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Health & Medicine, Nursing

Theterm “ transition care” discusses about the movement patients between healthcare system level and settings as patient’s condition requires change duringthe development of an acute or chronic disease. (Naylor, 2008) For instance, apatient with renal disease during an acute exacerbation of disease, a patient willhave admitted to a hospital to receive care from physician with specialties andnursing team during stay hospital. Thereafter, the patient will discharge andmight return home. Based on patient’s condition he or she might receive care froma nurse in home setting.

Each of these changes from hospital to home is definedas a care transition for continuity of health care. Transition of care isimportant because more and more health care is moving from inpatient setting topatient’s home due to costs of hospitalization is very expensive. In thetransitional care, nurses work with patients and entire healthcare team to makesure that patient after discharge, patient receives continuity of care andstability during their transition from hospital to home. Transitional care is comfortingsource of support for patients after discharge. Nurses are able to track allproblems that happens after transition from acute care to home.

In addition, nurses are able to focus on preventing the signs of readmission that resultingin bad outcomes later. Nurses must keep tracking that patient is functionalphysically and emotionally with in weeks after discharge. It is critical firstweeks coming out the hospital especially for older population because manythings can happen during this time.

Therefore, it is important to make goodrapport with patient and knowing their concerns in order to reduce their stressand address their concerns.

Although, transitional care emphasizes oncontinuity of care but there are barriers to achieve successful transition ofcare. Poor communication would initiate unpleasant transition. For instance, after discharge of the patient the health care professionals responsible forcarrying out discharge plan including physician, pharmacist, and nurse.

Theyare all disconnected from each other and no one is able to see the patient takingmedications filled, or patient was able to arrange a follow up appointment withphysician. Both lack or poor communication among health care professionalcauses breakdown in the continuity of care. Also, incomplete transfer ofinformation and inadequate education of patient especially older population arecausing breakdown to this system. Language barrier, health literacy, andcultural differences make barrier though this transition. In order to achieve affective transitioncare three criteria such patient-centered care, lower costs, and quality ofcare should overcome.

Each of these component is like an umbrella thatencompasses many other factors to lead effective transition care. As mentionedearlier, poor communication affects the transition care, clinical communicationshould improve between caregivers and receiver. Some of the benefits of the transitioncare approach is the provider care plan. When patients are going home, they receiveinformation about the next appointment, the physicians contact numbers. Thissimple information can display support and continuity of care before their departurefrom hospital. This system also, enhance the team work among health professionalsbecause the whole team should preset to plan discharge that is more meaningful andbeneficial to the

patient. In addition, when crisis has come up instead everyonetrying to scramble and figure out best solution, health professionals are all insame team from the beginning, so they can participate the problems and quickly andefficiently counter unexpected problems.