Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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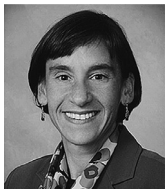
Editorial



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Transitions of care from our inception to COVID-19: What have we learned?

When we initially conceptualized our anniversary issues for Geriatric Nursing we certainly did not know that we would experience a national pandemic due to the coronavirus. Surprisingly, however, the topics addressed in our history and today are extremely relevant to our activities during this pandemic. Optimizing transfers to the acute care setting from a long term care facility has always been important and is increasingly so during this pandemic. The pandemic forced us to think about limited resources in all settings of care and to carefully consider where the resident would receive the best possible care consistent with his or her care goals. To address transitions to acute care during the pandemic, in my own practice I called all of our resident's legally authorized representatives or spoke with the resident him or herself if appropriate to review end of life care preferences and particularly what they would want in the event that the individual became positive for Covid-19. It was extremely helpful to have these discussions ahead of time and not to have to address these issues in the middle of the crisis.

Neither of our featured articles related to care transitions in this anniversary year issue, the article from 1982, Transfer: Nursing Home to Hospital[1] or the current article in this journal, Models of Care that Avoid or Improve Transitions to Hospital Services for Residential Aged Care Facility Residents: An Integrative Review,[2] addressed advanced care planning and ways to address acute and potentially life-threatening events such as Covid-19 and decisions around transitions to acute care from long term care settings. The 1982 article[1] provides what are still timely suggestions about how to facilitate a transfer to the acute care setting for residents. Those recommendations include sending the resident's preferences for use of "heroic measures", their "living will", and their consent for the donation of organs. The current article in this journal[2] reviewed studies of models of care that helped to avoid or improve transitions of care with a focus on early identification of clinical problems and onsite management of those problems rather than preplanning and clarifying decisions about transferring to the hospital for any type of event.

What have we learned about transitions of care

The 1982 article starts out by noting that a transfer to an acute care facility has a significant impact on the resident's well-being. Multiple studies have shown that when hospitalized older patients engage in very low levels of activity[3-12] they are more likely to experience potentially preventable complications such as delirium, neuropsychiatric symptoms, pressure ulcers, falls, nutritional deficiencies[13-15] and functional decline.[12,16-19] There is little evidence that we have improved the clinical outcomes associated with hospitalizations as per the integrative review published in this issue.[2]

The reasons for transfers to the acute care setting back in 1982 are quite similar to the reasons for transfers today. Specifically, the 1982 article noted that there was variability in what care could be provided during an acute event depending on the long term care setting. Transfer to acute care generally occurred for residents who needed intravenous or oxygen therapy, stat blood work or x-rays that could not be obtained in the setting. This is quite true today particularly with regard to assisted living settings. Increasingly, however, there are options such as companies that can provide blood transfusions in nursing home settings to avoid hospital transfers.

Of the list of recommendations for ways to optimize hospital transfers provided by Feldman in the 1982 article, there were two glaring issues that would not be appropriate today: (1) the recommendation to share information about the resident that was sent out with fellow residents to reassure them that the resident was being cared for appropriately. This is no longer possible since the Health Insurance Portability and Accountability Act; and (2) the picture of a resident restrained with a vest restraint and geri-chair table restraint being lovingly cared for by a nurse in a white uniform with a cap! These points are a reminder, particularly relevant as we muddle through care of Covid-19 residents, that we do the best we can with the knowledge we have at the current time.

The current paper in this issue about transitions of care is an integrative review that evaluated 21 papers and essentially noted that communication tools such as resident transfer forms, advanced directives and medication lists, all of which were recommended to be sent with a resident in the 1982 paper, helped to improve the transfer of

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information during care transitions. Newer concepts for facilitating or decreasing transfers and improving outcomes for residents focused on coordination of care between the settings, better access to health care providers in the long term care settings, and the building of partnerships between the settings. Given the heterogeneity of these models, more research is needed to establish best practices.

At this point in time we have yet to learn about the impact of transitions of care for older adults in long term care settings that were transferred to the hospital for Covid-19 associated symptoms versus those cared for within the setting. As with all end of life decisions the decision for transfer during the pandemic is a personal choice for the legally authorized representation and/or resident and should be based on the best information we have to date. Carefully and realistically thinking through what the transfer might mean-the hospital might provide access to more rapid and aggressive treatment options even short of intubation, versus care in the facility which would likely focus on supportive care with regard to fluids, oxygen, and good basic nursing care among caregivers that are likely to be more familiar than those encountered in the acute care setting. The impact of Covid-19 may guide future recommendations about transfers for older adults during pandemics or epidemics such as this. I hope, however, it helps us all be more thoughtful of what we want for ourselves, for our families, and how we can help assure that our residents likewise have their end of life, or potentially end of life preferences met. I leave you with one thought. . ..one little silver lining to Covid-19 is to use this opportunity to update advanced directives using whatever format might be required in your state and to carefully review how transitions and decisions around transfers are met within your settings of care.

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