need for person-centered information in educating older persons and informal caregivers on the transition process.[8,22–24] Here, information is defined as more than classic knowledge provision. It also includes education and skills training.

In the pre-transition phase, information was gathered to make an informed and shared transition decision.[5,6,8,14] Several studies described the information requested by older persons and informal caregivers. First, there was a need for information on the dementia process or general health decline in frail persons.[4,8,23] Second, information on care alternatives and the legislation and finances of nursing home admission should have been made available to make an informed decision.[4,8,22,24] The latter decision then announced the need for information and recommendations concerning different nursing homes (eg, the need to visit a nursing home).[6–8,14,18]

In the mid-transition phase, the evidence addressed the importance of transferring the information on the older person's needs, life story, and family situation to the nursing home.[14,21,23,27] At the same time, studies indicated the need for detailed information on first the admission process and second the future nursing home. The latter should have been provided by health care professionals and peers at the nursing home.[7,18,26]

The evidence regarding the post-transition phase suggested that information should be individualized. Informal caregivers wanted to stay involved and, therefore, their knowledge should have been acknowledged and information on the care plan and the older person's health provided.[21,22,27] The older person, conversely, requested information on the routine, habits, and rules of the nursing home and vice versa.[4,6,14,23,26,27]

Time

Overall, the studies highlighted the need for continuity of care and sufficient time to prepare for the transition. This allowed the health care professional to organize the transition and plan regular contacts. It could improve the feeling of preparedness necessary during this process.[3,4,6,7,14,22]

In the pre-transition phase, the need for a multidisciplinary team to set up a timely transitional care plan was expressed.[7,27] Older persons and informal caregivers wanted a plan that aims to continue and efficiently coordinate care.[8] Furthermore, they needed a care plan that anticipated a crisis moment and defined the right placement time.[5]

During the mid-transition phase, studies indicated that an acceptable waiting time, with the provision of regular updates, allowed older persons and informal caregivers to anticipate the move.[4,7,8] This anticipation was needed to sort through belongings and plan a timely meeting with the health care professionals of the nursing home.[6,7,18,26] Finally, older persons and informal caregivers requested a flexible and simple admission procedure where administrative work was filled out beforehand.[6,7]

In the post-transition phase, time was related to persistence and flexibility.[6–8,14,18] This flexibility, according to multiple studies, should have been created by allowing older persons to establish previous routines, habits, and the creation of valuable activities.[7,23,27] The persistence could have been created by allowing older persons to stay connected to their communities and former homes.[6,14,18,26] For informal caregivers, the latter meant continuing their lives while remaining close to the older person.[14,21]

A Transitional Care Partnership

Together, the included studies provided important insights into the overall need of older persons and informal caregivers to form a partnership with health care professionals throughout the transition process.[4,6,16,21–23,27] Within this partnership, they expressed the importance of being an autonomous person who feels in control throughout the transition process. Moreover, they wanted to add knowledge, experiences, and opinions to facilitate the transition.[5,7,21,26] Inadvertently, the 4 key components promoted the need for involvement and a partnership. In other words, clear communication, accurate information, ongoing support, and sufficient time are crucial ingredients to a successful partnership.

Discussion

The TRANSCIT model identified 4 key components support, communication, information, and time, and one overall need for a partnership to optimize the transition from home to a nursing home. The TRANSCIT model is, to our knowledge, the first model based on the needs of older persons and informal caregivers making the transition from home to a nursing home. This perspective is important as the WHO encourages practices to include their needs into care.[20] Furthermore, the TRANSCIT model and consistency of the key components throughout the transition verifies the need for consistency throughout the transition process. In other words, the TRANSCIT model validates the necessity to see the transition from home to a nursing home as an entity. This is an important implication for intervention development and evaluation as current transitional care interventions mostly focus on only 1 phase or 1 key component of the transition process.[31] Finally, the TRANSCIT model provides important information on the resources necessary to improve care. More specifically, the 4 key components, although initially recognized as important needs, can be interpreted as resources necessary to meet other needs identified (eg, the need for control and autonomy), ultimately leading toward the optimization of transitional care.[32,33]

Implications for Practice and Policy

First, the TRANSCIT model aims to defragmentize the transition from home to a nursing home. The defragmentation and therefore optimization of care is associated with reduced health care costs. More specifically, defragmentation of care is associated with a higher quality of care, which inadvertently means the reduction of transition-related negative outcomes such as preventable hospital admissions.[34] This cost reduction can be used to reimburse health care professionals guarding the continuity of transitional care from living at home to moving into a nursing home. This is important considering the current lack of reimbursement systems for health care professionals in transitional care.[35]

A second implication for policy making is that the TRANSCIT model can promote the continuity of transitional care, which can decrease the workload of health care professionals. This promotion of care continuity avoids duplication of services and therefore reduces additional work, which remains a reoccurring problem within the long-term care continuum.[36,37]

Third, a standardized quality-monitoring system for transitional care is missing in the transition from home to a nursing home. This makes efforts to improve or validate the transitional care pathway difficult, as there is no standard of care.[35] The TRANSCIT model could be the first step toward such a monitoring system. The model provides a comprehensive overview of the transition process as well as the most prominent components that should be present during transitional care according to both the older person and the informal caregiver. Health care organizations could use this model to compare

the provided care with the TRANSCIT model and optimize where necessary. The proposed TRANSCIT model can thus be used as a guideline to provide optimal transitional care reckoning the care needs of older persons and informal caregivers. Future research should present the TRANSCIT model to both older persons and informal caregivers as a means to further validate the model. Once validated, the focus should shift to the applicability of the model as a tool to develop and evaluate transitional care interventions.

Finally, the TRANSCIT model not only presents overarching components of transitional care, it also specifies the care needs of older persons and informal care per transition phase and key component. These specifications could help the alignment of care to the needs identified by the key stakeholders. Moreover, the specification of those needs can help professional caregivers to improve care in daily practice.[20] Specifically, it can facilitate communication with the older person and informal caregivers regarding their care needs, subsequently identifying the best transitional care plan.

Limitations

Despite the comprehensiveness of this article, a few limitations need to be addressed. First, the literature review was conducted by the lead author only. However, potential confirmation bias was reduced by validating the results with both the research team and geriatric and palliative care experts in research and practice. Second, the authors only searched in the databases PubMed and CINAHL. However, the researchers felt that the most valuable search engines were covered and all relevant articles, necessary to build the model, were identified. Finally, despite it being a conceptual model, aiming at the defragmentation of the transitional care process, empirical data verifying its value are missing. Therefore, future research is necessary to assess the model's ability to defragmentize and optimize transitional care from home to a nursing home.

Conclusions and Implications

The TRANSCIT model is a proposed model with the goal of defragmentizing and optimizing the transition from home to a nursing home. Future studies should assess the TRANSCIT model as a tool to develop and evaluate transitional care intervention. Finally, with the TRANSCIT model, the first step is taken toward optimizing care for older persons and informal caregivers throughout the transition from home to a nursing home.

Supplementary Data

Supplementary data related to this article can be found online at https://doi.org/10.1016/j.jamda.2020.09.041.

References

1. Coleman EA, Boult C. Improving the quality of transitional care for persons with complex care needs: Position statement of the American Geriatrics Society Health Care Systems Committee. J Am Geriatr Soc 2003;51:556–557.
2. American Medical Directors Association. Transitions of Care in the Long-Term Care Continuum Clinical Practice Guideline. Columbia, MD: AMDA; 2010.
3. Davies S. Meleis's theory of nursing transitions and relatives' experiences of nursing home entry. J Adv Nurs 2005;52:658–671.
4. Afram B, Verbeek H, Bleijlevens MH, Hamers JP. Needs of informal caregivers during transition from home towards institutional care in dementia: A systematic review of qualitative studies. Int Psychogeriatr 2015;27:891–902.
5. Lord K, Livingston G, Cooper C. A systematic review of barriers and facilitators to and interventions for proxy decision-making by family carers of people with dementia. Int Psychogeriatr 2015;27:1301–1312.
6. Sussman T, Dupuis S. Supporting a relative's move into long-term care: Starting point shapes family members' experiences. Can J Aging 2012;31:395–410.
7. Sussman T, Dupuis S. Supporting residents moving into long-term care: Multiple layers shape residents' experiences. J Gerontol Soc Work 2014;57:438–459.
8. Hainstock T, Cloutier D, Penning M. From home to "home": Mapping the caregiver journey in the transition from home care into residential care. J Aging Stud 2017;43:32–39.
9. Coley N, Gallini A, Garès V, et al. A longitudinal study of transitions between informal and formal care in Alzheimer disease using multistate models in the European ICTUS Cohort. J Am Med Dir Assoc 2015;16:1104.e1–1104.e7.
10. Snow V, Beck D, Budnitz T, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med 2009;24:971–976.
11. Naylor MD, Feldman PH, Keating S, et al. Translating research into practice: Transitional care for older adults. J Eval Clin Pract 2009;15:1164–1170.
12. Laugaland K, Aase K, Barach P. Addressing Risk Factors for Transitional Care of the Elderly—Literature review; 2011.
13. Coleman EA. Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. J Am Geriatr Soc 2003;51:549–555.
14. Eika M, Espnes GA, Soderhamn O, Hvalvik S. Experiences faced by next of kin during their older family members' transition into long-term care in a Norwegian nursing home. J Clin Nurs 2014;23:2186–2195.
15. Cheek J, Ballantyne A. Moving them on and in: The Process of Searching for and Selecting an Aged Care Facility. Qual Health Res 2001;11:221–237.
16. Graneheim UH, Johansson A, Lindgren BM. Family caregivers' experiences of relinquishing the care of a person with dementia to a nursing home: Insights from a meta-ethnographic study. Scand J Caring Sci 2014;28:215–224.
17. Nolan M, Dellasega C. "I really feel I've let him down": Supporting family carers during long-term care placement for elders. J Adv Nurs 2000;31:759–767.
18. Robison J, Shugrue N, Porter M, et al. Transition from home care to nursing home: Unmet needs in a home- and community-based program for older adults. J Aging Soc Policy 2012;24:251–270.
19. World Health Organization. Fact sheet: Ageing and Health. Geneva: World Health Organization; 2018.
20. World Health Organization. Transitions of Care: Technical Series on Safer Primary Care. Geneva: World Health Organization; 2016.
21. Pritty B, De Boos D, Moghaddam N. Factors influencing the transition experience of carers for persons with dementia, when the person with dementia moves into residential care: Systematic review and meta-synthesis. Aging Ment Health 2020;24:1371–1380.
22. Afram B. Informal caregivers' needs during care transition to institutional long-term care in dementia: A focus group study. In: From Home Towards the Nursing Home in Dementia, Vol 1. Enschede, the Netherlands: Universiteit Maastricht; 2015. p. 165.
23. Johansson A, Ruzin HO, Graneheim UH, Lindgren BM. Remaining connected despite separation—former family caregivers' experiences of aspects that facilitate and hinder the process of relinquishing the care of a person with dementia to a nursing home. Aging Ment Health 2014;18:1029–1036.
24. Cottrell L, Duggleby W, Ploeg J, et al. Using focus groups to explore caregiver transitions and needs after placement of family members living with dementia in 24-hour care homes. Aging Ment Health 2020;24:227–232.
25. Johnson RA, Bibbo J. Relocation decisions and constructing the meaning of home: A phenomenological study of the transition into a nursing home. J Aging Stud 2014;30:56–63.
26. Brownie S, Horstmanshof L, Garbutt R. Factors that impact residents' transition and psychological adjustment to long-term aged care: A systematic literature review. Int J Nurs Stud 2014;51:1654–1666.
27. Groenewoud JH, Lange de J. Ondersteuning van mensen met dementie en hun mantelzorgers: Handreiking voor zorgverleners: Van thuis naar het verpleeghuis. Den Bosch: Hogeschool Rotterdam; 2012.
28. Sury L, Burns K, Brodaty H. Moving in: Adjustment of people living with dementia going into a nursing home and their families. Int Psychogeriatr 2013;25:867–876.
29. Afram B. From home towards the nursing home in dementia: Informal caregivers' perspectives on why admission happens and what they need. Maastricht: Maastricht University; 2015.
30. Afram B, Stephan A, Verbeek H, et al. Reasons for institutionalization of people with dementia: Informal caregiver reports from 8 European countries. J Am Med Dir Assoc 2014;15:108–116.
31. Müller C, Lautenschlager S, Meyer G, Stephan A. Interventions to support people with dementia and their caregivers during the transition from home care to nursing home care: A systematic review. Int J Nurs Stud 2017;71:139–152.
32. Kahana EA. Congruence model of person-environment interaction. In: Windley P, Byerts T, Ernst F, editors. Environment and Aging. Washington, DC: Gerontological Society; 1975. p. 181–214.
33. Nahemow L, Lawton MP. Toward an ecological theory of adaptation and aging. In: Preiser W, editor. Environmental Design Research. Stroudsburg, PA: Dowden Hutchinson & Ross; 1973.
34. Frandsen BR, Joynt KE, Rebitzer JB, Jha AK. Care fragmentation, quality, and costs among chronically ill patients. Am J Manag Care 2015;21:355–362.
35. Hinshaw AS, Grady PA. Shaping Health Policy Through Nursing Research. Berlin: Springer; 2010.
36. Robinson DK, Mead MJ, Boswell CR. Inside looking out: Innovations in community health nursing. Clin Nurs Spec 1995;9:227–229. 235.
37. Rustad E, Cronfalk B, Furnes B, Dysvik E. Continuity of care during care transition: Nurses' experiences and challenges. Open J Nurs 2017;07:277–293.