

SHORT COMMUNICATION

Rehabilitation Nursing Intervention with the Post-Stroke Person: Application of the Transitions Theory

Intervención de Enfermería de Rehabilitación con la Persona Post-ictus: Aplicación de la Teoría de las Transiciones

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ABSTRACT

In the context of the community, Rehabilitation Nurses are seeing an increase in the ageing population. As well as facing the natural challenges of life-long transitions, this population is more vulnerable to chronic and degenerative diseases, which have a direct impact on their functional and cognitive abilities and quality of life. It is the responsibility of rehabilitation nurses to develop strategies that respond to the specific needs of this ageing population, promoting their autonomy, independence and well-being in the community. Stroke has been identified as a public health problem and is one of the cerebrovascular pathologies that cause permanent disability. Afaf Meleis' theory of transitions offers a conceptual framework that allows a deeper understanding of the process of change and adaptation of people to the transition they experience, contributing to personalized care. It helps specialist nurses to understand and intervene in the transition processes experienced by people who have suffered a stroke. This article analyzes the application of this theory to the practice of rehabilitation nursing, highlighting the challenges and essential interventions for a successful transition from a medium-stay and rehabilitation unit to home.

Keywords: Rehabilitation Nursing; Stroke; Transitional Care; Hospital to Home Transition.

RESUMEN

En el contexto comunitario, las Enfermeras de Rehabilitación observan el creciente envejecimiento de la población. Esta población, además de enfrentar los desafíos naturales de las transiciones a lo largo de la vida, es más vulnerable a enfermedades crónicas y degenerativas, que impactan directamente en sus capacidades funcionales y cognitivas y en su calidad de vida. Es responsabilidad de las enfermeras de rehabilitación desarrollar estrategias que respondan a las necesidades específicas de esta población envejeciente, promoviendo su autonomía, independencia y bienestar en la comunidad. El accidente cerebrovascular se identifica como un problema de salud pública, siendo una de las patologías cerebrovasculares que generan discapacidad permanente. La teoría de la transición de Afaf Meleis ofrece un marco conceptual que permite una comprensión más profunda del proceso de cambio y adaptación de las personas a la transición experimentada, contribuyendo a la atención personalizada. Ayuda a enfermeras especializadas a comprender e intervenir en

los procesos de transición que viven las personas que han sufrido un Accidente Cerebrovascular. Este artículo analiza la aplicación de esta teoría en la práctica de la enfermería de rehabilitación, destacando los desafíos y las intervenciones esenciales para una transición exitosa de una unidad de rehabilitación de mediano plazo al hogar.

Palabras clave: Enfermería en Rehabilitación, Accidente Cerebrovascular, Cuidado de Transición, Transición del Hospital al Hogar.

INTRODUCTION

Stroke is still the second leading cause of death in the world and one of the main causes of disability in adults in Europe. A 34 % increase in the number of new stroke cases is predicted, due to the aging of the population that all of Europe and developed countries are experiencing.⁽¹⁾ At that time, it is estimated that the incidence of stroke will continue to occur mostly over the age of 65 and that the number of people living with stroke is expected to increase by one million.^(1,2) The majority of stroke survivors suffer from neurological deficits and significant long-term physical, sensory, cognitive, language and visual impairments, implying a reduction in functional capacity to carry out the various activities of daily living.⁽³⁾ In addition, there are sequelae such as reduced muscle strength, movement incoordination, language alterations, visual field impairment, deglutition.⁽⁴⁾

The Rehabilitation Nurse Specialist (RNS) is essential in the rehabilitation process after a stroke, offering specialized care that promotes physical, emotional and social recovery, helping the person to achieve the maximum possible independence and improve their quality of life.^(5,6)

All the clinical practice of the specialist nurse must be based on the theoretical references of the discipline, in order to justify interventions and decision-making, supported by scientific evidence.⁽⁷⁾

Rehabilitation Nursing (RN) is currently asserting itself as one of the health professions that implements in its care its own distinctive knowledge that comes from scientific research, but above all from the experience of practice (PBE), orienting itself under the specific guidelines of its specialized area of activity.⁽⁸⁾

It is essential for the RNS to reconsider its interventions in different work contexts, aligning its practice with theory, keeping up with population and technical-scientific developments, thus guaranteeing a conscious, strategic professional practice aligned with objectives.

Understanding specialized rehabilitation care based on Afaf Meleis' theoretical framework means recognizing that nursing care is intrinsically linked to human relationships and the dynamic and transformational context in which they occur (environment)⁽⁸⁾, resulting in health and well-being.⁽⁹⁾

The aim of this paper is to reflect on the importance of applying Afaf Meleis's Transitions Theory as a basis for rehabilitation nursing practice in caring for people with strokes in the process of transition from a medium-stay rehabilitation unit (MSRU) to home.

DEVELOPMENT

SRN care is aimed at people with special needs in their context of life, requiring professionals to draw up and implement care plans adapted to different clinical scenarios⁽¹⁰⁾, an example of which is the specific context under study. Highlighting the importance of rehabilitation nursing care and justifying the RNS's intervention in assisting people with strokes allows them to guide their practice under the different theoretical models, contributing to the quality of care and the excellence of the profession.^(10,11,12)

The excellence of professional practice is directly reflected in the achievement of health gains, as a result of the continuous monitoring of the individual rehabilitation plan and the centralization of care in the person.⁽¹³⁾ This process is driven by the early intervention of the RNS, whose skills profile directly influences the quality of RN care, by promoting quality of life, enhancing functionality, self-care, preventing complications and minimizing disabilities.⁽¹¹⁾

Meleis defines transition as a complex process involving a change in the state, situation, condition or role of a person, family or community.⁽¹²⁾ These changes can be physical, emotional, cognitive or social. They can be voluntary or involuntary.⁽⁹⁾

In the transition process, the RNS develops therapeutic nursing interventions, through activities and nursing actions deliberately designed to provide care. In this way, it is possible to promote quality care, ensuring that the therapeutic interventions are the most appropriate to achieve the desired results, respecting the individuality of each person and promoting their functional and social reintegration.⁽⁹⁾ The goals outlined with the person being cared for should be specific, measurable, achievable, relevant and time-bound (SMART criteria), which makes it easier to monitor progress and make the necessary adjustments to interventions.

Meleis, describes the nature of transitions as processes that involve significant changes in health status (health/illness), environment (organizational), relationships (situational) or personal development, fitting into

new roles and life stages (development).^(12,14)

The transition from MSRU to home can be challenging due to the person's physical, emotional and social limitations. It is essential to understand the art of "caring" at this time of transition, as it is a multifactorial, complex and diverse process⁽⁸⁾, being much more than a simple event of moving from one stage of life to another.⁽¹⁴⁾

The transition experienced by the person with a stroke involves reorganizing and redefining their roles, as well as those of their family or caregiver, in order to integrate the new changes in their lives.^(12,13) According to the Meleis Theory, this transition is classified as situational, resulting in a limited dependence of the person with a stroke on their environment. This limitation can make it difficult for them to satisfy their self-care needs, perform their family role and participate in society and the workplace.⁽¹³⁾ In addition, the transitions experienced by both the person with the stroke and their caregiver or family can overlap, especially in the process of moving from the acute hospital unit to the MSRU and then home. According to Meleis, the nature of the transitions can occur simultaneously and present different patterns (simple, multiple, sequential or related).⁽¹³⁾

The RNS has a privileged position, making a significant contribution to the empowerment and capacity building of the person with a stroke and their family⁽⁹⁾, passing on their specific and differentiated knowledge, which comes from the latest scientific knowledge on cerebrovascular pathology.

The RNS plays a fundamental role as a facilitator in the transition process⁽⁸⁾, from the acute phase to final rehabilitation, implementing strategies aimed at responding to the person's real and potential needs.^(13,14) These strategies aim to promote awareness of the person's limitations and the changes in their life, while integrating the active participation of all those involved in the development of the individual Rehabilitation Nursing plan. This plan, drawn up in collaboration with the person, the family, the caregiver and the RNS, is adapted to the specific needs of each person and can be adjusted over time, depending on the person's evolution and response to the rehabilitation plan.

At the same time, the RNS assesses each person's adaptation to the new health condition and analyzes the individual's management of the current situation and the associated changes.⁽¹⁴⁾ In addition, their intervention promotes autonomy in the decision-making process⁽⁹⁾, since, by implementing person-centered strategies, they enable people to become more aware of their health condition and the options available for treatment and rehabilitation.

The theoretical framework of Afaf Meleis emerges as a valuable support, guiding the daily practice of the RNS and structuring its interventions, ensuring an effective adaptation of the person with a stroke to their new health reality or to an altered functional state after the event, minimizing risks and promoting continuity of care at home. RNSs play an essential role in caring for people who become dependent after a stroke. They use their specific skills to implement self-care training programs, promoting functional readaptation and maximizing autonomy.⁽¹¹⁾ They develop and implement self-care training programs tailored to the needs of each person, taking into account their abilities, limitations and rehabilitation goals. Through these programs, the RNS teaches the person to carry out daily tasks independently, always respecting the individual's pace and abilities.

Self-care training is not limited to physical aspects; it also involves the promotion of cognitive and emotional strategies, since many stroke sufferers face difficulties with memory, attention and controlling emotions. The RNS is responsible for teaching the person how to deal with these changes, providing tools for managing frustrations and anxiety, thus promoting a balance between cognitive, emotional and physical functions.

The involvement of the family in care is indispensable, as is the continuous education of the caregiver, the family and the person themselves⁽¹⁴⁾, who are not always qualified and prepared to deal with the specificities of the person with a stroke, namely in the handling of medical devices, functional rehabilitation.

The RNS should guide, educate and supervise the care provided, maintaining a close relationship with the family and the person with stroke sequelae. In addition, they should liaise with other professionals, namely home support teams and community care unit RNSs whenever necessary, facilitating the transition process from the MSRU to the home, avoiding care failures.⁽¹⁴⁾

It is up to the RNS to carry out an assessment of housing conditions before discharge from the MSRU, in order to prevent barriers that could impede a healthy transition. This assessment will allow problems to be identified when the person returns home, as a lack of support at home could lead to complications which could result in re-hospitalization rates.^(14,16)

The therapeutic nursing interventions that can be implemented in this transition phase include actions such as instructing, teaching, training and advocating, which guarantee a safe and effective transition, with the acquisition of new skills by the person/caregiver/family. This process ensures the smooth integration of the person into their new identity and feeling empowered (mastery)⁽⁹⁾, not only overcoming the physical limitations imposed by the stroke, but also accepting and adapting to a new way of life.

Through specialized and personalized intervention, the person is empowered to take back control of their

life, promoting confidence, independence and, ultimately, improved quality of life. In this way, the RNS's intervention contributes to improving the general state of health, demonstrated in outcome indicators that reflect the process of empowering the person in transition.⁽⁹⁾

CONCLUSION

The combination of RN and Transitions Theory in the context of people with stroke sequelae not only addresses the person's physical needs, but also recognizes and supports the emotional and social adaptations necessary for regaining independence and autonomy and improving quality of life. By adopting the transitions theory, it becomes possible to offer care that is more holistic and tailored to the human responses of people who have suffered a stroke and their caregivers, promoting a smoother adaptation to the new post-stroke phase.

This approach takes into account the multiple dimensions of the transition process, not just the physical changes, but also the psychological, social and emotional ones, providing comprehensive support. Transitions theory allows care to be personalized, recognizing the specific needs and challenges of each individual and providing the necessary tools for successful reintegration into everyday life.

In this way, the RN plays an essential role in the adaptation of the person and family to health limitations, promoting humanized and evidence-based care. The applicability of theoretical references in the daily practice of nurses, particularly those specializing in rehabilitation nursing, is essential for the evolution of nursing as a science and profession.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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