Positioning nursing in transitional care: program design, nurse competence and outcomes

Contemporary health care management often struggles between quality and cost containment. Hospital is an expensive place and therefore is theoretically used mainly for patients who require care that can only be offered in a hospital setting. When the clinical problems are resolved or under control, the patients are discharged home. The transitional care support facilitating the patients returning home from hospital is very important. One of the key indicators in reflecting the adequacy of transitional care is hospital readmission. The 28-day hospital readmission rate for medical patients can range from 15% to 36%. Hospital readmission is a revolving door syndrome. If there is a lack of effective transitional care support, the patient who is not feeling well will return to the hospital within a very short time after discharge. Hospital readmission also adds burden to hospital. Evidence has shown that nurses are effective to help reduce readmission rate and enhance patient well-being in providing transitional care. This paper will discuss the unique features that make up a successful transitional care program, the competence required by the nurses and the outcomes that can be achieved. A successful transitional care program carries 4-C features which are comprehensiveness, coordination, collaboration and continuity. Nurses working in this program needs to be proficient in home and health assessment skills, telephonic nursing, patient empowerment, clinical decision-making and specific disease management. The outcomes can be achieved are clinical outcomes, client outcomes, health care utilization and satisfaction with care.

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