Transition care Plan

Student's Name

Module

Module Code

Introduction

Transitional care planning is a patient-centered interdisciplinary process that is continuous throughout the care process. This undertaking incorporates diverse services aimed at increasing the overall health outcomes of the patients at the end of life. According to Naylor et al., (2017), transitional care advocates for patient's safety and timed transition at all care levels. Of importance is the continuity and coordination of care during the end of life as there are critical decisions that must be made to support patient's preferences and wishes. In most cases, critically ill patients are unable to make rational decisions concerning their end of life care. This necessitates inclusion of a surrogate decision maker either chosen by the patient or an attorney to make a decision on behalf of the patient.

According to Le Berre et al., (2017), one of the impetus aspects in transitional care is open and clear communication with the stakeholders. This approach enables the patient and their families to understand the care preferences and promotes positive outcomes. Besides, this undertaking gives the patient autonomy concerning treatment modalities and preferences. The implications of these parameters to healthcare providers are that there is an overarching need to solve the barriers that may present an impediment to efficient transition. This paper will adopt a case study of Mrs. Snyder to develop a transitional care plan considering her current health condition.

Key plan elements and information needed

Several elements are critical to ensure effective transition of care for Mrs. Snyder. Besides, the care team must attain essential information to facilitate smooth transition for the patient. According to Sezgin et al.,(2020) transition of care for patients require six steps incorporating review of admission, patient assessment, conducting transition site contact, inter-professional collaboration, analysis of patient's risk levels and linking the patient to

primary care team. The transitional care model (TCM) advocates for close adherence to these protocols to ensure that patients attain optimum health outcomes due to safe transition (Morkisch et al., 2020). Patient screening enables care takers to collect evidence-based data that will enable them to make effective decisions during transitioning. This information is essential to determine the risk levels of the patient or potential of chronic illness. These elements also dictate to a significant degree the levels of relationships that will be created in the transition care process. As noted by McGilton et al., (2020), maintaining relationships with the patients will play a crucial role in facilitating effective implementation of care plan as everybody is aware of their scope in this perspective. Adopting these elements and information facilitates the success of transitional care.

Importance of ach key elements

Examining the patient on admission allows determining the risk level. This aspect determines if a patient is at high or low risk and therefore, developing accompanying transitional care modalities. The rationality of conducting an in-depth patient assessment is informed by the need to develop support mechanisms according to patient's needs (Rezapour-Nasrabad, 2018). Besides, conducting site contact for transition is an imperative aspect as it creates continuity in care process. In this aspect, the care takers understand the patient's new home during discharge and care takers during handoff.

The importance of involving the right personnel during transition is to facilitate delivery of professional care and patient's safety. As cited by Le Berre et al., (2017), inter-professional collaboration in transitional care enables sharing evidence based information crucial to effective transition. In addition, it's vital to depend on patient's risk level to determine the accompanying level of risk. This undertaking allows the patient's wish to be fulfilled in delivery of care. The importance of connecting patients to primary care

givers is evident during handoff and transition. This process averts any case of disconnections and compromise of patient's safety.

Importance of effective communication

Transitional care includes considering the patient's physical, medical, economic, mental and economic strengths and abilities and available support systems. This implies that coordination of these parameters is critical to allow for successful implementation of transitional care. In this aspect, effective communication plays a crucial role in this undertaking. Effective communication averts miscommunication hitches and errors that could cause adverse health events and errors in medication.

As noted by Philpott and Kurowski (2017), approximately 80% of transitional errors could be averted with effective communication. Unfortunately, most of these errors resulted in adverse effects, medication errors or fatalities due to ineffective communication. Ingber et al., (2017) noted that an effective approach to reduce risk of adverse events is to use SBAR communication. This approach will allow for assessing the situation, patient's background, assessing the current situation and making recommendations. Effective communication will also increase patient's safety and enable delivery of evidence-based practice.

Barriers (actual or potential) to the transfer of accurate patient information

Transitional care involves many barriers that must be addressed to ensure smooth transition. Some of the common encountered barriers include poor integration of care services, ineffective communication, and poor reporting and during patient hand off. These barriers present imminent limitations to attainment of patient safety and effective transition. A study conducted by King et al., (2013) indicated that poor communication leads to omission of advance directives and patient's preferences in transitional care. From the case

study analyzed herein related to Mrs. Snyder, it's evident that she will transition to a hospice facility considering her health condition. This aspect calls for adoption of a standardized communication and reporting tool among all care takers to facilitate continuity of care.

From Scott et al., (2017) perspective, transitional costs have been a major hindrance to effective transition. This aspect incorporates insurance reimbursements parameters outside an inpatient facility. This implies that it will be imperative to plan early for discharge to avert cases of negative eventualities that could negate with transitional care. It's also imperative to seek support for Mrs. Snyder through discussing with her and her family attributes related to transitional care. Including family members in the process is critical to eliminate potential barriers that may hinder effective transition.

Strategy for ensuring that the destination care provider has an accurate understanding

One of the fundamental success factors in ensuring continuity of care is linking information between current and destination care providers. The application of Continuity Assessment Records and Evaluation (CARE) framework has played a key role at our health facility in delivering optimal communication. This framework delivers optimal communication for successful transition. According to Kripalani et al., (2019), the application of CARE framework enables care takers in the transition to acquire updated information that enables creation of effective care.

Another imperative undertaking would be to employ the Electronic Health Record (EHR) system to ensure safe transfer of patients and quality of care to the patients. This proposition is avouched by Gordon and Catalini (2018) in assessment of current technology during care transitioning. The author notes that use of an up-to-date heath record system creates a strong evidence-base for continuity of care. Of importance is the scope of this

undertaking in increasing patient's safety. Vest et al., (2019) recommend the application of health information technology to avert adverse effects during transition and ensure patient's safety. This process enables for creation of medical records that can be referred to by care takers during transition process and after hand over.

Conclusion

Coordination of care for Mrs. Snyder is critical in facilitating her effective transition. It's evident from the scenario provided that coordination of care across care settings requires effective assessment, analysis and oversight to increase overall transition outcomes. One of the vital elements that arise from this analysis is the importance of effective communication. The delivery of patient's information across care process reduces instances of adverse effects and reduces patient's safety. Success in transitional care has been cited to incorporate six elements that must be adhered by care takers. The understanding of transition modalities by care takers leads to successful delivery of transitional care. An evidence-based transition leads to overall increase in patient's safety and contributes to attainment of patient's needs.

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