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The Care Setting Is Part of the Treatment: Reducing Transfer Trauma in Older Adults

A hospital can save an older adult's life. It can also, at times, introduce a second set of clinical risks.

For patients living with Alzheimer's disease or another form of dementia, frailty or multiple chronic conditions, leaving familiar surroundings may trigger confusion, anxiety, disrupted sleep, agitation or withdrawal. This response is often called transfer trauma or relocation stress. Not every move produces these effects, but an abrupt change in environment can be especially destabilizing for someone who relies on familiar people, routines and sensory cues to remain oriented.

Familiarity can itself be clinically valuable. Caregivers who know the patient may detect subtle changes from baseline, while established routines support nutrition, toileting, sleep and mobility. For a person with dementia, a recognizable room, a trusted voice or a consistently timed meal is not merely comforting; it can help preserve orientation and participation in care.

The risks can extend beyond emotional distress. Hospitalized older adults are vulnerable to delirium, immobility, medication-related complications, sleep disruption and deconditioning. A meta-analysis found that 30% of hospitalized adults 65 and older experienced hospital-associated disability—a new loss of independence in activities such as walking, bathing or dressing. A patient may recover from the illness that prompted admission yet leave the hospital with less function than before.

This does not mean hospitalization should be avoided when emergency intervention, surgery, advanced diagnostics or intensive monitoring are required. Hospitals remain essential and lifesaving. The geriatric question is more precise: What is the least disruptive setting capable of safely providing the care this patient needs?

When a patient is clinically stable and the necessary treatment can be delivered safely in a familiar environment, treating in place should be considered. That environment may be a private residence, assisted living community or skilled nursing center. Depending on the patient's condition, support may include physician oversight, skilled nursing, medication management, rehabilitation therapy, wound care, palliative care or hospice.

The decision must be individualized. Clinicians should assess the severity of the acute condition, the patient's cognitive and functional



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baseline, caregiver capacity, available clinical resources and the patient's goals. Avoiding a transfer is never appropriate when it would delay necessary care. At the same time, transferring a frail older adult by default—without first asking whether the required care can safely come to the patient—may expose that individual to preventable harm.

The Age-Friendly Health Systems framework provides a useful guide. Before a transfer, the care team should consider the “4Ms”: What Matters to the patient; Medication, including drugs that may impair cognition or mobility; Mentation, including dementia, depression and delirium; and Mobility, with a plan to preserve movement and function. These considerations should follow the patient across every care setting.

A coordinated continuum makes this approach more achievable. Catholic Health Services, for example, provides inpatient and outpatient rehabilitation, skilled nursing, assisted living, home health, palliative care and hospice throughout South Florida. These interconnected services give physicians, patients and families options for selecting the appropriate level of care, limiting unnecessary transitions and better coordinating those that cannot be avoided.

When a hospital transfer is necessary, preparation matters. Families and caregivers should communicate the patient's cognitive baseline, complete medication list, mobility needs, communication preferences and sources of comfort. Glasses, hearing aids and mobility devices should accompany the patient whenever possible. In the hospital, early mobility, protected sleep, careful medication review and caregiver participation can help reduce disorientation and functional decline.

Before transferring an older adult, every clinical team should ask three questions: What capability is unavailable in the current setting? Can that care be brought safely to the patient? If a transfer is necessary, how will we protect the patient's mentation, mobility, medication continuity and personal goals?

In geriatric medicine, place is not incidental to the treatment plan. Place is part of the treatment.

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