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Research Article

Transitions From Hospitals to Skilled Nursing Facilities for Persons With Dementia: A Challenging Convergence of Patient and System-Level Needs

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Abstract

Purpose of the Study: To describe skilled nursing facility (SNF) nurses' perspectives on the experiences and needs of persons with dementia (PwD) during hospital-to-SNF transitions and to identify factors related to the quality of these transitions.
Design and Methods: Grounded dimensional analysis study using individual and focus group interviews with nurses (*N* = 40) from 11 SNFs.
Results: Hospital-to-SNF transitions were largely described as distressing for PwD and their caregivers and dominated by dementia-related behavioral symptoms that were perceived as being purposely under-communicated by hospital personnel in discharge communications. SNF nurses described PwD as having unique transitional care needs, which primarily involved needing additional discharge preplanning to enable preparation of a tailored behavioral/social care plan and physical environment prior to transfer. SNF nurses identified inaccurate/limited hospital discharge communication regarding behavioral symptoms, short discharge timeframes, and limited nursing control over SNF admission decisions as factors that contributed to poorer-quality transitions producing increased risk for resident harm, rehospitalization, and negative resident/caregiver experiences. Engaged caregivers throughout the transition and the presence of high-quality discharge communication were identified as factors that improved the quality of transitions for PwD.
Implications: Findings from this study provide important insight into factors that may influence transitional care quality during this highly vulnerable transition. Additional research is needed to explore the association between these factors and transitional care outcomes such as rehospitalization and caregiver stress. Future work should also explore strategies to improve inter-setting communication and care coordination for PwD exhibiting challenging behavioral symptoms.

Keywords: Care transitions, Behavioral symptoms, Discharge communication, Dementia caregiver, Informal caregiving

Persons with dementia (PwD) experience frequent transitions across the continuum of care, including transitions into and out of hospital and skilled nursing facility (SNF) settings (Callahan et al., 2015). PwD are particularly heavy utilizers of SNF care as the majority of SNF residents suffer

from dementia and most PwD require SNF care at some point in their illness trajectory (Bernstein & Remsburg, 2007; Callahan et al., 2012; Gozalo et al., 2011; Mitchell, Teno, Miller, & Mor, 2005; Smith, O'Brien, Ivnik, Kokmen, & Tangalos, 2001). Both dementia (Callahan et al., 2012;

Davydow et al., 2014) and discharge to a SNF (Jencks, Williams, & Coleman, 2009) have been shown to significantly increase rehospitalization risk, yet there is a paucity of research examining what contributes to this increase risk as PwD often are excluded from transitional care research (Piraino, Heckman, Glenny, & Stolee, 2012). Understanding the experience of hospital-to-SNF transitions for persons PwD is critical to identifying potentially modifiable factors that may impact care quality and post-hospital outcomes, such as rehospitalization.

SNF nurses are key informants regarding transitional care practices. SNF nurses work in largely autonomous roles to gather information about new residents' medical and social needs. SNF nurses utilize this information to develop and implement new residents' care plans (e.g., medications, diet, activity orders) while also disseminating this information to allied health professionals (e.g., occupational/physical/speech therapy) within the SNF environment (Bowers, Lauring, & Jacobson, 2001; King et al., 2013). They are also responsible for communicating change of condition and other concerns that arise in the SNF to advanced practitioners, which is particularly important as SNF residents are not required to be seen by a physician for up to 30 days (Centers for Medicare and Medicaid Services, 2015; Dimant, 2003). Through their role facilitating post-acute transitions, SNF nurses have valuable insights into both resident/caregiver experiences surrounding transitions and decisions to transfer residents back to the hospital, or other environments as needed, when care cannot be provided within the SNF.

The objective of this study was to examine SNF nurses' perspectives regarding experiences and needs of PwD during hospital-to-SNF transitions and to identify factors related to the quality of these transitions. Determining SNF nurses' perceptions of the various challenges encountered by PwD and their caregivers may inform the development of improvements in hospital-to-SNF transitions to address potential shortfalls in care coordination for this vulnerable population.

Methods

Design

This study employed a qualitative design using Grounded Dimensional Analysis (GDA), a qualitative approach involving concurrent data collection and analysis similar to grounded theory. GDA employs systematic analytic techniques, such as the ongoing pursuit of comparisons across specific events/situations reported by participants in order to establish relationships between certain care processes (e.g., transitioning between healthcare settings) and related consequences (e.g., stress, communication error) as well as the factors that influence those relationships (Bowers & Schatzman, 2009; Kools, McCarthy, Durham, & Robrecht, 1996).

Setting and Participants

Data were collected from 40 licensed nurses employed at 11 SNFs in Wisconsin (Table 1). Participants included both practical and registered nurses as practical nurses compose about half of the licensed nurse workforce in nursing homes (Rantz et al., 2004) and function in a similar capacity despite differences in scope of practice (Corazzini et al., 2010). Participating SNFs were purposely selected and invited to participate in the study in order to obtain a diverse representation of facilities. Participants were invited to participate through flyers distributed by each facility's Director of Nursing or Administrator. In GDA, sampling decisions are informed by emergent categories and situations that are identified during interviews, rather than by participant characteristics. As a result, we did not systematically collect demographic information on participating nurses. Participants received a $30 honorarium per hour of interview participation. Interviews took place either over the phone or in a secure, private room at the participating facility or the University of Wisconsin. The study was approved by the University of Wisconsin Institutional Review Board.

Table 1. Participating Skilled Nursing Facility Characteristics

Facility	Ownership type	Rural/urban	CCRC[a]	Resident beds (#)	Nurses interviewed per facility
1	Nonprofit religious	Urban	Yes	140	3
2	Nonprofit religious	Rural	No	97	3
3	Nonprofit religious	Urban	Yes	42	1
4	Government	Rural	No	104	4
5	Nonprofit religious	Urban	No	184	9
6	For-profit	Urban	Yes	32	1
7	Government	Urban	No	120	7
8	For-profit	Rural	No	50	1
9	Nonprofit religious	Rural	No	97	2
10	For-profit	Urban	No	60	8
11	Government	Urban	No	110	1

Note: [a]Continuing Care Retirement Community (CCRC) is an institution that provides a continuum of care including independent living, assisted living, and skilled nursing care.

Data Collection and Analysis

SNF nurses were interviewed individually (*n* = 4) or in focus groups (*n* = 36). Interviews were recorded and transcribed verbatim. In GDA, data collection and analysis occur concurrently. Open, axial, and selective coding were used to analyze the data. During open coding, interviews began with broad, open-ended questions such as: "Tell me about your experiences caring for people with dementia who are discharged from the hospital?" Each interview was then analyzed by an interdisciplinary research team using line-by-line coding to identify central categories relevant to the research question (e.g., timing of admission) and their relevant dimensions (e.g., controllable/uncontrollable). Interview questions did not specifically relate to short-stay or long-stay (permanent) nursing home residents, as our objective was to identify participants' perspectives regarding variations across different situations including different types of admissions, conditions, and residents. More specific interview questions were developed in light of these analyses. Study participants were asked in interviews to focus exclusively on factors that were unique to PwD, as the general process of transitioning medical care from hospitals to SNF settings has been previously reported (King et al., 2013).

As salient categories became saturated (recurred regularly in interviews), axial and selective coding were employed to identify interrelationships between different categories and the various consequences that result from those interactions. Throughout all stages of analysis, specific procedures were engaged to verify accuracy of the analysis including ongoing revision of conceptual diagrams, constant comparative analysis, and member checking. Constant comparative analysis, which involves the explicit pursuit of variability in the process of interest (e.g., transition process), was achieved through modification of interview questions, examination of variations within singular events (e.g., description of situations where a resident was rehospitalized), and the use of group interviews, which provided opportunities to compare events across individuals. Member checking was done by presenting conceptual diagrams to participants and soliciting feedback towards the end of the study in order to validate findings.

Study Team

Interviews and focus groups were led by one or two members of the study team, one of whom has a clinical background as a Registered Nurse in subacute/transitional care settings and another who has a clinical background as a Geriatric Nurse Practitioner with experience in inpatient and outpatient settings. Both interviewers are PhD-trained and have extensive experience in focus group facilitation and GDA. Data were analyzed by the entire study team which included PhD-trained researchers with clinical backgrounds in nursing, medicine, and pharmacy.

Results

Experiences and Needs of PwD During Hospital-to-SNF Transitions

Across participants, descriptions of the hospital-to-SNF transition were laden with system-level issues that nurses thought impacted transitional care experiences at the individual resident level. SNF nurses perceived that PwD have unique transitional care needs that they believed conflicted with organizational demands and norms in the hospital setting and during the transitional period. These areas of conflict arose, in part, from the difficulty SNF nurses faced when trying to meet the needs of PwD. SNF nurses consistently identified three overarching, interrelated transitional care needs that that they described as challenging to meet and unique to PwD: (a) preparing the PwD for the transition, (b) obtaining detailed personal/social history and developing a tailored behavioral/social care plan, and (c) preparing an individualized physical environment prior to transfer. Subsequently, transitions into the SNF setting were predominantly characterized as burdensome and stressful for the resident, their caregivers, and SNF staff.

To some extent, all of these processes relied on ongoing access to informal caregivers or knowledgeable informants in order to obtain a detailed personal and social history regarding the PwD. Participants explained that their ability to meet these needs was limited by perceived time pressures surrounding hospital discharge and rapid transfers. Detailed descriptions of dementia patients' transitional care needs, perceived impacts, and supportive quotes for each of the areas of need can be seen in Table 2.

Preparing the PwD for the Transition

Several SNF nurses described examples of PwD being excluded from or uninformed about care decisions regarding admission to the SNF which they believed made transitions more stressful. These examples commonly involved situations wherein the PwD was reportedly told by hospital personnel or family that they were going home rather than to a SNF: "And then they get here, they may start crying, they start swearing, they start carrying on, 'this isn't home.' And sometimes that's how they got them out to the car was 'hey it's time to go, we're going home.' And that's really not what's happening. It's not right to just lie to them like that… and then they are upset with us." SNF nurses stated that when they had time to work with caregivers in advance, they encouraged them to "prepare" the PwD gradually before the transition rather than "excluding them" from the decision and transition process. One SNF nurse described having time for family to prepare the PwD for the transfer as "the perfect scenario," noting that while some individuals are unable to engage in the process, some may adapt to the transfer more easily or express their preferences if they are aware of the impending transfer (Table 2).

Table 2. SNF Nurse Participant Perceptions of Transitional Care Needs of Persons With Dementia (PwD): Preparing the PwD, Obtaining Detailed Personal/Social History and Developing a Tailored Behavioral and Social Care Plan, and Preparing an Individualized Physical Environment

Participant description of elements of transitional care need	Perceived impact of transitional care need	Quotes from SNF nurse participants
Preparing the PwD for the transition		
• Ensuring PwD is informed of impending transfer • Giving PwD opportunity to be involved in transition process • Showing PwD pictures of facility or room if possible • Allowing sufficient time for PwD to "realize" they are transitioning to a SNF after discharge	• Taking steps to prepare the PwD provides them an opportunity to learn about and be involved in the transition if they are able • The PwD might be able to communicate about their preferences for the transition • The person might experience less stress and behavioral issues upon transfer if they had additional time or were prepared for the transition • Participants felt that lying to the PwD was unethical and potentially harmful	"If we have a chance we'll always try to make sure the family prepares them….lets them know it's coming. They might ask family to stay for a while. They at least have a chance to do what they can to adapt. That is always the better situation." (39) "Lots of times people, you know the nonverbal folk, I don't think we can do much to prepare them. But some folks you'd be really surprised even when they seem totally out of it they might be tell the family 'make sure you tell them I don't want a roommate' or other things they want. Even if they don't seem like they can I do think they still should have a chance. You can really see the hurt when someone just gets dropped off by an ambulance with no family especially when they were expecting to go home. I don't know how that is even allowed to happen but we see it quite a bit." (5) "Prepping the person, well plus the family even, we do a ton of stuff when we bring in admissions from the community and part of it is simply we have more time to work with family- bring them in for a visit and the resident if they can come or just show them pictures and rooms. They need lots of reminders that it's coming then it's not such a shock when they get here. And I think with early elopement attempts a lot of times it's just people were not aware." (40) "Just dumping someone is the worst. I mean, the hospital or the family tell them they are going home and then pack them up and drop them off here like they don't even exist." (7)
Obtaining detailed personal/social history and developing a tailored behavioral and social care plan		
Obtain detailed history including: • Social preferences (e.g., solitary, 1:1 interaction, small/large group), strategies for engaging the person socially • Personal/lifestyle preferences, long-standing routines (e.g., late riser, dietary preferences) • Personal hobbies/activity preferences • Past occupation • Known history of trauma or abuse • Differential response to female/male caregivers	• This information enables staff to develop a plan tailored to individual preferences and habits which reduces stress/disorientation • This information can inform changes to their care plan that relate to patient safety, such as use of alarms	"Their history. Knowing that is extremely helpful. *Who is this person? We can never get that ahead of time…*" (3) "If we don't get it [preferences] ahead of time, in my mind I feel like we are not providing the best care that we can provide, that the resident is lonely… or just doesn't feel as connected….You've really got to look at people for what environment is really going to work. How do we engage with this person? Are they a social person or are they more introverted usually? Is there anything – with showering or cares. Any issues…you know some people are terrified of the shower maybe a bed bath is better. Sometimes just with that you can avoid stress." (15)

Table 2. *Continued*

Participant description of elements of transitional care need	Perceived impact of transitional care need	Quotes from SNF nurse participants
Obtaining detailed personal/social history and developing a tailored behavioral and social care plan		
• Strategies that have been used successfully at home for reorientation (e.g., signage/reminders) • Past behavioral issues and how they have been successfully managed at home or in the hospital • Religious routines/activities usually observed at home	• Staff can apply individual strategies for engaging the PwD in dialogue/activities and responding to behavioral issues	"Some people watch mass on the TV every day at home or have had meals in front of the TV for decades. We can adjust to those habits from the get go to make people feel more at home." (25) "Everything needs to be very individualized here…it just starts you off on the right foot with that person's routine and personal background, so that you have the best chance to succeed with them… without it, well if I have someone with dementia, I have to prepare for anything - automatically alarm them, because you don't know what they're going to do… in a new situation they're going to act different. It is very hard to know how to avoid or deal with behaviors if you're not taking care of who they are and what they need as a person." (25) "Yes they have health needs, but what about who they are, what activities can we try, what do they like and need to be happy here. It can take weeks to figure that out and you can really see people struggle in between… I think some of it is just trauma, for someone who is already lost the move can be just devastating and very stressful if we have no idea who they are." (9)
Preparing an individualized physical environment prior to transfer		
• Tailored physical environment needs such as specific arrangement for bathroom/room set-up • Previous experiences with roommates • Features of past environment that enhanced function/safety • Familiar items that have consistently been in home and are familiar to person • Pictures of people the person enjoys being reminded of or seeing • Special memorabilia the person is accustomed to having • Specific bedroom comfort items that aid sleep	• Staff are able to work with caregivers to create a home-like environment • More immediate availability of familiar objects/environment reduces disorientation and may reduce behavioral issues associated with the transition • May lead to a better experience for informal caregivers if they are more involved and the resident experiences less stress	"Something that helps with the transitions is that we set the room up ahead of time and have the pictures hung; have the room set up. So that it looks like their room… like a certain blanket on their bed and they can remember that. A cue." (32) "We do have families that come and see our unit specifically. And see how a room could be set up for them…they bring in memorabilia, pictures, make a photo album, and she [resident] looked at it day after day. This almost always leads to a better transition." (21) "We get the referral, have the family come in and give them a tour so they know what they are getting into… we can make suggestions like bring this and this and this or you know bring some familiar things in. We can get things set-up." (17) "Details like where the nightstand goes, how to copy the way they were functioning at home. Leaving bathroom lights on if they are accustomed to it sound negligible but they are not. Plus it brings the family in and helps them feel better, to see dad is in his environment… he's ok. Sometimes if they are very confused we get creative. We had a businessman with advanced dementia-had always said he never wanted to go to a nursing home, so we had his room set up like a hotel room with a work desk and things he used, his old appointment book, he used that stuff on day one, it had meaning for him. We worked quite a bit with the family to devise this plan and they felt this strategy was right for him as an individual." (17)

Note: SNF = skilled nursing facility.

Obtaining Detailed Personal/Social History and Developing a Tailored Behavioral and Social Care Plan

While participants described challenges related to inaccuracies in medical information, they also consistently emphasized the need to gather sufficient personal/social information in order to "understand the person" when transitioning someone with dementia. Nurses described key information needs prior to transition for PwD as extending beyond the medical plan of care, such as functional abilities, long-standing behavioral issues or habits prior to acute illness, preferred activities, and social preferences. SNF nurses described PwD as benefiting most from care plans that were highly tailored to the individual and developed early on in the transition process. They described "knowing the person" from a social aspect as a marker of high-quality care and described using this information to inform individualized plans (e.g., prefers baths to showers, long-standing routines such as late rising, specific activity preferences) and develop strategies to better prevent and respond to behavioral and resident safety issues that might arise (e.g., risk for falls or elopement due to restlessness or wandering, increase staffing due to risk for aggression). SNF nurses stated that having these individualized plans in place early on in the transition process was important and led to "smoother," less stressful transitions for both the resident and their caregivers. This information also enabled staff to respond more promptly and effectively to behavioral issues that did arise during the transition (Table 2).

Preparing an Individualized Environment Prior to Transfer

Participants also described PwD as having a need for more individualized preparation of the physical SNF environment in order to reduce stress and disorientation associated with the transfer. Although not all PwD are admitted for long-term nursing care, SNF nurses contextualized all transitions into the SNF environment as a transition into a "new home environment." Nurses described individualizing the physical environment as an important transitional care need noting that PwD benefit from consistency, familiar routines, and limited change in environment, and that certain behavioral issues including repetitive questioning and wandering/exit-seeking that frequently occurred following transitions might be minimized by having a familiar environment upon arrival. All participant descriptions of preparing the physical environment involved working directly with family or other caregivers. One SNF nurse described regularly asking family to bring in pillows and comfort items from home as a step to ease transitions and also described using this as an opportunity to build relationships with caregivers (Table 2).

SNF Nurse Perceptions of Successful Hospital-to-SNF Transitions

Participants largely described the quality of transitions for PwD in terms of their ability to meet their transitional care needs by providing more immediate individualized care and defined a "successful" transition as one in which the PwD is able to stay in the intended care environment without need for additional transfers. The majority of SNF nurses stated that transitions into the SNF were stressful for PwD. Strategies used by SNF nurses to reduce resident distress were to be immediately responsive to personal preferences and established care routines. Participants described the timeframe for evaluating good transitions for PwD as often extending beyond the traditional 30-day window due to challenges with behavioral care, prolonged adjustment times, and ongoing information-seeking necessary to develop a sufficiently tailored care plan.

Factors Impacting the Quality of Transitions for PwD

SNF nurses identified several factors that they felt directly impacted the quality of hospital-to-SNF transitions for PwD, including inaccurate/limited hospital discharge communication regarding behavioral symptoms, limited nursing control over SNF admission decisions, short discharge timeframes, and engaged caregivers prior to and during the transition (Table 3).

Communication About Dementia-Related Behavioral Symptoms

Across all participants, hospital-to-SNF transitions for PwD were described as being dominated by behavioral symptoms, which nurses generally thought were intentionally under-communicated by hospital personnel. SNF nurses spontaneously highlighted the dominant role of behavioral symptoms as "the single most important thing" in orchestrating transitions into the SNF for PwD. One nurse manager stated, "For any dementia admission, it's all about behavior." SNF nurses recognized that the transition was likely to result in behavioral changes but also described situations where they discovered that behaviors were present during hospitalization and not communicated in verbal or written discharge communication even when SNF nurses specifically questioned if behavioral symptoms existed (Table 3). Nurses shared a widespread perception that many behaviors and accompanying care needs were intentionally not communicated due to concerns about placement. This was described by one SNF nurse as: "[It] seems like hospitals have a 'don't ask don't tell' policy, so we're finding out when we're doing referrals that we have to ask even more specific questions all the time when the nurse is not answering. So they're not going to offer a lot of information, it feels like then 'if I tell them that, they're not gonna take this guy.'" While nurses noted that hospital providers do not always possess sufficient longitudinal knowledge regarding behavioral care needs, they stressed the importance of having time to seek out this information from other informants.

Table 3. SNF Nurse Participants' Perceptions of Factors That Impact the Quality of Hospital-to-SNF Transitions for Persons With Dementia: Communication About Dementia-Related Behavioral Symptoms, Control Over Admission Decisions, Caregiver Engagement During the Transition

Participant description of factors impacting the quality of transitions	Perceived impact on quality of transition	Quotes from SNF nurse participants
Communication about dementia-related behavioral symptoms		
• Types of behavioral symptoms that occurred in hospital • Detailed information about how behaviors are exhibited • Course and onset of behavioral symptoms if known • Treatment strategies tried at home (if persistent) or in hospital and their effectiveness • All pharmacologic agents used to address behaviors scheduled or as needed and any known side effects if medications were withdrawn • Specific care needs during hospital stay, including restraints or 1:1 supervision • Potential or actual safety concerns, such as wandering or aggression	• Able to ensure potential safety issues are addressed prior to transfer • Plan in place if behaviors become a concern • This information is important for safe and appropriate placement decisions including need for secured unit and roommate matching • Without this information, placement may not be appropriate, increasing risk for negative outcomes such as falls, rehospitalization, or being transferred to a different SNF • Without this information, both patients and their caregivers experience greater stress and dissatisfaction with the transition process	"If their behavior gets out of control, we can't medicate people here like they can at the hospital… if we get incorrect information and we cannot handle them now they became our responsibility to place them somewhere else more appropriate… If they are agitated, or they are striking out at others. It's a big thing. You know, because we have to protect the other residents in that environment." (4) "Sometimes the social worker or discharge planner at the hospital says 'Oh there is no behaviors at all,' the resident will come and have all kinds of behaviors, and then the nurses notes they fax talk all about their behaviors." (19) "My experience would be the more challenging the resident, the more discrepancy we hear… we need to know…how confused are they, have they had a sitter at the hospital, what- what can we expect because we can't provide, you know the one-to-five ratio-, you know, we've got a one-to-twenty or one-to-nineteen." (11) "We don't really have a problem with just behaviors. They have dementia it is a part of their disease. But we have limits and are not a safe place for every type of problem – I don't think hospitals always get that, the impact is also just that the guess work of their admission is a nightmare and it's very stressful for us because without the right information we cannot possibly do a good job, then someone ends up falling or is very aggressive and needing to go back to the hospital." (1) "To me it seems like sometimes the hospital just wants to dump the patients so to speak. Because they've got to get them out of there, and that's what they tell us all the time how they need beds and they can't do anything for someone with dementia – they just need our long term care. But then a lot of times it's completely different from what the social worker at the hospital tells our social worker." (2) "Just recently the social worker [in the hospital] had said 'Oh once in a while he may yell out or call out' and then we get someone who is inconsolable, just hollering constantly, it is very disruptive to the roommate and other residents in close proximity-sure enough we dig for more information and find this issue is ongoing. This is just always the case you know, at least tell us that he's like that, give us a heads up." (27) "Safety is such a concern with the dementia people and we have a lot of falls that happen and I think, maybe are avoidable if we're told if they are trying to get up and elope or wander all the time, so we can make sure we get the bed alarm in the room, mats on the floor or low beds… sometimes it's too late and they already fell and then we get dinged on that. That will send them back to the hospital for sure. I mean, they've got dementia it's not like they can tell us they're restless and apt to fall if the paperwork missed it." (16) "It's unrealistic to take somebody that is confused and sick and expect them to move into a new place and be happy…if we don't know about behaviors, we don't have the resources, literally sometimes you need two or three staff if someone is aggressive." (38)

Table 3. *Continued*

Participant description of factors impacting the quality of transitions	Perceived impact on quality of transition	Quotes from SNF nurse participants
Control over admission decisions		
• Clinical knowledge of staff reviewing potential admissions • Authority DON has to make admission decisions • Ability of facility to safely meet potential resident needs	• More likely to be able to ensure placement decision is appropriate and that facility can meet resident's needs • Able to seek out important information with appropriate clinical background • Authority to deny admissions deemed unsafe	"The marketing person didn't know diddly-squat about long-term care… no clinical background whatsoever. We were trying to train her but she didn't know anything about behavior and nothing about medication. The person would come in totally confused and she said they were A&Ox3. Where I am now, we have me and [Director of Nursing] doing referrals and admissions. Here we make sure if someone is coming to us they have a good shot at staying because we know what we're looking for." (1) "Part of the agreement I have with administration is that as DON I have the ultimate say on who we admit. I worked in an organization where all that drove admissions was the bottom line and I will never be in that situation again of admitting residents you cannot safely care for." (40)
Caregiver engagement during the transition		
• Contact information for family or informal caregiver • Time to contact caregiver • Engage caregiver throughout the transition process in order to build tailored care plan • Build relationship with caregiver prior to admission • Encourage caregiver to prepare PwD	• Caregivers may experience less stress as a result of a smoother transition • Engaged caregivers serve as key information sources for learning about the PwD and developing a care plan • Engaged caregivers can be physically present during transition • Caregivers have the opportunity to be involved in care early on and establish relationship with SNF staff	"So with a perfect admission, the resident would come in and we would greet them before change of shift, we'd know things about them, we can have visits with the family. The family could stay for lunch or even overnight if needed. We would know 'what should we expect tonight and tomorrow'… not pills and stuff, but 'what are we working with here?' That would be perfect." (39) "What made it [transition] better was we had a lot of interaction with the family saying what works better for her mother… things that her mother liked to eat, things she was interested in doing; you know, she liked magazines – so they always had a stack of magazines they brought in…. if we can do this I think it's better, you know, for the family. Because if there's a lot of stress and behavior issues and the family has to also see this or we're calling and telling them about it – of course it's very upsetting, I think we start off on a bad foot with a lot of dissatisfaction because of that most of the time" (34) "If someone doesn't have any family, well we just kind of have to dig into a background somehow with neighbors, or a distant relative, anybody…we need to know who someone is. If we know this the plan is stronger." (30)

Note: A&O = alert and oriented; DON = Director of Nursing; SNF = skilled nursing facility.

Participants discussed feeling ill-equipped to safely care for someone with dementia without detailed information about their behaviors and the type of supportive care required to manage them. Lack of transparency about behavioral care needs was described as contributing to a range of negative consequences including an inability to prepare a safe environment, falls, injury of other residents or staff, staff anxiety, increased staffing needs/care costs, and rehospitalization or transfers to a different SNF (Table 3). Nurses thought that detailed information about the range and features of different behaviors was necessary to prepare staff for possible behavioral changes. One SNF nurse shared a story of a resident who was not placed on a secured-locked unit as they were told by the hospital that she did not wander, but who ending up quickly eloping and as a result sustained severe cold-related injuries: "They said 'Oh no, she never wandered'…after the whole thing her son shows up, 'Oh yeah, they knew we'd be out looking for mom.'" Another SNF nurse described a situation wherein a newly admitted resident was aggressive towards another resident during their first meal in the facility which ultimately led to the resident being transferred to a different SNF: "You see, to the families we dropped the ball but no one told us to keep this person arms distance or anything. Then we find out this has happened before and… well this is not the first time, it's a pattern. And the other resident is injured so that's a citation for us and the lady, well she just had to go to a different facility."

The difficulty associated with finding SNF placement for individuals with challenging behavioral symptoms, such as aggression, was a prominent recurring theme. Due to concerns regarding safety and regulatory penalties for use of antipsychotics in their facilities, some participants identified screening for specific types of behaviors or characteristics such as aggression, constant calling out, and requiring regular use of antipsychotics. Some SNF nurses indicated that PwD that exhibited these behaviors/characteristics would never be admitted to their facility due to monetary or safety concerns.

Management of behavioral symptoms during the early transfer period was also described as being relevant to the greater social milieu. One nurse noted that because their facility provided long-term care, the addition of new residents could often disrupt other residents' "actual lives." Collectively, these additional complexities contributed to the perception of hospital-to-SNF transitions for PwD as being especially difficult, resource intensive, and requiring more time and planning.

Impact of Control Over Admission Decisions

Nurses described having better transitional care outcomes when the Director of Nursing in their facility had authority to deny admissions deemed unsafe and the staff member screening admissions had clinical knowledge as opposed to having no clinical training. Participants described admission decisions as being influenced by perceived resident safety issues, administrative pressure to fill beds, perception of the risk/disruption the new resident might pose to the environment, whether resident needs could be safely met and potential additional staffing needs. In situations when nursing staff did not have control over admission decisions, new residents whose needs surpassed the environmental capacity were sometimes admitted, which SNF nurses believed placed them at high risk for rehospitalization or transfer to a different SNF (Table 3).

Caregiver Engagement During the Transition

When asked about examples of transitions that went well, almost all nurses identified a situation in which they had the opportunity to work closely with the resident's family or caregiver prior to the transition. This provided them a chance to discuss goals of care with the caregiver, acquire valuable information about personal/social needs and preferences, and help the caregiver prepare the PwD for the transfer (Table 3). Access to caregivers was particularly important because SNF nurses described rarely being able to build an adequate behavioral and social care plan based upon information sent from the hospital, which focused predominantly on medical needs and care. SNF nurses also specifically sought information about previous strategies that were used successfully in the home to engage the PwD or to mitigate behavioral symptoms that arose. Several participants described having informal caregivers physically present during the transition period, in some cases

overnight, as a useful strategy for "easing the transition" for the PwD.

The Role of Timing in Transitions for PwD

The importance of having sufficient time to prepare the PwD, their caregivers, SNF staff, and the physical environment was highlighted by all participants and served as a dominant underlying issue complicating efforts to meet the transitional care needs of PwD. Nurses noted that in many instances, the transitional care needs of PwD, specifically with regards to discharge communication, were likely beyond what was readily available in the hospital setting. While SNF nurses had developed strategies to obtain detailed personal/social information from other informants, they reported rarely having access to contact information for potential informants or adequate time to seek this information. One nurse described a typical timeframe as, "You know I get the call at 2 pm and they show up at 4 pm. What can I do in that time? I may not even have all of their information. How can that work for someone who is already confused and disoriented?" Across all participants, nurses reported that it was nearly impossible to develop and implement sufficiently tailored care plans or prepare someone with dementia for the transition under the time constraints of typical hospital transfers: "They've got no time to even realize what's coming. And maybe that works for you or me but for someone with issues like dementia, they are just side swiped and have no clue, it makes everything worse for them."

Perceived Misalignment Between Hospital Pressures and Transitional Care Needs of PwD

SNF participants described the inability to consistently meet the transitional care needs of PwD during hospital-to-SNF transitions as resulting, in part, from misalignment in priorities and system-level pressures between the hospital and SNF setting. Many of the areas of conflict between the hospital and SNF setting were interrelated with the conditions they described as enabling or hindering successful transitions. The most salient areas of conflict identified included: (a) hospital time pressures to discharge patients quickly, (b) differences in the degree of emphasis on medical and social/behavioral needs between hospital and SNF settings, (c) differing views regarding the impact of transparency about behavioral symptoms and associated care needs, and (d) different perspectives regarding what defines a successful transition. SNF nurses noted that hospital providers are frequently pressured to discharge patients quickly and that this pressure may further limit their willingness to share information about behavioral symptoms, stating that hospital providers may not disclose information in order to avoid jeopardizing placement (Table 3). SNF nurses also felt that they had "a different idea (about what) success means," indicating that hospital providers might engage in different activities if their goals for transitions extended

beyond discharging a patient on time or avoiding rehospitalization within 30 days. SNF nurses described several ways that this misalignment impacted the transition process, which generally fell into four overarching categories: (a) limited opportunity to plan, (b) unmet information needs, (c) unmet safety needs, and (d) unexpected transitions and distress. These areas of impact all related specifically to the unique transitional care needs nurses identified being relevant to PwD and the strategies they sought to engaged in order to address these needs.

Discussion

This study provides an understanding of SNF nurses' perspectives of the experiences of PwD transitioning from hospitals into a SNF. Participants identified PwD as having unique transitional care needs that require a comprehensive understanding of social/behavioral histories in order to optimally transition them into a SNF environment. SNF nurses consistently identified hidden needs relating to behavioral symptoms as the single most challenging aspect of transitional care for PwD.

SNF nurses highlighted the importance of tailoring transitions to individual social contexts, preferences, and needs. The concept of tailoring transitional care activities to individual resident backgrounds/preferences is not widely reflected in existing evidence-based transitional care programs, which rely heavily on standardized approaches (Coleman, Parry, Chalmers, & Min, 2006; Feltner et al., 2014; Kind et al., 2012; LaMantia, Scheunemann, Viera, Busby-Whitehead, & Hanson, 2010; Naylor et al., 2004; Rennke et al., 2013; Snow et al., 2009). Transitional care activities generally emphasize improvements in the coordination of medical care, often emphasizing medication management as medication errors are known to contribute substantially to adverse outcomes following hospitalization (Coleman et al., 2006; Feltner et al., 2014; Kind et al., 2012; LaMantia et al., 2010; Naylor et al., 2004; Rennke et al., 2013). The importance of social care highlighted in this study is perhaps partially reflective of the focus of care in SNF settings which often serve as a long-term home for many residents. Because the ability to manage behaviors was cited as impacting other outcomes such as decisions to rehospitalize or transfer someone out of the SNF, it is possible that other vulnerable populations with challenging behavioral care needs, such as some mental illnesses, may also benefit from transitional care activities that are tailored to individual social and behavioral needs. Further research is needed to document the accuracy and prevalence of discharge communication about behavioral symptoms for PwD and to understand the impact of inaccurate or omitted social and behavioral communication.

The current study also identified perceived areas of conflict between the needs of PwD and standard processes within the hospital–SNF care systems. Many of the unique transitional care needs nurses described relied upon having the time and opportunity to acquire additional information, which can be challenging under the pressures many hospital settings feel to discharge patients quickly (Connolly et al., 2009). As we increasingly operate in an era of episodic care, consideration should be given to how these conflicts might be addressed in more integrated care networks where entities share responsibility for a group of patients, such as Affordable Care Organizations (ACOs). In these care models, existing relationships across systems may enable earlier information sharing so as to allow nurses' access to knowledgeable informants without delaying discharge (King et al., 2013).

Caregivers were described as playing a central role in improving the quality of the transition for the PwD. It would be of great interest to explore whether caregivers can be activated to consolidate and share their unique knowledge of the PwD during existing discharge planning processes. This may prove a more effective approach to completing the picture of "the person" with dementia that SNF nurses describe needing, as hospital providers are unlikely to have the opportunity to develop the necessary longitudinal knowledge in order to provide sufficiently detailed information about personal history and long-standing behaviors.

Under-communication of behavioral symptoms was perceived as resulting in inappropriate placement, risk for rehospitalization, and resident harm. Participants thought this was due to the hospitals' difficulty finding placement for people with challenging behaviors or people requiring antipsychotic medications as SNF providers may avoid these admissions due to potential regulatory repercussions. This finding raises questions about under-communication of behavioral symptoms as a potential unintended consequence of regulations aimed at reducing antipsychotic use among nursing home residents (Centers for Medicare and Medicaid Services, 2014). The Partnership to Improve Dementia Care in Nursing Homes, which was initially launched in 2012 with the goals of improving quality of life and function for nursing home residents—specifically targeted those with dementia, focused on increasing the use of person-centered nonpharmacologic approaches to reducing dementia-related behaviors and reducing the use of off label antipsychotics (Centers for Medicare and Medicaid Services, 2014). In line with this initiative, nursing homes face monetary penalties for failing maintain compliance with federal regulations mandating that nursing home residents remain free from inappropriate antipsychotic usage and that those who are prescribed antipsychotics have an appropriate diagnosis recorded and undergo regular monitored gradual dose reduction (Centers for Medicare and Medicaid Services, 2015). Consistent with other studies, participants in this study acknowledged the ongoing burden of coping with the overwhelming amount of regulatory pressures (Klerks, Ketelaars, & Robben, 2013; Shield et al., 2014) and identified the pressure to further reduce

antipsychotic usage as an important decisional factor in decisions to accept/transfer patients as they are ultimately responsible, and penalized for the range of outcomes associated that occur following either poorly managed behavioral symptoms (such as patient harm) or ongoing antipsychotic use. While these policies focus largely on antipsychotic usage, participants in this study described the influence of under-communicated behavioral symptoms for as adversely impacting patient safety and the SNF regardless of antipsychotics as behaviors sometimes resulted in patient harm for which the staff and facility were held responsible despite their inability to prepare for these events.

While any transition can be reasonably expected to result in some behavioral changes in a PwD, many behavioral symptoms have been shown to be highly persistent even after the transitional period (Steinberg et al., 2004). Identifying and communicating long-term behavioral issues presents several challenges as hospital providers may not have knowledge of all relevant behaviors, these findings suggest that there is a need to develop strategies which facilitate and incentivize this communication. Longitudinal care plans (LCPs) may serve as a valuable mechanism for improving communication transfer about social and behavioral needs across a range of transitions for PwD (Dykes et al., 2014). An LCP is intended to be patient-centered and to communicate specific patient values and preferences and has broader immediate applicability in care settings with high levels of electronic health information sharing. Development of LCPs may involve dementia clinics or primary care providers partnering with caregivers. Considering the potential for existing interventions to serve as a framework for enhanced identification and communication about behavioral symptoms is also important. The Interventions to Reduce Acute Care Transfers (INTERACT) program is one example of a nursing home-based intervention that has been efficacious at improving communication between hospitals and nursing home settings (Ouslander & Handler, 2015). Existing features of this program may provide a unique platform for addressing communication between the hospital and SNF setting.

While the hospital-to-SNF transition for PwD is an understudied area, findings from this study are consistent with other studies that found poor quality discharge communication as common and adversely impacting the hospital-to-SNF transitions (Kind & Smith, 2008; King et al., 2013). Past descriptive research also has found nursing facility staff were reluctant to accept patients with behavioral problems, particularly patients requiring individual 1:1 attention. However, nursing facility staff believed that communicating with a single knowledgeable person about the resident prior to admission would be helpful (Popejoy, Galambos, & Vogelsmeier, 2014). Future research is needed to explore the placement needs for individuals with intensive care needs, who were also described in this study as being denied admission to facilities based upon their behavioral care needs.

This study has limitations. All nurses interviewed were from a similar geographic area and interview data were not supplemented with participant observations. Findings from this study represent the perspectives of SNF nurses, additional research is needed to examine hospital provider perspectives and care practices regarding these transitions as well as the perspectives of PwD and their caregivers. Despite these limitations, this study has identified factors that may influence the quality and possibly care trajectories for PwD which have previously not been reported in the published literature. Future research exploring the quantitative associations between these factors and transitional care outcomes is merited.

Implications

PwD transitioning from hospitals to SNFs have highly specific transitional care needs, which are often not adequately addressed by existing health system approaches to care. To improve transitional care for PwD, health systems must recognize these needs and tailor transitional care processes accordingly. Specifically, hospitals and SNFs must work hand-in-hand to optimize the transition for these highly vulnerable patients—improving real-time and bi-directional communication between settings, ensuring that planning time is adequate for full preparation for the transition, and involving patients and informal caregivers/families throughout the planning process. These findings also suggest that providing SNF staff with contact information for knowledgeable informants early on in the planning process/ prior to discharge would strengthen the SNF's ability to prepare and orchestrate a high-quality transition. This will require a substantial change in the way such transitions are handled currently. Addressing the transitional care needs identified by SNF nurses in this study would require hospitals, in particular, to embrace accountability beyond their own walls. The perceptions of hospital providers regarding the quality of communication and their accountability for facilitating this communication have not been previously examined; however, some research has shown that hospital providers may not have an understanding of the needs and limitations of SNF settings (King, 2015; King et al., 2014). Both hospitals and SNFs may also consider further exploring communication resources available through the INTERACT program at https://interact2.net/, which may provide a useful platform for informing enhanced bi-directional communication.

Conclusion

SNF nurses perceive hospital-to-SNF transitions for PwD as challenging, resource intensive, and generally poor in quality. Nurses emphasized the need to gather a detailed understanding of the PwD's unique personal, social, and behavioral care needs prior to transfer in order to improve transitional care quality and outcomes. Provided the

remarkably high risk for rehospitalization associated with both discharge to a SNF and dementia, further investigation of the prevalence and potential impact of the perceived unmet transitional care needs during these transitions is warranted.

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