Summary Report
Virtual Visiting Professor by Professor Jos Latour

1st Session (November 8, 2021 from 14.30 – 16.30 hours)

Topic: "Patient Outcomes, Nursing Outcomes, and Quality of Care"

Patient-reported outcome measures capture a person's perception of their health through questionnaires. They enable patients to report on their quality of life, daily functioning, symptoms, and other aspects of their health and well-being. Patient outcomes are measurable changes in health, function, or quality of life that result from our care. Constant review of our clinical outcomes establishes standards against which to improve all aspects of our practice continuously. I have experience assessing patient outcomes, namely the quality of life of brain tumor patients, before, shortly before discharge, one month, two months, and three months after discharge from the hospital.

Monitoring the patient's quality of life was carried out using the EuroQol questionnaire. The EuroQol Group introduced the 5-level EQ-5D version (EQ-5D-5L) in 2009 to improve the instrument's sensitivity and reduce ceiling effects compared to the EQ-5D-3L. The EQ-5D-5L essentially consists of 2 pages: the EQ-5D descriptive system and the EQ visual analog scale (EQ-VAS). The illustrative method comprises five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each dimension has five levels: no problems, slight problems, moderate problems, severe problems, and extreme problems. The patient is asked to indicate their health state by ticking the box next to the most appropriate statement in each of the five dimensions. This decision results in a 1-digit number that expresses the level selected for that dimension. The digits for the five dimensions can be combined into a 5-digit number that describes the patient's health state. The EQ-VAS records the patient's self-rated health on a vertical visual analog scale, where the endpoints are labeled 'The best health you can imagine and 'The worst health you can imagine. The VAS can be used as a quantitative measure of health outcomes that reflects the patient's judgment.

The result was that brain tumor patients experienced improvements in all five dimensions of quality of life at three months after discharge from the hospital, compared to the time of hospital admission. However, a third of the participants still experience various problems in various levels of quality of life. This result is beneficial for the sustainability of long-term care nursing services. Nurses can develop interventions to optimize the quality of life of post-treatment brain tumor patients.

Measuring nursing outcomes has the potential to support and strengthen nursing in all areas of practice. Evaluation of nursing practice comprehensively can facilitate improvements in nursing quality, patient safety, the patient experience of care, and healthcare outcomes. Nurses have a social and an economic imperative to measure outcomes. Nurses are accountable for and obligated to measure interventions and outcomes in health promotion, prevention of illness and injury, and alleviation of suffering. Therefore, nurses have a social obligation to develop and document the evidence base for the entirety of nursing practice and shift from a task-based practice, which emphasizes what nurses *do for* patients, to an outcome-based practice that emphasizes what nurses *achieve with* patients.

Nurses have a social responsibility to evaluate the effect of nursing practice on patient outcomes in health promotion, prevention of injury and disease, and reduction of suffering. However, quality assessment initiatives are hampered by the lack of available data related to the nursing process and patient outcomes in these three practice domains. Direct care nurses are an integral part of self-regulation for the discipline because they are the best source of information about nursing practice and patient outcomes.

2^{nd} Session (November 15, 2021 from 15.00 – 17.00 hours)

Topic; "Transition of Care and Follow-up care"

Transitions of care are a set of actions designed to ensure coordination and continuity. They should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient's treatment goals, preferences, and health or clinical status. They include logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition. Research on transitional care is essential to optimize patient health. For example, the importance of conducting research on the challenges faced in the transition of adolescents with chronic conditions from pediatric to adult care. From the investigation, it was found that several components that need to be prepared during this period are managing your care; namely, adolescents with chronic conditions need to take over responsibility from parents, self-management: at home, but adolescents should also be involved as active partners during consultations and managing your own life: social participation & empowerment. So, we need an effective transition program, including a cultural shift in staff attitudes and training, put an effective transition program in place, and train young people to become care partners.

In addition to quantitative research, transitional care can also be studied with a qualitative approach. An example is a research on patient experience in the emergency department. Patient experience is positively associated with clinical effectiveness and patient safety and should be a priority for emergency care providers. However, the emergency department (ED) environment presents many potential barriers to optimal patient experience. Based on the perceived 'needs' of patients visiting the ED, the results were defined as communication, emotional, competent care, physical/environmental, and waiting for needs. Findings were translated into a conceptual model for optimizing patient experience in the ED.

Another qualitative research is about exploring the experiences of parents of children admitted to pediatric intensive care units. Admission to a pediatric intensive care unit (PICU) is often a transitional phase in the child's recovery from a critical illness. Most parents experience a PICU admission with a specific emotional impact. Parents were interviewed within one month after their child's discharge from a PICU. The subthemes were categorized into six major themes: attitude, coordination of care; emotional intensity; information management; environmental factors; parent participation. Most themes had an overarching relationship representing the array of experiences encountered by parents when their child was staying in a PICU. The findings of this study have important clinical implications related to the more profound understanding of parental experiences and improving family-centered care.

Care transition is defined as a hospital discharge or movement from one care setting to another. The risk that readmissions pose to patient safety requires transitional care processes under constant evaluation for the patient experience. Nurses must navigate clinical communication and coordination of patient care, and they are best equipped to coordinate a successful transition. The bedside nurse, for example, may understand more about the patient's needs as they travel through the care continuum than other care team members. And when those needs are communicated effectively, the nurse can extend high-value care to the patient. Nurses create transitional care plans by compiling all the pertinent patient information and creating instructions to be followed. Then they collaborate and share the procedure in detail with all new care team members. This ensures the handoff is seamless for both the patient and the new unit or facility. The most crucial factor in transition care is communication during and after this handoff process.

Nurses have several roles that can contribute to the success of a transitional care program. These roles include nurses playing a pivotal role in promoting successful transitions by developing and evaluating the transition plan and identifying and communicating barriers to the project. In addition, nurses must engage patients and caregivers as active partners and advocates for their healthcare and community support needs. Also, nurses must extend their scope of influence on longer-term outcomes by identifying and documenting transition issues early, implementing strategies to address concerns, and communicating the transition plan to the next level of care.