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GUEST EDITORIAL

Transitions, Continuity, and Nursing Practice

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Continuity of care is a term commonly used in nursing and in health-care circles. The continuity-of-care concept is considered both an aim and a philosophy that affects the delivery of care. Most clinicians consider continuity a standard of care. The notion of continuity has been conceptually intertwined with discharge planning, transitional care, coordinated care, continuing care, and ongoing care.

A distinction must be made between regular, ongoing sources of care, referred to as longitudinality, and the concept of continuity (Bedder & Aiken, 1994; Rogers & Curtis, 1980; Starfield, 1980). A definition that encompasses longitudinality, but also integration and comprehensiveness across transitions, with care provided over time in various episodes, is crucial. Consideration must be given to care activities (therapeutic and self-care) and linkages (communication, documentation, referrals, etc.) and the balance of care provision between professionals on the one hand and individuals and families on the other (Harrison, Browne, Roberts, Graham, & Gafni, 1999). For patients this means receiving the care they need, over time, in a coordinated and connected manner, with planned and supported continuity between the care they receive from professionals such as nurses and the care they may be assuming (or resuming) themselves. From a provider's perspective, it means articulating *transfe*r rather than *admit and discharge,* where responsibility typically begins and ends. Ideally it involves an in-reach and outreach that may not be formally funded or administered, by either the setting or the sector of care. To achieve continuity, settings and providers must make a proactive, systematic, intersectoral effort at the transition points.

Continuity always involves transitions on the part of individuals, such as well to ill, home to hospital, and the gaps they may encounter along the way. For nurses, transitions are a focus of practice, as continuity involves transitions in care and affects mainly populations with complex health issues. During times of transition, the nurse is very often the health professional most involved in evaluation and in planning and delivering the change in care that is required. Complex health populations are char-

acterized by requiring care in more than one health sector, having two or more chronic conditions, or when day-to-day management calls for the participation of the individual and the family (Harrison, Browne, Roberts, Tugwell, & Gafni, 2002).

Transition may take many forms. A developmental transition could be that from couple to family in maternity care or from pediatric to adult care in the management of muscular dystrophy or cystic fibrosis. Health-sector transitions include hospital to home or home to long-term care. There may be transitions related to the illness itself such as diagnosis to treatment to palliation in cancer care. Sometimes two or more transitions occur at the same time — for example, condition and sector transitions in the case of diagnosis in an outpatient venue and subsequent hospitalization for complex medical or surgical care. Nursing bridges all types of single and multiple transitions. Once the diagnostic procedures and medical treatments are complete, the nursing care shifts to support for self-management and the maintenance of wellness throughout the transitions. Nursing therapeutics may be restorative, promotive, preventative, or interventive in nature (Chick & Meleis, 1986; Meleis, Sawyer, Im, Messias, & Schumacher, 2000; Schumacher & Meleis, 1994). Nursing care is critical to successful transition.

Continuity-of-care concepts date back to the rise of hospital care in the early 1900s (Shamansky, Boase, & Horn, 1984). Nurses provided leadership in research focused on transitions and continuity. One of the first studies was an investigation of the hospital-to-home transition (n = 200) conducted in Cleveland by Mary Strong Burns, RN, early in the last century (Burns, 1921). Discharge planning grew out of the early work on hospital-to-home transition. More recently, continuity has become a focus of professional and accreditation bodies, and, although still largely centred on hospital transitions, has broadened to include transitions in other sectors. This is partly due to the profound shift in the direction of health-care delivery in the mid-1980s in North America, from largely institutionally based care to community- and home-based alternatives. This direction has continued and challenges existing structures and processes across the entire continuum to address continuity. Research, however, remains developmental. A report commissioned by the Canadian Health Services Research Foundation (CHSRF), involving a literature review and consultation process, concluded that (1) continuity is perceived differently in primary care, mental health care, nursing, and condition-specific care; and (2) it is premature to identify specific indicators of continuity (Reid, Haggerty, & McKendry, 2002). The CHSRF identified two core elements: experience of care by an individual with his/her provider, and the fact that care continues over time. Conceptual and measurement issues in continuity clearly merit

more research attention, and this effort must be addressed by many disciplines using multi-method approaches.

For this issue of the Journal, we received papers describing research studies, addressing methodological issues, and analyzing theoretical issues related to continuity of care. The authors report on transitions within several different complex populations. Durbin and colleagues evaluate the structure of community and outpatient programs dedicated to continuity in mental health care. They conclude that program structure and delivery do not influence the continuity of care experienced by clients, but that "subjective continuity" may be more dependent on provider and relationship variables and should be further examined. Sword and colleagues address continuity following a reduction in the length of postpartum hospital stays in Ontario. The authors raise concerns about current health strategies and the lack of attention to a potentially significant aspect of care, informal and voluntary supports during the postpartum period. This may be an overlooked component of multi-interventions for families following childbirth. Flanagan describes transitional measures for newly released prisoners with significant health problems such as AIDS, tuberculosis, and hepatitis. A key issue in enhancing continuity for these groups is improved tracking of information across correctional and intermediary settings.

The research papers are augmented by several invited pieces focusing on different aspects of continuity. A recent nurse-led community service (Karen Lorimer) for a population with chronic wounds demonstrates the iterative process of producing and using evidence to improve continuity. Capturing meaningful outcomes and the challenge this presents across the continuum of care is addressed in the Designer's Corner as Diane Doran reflects on a recent Ontario-wide initiative. Policy analyst and family physician Sam Shortt challenges health ministries to think more broadly about continuity within primary care, and particularly to go beyond the singular focus on longitudinality. Knowledge transfer presents special challenges during transitions and across the continuum. Graham and Logan summarize several frameworks that can be used to guide nurses in implementing research-based practice across the continuum of care.

Transitions are an important research focus for nursing practice, and the CHSRF report deals with continuity according to its notions about informational, relational, and management continuity (Reid et al., 2002). The range of subjective, cognitive, behavioural, environmental, emotional, and physical conditions that are present during transitions demands a comprehensive nursing research approach. Such an approach is necessary to deepen our understanding of the phenomenon of transitions — both the continuity gaps and the effectiveness of interventions to narrow them. Since this is an emerging area of research, any inquiry will have to

entail both clinically focused research and a health-services perspective using quantitative and qualitative approaches. Conceptualization issues will be advanced through rigorous concept analysis and qualitative inquiry into the phenomenon from the perspective of individuals and families as well as the perspective of providers and the system.

The nature of continuity requires a multi-interventional approach, one that challenges the value of traditional evaluation methodologies. The coming of age of health-services research is a positive step in this direction, and nurse investigators must be key players here as well. The challenge is ours to take up.

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