

Continuity of Post-hospitalisation Nursing Services at the Homes of Older Patients in Lithuania

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Key Words: nursing, home care needs, older people, health status, institutional nursing, interRAI (HC), MAPLe.

Summary. The aim was to determine the efficiency of state funded nursing services at the homes of older patients in Lithuania by applying the standard interRAI Assessment Form.

Materials and Methods. All geriatric patients discharged after 90–120 days of stay at the nursing hospital with a determined need for permanent nursing (home care) were examined.

Research Methodology. An interview was conducted at the homes of the older patients. In all, data were collected from 113 respondents. The capacities of patients, as well as the received nursing and assistance services, were discussed with the patients and their relatives. The cognition and functional statuses of respondents were assessed by employing the interRAI Home Care (HC) Assessment Form.

Results. From the group of the respondents determined to need permanent nursing ($n = 75$), only 26.7% received official nursing services at homes, and 13.3% of the research subjects were consulted on nursing services. From the group of the respondents determined to need assistance ($n = 38$), only 5.3% received assistance services at home.

Conclusions. The current system of providing nursing services at home is inefficient. The patients with a determined need for permanent nursing and assistance were only taken care of by informal carers. The interRAI (HC) instrument is suitable for determining the efficiency of nursing services provided at home.

Introduction

The ageing population in Lithuania, as well as other in European countries, is a demographic process creating many social, economic, political, and legal problems that cover various areas, including education, public health, social services, and the labour market. As the data of Eurostat presents, 18.7% of the general population of Lithuania was composed by inhabitants of 65 years and older in 2015. It is forecasted that this part of inhabitants will reach 20.3% in 2020 and 33.0% in 2060 (1).

In seeking to resolve the problems associated with an ageing population, the key goals of the Lithuanian Health Programme for 2015–2025 are to ensure more effective healthcare with better quality that would be focused on the needs of citizens, create a more secure social environment, reduce the unevenness of health and social exclusion, establish beneficial physical work and living environments, and form healthy lifestyles and a culture of health (2). Similar goals and objectives have been also set by neighbouring countries Latvia (3) and Estonia (4) in their (public) health programmes. These goals and objectives reflect the provisions established in strategic documents on the health of the World Health Organization and the European Union.

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Human healthcare and social needs can be completely met by just creating an integrated system of healthcare and social services networks. One of the means to reach this goal is to provide integrated nursing and social services at the homes of patients. An integrated system of healthcare and social welfare would allow the system to approach residents with needs, as well as to meet those needs (5). Nursing services at home are personal healthcare services provided at the homes of patients to ensure the accessibility of nursing services and their continuity toward meeting the nursing needs of patients at home as well as encouraging the self-care of patients (6). The Ministry of Health (MH) of the Republic of Lithuania and the Ministry of Social Security and Labour of the Republic of Lithuania (DWCAO) have dedicated an increasing amount of attention to the development of nursing services at home and the strengthening of the authorities of family physicians and nurses. In 2007, the Regulation on Provision of Nursing and Social Services in the Republic of Lithuania was approved. This regulation determines the key goals and principles of the general provision of nursing and social services, the main recipients of these services, as well as the organisation, documentation, and funding of long-term care services (7).

When providing nursing and/or assistance services at the homes of patients, the acknowledgement of informal nursing is essential. Relatives of severely ill, dying people or people with acute diseases can be so exhausted by the nursing process that they themselves may need help. Frequently, relatives become physically or psychologically tired from nursing patients with a severe health status or patients with acute diseases at home and believe that they have not done everything that has been required (8). Several studies confirm that people taking care of severely ill patients inevitably suffer from physical, social, emotional, and economic difficulties that are hard to overcome without the help of others (9–11).

One of the main goals of healthcare services is adequate quality of provided services. In order to reach this goal, it is essential to ensure the accessibility, timeliness, and continuity of services. One of the ways to ensure the continuity of both medical and social services (aiming at sufficient quality of the services) is to provide nursing and/or social services at the homes of residents (patients). In Lithuania, the development of nursing services at home has only just begun, and both the Ministry of Health and the Ministry of Social Security have devoted maximum effort toward the provision of joint nursing and social services at the homes of patients; however, there is no exhaustive research regarding the operation of the created system, its weaknesses, and what should be improved.

The aim of this article is to determine the organisation efficiency of nursing services at the homes of patients by applying the international and standardised interRAI Assessment Form.

Methods

Study Design and Method. A quantitative cross-sectional study design was implemented. The research was carried out in two stages from June 2017 to June 2018.

The research methodology was a face-to-face interview conducted at the homes of older patients. The skills, status, psychosocial wellbeing, and skin condition of the patients, as well as official care, social support, responsibility, and the general state of the patients, were assessed by discussions with them and their relatives in accordance with the study instrument.

Sample. The participants were patients 65 years of age and older. All the patients that stayed in the nursing and supportive treatment facility for 90 or more days (but not more than 120 days, since this is the maximum state-funded amount of days in one calendar year) participated in the first stage ($n = 152$). The nursing and supportive treatment facility of 150 beds providing primary care service belonged to the hospital of the secondary level health-

care service in the second largest city of Lithuania. This facility was selected as it is the working place of the principal investigator.

The patients (or on behalf of them, their relatives) were interviewed one week before their discharge. The interviews were conducted by the principal investigator at the patients' home. Only the respondents ($n = 124$) with an established need for permanent nursing ($n = 85$) or assistance ($n = 39$) participated in the second stage of the research. These needs were officially recognised and assigned to the patient by the Disability and Working Capacity Assessment Office Under The Ministry of Social Security and Labour Republic Of Lithuania (<http://ndnt.lrv.lt/en/>). The aforementioned patients were interviewed following their discharge from nursing and supportive treatment hospitals after a stay of 90 or more days (not exceeding 120 days). The discharges were to people's ordinary homes but where they would have other family members to provide necessary support.

No one refused to participate. There were 10 deceased patients from the group with a determined need for permanent nursing and one deceased patient from the group with a need for care and assistance. In all, the data on 113 respondents were collected. In the majority of cases, the answers to the questions were collected from the relatives of the patients.

Study Instruments. The instrument of the research was the interRAI Home Care (HC) Assessment System that was designed to be a user-friendly, reliable, and person-centred system to inform and guide the comprehensive planning for the care and services of elderly and disabled people in community-based settings (12). In order to translate the assessment form and adjust it to the Lithuanian language and culture, the following main steps, as described in the scientific literature, were taken: first, translation (from English into Lithuanian); second, back-translation (from Lithuanian into English); and third, a comparison of texts in both languages and their coordination until they fully coincided and the content was considered valid following an assessment. The assessment of content validity allowed for the answering of questions as to whether the assessment form was suitable to reflect the features of the researched phenomena. The first translation was provided by a graduate of English language studies from a university who was familiar with American culture (lived in the United States for 2 years). The second translation was also carried out by another student of the same university who knew the English language quite well and has lived in the United States for 2 years. These two English texts were compared by a Professor of Humanities that has lived in the United States for 7 years.

The functional status of respondents was analysed in the first stage of the research using questions from

Section G (Functional Status) of the interRAI Home Care (HC) Assessment Form. Instrumental activities of daily living (meal preparation, ordinary housework, managing medications, phone use, and walking on stairs) were assessed by questioning the nursing personnel that had constantly taken care of the patient.

The performance of completing ordinary daily activities was assessed in the first stage of the research by observing the patient and evaluating the nursing documentation. Bathing, personal hygiene, dressing upper body, dressing lower body, walking, toilet use, and eating were assessed. The skin condition, management of prescribed medication, official care, responsibility, unofficial nursing was discussed with the relatives of the patient and/or other people nursing the patient. The physical independence of the patients was assessed by employing the standard methodology of the Barthel Index (point-scale assessment) (13), with the scale for the assessment of independence as follows: independent, 100 points; minimally dependent, 91–99 points; moderately dependent, 62–90 points; severely dependent, 21–61 points; and totally dependent, 0–20 points.

The priorities for determining nursing services and assessing the independence of the patients were identified by applying the Method for Assigning Priority Levels (MAPLe) algorithm and coordinated with the interRAI (HC) Assessment Form. Scores from 1 to 5 were applied for the assessment. An increasing score indicates decreased independence, resulting in an increased priority for the provision of nursing services: 1, low priority; 2, mild priority; 3, moderate priority; 4; high priority; and 5, very high priority (14).

Statistical Methods. Statistical data analysis was performed by employing the IBM SPSS Statistics® Statistical Package for Social Sciences 20 for Windows and Microsoft Office Excel 2010. The χ^2 or Fisher's exact test and the z-test were used to assess the interdependence of qualitative features. The se-

lection of institutional nursing or nursing services at home was assessed using univariate logistic regression methods. The odds ratio (OR) values and their 95% confidence intervals (CIs) were calculated. While checking the statistical hypotheses, the selected significance level was 0.05. Cronbach's alpha was calculated to assess the internal consistency of the assessment form scale. In our case, this coefficient was 0.83 (Part C of the assessment form) and 0.95 (Part G of the assessment form).

Ethical Considerations. The research was only carried out after obtaining permission from Kaunas Regional Biomedical Research Ethics Committee (No BE-2-36; 28/06/2017). Before interviewing the respondents (and/or their relatives), their consent to participate in the biomedical research was obtained.

Results

A total of 113 respondents participated in the research, and their average age was 83.8 ± 7.8 years old. In all, 73.4% ($n = 83$) were women and 26.6% ($n = 30$) were men. Two-thirds of the respondents (66.4%, $n = 75$) needed permanent nursing, whereas 33.6% ($n = 38$) of the respondents needed assistance. The majority of the participants ($n = 68$; 60.2%) lived together with their children, 17.7% ($n = 20$) lived with their spouse or with their spouse and other people, 15.9% ($n=18$) lived with their brother, sister, or others, and 6.2% ($n = 7$) of the respondents lived alone.

According to the Barthel Index of physical independence, the majority of research participants were severely or totally dependent. Those with an established need for permanent nursing were statistically significantly less independent (Table 1). Based on the Barthel Index, there were no independent or practically independent older patients.

By applying the MAPLe methodology, we divided the participants into five levels, based on their independence, and compared them with the

Table 1. Distribution of the Participants Based on Physical Independence (Barthel Index) and Priorities of the Nursing Services (MAPLe)

Variables	Established Needs for Permanent Nursing, n (%)	Established Needs for Assistance, n (%)	In Total	<i>P</i>
Physical independence based on Barthel Index				
Moderately dependent	0	3 (7.9)	3 (2.7)	$\chi^2 = 28.7$; $P < 0.0001$
Severely dependent	32 (42.7)	32 (84.2)	64 (56.6)	
Total dependence	43 (57.3)*	3 (7.9)	46 (40.7)	
Priorities of nursing services based on MAPLe				
3 Moderate	3 (4.0)	3 (7.9)	6 (5.3)	$\chi^2 = 5.55$; $P = 0.06$
4 High	47 (62.7)	15 (39.5)	62 (54.9)	
5 Very high	25 (33.3)	20 (52.6)	45 (39.8)	
In total	75 (100)	38 (100)	113 (100)	

* $p < 0.05$, comparing with the group of patients with established needs for assistance.

determined demand for nursing and assistance in Lithuania. According to MAPLe, 39.8% of the older patients were considered level 5 (highest priority for nursing services), whereas 52.2% of the patients belonged to level 4. Based on MAPLe, none of the participants were considered level 1 or 2 (Table 1). The obtained results revealed severely low independence of our patients, indicating that they should be given high or very high priority regarding nursing services. The research pointed out that the distribution of special needs in Lithuania is akin to the priority of nursing services based on MAPLe, although this result was not considered statistically significant, with $P = 0.06$.

Our participants were characterised by polypharmacy. On average, 5 (± 2.2) types of medication were prescribed to the older patients per day. Irrespective of the established needs (permanent nursing or assistance), differences in the amount of prescribed medication in both groups were not considered statistically significant. It was observed that the patients cared at home were inclined to adjusted management of their medication from the one prescribed by the physician. Around 53.98% ($n = 61$) of the participants managed their medication in accordance with the physician's prescription, whereas 46.02% ($n = 52$) of them adjusted their management and used less medication than prescribed.

By comparing the change in the general independence of older patients (independence in ADL and IADL activities) after 90–120 days in the nursing hospital and at home, it was identified that the level of independence decreased more after being nursed at home (Table 2).

The research revealed that in the group of the respondents with declining independence in the nursing hospital, the independence level remained the same for 6.7% ($n = 5$) of the patients; meanwhile, it

lowered in 18.9% ($n = 7$) of the patients. Thus, the research proclaims that people discharged from hospital suffered from a decreasing general independence after being cared at home.

When analysing the formation of pressure ulcers at the nursing hospital and at home, it was determined that in the nursing hospital, pressure ulcers formed for 3.5% of the respondents, whereas they appeared for 20.3% of the patients being cared at home (Table 2).

Almost half ($n = 31$; 41.3%) of the recipients of permanent nursing services were left unattended and without assistance for 2–8 hours during the day. From the group of the respondents determined to be in need of assistance ($n = 38$; 47.4%), only 5.5% ($n = 6$) had an opportunity (managed) to call for assistance in the case of an emergency.

The patients with an established need for permanent nursing ($n = 75$; 100%) were, according to the legislation, eligible for official nursing services at home; however, these services were appointed only for 26.7% ($n = 20$) of the older patients and, generally, were only appointed in cases where a patient needed to have blood tests ($n = 18$; 24.0%) or injections ($n = 2$; 2.7%). The nursing services provided at home only lasted for the period of time required for administration of the blood test, i.e., for 20 min once every 4 months. At the same time, 13.3% ($n = 10$) of the participants were consulted on nursing services.

When comparing the provision of official nursing services at home to respondents with an established need for permanent nursing vs. respondents with an established need for assistance, no statistically significant differences were identified ($P < 0.102$). The research revealed that at least once in the last 4 months, 22.1% ($n = 25$) of the older patients had an emergency room visit without an overnight

Table 2. Distribution of Participants Based on General Independence and the Change in the Number of Pressure Ulcers when Nursed at the Hospital and at Home ($n = 113$)

Monitored Variable	At the Nursing Hospital, n (%)	At Home, n (%)	<i>P</i>
Change in overall independence			
Improved	26 (23.0)	1 (0.9)	0.0001
No change	75 (66.4)	75 (66.4)	1
Declined	12 (10.6)	37 (32.7)	0.0001
Pressure ulcers			
No prior or new pressure ulcers	93 (82.3)	76 (67.3)	0.013
Prior pressure ulcers were healed	6 (5.3)	3 (2.7)	0.498
No prior pressure ulcers but new ones formed	4 (3.5)	23 (20.3)	0.0001
Prior pressure ulcers remained unhealed	10 (8.9)	11 (9.7)	0.999

stay and 4.6% ($n = 5$) had an emergency room visit with an overnight stay. A family physician visited 19.5% ($n = 22$) of the respondents at home. No statistically significant differences were found for the number of visits at the hospital (regardless of whether there was an overnight stay) and the visits by the family physician at the homes of the respondents based on the needs (permanent nursing or assistance) that were determined for the respondents. However, the visits from a family physician to the respondents were statistically significantly related to the visits of the respondents to the hospital ($P = 0.001$).

Generally, the main informal carers of the respondents were their children ($n = 74$; 65.5%), 15.0% ($n = 17$) of whom were brothers/sisters or other relatives, 14.2% ($n = 16$) were their spouses/partners, while 5.3% ($n = 6$) were their friends and neighbours. A substantial majority of the respondents (92.9%, $n = 105$) lived with people reliant on their care.

The research showed that a considerable number of key carers took care of their patients alone, without any help from other people, which was the case for 38.9% ($n = 44$). Others had helpers. Usually, this additional helper was an employed person ($n = 28$; 24.8) or another child of the patient ($n = 23$; 20.3). In order to take care of their relatives at home, 18.6% ($n = 21$) of all ($n = 113$) the patients' relatives left their jobs. People who took care of the patients alone constituted a greater part of the respondents who left their jobs (Table 3).

The majority of key carers indicated that they felt

Table 3. Distribution of Respondents Based on the Number of Informal Carers and Their Need to Leave Their Jobs

Number of Informal Carers / Helpers	Left Their Jobs to Take Care of the Patients		In Total n (%)
	No n (%)	Yes n (%)	
One	29 (31.5)*	15 (71.4)	44 (38.9)
Two (had helpers)	63 (68.5)	6 (28.6)	69 (61.1)
In total	92 (100)	21 (100)	113 (100)

$\chi^2 = 11.45$, $lfs = 1$, $P < 0.001$.

* $P < 0.05$, comparing with those who left their job.

constant distress, anger, or depression in connection with the caretaking of their relatives. Moreover, they also indicated feeling overwhelmed by the person's illness. A great number of these carers pointed out that it was challenging to take care of their relatives due to their own poor health. More frequent difficulties were faced by those relatives that took care of totally dependent patients, i.e., patients that had established needs for permanent nursing (Table 4).

It was determined that carers who had left their jobs due to the need to take care of their relatives were also more likely to indicate feeling distress, anger, and depression. These feelings were statistically significantly related to the lack of funds ($P = 0.004$).

After 90–120 days of nursing at home, the majority of informal carers changed their opinion as

Table 4. Experiences of Informal Carers when Taking Care of Their Relatives ($n = 113$)

The Status of the Key Informal Helper	Established Needs for Permanent Nursing n (%)	Established Needs for Assistance n (%)	In Total n (%)	P
Cannot take care of the patient because of his/her own poor health	29 (38.7)	2 (5.3)	31 (27.4)	< 0.001
Feels distress, anger, or depression	65 (86.7)	25 (65.8)	90 (79.7)	0.009
Feels overwhelmed by the patient's illness	46 (61.3)	15 (39.5)	61 (54.0)	0.027
Faces difficulties of taking care of the patient due to work	43 (57.3)	23 (60.5)	66 (58.4)	0.744

Table 5. Survey of Patients Regarding Place Where the Informal Carers Preferred Nursing Services to be Provided

Survey 1 (taken upon being discharged from the nursing hospital)	Survey 2 (taken after 3 months at home)	n (%)
Nursing at home	Nursing at home	25 (22.1)
Nursing at home	Institutional nursing	59 (52.2)
Institutional nursing	Nursing at home	5 (4.4)
Institutional nursing	Institutional nursing	24 (21.3)

to the place for nursing services and would choose institutional nursing for their relatives (Table 5).

After conducting univariate regression analysis, it was determined that relatives of the respondents who felt distress, anger, or depression selected institutional nursing 5.6 times more often (OR 5.582; PI 2.097–14.857; $P = 0.001$).

According to the study data, during 24 h relatives and other informal care givers dedicated 21.2 (SD \pm 5.5) hours of their time to the care of patients with permanent nursing needs and 10.7 (SD \pm 6.3) hours to patients with assistance needs ($P < 0.001$).

Discussion

Although respondents had an extremely low level of independence when being discharged from the hospital, their further care was left only to informal carers. Generally, they were taken care of by their children. The fact that family members usually become informal carers has been discussed not only in Lithuanian research (15, 16), but also in studies conducted in other countries (17, 18). According to the data of the research conducted by Blažienė and Žalimienė, 67.8% of Lithuanian residents 50–65 years old would choose care from their family members or relatives if they required nursing services when they got old (19). Based on the data of the research carried out by the Lithuanian Social Research Centre, the main reasons for taking care of older relatives at home were the feeling of responsibility, duty to take care of their parents, intention to be an example for their children, strong and close relationships with the relative in care, distrust in the services provided by other people, belief that a home environment helps the healing process and that caretaking services for old people were expensive, caretaking benefit as an additional source of funds for caregivers, and reasons related to inheritance from parents (20). Informal nursing is widespread not only in Lithuania, where formal nursing services are only taking their first steps, but also in countries where these services are already developed (21). For instance, 70% and 66% of older people (75+ years old) who live at home are taken care of by their family members in Sweden and Italy, respectively (22).

The fact that older people are usually taken care of by their relatives is not a problem in itself; however, the difficulties faced by relatives in providing care also need to be taken into consideration. This fact is demonstrated by our research. The independence level of our patients decreased more when they were nursed at home than in the nursing hospital. In addition, more pressure ulcers appeared when they were cared at home. In order to avoid pressure

ulcers, the position of the body should be changed at least once every 2 hours during the day, and at least once every 4 hours at night (23). Almost half of our participants with an established need for permanent nursing (totally dependent based on the Barthel Index) were left unsupervised for 2–8 hours per day. In accordance with our research data, some informal carers had to leave their jobs to take care of their relative at home, or combine their job with this care; others nursed alone or with the help of other family members, friends, or a second informal carer they employed. According to the research data of the Lithuanian Social Research Centre, the coordination of work and care creates quite a few problems. Some people do not leave their jobs because they are concerned about the size of their retirement benefit in the future, while others see their job as a possibility to escape from the routine related to care (20).

Based on the data of our research, the intention of relatives to take care of their patients at home changed after 90–120 days of nursing. Before discharge from the nursing hospital, the majority of relatives preferred nursing at home. After the same period of time of nursing at home, they then prioritised institutional nursing. Like in our research, Jankauskienė and Rapolienė noticed “the necessity to take up the role of the carer creates psychological, social, and financial consequences and affects health” (24). According to our research data, the majority of people who took care of their relatives felt distress, anger and depression. The health of some carers also grew poorer. The fact that the health of informal carers becomes poorer due to constant distress when taking care of their relatives is also confirmed by other studies (25). The research of Tamutienė and Naujanienė revealed that “older people dealing with severe health problems do not always agree to let the providers of services into their homes. The distrust and fear to let an unknown person inside their homes is reflected as the key reason for not using these services” (26). Additionally, the “financial position of older people limits the accessibility of the services since people refuse to buy them and attempt to survive with the help of their neighbours or relatives” (26).

In Lithuania, informal caregivers do not receive care benefits. If a family member gets sick and requires nursing, relatives have the right to receive a benefit for caring for a sick family member with a maximum period of 7 days (27). Caregivers of old or disabled people at home also have the right to submit a request for unpaid leave from their employer. No legally binding instruments require the

employer to coordinate the work schedule with the nursing of relatives. It is worth mentioning that, following the Law on State Social Insurance, an individual who takes care of a disabled person with an established special need for permanent nursing care is covered by pension and unemployment social insurance, but only in cases when he/she does not have an insured income or his/her income is lower than the minimum wage (28). Relatives can also request help from facilities that provide nursing services; however, these services are only state-funded for 120 calendar days, and it is difficult to get into these hospitals due to existing queues with waiting periods that can last up to 4–5 months. Based on the Requirements for the Provision of Nursing Services at Outpatient Healthcare Institutions and at Home, 104 nursing services are covered during the calendar year. The following services that are provided at home are covered: collection of blood for tests, various injections, connection of patient's intravenous drip (implementation and teaching relatives how to perform the procedure on their own), care of artificial openings (stomata) (implementation and teaching relatives how to perform the procedure on their own), care of wounds and pressure ulcers (wound dressing and teaching patients about the prevention of pressure ulcers, wound dressing), etc. Only 12 procedures to remove mucus from the trachea (including teaching relatives how to perform the procedure) are covered during the year. The ability of informal carers to take care of relatives at home is not evaluated. Only the vital activities of the patient and the vital activities in which assistance is required are assessed (7).

Regarding the significance of informal carers and the advantages they provide, more attention is given to informal carers and their support in some countries than others. In Europe, various means of supporting caregivers are prevalent: financial support for caregivers (e.g., Carer's Allowance in the United Kingdom and Ireland), support of occupation of caregivers (e.g., the right to receive paid leave in the Netherlands and Belgium, the right to not come to work with the permission of the employer in Finland), local support centre for family caregivers (e.g., in the Netherlands, United Kingdom, Ireland), coordination of work and taking care of relatives (e.g., in Denmark and Belgium, conditions exist for making flexible work schedules or working from home), teaching/education of caregivers (e.g., primary healthcare centres provide training programmes for caregivers in Spain), and respite care services (e.g., short-term institutional

care or substitution of the informal carer in Sweden and Ireland) (29).

Evidence exists that proper continuity of care is related to better results, e.g., a lower number of visits to emergency rooms, fewer cases of staying at the hospital, shorter periods of hospital stay, better treatment results, greater satisfaction of patients and their relatives regarding the quality of provided services, etc. (30, 31).

Research Limitations

The provision of nursing services at home for patients with a better health status was not assessed, as patients discharged from the nursing hospital were considered significantly dependent as based on the Barthel Index, and they were attributed the highest level of priority according to MAPLe. This research does not cover the whole nursed population but is competent for assessing the efficiency of the system.

Conclusions

The research revealed that the current Lithuanian system of providing nursing services at home is inefficient. The older patients determined to be in need of permanent nursing and assistance were only taken care of by informal carers that had no state-funded support or established assistance.

The provision of official nursing services did not differ according to the needs (permanent nursing or assistance) established for the older patients. The official nurse visited both the patients with established needs for permanent nursing and the patients with only established needs for assistance in when tests had to be done. The independence level of the older patients decreased more at home after being discharged in comparison with the patients at the nursing hospital. In addition, more pressure ulcers formed when the patients were cared at home.

It is necessary to determine all the reasons why the provision of nursing services at home is not efficient in Lithuania and to look for possibilities to eliminate these reasons. It is essential to review all national legislation on the provision of nursing services at home to determine their drawbacks and how to address them.

For the methodological consideration, the interRAI (HC) instrument is suitable for determining the efficiency of nursing services provided at home.

Statement of Conflict of Interest

The authors state no conflict of interest.

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