

Psychosocial Factors Associated with Hospital-to-Home Transitions of Older People: A Review

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Abstract

Background: Hospital-to-home transitions are periods of vulnerability for older people and their caregivers. Furthermore, few studies have looked thoroughly into the psychosocial factors influencing these transitions. Nurses must understand those factors well in order to provide effective care during transitions.

Objectives: To explore the psychosocial factors associated with the hospital-to-home transitions of older people, and to describe how they influence those transitions.

Methods: We made a literature search of seven electronic databases for qualitative articles published from 2000-2017 and focusing on the psychosocial factors related to the hospital-to-home transitions of older people discharged from acute care hospitals. Data were synthesized using a thematic synthesis.

Results: Eight articles met the review's inclusion/exclusion criteria. Six significant psychosocial factors emerged from the thematic synthesis: Self-management of activities of daily living, informal support, and formal support, participation in discharge planning, living alone, and social participation. The factors emerged mainly after discharge and could either facilitate transitions via positive influences (e.g., patients' feelings of safety, and independence in activities of daily living) or hinder them via negative influences (e.g., patient anxiety, poor adherence to medication, emotional burden on the caregiver, discontinuity in the activities of daily living and care, and risk of rehospitalization).

Conclusion: The influences of psychosocial factors can be associated with patient health and continuity in the activities of daily living and care. Integrating the evaluations of both patients and caregivers to identify needs or problems related to medical and psychosocial factors in transitional care seems essential for facilitating those transitions.

Keywords: Older people; Transition; Hospital discharge; Home; Psychosocial factor; Qualitative review

Introduction

Older people with multiple chronic diseases and complex needs often require care in multiple settings. They are particularly vulnerable, as are their caregivers, to poorly executed transitions in care, for example, moves from hospitals to other care sites or returns home [1]. However, pressures to reduce hospital costs encourage shorter hospital stays and imply that transitions lead to a large part of convalescence taking place in patients' homes. Transitions home may be problematic in this context due to adverse events such as medication errors, a lack of communication between hospital and primary healthcare staff or rehospitalizations [2] involving even greater healthcare costs [3].

One systematic review has reported relevant insights about the factors linked to the problematic hospital-to-home transitions of older people (HHTOP), but it principally revealed the medical factors associated with adverse outcomes, including comorbidities, cognitive impairment, depression, previous hospitalization or polymedication

[4]. Yet given that older people have multiple care needs and so many factors contribute to problematic hospital-to-home transitions, the multidisciplinary care teams involved in these transitions should develop interventions based not only on medical assessments but also on non-medical ones, such as psychosocial assessments [5]. Some studies have found that psychosocial factors (PSFs) such as less social support, living alone, unmet functional needs in terms of the activities of daily living (ADLs), and a lack of skills to self-manage care post-discharge may lead to hospital readmissions [6,7]. Altfeld et al. evaluated a telephone-based post-discharge care intervention and reported the following psychosocial problems among the patients in the intervention group: difficulties obtaining home-health services, caregiver burden, and medication management, with the latter factor being linked to readmissions. Their study revealed that for most patients, psychosocial issues only emerged after hospitalization, thus presenting them with an unexpected challenge on their return home and a further obstacle to adhering to their care plan [6]. This suggested that despite discharge planning (DP) interventions; patient needs related to PSFs-absent in hospital and unanticipated by patients and families—could suddenly appear at home. Of course, as reported by

Sheppard, non-medical factors may also emerge before discharge, including issues that contribute to delaying hospital discharge, such as the late booking of transport to take a patient home [8]. Therefore, given that effective DP requires the involvement of patients and their caregivers in order to develop appropriate strategies to meet every discharge need [9], that planning should address both medical factors and PSFs related to the HHTOP [6,10]. Despite this, most transitional care—the actions designed to ensure the coordination and continuity of care between different levels of healthcare and across healthcare settings [1] is aimed mainly at medical needs [10].

When transitions are being planned, one of the main nursing goals is facilitating them—preparing and helping patients to meet their upcoming challenges [11]. As PSFs may expose older patients to unexpected trials at home and the subsequent risk of rehospitalization, knowledge of the PSFs influencing HHTOP is essential. To recognise the PSFs related to transitional care, identify patients at risk of problematic transitions because of them, and develop pertinent interventions, nurses and other health professionals must have a good understanding of them. However, few studies have looked thoroughly into the PSFs associated with HHTOP [4,5,12]. To the best of our knowledge, no review of these PSFs has been conducted in the last 17 years. With regards to the above elements, a review of qualitative studies examining the influence of PSFs on HHTOP contributes to deepening the understanding of these factors. The present review's objectives were therefore to explore the PSFs associated with the hospital-to-home transitions of older people and to describe how these factors influence that transition.

Literature Review

According to the definition of the PSFs of health proposed by Martikainen, Bartley, and Lahelma, psychosocial describes an intermediate level between individual and social structures [13]. These factors, such as social support, produce psychological changes within individuals, which can influence their health via psychobiological processes or modified behaviors [13]. For instance, less social support can contribute to a patient's non-adherence to the post-discharge care plan, as reported by Altfeld et al. [6]. However, in practice, psychosocial exposure does not necessarily affect health purely via psychosocial pathways. For example, social support may provide physical assistance as well as emotional support, but only the latter should qualify as a psychosocial pathway [13]. Thus, in the context of HHTOP, if social support (i.e., help from the social environment, such as from family caregivers or home-care professionals) includes physical aid with ADLs like bathing, a psychosocial process is also in operation when that support results in increased patient self-esteem and its benefits to health. Hence, the definition of PSFs used in this review describes an intermediate level that links patients' psychological structures with their social environments (hospital and home) and involves the psychological processes (cognitive, emotional, and behavioral) which could influence the transition.

Methodology

Inclusion and exclusion criteria

This review considered studies of people ≥ 65 years old and discharged from acute care hospitals, without distinction of sex, ethnic/linguistic origin, or geography. Studies were excluded if their target populations were: In terminal phases of illness; undergoing

palliative care; discharged home from emergency departments—these patients' experiences of transition can be very different; or discharged home from a rehabilitation hospital or ward—these patients have already regained a certain amount of autonomy allowing them to cope better with ADLs. The review considered studies focused on the PSFs associated with HHTOP or studies of HHTOP with results providing insight into those PSFs. It was found that each person's experience of transition was continuously changing, and it could take six months, one, or even two years before a transition brought about major changes [14]. This is why studies documenting results between the time of DP and one year after discharge were included. Study outcomes included: PSFs associated with HHTOP according our definition of psychosocial, described above; the influences of PSFs involving positive perceptions or emotions (e.g., confidence) or negative ones (e.g., fear); and their influences associated with health (e.g., behaviors such as medication adherence, improving or worsening health, hospital or nursing home admission). The review considered qualitative studies including, but not limited to, designs such as phenomenology, grounded theory, or ethnography, and published in English, French, or Spanish from 2000–2017. Doctoral theses were included; conferences abstracts and literature reviews were excluded.

Search strategy

With the assistance of a specialist health-sciences librarian, the first author (LCL) searched the PubMed, CINAHL, PsycInfo, Sociological Abstracts, BDSP, Cyberthèses, and Open Grey databases. A search via PubMed and CINAHL analyzed words in the titles, abstracts, and indexing terms used to describe articles. After this, a search of all the databases was made using keywords and the indexing terms. The citations obtained were imported into Endnote Bibliography Software. Initial keywords included: "aged", "frail elderly", "elderly", "aging", "older", "health transition", "patient discharge", "care transition", "hospital discharge", "psychosocial factor", "social support", "psychosocial deprivation", and "environment, social".

Two reviewers independently screened all titles and abstracts and then examined the full text of each potentially eligible article using the inclusion/exclusion criteria. They examined the references in the articles fulfilling all the criteria, generating further articles and providing eight articles in total for quality appraisal (Figure 1). Disagreements about study selection were resolved by discussion.

Quality appraisal

The articles were assessed by two independent reviewers for methodological quality using the JBI-Qualitative Assessment and Review Instrument (JBI-QARI) for Interpretive/Critical Research (10 criteria). If there was no consensus, a third reviewer was consulted for a final decision. Criteria included agreement between:

- (1) The philosophical perspective and the methodology.
- (2) The methodology and the research question/objectives.
- (3) The methodology and data collection methods.
- (4) The methodology and the representation and data analysis.
- (5) The methodology and the interpretation of results.
- (6) Also addressed were: locating the researcher culturally or theoretically.
- (7) The researcher's influence on the research, and vice-versa.

- (8) The representation and voices of participants.
- (9) Ethical approval by an appropriate body, and
- (10) The relationship between the conclusions and the analysis, or data interpretation [15].

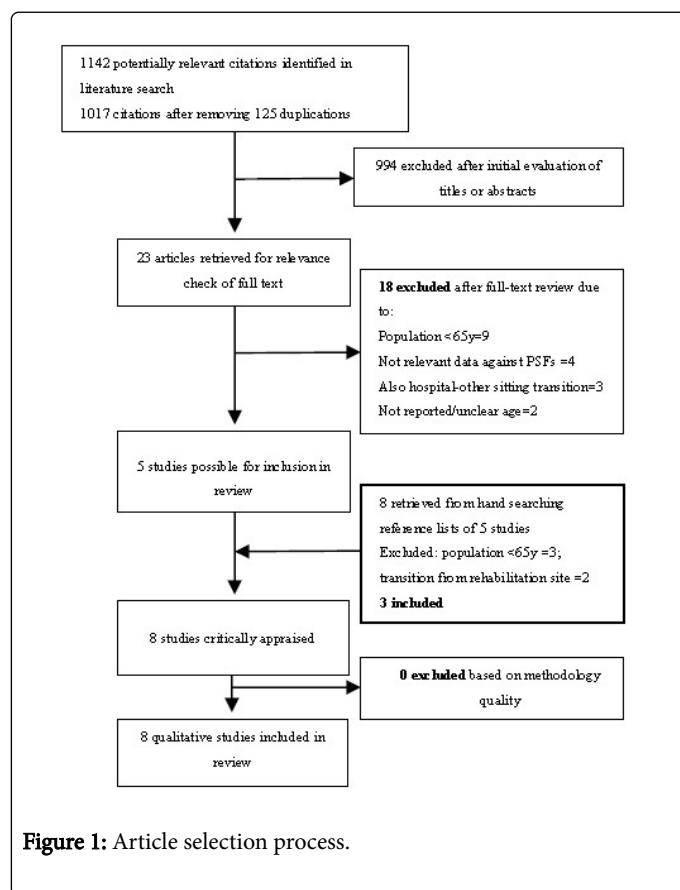


Figure 1: Article selection process.

Data extraction and synthesis

Two reviewers independently extracted the data from the studies selected, including the country where the study was conducted, study

Authors/Years publication/ Country	Aims	Participants	Methodology/ Methods	Psycho-social factors
Graham et al. (2009) USA [17]	To assess the needs of patients and caregivers during hospital-to-home transition.	5 patients; mean age=75 (61-91); female=4159 caregivers; mean age=50, 48% family, 14% friends	Qualitative survey 20 focus groups with caregivers; 5 case study (2 interviews with elderly: 1 month and 4-6 weeks of discharge).	Self-management of activities of daily living. Informal, formal support. Participation in discharge planning, Living alone.
Grimmer et al. Australia (2004) [18]	To describe the experiences of elderly patients regarding their transition from hospital to independent community living.	100 patients; mean age(male=77.4,female=74.1); female=65.7%	Qualitative survey, Semi-structured telephone interviews conducted monthly for 6 months post discharge.	Self-management of activities of daily living. Informal, formal support, Participation in discharge planning, Living alone, Social participation.

aim, participants' characteristics, setting, method, and key outcome data concerning psychosocial aspects linked to HHTOP. The key data were extracted from the studies' results sections.

Key data were synthesized thematically using a three-step methodology (free coding, development of descriptive themes, and generation of analytical themes) for synthesizing qualitative research findings, as developed by Thomas and Harden [16].

(1) Two reviewers independently coded each line of text according to its meaning/content in relation to key data. Codes were checked by the third reviewer.

(2) The two reviewers looked for similarities and differences between the codes in order to group them into related themes describing different psychosocial aspects. These were checked and agreed on by the third reviewer.

(3) The three authors independently identified the influences of the psychosocial aspects within the descriptive themes. They then worked together to re-examine and compare the descriptive themes and the influences, finally generating six analytical themes by consensus discussion, each one being a PSF (see results). The analytical themes included descriptive themes and influences respectively.

Results and Findings

A summary of the studies included is shown in Table 1. The study population included patients discharged from general hospitals, with differing medical conditions including heart problems [17-20], respiratory or abdominal problems [18], chronic diseases like diabetes [19,20], post-stroke [17,18], and surgical conditions requiring cataract [19] and orthopedic surgery [21,22]. Although the review was aimed at studies of people ≥ 65 years old, one study involving a patient aged 61 was selected due to its relevance [17]. No studies focusing exclusively on the PSFs linked to HHTOP were found, but they all reported results on data related to PSFs. All eight studies were judged to be of sufficient methodological quality for inclusion in the review. They all met at least seven of the ten JBI-QARI criteria [15].

McKeown (2007) Ireland [19]	To explore the experiences of hospital to- home discharge among older people following assessment by the public health nurses.	11 patients; mean age=81; male=6; living alone=6	Phenomenological interviews 2 weeks post discharge, field notes.	Self-management of activities of daily living, Informal, formal support, Living alone, Social participation.
Rush et al. (2016) Canada [20]	To understand risk related practices of older people returning home posthospitalization.	8 patients; mean age=82; male=5	Discourse approach interviews within three weeks of discharge.	Self-management of activities of daily living, Informal, formal support.
Perry et al. (2011) New Zealand [21]	To explore the perceptions of patients returning home following lower-limb orthopedic surgery.	11 patients; age=66–88; female=8	Phenomenological interviews 6 and 12 weeks post-discharge.	Self management of activities of daily living. Informal, formal support, Participation in discharge planning, Social participation.
Zidén et al. (2008) Sweden [22]	To explore the consequences of an acute hip fracture as experienced by home dwelling older people shortly post hospitalization.	18 patients; median age=80; female=16; living alone=14.	Phenomenographic interviews 1 month and 1 year post-discharge.	Self-management of activities of daily living. Informal, formal support, Participation in discharge planning, Social participation.
Le Clerc et al. (2002) [23]	To explore the challenges and needs of elderly, community dwelling women.	14 patients; mean age=84.3.	Descriptive photo-novella or photovoice,in-depth interviews, 6–8 weeks post-discharge.	Self-management of activities of daily living. Informal, formal support, Participation in discharge planning, Social participation, Living alone, social participation.

Table 1: Summary of included studies.

The PSFs and their influences that emerged from thematic synthesis are reported below:

Self-management of activities of daily living

Older people had to manage both their basic ADLs or BADLs (bathing, dressing, toileting, transferring or walking, and eating), and their instrumental ADLs, or IADLs (telephoning, transportation, shopping, meal preparation, housework, taking medication, and financial management) [17-23]. Self-management of medical care was rarely reported, although certain problems were mentioned, such as insulin administration [19].

After discharge, in order to manage their ADLs, patients took initiatives to put in place coping strategies, thus displaying how capable and creative they could be in their determination to maintain or recover their independence in the ADLs [18-23]. Coping included:

- (1) Changing the layout of their home's physical environment, e.g., moving furniture to facilitate movement.
- (2) Self-care, such as taking analgesics to manage housework.
- (3) Changing their manner of carrying out BADLs by adding rest periods, and
- (4) Using formal and informal support. Managing ADLs also involved negative effects like anxiety and the fear of falling [18,22,23], as well as reduced safety due to risk-taking (e.g., falls) in performing those ADLs [18,20-22].

Informal support included assistance given to older people by caregivers (family, friends, neighbors) during hospital-to-home transitions [17-24]. This came in the form of help with ADLs,

emotional support, medical care (e.g., wound treatment), and the maintenance of social relationships.

Before discharge, patients felt reassured by the presence of family members at DP meetings—somebody was there to plead their cause with health professionals [24]. Family gave people the confidence necessary to return home, especially with regard to the continuity of their rehabilitation [21]. After discharge, caregivers contributed to managing patients' ADLs [17-19,23]. Patients receiving informal support for administering medication showed better medication adherence [19]. One patient was happy with the help received from his children and wondered whether he could have made the transition successfully without them [18]. Patients living alone and with reduced mobility felt reassured by informal aid with their IADLs (e.g., grocery shopping) and emotional needs (e.g., calming fears of being home alone or falling, and anxiety due to difficulties with ADLs), things that were not taken into consideration by community health services [23]. However, there was a tension between their thankfulness to their caregivers and the worry of being a burden on them [21,23]. Moreover, caregivers facilitated patients' social links by doing activities with them (e.g., shopping, bingo) [19].

Formal support

Formal support involved the assistance that older patients received from health professionals (nurses, physiotherapists, occupational therapists, or doctors) from hospitals or community health centres [17-24]. This included healthcare or help with ADLs, but only rarely emotional support. One study noted the key role of public health nurses in the provision and coordination of clinical nursing and other services for patients and in the identification of their needs after hospital discharge [19].

Before discharge, the presence of health professionals in DP meetings made patients feel safe [24]. After discharge, patients who had benefitted from limited occupational therapy services before discharge expressed their needs for bath/shower modifications for their safety [19]. Studies described patients' difficulties in getting access to formal support. Reasons included the poor information given to patients and caregivers by hospital professionals, ineffectively coordinated post-discharge care, and an absence of home-care services on weekends—all elements which created difficulties in care plan follow-up [17-19,21-23].

Participation in discharge planning

The elements making up participation in DP were: health professionals' roles in encouraging patients (and caregivers) to participate in DP; patients' ability and desire to participate in decision-making about discharge plans; and effective communication, including information sharing between health professionals and patients and caregivers [17,18,21-24].

Before discharge, patients with difficulties understanding the information received from professionals during DP meetings felt that they were unable to influence their care [24]. After discharge, patients who had not participated adequately in DP had uncertainties about their care plans [22], lacked understanding about access to community health services [18], and were less able to manage ADLs, leading to anxiety due to difficulties with ADLs not having been anticipated at the hospital [23]. Others were reluctant to take analgesics [18] or were fearful of disrupting their recovery, subsequently becoming extremely careful and using trial and error to find the best way to perform activities [21]. It was noted that poor participation in DP created difficulties for caregivers trying to provide help [17,18] and increased the emotional burden of caregiving [17].

Living alone

On their return home, older people living alone [17-19,23] used home healthcare services but mainly informal support to meet their needs for care or ADLs.

Before discharge, one widow, who had felt left out of DP, was worried about going home alone because she was not confident in her ability to manage IADLs [18]. After discharge, people living alone were at risk of rehospitalization and unmet hygiene needs when lacked

informal support [17]. Women who had not been involved in DP experienced the fears and anxiety of living alone and falling [23] and had difficulties with ADLs [17-19,23]. Patients stated that being alone was worrisome, suggesting the importance of having someone to welcome them home [23]. Nevertheless, the typical independent mindset of patients living alone was highlighted by their habit of managing their own difficulties [19,23].

Social participation

Older people's social participation was described as the accomplishment of social activities involving social interactions with others, e.g., shopping, going to church, or volunteering [18,19,21-23].

After discharge, people appreciated social participation activities [19,21], but others enjoying less social participation felt less social functioning and that they were prisoners in their own homes [18,22,23]. Women living alone who had difficulties buying groceries or travelling to medical appointments felt isolated from the outside world and depressed [23]. Patients no longer able to take part in social activities which had previously been important to them—visiting friends, participating in community groups—described a sense of no longer feeling useful. A lack of social participation significantly affected their feelings of well-being [18].

Discussion

The review revealed six PSFs associated with HHTOP: self-management of ADLs, informal support, formal support, participation in DP, living alone, and social participation. Those factors emerged before but mainly after discharge, which corroborated other studies [6]. For older people, hospital-to-home transitions involved changes in their physical condition, which necessitated re-adaptation to their home lives. In this context, PSFs facilitated or hindered their transitions via positive or negative influences, respectively (Table 2). PSFs were often interrelated, e.g., living alone, less participation in DP, and less informal/formal support contributed to poor self-management of ADLs. Moreover, certain physical factors may influence the impact some PSFs in patients. For instance, pain, fatigue, or decreased mobility linked to their medical/surgical conditions hindered their capacities to manage ADLs [17-23] and social participation [18,23] or increased their needs for informal/formal support [17-24].

Psychosocial factors	Positive influences	Negative influences
Self-management of activities of daily living.	Management of BADLs/IADLs difficulties. Coping strategies. Independence in BADLs/IADLs.	Safety risks (e.g., falls), fatigue. Poor self-management of BADLs/IADLs: confusion, anxiety; risk of less social participation.
Informal support	Patients' feelings of confidence and safety about the return home; confidence after discharge. Reduction of patient anxiety. Continuity of BADLs/IADLs/care. Maintained social participation.	Patients' feelings of being a burden on their caregivers.
Formal support	Patients' feelings of safety. Continuity of BADLs/IADLs/care.	Poor formal support at hospital: less safety in self-care and unexpected care needs post-discharge. Poor formal support post-discharge: ineffective follow-up care plan.
Participation in discharge planning	Patients' feelings of being a part of discharge planning.	Lack of participation: worries about managing IADLs before discharge; difficulties in managing BADLs/IADLs, uncertainty concerning care plan and poor adherence to medication post discharge. Poor involvement of caregiver: difficulties in providing care, emotional burden.

Living alone	Self-management of BADLs/IADLs difficulties.	Worries about going home alone; anxiety, fears and loneliness after Discharge. Risk for rehospitalization and unmet hygiene care needs
Social participation	Patients' feelings of satisfaction	Less social participation: feelings of uselessness, isolation, depression, reduced feelings of well-being and belonging.

BADLs: Basic Activities of Daily Living; IADLs: Instrumental Activities of Daily Living

Table 2: Summary of psychosocial factors and influences on HHTOP.

Older patients had difficulties with ADLs (mostly bathing) and IADLs (mainly housework, shopping, preparing meals, or using transportation) in the early post-discharge period [17-19,22,23]. Other studies also found these problems significant [25,26]. Bathing is a physical activity that requires significant postural control, and older patients are more fearful of falling while bathing than with any other ADLs [25]. Problems managing IADLs have been associated with living alone, a lack of informal help or absent community health services, and poor participation by patients and caregivers in DP, as reported in this review [18,19,23]. These problems with IADLs may lead to negative consequences on their health, e.g., difficulties in managing grocery shopping or cooking can lead to nutritional problems associated with increased risks of rehospitalization [27].

This review showed that difficulties with ADLs in the post-discharge home environment determined patients' behaviors to do with their autonomy over these tasks and their skills to put in place adaptive strategies to deal with them, thus contributing to their functional independence and continuity with ADLs. Their great efforts to manage ADLs [18-23] might, however, suggest the presence of stress linked to the need to accomplish them. It was reported that functional difficulties and needs for aid in BADLs/IADLs might represent stressful situations for older people [28]. In this context, patients principally used aid from caregivers, mainly family members, to manage ADLs [17-23]. Patients described feelings of happiness and safety linked to this help [18,23], suggesting that this assistance improves their well-being, is beneficial to their health, and contributes to a reduction in the psychological pressures on their ADLs. Indeed, Ekstrom, Dahlin Ivanoff and Elmstahl noted that informal support fulfilled a stress-reducing function by providing emotional and physical aid in ADLs [29]. Huang and Acton reported that both emotional support and help in ADLs from the family favored the maintenance of independence in older people after hip fractures [30]. Informal support thus contributes to the biopsychosocial well-being of older patients, and to successful transitions. Likewise, it decreases the risks of hospital readmission [9]. Yet findings also described how patients' feelings of well-being, thanks to informal aid, might be tempered by their concerns over being a burden on the caregiver [21,23]. This concern shows the need for some sort of formal, professional post-discharge support [31]. Additionally, findings reported that caregivers felt an emotional burden if they had participated poorly in DP, which can be problematic for the provision of care [17]. Caregiver burden was associated with anxiety and frustration and often affected their relationships with the patient and quality of care [9]. These results indicated the pertinence of transitional care that includes informal and formal support, according to the patient's and caregiver's needs. This could reduce the risks of emotional tension and overburdening caregivers, and thus avoid negative outcomes for the care provided and for patients' and caregivers' health. A significant association was found between unmet needs with regards to IADLs and psychological distress in older women [32].

It is necessary to consider PSFs and medical issues in order to develop appropriate discharge plans: effective DP contributes to reduced rehospitalization [9]. However, patients and caregivers in the present review experienced inadequate participation in DP [17,18,20-24]. Other obstacles to DP reported in the literature included health professionals' poor knowledge of the discharge process, the lack of time available to discharge planners due to high patient throughput, pressure to discharge patients quickly, and poor communication between hospital and community health professionals [33]. Furthermore, many patients in this review lacked or had poor support from health professionals, leading to gaps in the continuity and coordination of post-discharge care. However, findings suggested that this support also contributed to adequate transitions, e.g., when patients required home healthcare or lacked help from caregivers [18,19,23]. Indeed, it is known that older people have high usage rates for home healthcare services: this formal support improves their functional independence and well-being and helps patients remain in their own homes, preventing rehospitalizations or readmissions to long-term care institutions [34]. Yet the heavy workloads facing homecare services result in the inadequate provision of care, which has implications for patients during their transitions. Patients in this review were dissatisfied with the shortness of the homecare allocated them and the lack of any service provision at weekends [19].

Moreover, in agreement with the review's findings, Kharicha et al. reported that older people living alone had a greater risk of difficulties in ADLs and of social isolation than those living with someone [35]. Findings suggested that the difficulties involved in carrying out IADLs reduce the social participation of people living alone [23]. Indeed, functioning in daily life was described as one of the dimensions of the concept of social participation [36]. Another study noted that informal support helped patients to join in participative social activities [19]. Similarly, a recent study found that informal support increased social participation by providing transport to an activity or by joining in with older people in performing that activity [29]. By creating better conditions for social participation, informal support also contributes to improving people's health. Social participation is associated with slower cognitive and functional decline, reduced drug consumption and depressive symptoms, improved perceived health, and increased feelings of well-being [36].

Hence, ideally, an appropriate HHTOP requires comprehensive DP involving the participation of patients and caregivers, and follow-up to link hospital and post-hospital care. Findings suggested that the support of public health nurses can ease transitions by evaluating patients' needs and providing and coordinating community services for them [19]. A recent study showed that a comprehensive assessment of older patients before hospital discharge, together with a post-discharge evaluation and follow-up by specialized nurses in patient's homes, was associated with lower rehospitalization rate [37]. Earlier studies also emphasized fewer rehospitalizations due to advanced

practice nurses interventions, involving older patients, caregivers, and health professionals in the implementation of discharge plans, home visits, and telephone follow-up [1]. Nurses play central roles in coordinating DP and ensuring successful care transitions [1].

Implications for practice

To design personalized care transition plans, it is vital that nurses and others (e.g., physicians, social workers) involved in DP perform comprehensive patient and caregiver assessments in order to identify any possible problems associated with medical and psychosocial factors relating to those transitions. Nurses can help older patients discharged home and living alone to identify and anticipate their needs and resources relating to psychosocial issues, such as the management of ADLs (e.g., cooking, transportation to the doctor), social participation, access to community health services, and the availability and aid of caregivers. One study found that having someone at home upon return from hospital and having adequate formal homecare services was significantly associated with older patients reporting that they were managing well after discharge [38]. A discharge evaluation should also consider patients' and caregivers' values and their wishes concerning participation in DP. Some patients prefer that health professionals make care decisions on their behalves [21]. Some potential caregivers are either unavailable or do not wish to take part in caregiving. Although providing support may prove fulfilling for some caregivers, it can also be a physical, emotional, and financial burden on them. The assistance and care required by elderly relatives after discharge may well be far more significant than before their hospitalization, and their needs and the caregiver's willingness to resume that role can change [1].

A dual patient-caregiver assessment in the early post-discharge period is also required. For instance, a public health nurse could assess patients' readaptation to post-discharge life and needs, particularly concerning their needs related to the PSFs identified in their situations and integrating the positive and negative influences of these factors. Collaborating with other health professionals would enable broader post-discharge adjustments to care plans, such as the type of support requested from community health services, and could take into account the physical and emotional needs of patients and caregivers. Interventions should aim to maintain or encourage patients' social participation, according to their resources and desires. As informal support facilitates social participation, health professionals should provide caregivers with information about this and facilitate their help (e.g., with formal support).

The elements described above suggest the value of using a transitional care model that would integrate medical and psychosocial issues. Naylor's Transitional Care Model may well be pertinent in this regard; it is centered on the needs of older patients and caregivers, and it comprises interventions carried out by advanced practice nurses who can ensure follow-up at home [39].

Limitations

This review only encompassed a few articles (8 studies), and the list PSFs identified was not exhaustive. Furthermore, it only included qualitative studies, preventing the identification of findings on these factors from quantitative studies. The findings provided little evidence of the causal mechanisms which might explain PSFs' effects on health. All the studies included were conducted in English-speaking or Scandinavian countries, so findings should not be generalized to other

contexts; neither should they be generalized to explain all the contexts surrounding HHTOP—our studies involved discharge from acute general hospitals, not psychiatric hospitals, for instance. Moreover, potentially useful studies may have been missed, and the review's authors were registered nurses, whose skills and subjectivity could have influenced study selection.

Conclusion

This review has contributed to a better understanding of the psychosocial factors (PSFs) related to the hospital-to-home transitions of older people. PSFs facilitate or hinder transitions *via* their respective positive or negative influences, which may be associated with people's health. For instance, informal and formal support generated feelings of safety in patients and helped them in the activities of daily living (ADLs) and care, which may have contributed to their overall biopsychosocial well-being. On the other hand, living alone was associated with the risk of rehospitalization; self-management of ADLs, poor participation in discharge planning (DP), and living alone were linked to patient anxiety; less social participation was linked to feelings of depression. PSFs also influenced ADLs and the continuity of post-discharge care. Informal support facilitated patients' adherence to medication, whereas poor participation in DP contributed to difficulties in managing ADLs, accessing community health services, and following care plans (by patients and caregivers). To facilitate transitions, it thus seems essential that nurses and the other health professionals involved in transitional care integrate patient and caregiver evaluations into DP to identify and anticipate patients' needs related to medical and psychosocial factors. Further research into these PSFs will be needed to deepen our understanding of them.

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