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Application of Transitional Care in COPD Diseases in Yunnan

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Abstract: Under the influence of the increasingly serious aging population in China, the incidence of chronic lung disease (COPD) is also increasing day by day. Due to the airflow limitation and the aggravation of the condition, it affects the cardiopulmonary and motor function of patients, and also has a negative impact on the daily life of patients. The transitional care model provides non-drug treatment programs to help patients pass the transition period safely and smoothly, improve patients' self-care ability, improve the quality of life, and reduce the readmission rate of patients. This paper expounds the feasibility analysis of APN, the concept and connotation of transitional care in Yunnan province, introduces APN to explore the application of transitional care model dominated by APN in COPD, and provides theoretical and practical basis for improving the quality of chronic disease management in COPD.

Keywords: Advanced care practice; Senior practice nurse; COPD; Transitional care

Introduction

Chronic obstructive pulmonary disease (COPD) is a chronic airway inflammatory disease characterized by progressive airflow limitation, and the main symptoms are cough, expectoration, and progressive aggravated dyspnea [1]. Currently, COPD is the fourth cause of death, and it is estimated that by 2030, COPD will be the third leading cause of death worldwide[2].In China, the number of COPD patients increased from 3090 to 51.5020 from 1990 to 2010, up 66.73% [3].Acute exacerbation of the disease is the most important reason for the hospitalization of COPD patients. At present, the current situation of COPD treatment in China is that patients are often hospitalized only because of the acute exacerbation of the disease. When the disease is relieved and enters the stable period, they are discharged from home recuperation [4],During hospitalization COPD patients under the guidance and assistance of medical staff, can be effective processing, but more patients after discharge due to the lack, or no medical staff supervision, prone to health needs, treatment, nursing serious disconnect and insufficiency, eventually lead to declining lung function, repeated, and even worse admission [5],Therefore, it is particularly important to find safe and effective interventions to provide patients with more professional care support to reduce the probability of acute exacerbation. herefore, in order to realize the elderly patients with chronic diseases from the medical environment to the community or family transition during health care seamless, the Naylor in 1989 complete put forward the definition of transitional nursing and combined with advanced practice nurses (advanced practice nurse, APN) for a lot to improve the chronic patients experience [6], improve population health and reduce medical costs related nursing model research. This paper expounds the feasibility analysis of APN, the concept and connotation of transitional care in Yunnan province, introduces APN to explore the application of transitional care model dominated by APN in COPD, and provides theoretical and practical basis for improving the quality of chronic disease management in COPD.

1. Feasibility of APN development in the Yunnan region

The education background, quality and comprehensive ability of the overall nursing team in Yunnan province have been greatly improved, Clinical nurses have accumulated rich experience in clinical specialty nursing —— Expert nurses, this part of the business backbone have to further improve the educational level and their own specialty knowledge and ability to obtain du Hui and professional recognition hope. With the reform of China's health care system, the quality of medical and nursing services will also be guaranteed. More emphasis on quality cost accounting, medical care services will be market internationalization. Carers will be challenged in quantity and quality. Therefore, training senior practice nurses is also a beneficial and positive measure to respond to challenges, retain the backbone of clinical nursing, and give full play to their comprehensive ability.

2. Transitional nursing mode

Transitional nursing mode (TCM) is one of a variety of continuous care modes, which refers to a series of corresponding nursing capacity adopted by nurses to ensure the coordination and continuity of nursing work during the transition period at the stage of disease diagnosis, treatment and rehabilitation. Some studies have shown that [7] provides transitional nursing intervention services for COPD discharged patients, which is beneficial to improve their nursing effect. For COPD patients, the work of transitional nursing intervention in addition to provide routine discharge care plan , its main content is on the basis of evidence-based, provide patients discharge needs plan involving multidisciplinary knowledge, to the family care institutions or family caregivers provide patient services written materials, including the patient's assessment, supervision, health education, follow-up and implement care, a series of family care services [8].

3. The role of advanced practice nurses in transitional care

The International Council of Nurses (The International Council of Nurses, ICN) to advanced practice nurses (Advanced Practice Nurse, APN) was defined as follows: a nurse practitioner (Nurse Practitioner, NP) or an advanced practice nurse must first satisfy being a registered nurse, Secondly, it should have expert-level knowledge breadth, complex decision-making ability and clinical expansion practice ability, Its role characteristics are determined by the state in which its qualifications are certified, It is recommended to develop after a master's degree. American nurses association (American Nurses Association, ANA), advanced practice nurses in the assessment, diagnosis and treatment of individual, family or community complex response to actual or potential health problems, prevention and injury, disease and health, and provide comfort showed a high level of professional knowledge and skills, they still perform some basic nursing practice work, but more extensive knowledge, data comprehensive ability, intervention and operational complexity of higher .According to the American College of Nurse Practitioners (American Academy of Nurse Practitioners, AANP), advanced practice nurses can make independent or collaborative healthcare decisions, record medical histories, conduct physical examinations, order, perform and explain appropriate diagnoses and laboratory tests, and even prescribe drugs for patients, and provide treatments and non-drug therapies. Generally, senior practice nurses are directly competent for multiple clinical tasks [9], including first-line clinical practice, expert guidance, consultation, research, leadership, collaboration, and ethical decision-making.

Since 1989, a multidisciplinary team based at the University of Pennsylvania has been testing and improving an innovative model of transitional care provided by the APN. Patients offering this treatment are high-risk, cognitively intact elderly, who have a variety of medical and surgical conditions and are transitioning from hospital to home. Working with each older person, home caregivers, physicians, and other health team members, the APN assumes primary responsibility for optimizing each patient's inpatient health status and designing a follow-up care plan under the guidance of an evidence-based treatment program. The same nurse implemented this program [10] after discharge by providing traditional home care services, conducting home visits and telephone service 7 days a week.

4. Application of the transitional care model dominated by APN in COPD

COPD, together with hypertension and diabetes, is known as the three major chronic diseases in China, requiring skilled nursing care in assessment, disease management and patient teaching. In addition to pulmonary problems, COPD patients with COPD also face decreased functional status. Therefore, identifying interventions promoting efforts to improve and maintain positive patient health outcomes is critical. Neff etal examined the impact of the APN-directed home care lung disease management team on improving the quality of patient health outcomes. The study intervention group COPD patients receive pulmonary care RN / LPN services, directed and directed by a cardiopulmonary care APN specialist. Care for patients with COPD includes home visits, telephone contacts, and 24 h telephone contacts with nursing specialists. APN oversees RN / LPN care and provides educational resources for follow-up nurses. The APN also provides clinical consultation services for high-risk patients and requires home visits, teaching, assessing complex care needs, and assisting in dealing with patient / family problems. It was found that few patients cared for by the APN directive visit group had care visits, rehospitalization, and acute care visits. And also had fewer depressive symptoms and increased lung function capacity compared to the usual care model. In the study of COPD patients, this nursing model has significant effects in improving the nursing ability of patients and their families and the understanding of their

own diseases, as well as the guidance on routine treatment of life, exercise and emergency, psychological counseling and other aspects . In China, AP[11], including doctors, and new communication means (such as WeChat and Tencent QQ), which can improve the lung function of COPD patients; reduce the of disease uncertainty of patients and their families, improve the self-care ability and life quality of discharged patients ,increase the medication compliance of[12,13],and reduce the readmission rate of patients[14].

According to the essential elements of TCM as defined by the latest study, APN should be used in the TCM care of COPD patients to: coordinating team members, tasking, Jointly develop personalized transitional care programs for patients, Including the patient's medication care protocol, Diet and exercise recommendations, Healthy lifestyle guidance; Complete the condition assessment of COPD from admission, The formulation of the medication care program, Follow-up of the discharged patients, pathography, Questionnaires such as quality of life assessment and self-care ability assessment, Patient presentation of routine knowledge, And to evaluate the patient's condition direction and give the corresponding guidance and suggestions; Do a good job in transferring units (including families, community hospital, Nursing home, etc.) of information communication, Nursing program guidance. At the same time, APN must have COPD expertise, rich nursing experience and specialized nursing skills [15].

5. Conclusion

The reasons for the readmission of COPD patients are complex and diverse, including the adverse effects of drugs, discontinuous drug treatment and specialist care, premature discharge, acute exacerbation, etc. Whatever the reason, transitional nursing mode to patients personalized nursing plan, combined new electronic technology products and communication means, provides a short time patient-oriented nursing service patients can more smoothly through the transition period, and in self care ability, reduce the readmission, improve the quality of life, reduce the burden of family and social and economic gain long-term benefits. At the same time, it also provides a new perspective for the long-term medication care program of COPD. However, it is still necessary to explore the COPD transition period in Yunnan. Cultivate high-quality APN and formulate corresponding policies or laws and regulations to strengthen the promotion and application of the transitional care model. Establish a sound information sharing network to ensure the sharing of patients' medication care information in the transfer units (including community hospitals, nursing homes, lower hospitals, etc.), so as to better ensure the continuity of care and treatment.

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