**Phase 1-Planning: Barriers to a successful transitional care program**

**Introduction to the Problem**

Transitional care is an important addition to the healthcare process, especially for those with chronic diseases.  At the time of discharge, there are important pointers which patients need to note in order to ensure that they would not return to the hospital or that they would be compliant with their discharge orders.  Transitional care helps patients transition from hospital to home without any issues or problems in their healthcare management.  Transitional care involves different healthcare personnel working in coordination with each other in order to promote efficient health outcomes for the patient, including his/her family caregiver.  Transitional care seeks to enhance patient and family caregiver outcomes, as well as to decrease costs among those who are chronically ill, including older adults in community as well as health system settings (Hirschman, Shaid, McCauley, Pauly, & Navlor, 2015).  Transitional care is also a type of care coordinated with advanced practice nurses working with patients, family caregivers, physicians, and other healthcare team members (Naylor, 2012).   
**Clearly Identify the Problem**

The implementation of transitional care however can have its issues.  These issues and problems during transition can compromise the patient’s health outcomes.  Inefficient transition processes for instance of older adults to their family caregivers from the hospital to their homes has been associated with negative events, including errors in medical care, readmission, injuries, and poor health outcomes (Naylor and Keating, 2008).  Issues in the transition process have also been associated with communication issues, specifically where there is an incomplete transmittal of information and where the patients and their family caregivers are not sufficiently informed about what they are supposed to do or not do after discharge (Naylor and Keating, 2008).  Issues in communication may also be associated with language and health literacy problems as well as cultural differences which may exacerbate the patient’s health issues (Naylor and Keating, 2008).  Related issues in transitional care can also refer to specific needs of family caregivers during the transition process (Naylor and Keating, 2008).  These family caregivers may not actually understand or know what they are supposed to do to care for the needs of the patients upon discharge.  As a result, these caregivers often rate themselves as poor in terms of meeting the needs of their sick family member (Naylor and Keating, 2008).  Transitional care can also pose major burdens on caregivers, leaving these caregivers stressed and sometimes depressed (Naylor and Keating, 2008).  Based on the above situation, this paper seeks to define the issues and barriers to an efficient transitional care program for both patients and their family caregivers.

**Significance of the problem to Nursing**

The significance of this problem to nursing is that in identifying and defining further the issues associated with transitional nursing, nurses can develop better plans during transitional care, most specifically during the discharge of patients.  This problem would be able to inform the nurses on the gaps in transitional nursing and the ways by which they can respond to such gaps.  This problem would prompt better efforts made by the nurse in terms of explaining to the patient and his/her caregiver the discharge notes.    
**Purpose of the research**

The purpose of the research is to improve patient and healthcare giver outcomes following transition.  The transition here would mostly refer to the transition from the hospital to the home where the patient and the caregiver may have to undertake some precautions and follow certain procedures in order to continue recovery, prevent further harm, or ensure maintenance care.  For chronic care patients and their caregivers for instance, this research would be able to establish what problems these individuals often face upon discharge, and what nurses may have failed to tell them before their discharge, information which would have helped improve their health outcomes.    
**Research questions**

The primary research question for this paper is: What are the barriers/issues to efficient transition encountered by chronic care patients and their family caregivers?

Specifically, it seeks to answer:

* What are the causes of said barriers and issues?
* Are these barriers/issues attributable more to patients/family caregivers or to nurses/other healthcare professionals?
* How can these issues/barriers be managed/prevented/addressed to promote better patient outcomes?

**Master's Essentials that aligned with your topic**

The master’s essentials which aligned with my topic included: organizational and systems leadership and interprofessional collaboration for improving patient and population health outcomes (American Association of Colleges of Nursing, 2011).  Organizational and systems leadership aligned with my topic as it acknowledges the importance of ensuring high quality as well as safe patient care and that leadership skills are important in securing effective working relationships within the healthcare system (American Association of Colleges of Nursing, 2011).  Interprofessional collaboration is application because in working with other professionals, it is possible to secure better care for patients, in this case, patients who are about to transition into home care (American Association of Colleges of Nursing, 2011).

**References**

American Association of Colleges of Nursing (2011). *The Essentials of Master’s Education in Nursing.* Retrieved from <https://www.bc.edu/content/dam/files/schools/son/pdf2/MastersEssentials11.pdf>

Hirschman, K., Shaid, E., McCauley, K., Pauly, M., & Naylor, M. (2015). Continuity of care: the transitional care model. *OJIN: The Online Journal of Issues in Nursing*, *20*(3), 1.

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