

How older people cope with frailty within the context of transition care in Australia: implications for improving service delivery

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Accepted for publication 25 July 2014

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What is known about this topic

- Transition care between hospital and home is an increasingly common form of subacute care for older adults in Australia and internationally.
- Most research into the quality of transition care to date has tended to focus on objective, service-centred criteria, with little known about older people's perspectives.

What this paper adds

- This paper involves frail older recipients of transition care, whose voices are rarely included in evaluations of this form of care.
- The key themes illustrated in the accounts of older recipients of transition care are: (i) the need to form a new definition of 'recovery'; (ii) complexities of control; and (iii) the 'system' as potentially disempowering.
- This paper has important insights for the improvement of transition care specifically, as well as underscoring the need for aged care services to be delivered in a client-centred and integrated manner.

Abstract

Transition care is increasingly common for older people, yet little is known about the subjective experience of the transition care 'journey' from the perspective of clients themselves. This study examines how older people cope with frailty within the context of a dedicated transition care programme and discusses implications for improving service delivery. Qualitative in-depth interviews were carried out during 2011 in the homes of 20 older people who had recently been discharged from a transition care programme operating in Adelaide, South Australia (average age 80 years, 65% female). Thematic analysis identified three key themes: 'a new definition of recovery', 'complexities of control' and 'the disempowering system'. Despite describing many positive aspects of the programme, including meeting personal milestones and a renewed sense of independence, participants recognised that they were unlikely to regain their previous level of functioning. For some, this was exacerbated by lacking control over the transition care process while adapting to their new level of frailty. Overall, this research highlighted that benefits associated with transition care can be undermined by fragmentation in service delivery, loss of control and uncertainties around future support.

Keywords: continuum of care, frailty, older people, qualitative research, rehabilitation, transition care

Introduction

In response to concerns over fragmentation in healthcare delivery, countries including the United States, United Kingdom and Australia have developed models of care which broadly come under the umbrella term 'transition(al) care', or:

A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care in the same location broadly. (Coleman & Berenson 2004, p. 533)

With an ageing population, attempts to reduce costs within the acute care system have led to a number of initiatives focused on reducing the risk of re-hospitalisation among older people in the post-acute phase (Hall *et al.* 2012). These models vary from country to country, but are generally aimed at older people with complex care needs who may be at risk of readmission to hospital or 'falling between the cracks' in the health and/or aged care systems (Coleman 2003).

In the United States, two main approaches have been developed over the last three decades to improve older people's experience of healthcare

transitions. The 'Transitional Care Model' was developed in the 1980s in response to concerns over older people with chronic disease being discharged from hospital with unresolved health issues (Naylor 2000). To address this, the model involved a designated advanced practice nurse (APN) who provided individualised support and continuity of care involving a minimum number of home visits post-discharge (Naylor *et al.* 2009). Importantly, the APN who conducts the home visits is the same individual responsible for the discharge plan in the hospital setting, hence enhancing the person-centred and integrated care approach (Naylor 2000). The 'Care Transitions Intervention' (Parry *et al.* 2003) focuses specifically on preparing both patients and caregivers to actively participate in care transitions following a hospital stay (Coleman *et al.* 2004). This approach is designed to encourage patient self-management and enhance inter-professional communication and collaboration across different care sites (Coleman *et al.* 2004). Qualitative and quantitative evidence suggests that these models are effective in reducing the risk of re-hospitalisation, increasing patient and caregiver confidence in managing conditions and medication regimes, as well as enhancing communication with healthcare professionals (Coleman *et al.* 2004, Naylor *et al.* 2004, Parry *et al.* 2006, 2009, Bradway *et al.* 2011).

In the United Kingdom, the term 'intermediate care' has been used to refer to a range of post-acute rehabilitation services for older people aimed at preventing unnecessary hospital readmission, facilitating timely hospital discharge and preventing premature admission to nursing home care (Godfrey *et al.* 2006). Rather than referring to one particular programme, the term refers to an overall 'intermediate care system', including services such as 'hospital at home', step-up and step-down care home places, supported discharge and day rehabilitation (DH 2009). Evidence suggests that intermediate care can prevent re-hospitalisation and result in positive patient outcomes in terms of health-related quality of life, most notably for those who are most frail (Kaambwa *et al.* 2008). Qualitative evidence from those working in intermediate care as well as patients and caregivers suggests, however, that despite these benefits, there remain considerable challenges associated with co-ordination and inter-professional collaboration at the systems level (Regen *et al.* 2008) and involvement in decision-making among clients and caregivers (Andrews *et al.* 2004, Bente & Spalding 2008).

In Australia, a government-funded transition care programme was introduced in 2004 at the interface between the acute and aged care sectors. Its aims are analogous to those of intermediate care, in that

it attempts to minimise the likelihood of older people experiencing extended hospital stays or premature admission to permanent nursing home care. It is goal-oriented, time-limited and targets those older people who at the end of their hospital stay require additional support to improve their functional capacity and/or arrange long-term care (Giles *et al.* 2009). Unlike the US models, the Australian transition care programme is primarily a service-delivery model focused on restorative care rather than on self-management per se. Prior to discharge from hospital, clients and family members meet with a programme co-ordinator to list rehabilitation goals, and are offered a 'menu' of services for up to 12 weeks' duration. These services may include low-intensity therapy (such as physiotherapy or podiatry), access to a social worker, nursing support and/or personal care. This model offers 'flexible care services', in that they can be provided at home for those who are discharged from hospital straight to home, or can be delivered in residential care for a brief period if the person is not ready to go home straight. Across Australia, the programme is managed by state and territory health departments, meaning that although the programme has consistent aims and funding models nationally, the states and territories are able to tailor their programme to best fit the community (Australian Government Department of Health and Ageing 2011).

Older people's experience of transition care

For older people, the transition from hospital to home typically follows a critical event, such as an exacerbation of chronic illness or a fall, and can be coupled with a new level of frailty or vulnerability to functional decline (Nicholson *et al.* 2013). The transition is often accompanied by a high degree of uncertainty for the older person and their family caregivers who are required to make life-adjusting decisions (Rydeman & Törnkvist 2010). Despite the significance of this event for older people, and a push over recent decades to enhance patient-centredness within transition care (Coleman & Berenson 2004), the lived experience from the perspective of older people remains under-researched. There is generally a lack of theoretical work that conceptualises the influence of transition care on the broader well-being of older people. That is, there is a need to understand the meaning of frailty for older people, and the potential role of transition care models to either enhance or detract from this experience.

There are a growing number of qualitative studies focusing on the experience of rehabilitation, discharge

and care transition processes in general, from the older person's perspective (e.g. Krevers *et al.* 2002, Benten & Spalding 2008, Godfrey & Townsend 2008, Graham *et al.* 2009, Rydeman & Törnkvist 2010, Toscan *et al.* 2012). These studies, carried out in a range of different settings, commonly find that while transition care can enable older people to 'pick up the threads of a normal life' (Godfrey & Townsend 2008, p. 950), there is often a failure to place the person at the centre of their own care, to consider the needs of the older person's carers or to provide care which is seamless and well co-ordinated.

A national evaluation of the Australian transition care programme (Commonwealth of Australia 2008) found that it is valued by clients and caregivers as offering increased options following a hospital stay, results in functional improvements and decreased risk of readmission to hospital. To date, however, there has not been any work to explore in depth the experience of clients with, arguably, the 'voices of older people excluded' (Gill *et al.* 2010). The current study thus sought to explore older people's reflections on this dedicated transition care programme. It focused not only on the 'quality' of the process itself but also on how adapting to a potential loss of independence, which may have come about due to a recent illness or event, occurs for older people *within the context of transition care*. The research questions therefore included: (i) how do participants adapt to a change in their level of independence or physical functioning once home? and (ii) what features of the transition care programme enhance or detract from the experience of dealing with new-found frailty?

Methods

Participants and recruitment

Consent to carry out the study was received from the Social and Behavioral Research Ethics Committee at Flinders University. An information sheet was distributed to clients from one of two local transition care programmes by programme staff on approximately day 4 of discharge from hospital. Clients were eligible to take part if they were aged 65 or over, deemed by programme staff as able to complete an interview in English and, for those receiving their programme in a nursing home, were intending to return home. All clients were instructed that if they wished to take part, they were to mail a completed consent form directly to the researchers who would contact them at the conclusion of their programme, to schedule a time for the interview. Any clients who were discharged from the programme due to a subsequent hospital stay or

were admitted permanently to a nursing home during or following completion of their programme were ineligible for the interview.

Data collection and analysis

Interviews were conducted over a period of 3 months during 2011 and took place in participants' homes within 1 month of discharge from the programme. Box 1 outlines the questions that guided the interviews. All interviews lasted on average 1 hour and were audio-taped and transcribed verbatim. Transcripts were analysed in NVivo (QSR International Pty Ltd, Melbourne, Victoria, Australia) using a process adapted from grounded theory (Strauss & Corbin 1998). The pre-existing lifespan development perspective of 'gains and losses' (Baltes *et al.* 1998) sensitised the researchers to the types of questions that were examined during the analysis. Existing theory was then integrated using the constant comparative process, resulting in an emergent theory that corresponded with both the new data and relevant concepts from existing theory. Data analysis was conducted according to the concept of open and axial coding (Strauss & Corbin 1998, Ezzy 2002); first, preliminary analysis or 'open coding' was carried out whereby the text of individual interviews was examined to reveal how participants talked about their experience, and the structures they drew upon to frame the issues, situations and relationships that were influential in their experience. Each transcript was read at least once and selected text coded under themes or 'nodes' that were used to analyse the following interview transcript. After devising a list of codes and collating them with data extracts, potential themes and subthemes were identified using the next level of analysis termed 'axial coding', or the integration of codes around central categories (Strauss & Corbin 1998, Ezzy 2002). The final level of analysis, 'selective coding', involved the abstraction of these themes into the final dominant categories. Data saturation was determined to have been reached once it was established that no new themes were emerging from the data and recruitment of further participants then ceased.

Findings

Participants

A total of 29 participants agreed to take part in an in-depth interview at the conclusion of their programme. Of these, nine participants were unable to take part at discharge from their programme either

Box 1 Interview questions

Preliminary question	Can you tell me about the hospital stay that you had recently? What led up to your hospital stay?
Assessment stage/coming onto the programme in hospital	Do you recall TCP staff talking with you in hospital about arranging some support for you once you go home/or to residential care? Tell me about what you understood as the purpose of the TCP (e.g. what it entailed, who was to provide the service, when it would end) Were you involved in any goal setting for your recovery and TCP?
Experience of Transition Care Program	What types of services did you receive from (<i>name of provider</i>)? Did you feel that your ideas and perspective were incorporated into the services you received? How did this happen? Did you feel that your spouse's or family's opinions were incorporated into the services you received from the programme? How did this happen? Did you feel that the programme took into account your broader living situation? (spouse's health/needs; ability of spouse to care; losses experienced by older person such as to their way of living; changes to relationships, etc.) Did the services you received match your needs in terms of availability of service providers, amount of time available, etc.? Was there anything you particularly liked or disliked about the way care was delivered by the programme? (e.g. number of workers in home at one time; multiple agencies, any confusion regarding who does what; attitude/reliability/confidence/trustworthiness) How well were your carer's needs/concerns met throughout the programme?
After TCP ended (TCP discharge)	How do you feel your health has improved (or not)? How do you think the support you received as part of the programme has helped your recovery? To what extent were your original goals met? Were there any unexpected outcomes? What was the process for discharge from the programme? (e.g. was ongoing care required? how was this arranged? was it available and suitable?) To what extent did the programme help you feel confident to manage your own care? Are there any other comments about the programme you would like to make?

due to change of mind ($n = 4$); readmission to hospital ($n = 3$); or unable to be contacted ($n = 2$). A final group of 20 participants took part in the in-depth interview (65% female; average age 80; age range 66–92). The majority (65%) had been discharged directly to home and just over half were living with a spouse or other family members. Just over half ($n = 13$) had been hospitalised due to fracture, with the remainder either due to stroke ($n = 3$), de-conditioning ($n = 2$) or dizziness/blackout ($n = 2$). One interview was conducted with a spouse acting as proxy, and three involved the participant and family caregiver (at the participant's request). In terms of gaining consent for the proxy participant, the spouse had returned the consent form to the researchers with her details stating that she wished to take part on behalf of her husband, given his high level of cognitive impairment. Pseudonyms are used in quotations below, and 'community' (i.e. home) or 'nursing home' corresponds to the setting where the participant received the majority of their transition care programme.

A new definition of 'recovery'

Although participants described some clear improvements in physical functioning following their transi-

tion care programme, most described how they were not yet back to the level of independence they had hoped for. In essence, they had re-defined for themselves what their 'recovery' looked like, which might have been quite different from the goals they set themselves at the beginning of the programme. When participants talked about their physical functioning currently, most talked in terms of 'loss' or coming to terms with a new level of frailty. However, it was clear that they had gone through a process of adjusting their expectations of what is meant by 'recovery'. Some had come to the realisation that the goals they had set for themselves, such as gaining weight or walking independently, were perhaps overambitious or would take more time, and felt that they had to make minor adjustments in their expectations or they described their 'progress':

People say, 'How are you going?', and I say, 'Slowly but getting there'. (Margaret, client, community)

This re-conceptualisation of 'recovery' also played out in the way participants described changes they had to make within their spousal living arrangements. For one participant, his fall and subsequent hospitalisation meant that his wife for whom he was the primary caregiver had needed to move into

permanent nursing home care. He expressed that because his recovery was taking longer than anticipated, the option of his wife remaining at home was now unrealistic:

[the decision] was all tied up with the fact that I didn't look like I was going to recover properly. Well, you know at that time and point I felt that I would like to go back to the way it was [caring for my wife at home], but it's just gone on and on and on. [My wife is] not terribly happy, she asks me most times when I go to see her when can she come home? (John, client, nursing home)

Overall, there was a sense of needing to make adjustments in accordance with 'the level that I have reached now', and that 'life is not going to be the same, and that's life'. This was often the way spouse caregivers also felt, the sense of needing to 'go with the flow' and not think about the future too much. One caregiver described how 'independence' for her husband now meant not requiring a lifter, and being able to feed himself, rather than 'full' independence *per se*. Participants generally demonstrated a strong sense of resilience and saw themselves as getting on quite well currently, albeit recognising the need to be adaptable, as the following quote illustrates:

I'm not a look backer, I'm an optimist and look ahead, I don't think in the past ... Because I do believe the less you do, the less you want to do, and so therefore I did need to help myself ... So really in a lot of ways, it's really just commonsense. If you can't do something one way, well you find another way to do it. (Nancy, client, community)

It was clear for some participants that their recent hospitalisation represented a first step in a general loss of independence. On the other hand, some participants did recognise that while they faced a series of 'losses', they also attributed considerable personal milestones or gains to their time in the programme:

My daughter comes up and takes me out. [The other day] we took my walker and we went in the supermarket and I walked all up and down the supermarket, and [my son's] got the trolley, he said, 'You alright mum?' I said, 'Yes', he says, 'You're doing so well' and my daughter said, 'Look he won't tell you ... but we are both so proud of you mum. It's been 5 months to the day since you done this and you've just walked round the supermarket!' (Margaret, client, community)

Complexities of control

Although it might be anticipated that older people wish to retain control in the transition care process, the data revealed that there was considerable diversity among participants in terms of the degree to

which they had or wanted control over the process and also what this meant for them individually. When reflecting on their experiences, some described feeling overwhelmed by the demands of having to juggle the visits of numerous care workers and having little choice over the types of services 'offered':

The telephone was running and people were coming [and going]. One woman [came] a couple of days later and said 'I will come and stay the whole day and help you, and have you had a shower?' I have always [showered myself] and I [have] a chair in the bathroom and I got a rail, so I got it already for a long time. I don't need cleaning. I got [someone] already who comes for cleaning and I don't need a woman [for the] whole day. I don't like that. (Eve, client, community)

Some participants simply felt resigned to the 'intrusion' of care workers and the somewhat 'regimented' nature of the programme. However, in the case of the following participant, the sheer number of care workers coming to her home meant that she had to curtail her social activities:

I just stayed inside. I mean I had so many people come in and out the whole time that I didn't have time to go out ... They were only doing what you are doing, you know talking to me. So by the time the fourth week was up, I was thinking, 'does this ever stop?' You know ... which it did. (Pauline, client, community)

While some participants felt dissatisfied by a lack of control over the transition care process, others demonstrated a sense of gaining control. This was particularly evident where participants valued being able to relinquish responsibility over their care needs to the programme. An important component of this diminution of responsibility was where participants felt it avoided them having to overburden their family:

I've got a sister who is very good and she would have come in and done all the things, like showering me at the beginning, but she works, she's got her own life, and I really didn't feel beholden to anybody. (Nancy, client, community)

Others mentioned how the availability of the programme gave them a good 'argument' to put to their adult children for why they should be able to remain in their own home, and avoid either moving in with them, or going into a nursing home:

[My daughter wasn't] really keen on the idea for me to come home and then [my son] wasn't either but he relented in the end because I said I was going home ... I wasn't going to be farmed out to one of the nursing homes, I'm not old enough type of thing, and I thought I could manage when I got home. So he agreed to that, and I think

now [my daughter] has agreed to it too. (Pauline, client, community)

The disempowering system

A prominent theme to emerge was the number of issues relating to the transition care *system*, which served to disempower either the client and/or their caregiver. This was experienced either in terms of access to the programme in the first place, during the programme or at discharge. At the hospital interface, finding out about the availability of the programme was a protracted experience for some participants, often in the time it took to learn that such a programme was available. In the case of the following participant, this knowledge could have substantially alleviated her concerns about returning home:

I think if I had known [about the programme] perhaps in the first week, because I was in hospital for 12 days, so that the first few days when I couldn't do anything, I'd think 'how am I going to manage when I get home?' But then I found out that I was going to get this help, and it took a lot of stress away. (Nancy, client, community)

The need for an advocate or someone who had some 'inside knowledge' of the programme was often required to be considered for the programme. This struggle to 'get on the programme' was particularly highlighted in the case of those participants who had significant cognitive impairment, whose caregivers often had to 'fight' to ensure the hospital allow them to be assisted to care for their spouse at home.

I think they just looked at him and they thought he's 86 and he's not very co-operative because he wasn't with the dementia and they looked at me and they thought she's an old woman too. [I could tell they thought] 'we'll decide the best thing is that he goes into a nursing home, she can go and visit'. That was the feeling. They didn't actually say that. (Joy, caregiver, community)

In terms of experiences *during* the programme, clients and caregivers raised issues about a lack of continuity of care and communication deficits between agency staff, care workers and clients/caregivers. Some particularly expressed concern about the high turnover of care workers:

It was a bit of a joke the first couple of weeks because I asked him if the transition was from hospital to home or was it the transition from professionals from one job to another, but that was just the way things went. Somebody would come [and say] I've got a different job next week so, so and so will be coming but then we always had the one constant, that was the carer. (Joy, caregiver, community)

Discharge from the programme could potentially occur twice over the course of one transition care programme (i.e. from hospital to nursing home and from nursing home to home). The following quote relates to a midpoint discharge from a nursing home to the participant's own home and highlights the need to be aware of client confusion over process issues. The participant talked about feeling let down even though she was expecting to be discharged from the programme. She was now lacking adequate support and was having to arrange ongoing services herself to cover, what she termed, 'holes' left by the programme:

Once I got home I had what was left of my 12 weeks, so I had a girl for an hour and a half once a week and I had somebody taking me shopping for an hour on Fridays and that was terrific, but then that finished ... of course, I knew it would happen. [The agency] tried to get rid of me back to [another agency] so I am now back with them and they are going to give me an hour and three quarters every 2 weeks ... but if you look at the size of this place, you can't clean this in an hour and a half ... and they don't do shopping. I am hoping to find someone privately who will come for a couple of hours and take me. (Mary, client, nursing home)

At the time of discharge, participants varied in the extent to which they had been involved in decision-making and whether they had been assisted with finding ongoing support. One participant described how he had felt quite fearful in terms of how he might cope independently at home after receiving his transition care programme in a nursing home:

It was sort of hard to go from those places with food turned on compared to [the thought of] making it myself. (John, client, nursing home)

Discussion

Despite describing many positive aspects of the programme, participants recognised that they were unlikely to regain their previous level of functioning. For some, the transition care process seemed to potentially exacerbate their uncertainty and concern over their decline in independence by undermining their sense of control while adapting to a new level of frailty. Overall, this research highlighted that benefits which are meant to be associated with the transition care model can be weakened by fragmentation in service delivery, communication breakdown between service providers and clients, and uncertainties around future support.

This paper aimed to fill a distinct gap in the transition care literature by revealing how older people

experience their journey from hospital to home within the context of a dedicated transition care programme. With the further development of transition care programmes both in Australia and internationally, it is becoming increasingly important to understand not only how older people experience these programmes from a 'quality-of-care' standpoint but also what this experience means at a time of increasing frailty. In so doing, we can uncover the potential role that transition care can play in not only improving physical functioning but supporting the broader adaptation to frailty that typifies older people's lives during this transition (Rydeman & Törnkvist 2010). While older people in this research recognised the need to be realistic in terms of what 'recovery' meant for them in a broad sense, several elements of the transition care programme potentially stood to impact their adaptation to frailty.

First, the issue of control seemed to have a significant impact on how the older person experienced the programme. The importance of retaining control in older people's adaptation to changing life circumstances has been found in numerous studies, including the transition to requiring formal assistance to remain at home (Janlöv *et al.* 2006) and moving into long-term care (Lee *et al.* 2013). In the current study, descriptions of a loss of control often related to fragmentation in terms of care delivery, or care being 'foisted' on to the older person, which only served to reinforce their physical frailty. On the other hand, the fact that the programme actually represented a diminution of responsibility was seen as a positive for some participants. Most noticeably, this was perceived to be important when it meant not having to rely on family for care. These findings are important in terms of evaluating the 'quality' of care as this relates to being 'client-centred', or keeping the client's interests at the epicentre of the programme. It is suggested that there is a 'fine-line' between a desire to relinquish control, and yet the need to maintain some control over the process.

The other important factor relating to participants' overall experience was the multitude of communication and fragmentation of care issues that were evident, either at the time of referral to the programme, during and/or at discharge from the programme. This factor has also been recognised as a deficit in UK intermediate care models (Benten & Spalding 2008) and was a key driver for establishing the Care Transitions Intervention in the US (Parry *et al.* 2003) with its focus on preparing and supporting patients and their caregivers as they transition between different care sites. Caregivers often assume major responsibility in the planning, co-ordination and

management of information and care during transitions between settings (Coleman & Williams 2007), and in the current research, it was evident that involving and listening to the needs of the client *and their family members* remain vitally important. Overall, most participants and family members were aware of the purpose of the transition care programme, its duration and the arrangement of ongoing care once it ceased; yet, some described dissatisfaction with the number and turnover of care workers, disempowerment in terms of needing an advocate to insist on receiving the programme in the first instance and feeling inadequately supported once the programme ceased.

The findings of this study can be partially understood in the light of the lifespan development perspective of 'gains and losses', particularly in terms of how older people adapt to change (Baltes 1987, 1995, Freund & Ebner 2005). This perspective recognises that development is an 'ongoing, changing and interacting system of gains and losses in adaptive capacity' (Baltes *et al.* 1998, p. 1046) and acknowledges that development involves both growth and decline. The dynamic interplay between psychological processes of 'gains' and 'losses' has been highlighted in studies of older people's adaptation to dependency (Abad-Corpa *et al.* 2012) or 'healthy' transitions in the lives of older people more broadly (Schumacher *et al.* 1999). In the current study, participants could be seen to experience a number of important developmental 'gains' from the programme, despite considerable physical 'losses' in terms of function and independence. These included being able to remain living at home, some restoration of independence and not having to rely on family support where this was not available, nor preferred. Unsurprisingly, some participants seemed to experience fewer 'gains' and their journey encompassed more noticeable 'losses' than others. This could potentially be exacerbated when there was a lack of control in terms of either involvement in decision-making around care needs or lack of continuity of care.

This research is not without its limitations. For instance, a weakness of this research is that there was no verification of the themes by participants. Given the time constraints of the project and the considerable frailty of participants, it was deemed to be outside the scope of the study to incorporate this element in the data analysis. Furthermore, as we did not obtain in-depth clinical data on the reason for hospital admission, we do not know the type of fracture (i.e. hip or upper extremity) for the large proportion of participants who experienced this event. A further potential weakness of this research is the inability to generalise

our findings to other settings with different variations in terms of transition care programmes. A considerable strength of the study, however, was our ability to overcome an inherent difficulty in incorporating the client perspective in transition care research due to high levels of frailty and cognitive deficit in this population group (Toscan *et al.* 2012). We did this by endeavouring to include the perspectives of a range of transition care clients, and where there were considerable difficulties due to cognitive or physical frailty, also involving caregivers.

These potential limitations aside, this study highlights some key areas of importance for policy makers and those responsible for service delivery. As evidenced for some participants in the current study, it is fundamental that the actual delivery of transition care does not contribute to a broader loss of control or force changes to older people's lifestyle, including social connection. Programmes need to be mindful of the complexity and individuality of the older person's lives and not to assume a 'one size fits all' service-delivery response. Effective communication is essential throughout the transition care journey as older people and their family caregivers will not always retain information delivered to them at times of stress and uncertainty, nor feel confident to 'speak up' and raise issues or ask questions. Even those clients who are content to relinquish control in the first instance may need to be enabled to take the control back when they feel more able. Lastly, a 'successful' journey through transition care can be based on numerous criteria and is clearly a very subjective experience. While the 'lessons' highlighted in this research are relevant to transition care programmes specifically, it is likely that they would be pertinent to aged care service delivery more generally, particularly given the shift towards models of 'consumer-directed' aged care internationally (Tilly & Rees 2007). This research highlights that good-quality, client-centred, aged care does not mean the development of a homogeneous client response, but one which is individualised and targeted to the needs of each individual's changing context. Listening to clients and their families and remaining cognisant of their changing needs over time are vitally important. This will allow them a voice in designing and navigating changes to their care situation, and ensure that they feel supported by an integrated model of service delivery in the face of increased levels of frailty.

References

- Abad-Corpa E., Gonzales-Gil T., Martinez-Hernandez A. *et al.* (2012) Caring to achieve the maximum independence possible: a synthesis of qualitative evidence on older adults' adaptation to dependency. *Journal of Clinical Nursing* **21**, 3153–3169.
- Andrews J., Manthorpe J. & Watson R. (2004) Involving older people in intermediate care. *Journal of Advanced Nursing* **46**, 303–310.
- Australian Government Department of Health and Ageing (2011) *The Transition Care Program Guidelines*. Department of Health and Ageing, Canberra.
- Baltes P.B. (1987) Theoretical propositions of life-span developmental psychology: on the dynamics between growth and decline. *Developmental Psychology* **23**, 611–626.
- Baltes M.M. (1995) Dependency in old age: gains and losses. *Current Directions in Psychological Science* **4**, 14–19.
- Baltes P.B., Lindenburger U. & Staudinger U. (1998) Life-span theory in developmental psychology. In: W. Damon (series ed.) & R.M. Lerner (vol. ed.) *Handbook of Child Psychology: Vol 1. Theoretical Models of Human Development*, 5th ed., pp. 1029–1043. Wiley, New York.
- Benten J. & Spalding N. (2008) Intermediate care: what are service users' experiences of rehabilitation? *Quality in Ageing and Older Adults* **9**, 4–14.
- Bradway C., Trotta R., Bixby M.B. *et al.* (2011) A qualitative analysis of an advanced practice nurse-directed transitional care model intervention. *The Gerontologist* **52** (3), 394–407.
- Coleman E.A. (2003) Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. *Journal of the American Geriatrics Society* **51**, 549–555.
- Coleman E.A. & Berenson R.A. (2004) Lost in transition: challenges and opportunities for improving the quality of transitional care. *Annals of Internal Medicine* **141**, 533–536.
- Coleman E.A. & Williams M.V. (2007) Executing high-quality care transitions: a call to do it right. *Journal of Hospital Medicine* **2**, 287–290.
- Coleman E.A., Smith J.D., Frank J.C., Min S.J., Parry C. & Kramer A.M. (2004) Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. *Journal of the American Geriatrics Society* **52**, 1817–1825.
- Commonwealth of Australia (2008) *National Evaluation of the Transition Care Program*. Commonwealth of Australia, Canberra.
- DH (2009) *Intermediate Care – Halfway Home*. Department of Health, London.
- Ezzy D. (2002) *Qualitative Analysis: Practice and Innovation*. Allen & Unwin, Crows Nest, NSW.
- Freund A.M. & Ebner N.C. (2005) The aging self: shifting from promoting gains to balancing losses. In: W. Greve, K. Rothermund & D. Wentura (Eds) *The Adaptive Self: Personal Continuity and Intentional Self-Development*, pp. 185–202. Hogrefe, New York.
- Giles L.C., Halbert J.A., Gray L.C., Cameron I.D. & Crotty M. (2009) The distribution of health services for older people in Australia: where does transition care fit? *Australian Health Review* **33**, 572–582.
- Gill L., White L. & Cameron I. (2010) Transitional aged care and the patient's view of quality. *Quality in Ageing and Older Adults* **11**, 5–18.
- Godfrey M. & Townsend J. (2008) Older people in transition from illness to health: trajectories of recovery. *Qualitative Health Research* **18**, 939–951.

- Godfrey M., Keen J., Townsend J. *et al.* (2006) *An Evaluation of Intermediate Care for Older People: Final Report*. University of Leeds, Leeds.
- Graham C.L., Ivey S.L. & Neuhauser L. (2009) From hospital to home: assessing the transitional care needs of vulnerable seniors. *The Gerontologist* **49**, 23–33.
- Hall C.J., Peel N.M., Comans T.A., Gray L.C. & Scuffham P.A. (2012) Can post-acute care programmes for older people reduce overall costs in the health system? A case study using the Australian Transition Care Programme. *Health and Social Care in the Community* **20** (1), 97–102.
- Janlöv A.C., Hallberg I.R. & Petersson K. (2006) Older persons' experience of being assessed for and receiving public home help: do they have any influence over it? *Health and Social Care in the Community* **14**, 26–36.
- Kaambwa B., Bryan S., Barton P. *et al.* (2008) Costs and health outcomes of intermediate care: results from five UK case study sites. *Health and Social Care in the Community* **16**, 573–581.
- Krevers B., Narvanen A.-L. & Oberg B. (2002) Patient evaluation of the care and rehabilitation process in geriatric hospital care. *Disability and Rehabilitation* **24**, 482–491.
- Lee S.P., Simpson J. & Froggett K. (2013) A narrative exploration of older people's transitions into residential care. *Aging and Mental Health* **17** (1), 48–56.
- Naylor M.D. (2000) A decade of transitional care research with vulnerable elders. *Journal of Cardiovascular Nursing* **14** (3), 1–14.
- Naylor M.D., Brooten D.A., Campbell R.L., Maislin G., McCauley K.M. & Schwartz J.S. (2004) Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *Journal of the American Geriatrics Society* **52** (5), 675–684.
- Naylor M.D., Feldman P.H., Keating S., Koren M.J., Kurtzman E.T., Maccoy M.C. & Krakauer R. (2009) Translating research into practice: transitional care for older adults. *Journal of Evaluation in Clinical Practice* **15** (6), 1164–1170.
- Nicholson C., Meyer J., Flatley M. & Holman C. (2013) The experience of living at home with frailty in old age: a psychosocial qualitative study. *International Journal of Nursing Studies* **50** (9), 1172–1179.
- Parry C., Coleman E.A., Smith J.D., Frank J. & Kramer A.M. (2003) The care transitions intervention: a patient-centered approach to ensuring effective transfers between sites of geriatric care. *Home Health Care Services Quarterly* **22** (3), 1–17.
- Parry C., Kramer H.M. & Coleman E.A. (2006) A qualitative exploration of a patient-centered coaching intervention to improve care transitions in chronically ill older adults. *Home Health Care Services Quarterly* **25**, 39–53.
- Parry C., Min S.J., Chugh A., Chalmers S. & Coleman E.A. (2009) Further application of the care transitions intervention: results of a randomized controlled trial conducted in a fee-for-service setting. *Home Health Care Services Quarterly* **28** (2–3), 84–99.
- Regen E., Martin G., Glasby J., Hewitt G., Nancarrow S. & Parker H. (2008) Challenges, benefits and weaknesses of intermediate care: results from five UK case study sites. *Health and Social Care in the Community* **16** (6), 629–637.
- Rydeman I. & Törnkvist L. (2010) Getting prepared for life at home in the discharge process: from the perspective of the older persons and their relatives. *International Journal of Older People Nursing* **5**, 254–264.
- Schumacher K.L., Jones P.S. & Meleis A.I. (1999) Helping elderly persons in transition: a framework for research and practice. In: E. Swanson & T. Tripp-Reimer (Eds) *Life Transitions in the Older Adult: Issues for Nurses and Other Health Professionals*, pp. 1–26. Springer, New York.
- Strauss A. & Corbin J. (1998) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Sage, Thousand Oaks, CA.
- Tilly J. & Rees G. (2007) *Consumer-Directed Care: A Way to Empower Consumers?* Paper 11. Alzheimer's Australia, Canberra.
- Toscan J., Mairs K., Hinton S. & Stolee P. (2012) Integrated transitional care: patient, informal caregiver and health care provider perspectives on care transitions for older persons with hip fracture. *International Journal of Integrated Care* **12**, 1–14.