**Problem-Based Research Paper: Transitions in Care**

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**Introduction**

Transitions in care are one of the most fragile points in healthcare. Patients move from the hospital to home, to rehab, or into long-term care every day. These moves are supposed to mark progress, but in reality, they often bring risk. Patients leave without wound supplies, with medication changes they do not understand, or with no follow-up visit arranged. Nurses in home health see this regularly. A discharge that looks “complete” in the chart can still leave a patient unsafe at home. This topic is essential because it shows where systems fail and how nursing becomes the last line of protection.

**Significance of the Issue to Nursing Practice**

For nursing, transitions are not just a handoff. They are a turning point that affects safety, outcomes, and workload. Research indicates that poor transitions lead to increased readmissions, errors, and complications (Tyler et al., 2023). Nurses carry the responsibility of filling the gaps—calling doctors to clarify orders, reconciling medications, and teaching families. This takes time and energy on top of already heavy workloads. When transitions occur smoothly, patients recover more safely, and nurses can focus on providing care. When they fail, everyone feels the strain. Transitional care is therefore a core part of nursing, not an add-on (Sakashita et al., 2025).

**Literature Review**

Recent studies confirm what nurses already know: transitions are risky, but structured programs can mitigate this risk.

**Discharge planning.** Many patients leave the hospital before they are fully recovered. Shorter lengths of stay are often driven by insurance, and not the patient's condition. Discharges can be rushed, and information does not always flow to the next provider. This leaves patients and caregivers trying to figure things out on their own (Wang et al., 2023).

**Effective models.** Nurse-led programs make a difference. A systematic review showed that nurse-driven transitional care lowered readmissions and improved quality of life (Sakashita et al., 2025). An extensive analysis found that even simpler transitional care programs reduced hospital use up to six months after discharge (Tyler et al., 2023). In heart failure, nurse-led care has been shown to lower mortality and rehospitalization rates, even in limited-resource settings (Koontalay et al., 2024). These results demonstrate that both general and disease-specific programs are effective when nursing is a central focus.

**Equity.** Transitions are more challenging for patients who lack support. Older adults, those with language barriers, and patients without caregivers are at greater risk. Reviews suggest that programs incorporating caregiver training, psychological support, and culturally sensitive education can enhance outcomes (Marini et al., 2025). Without these elements, vulnerable patients remain the most vulnerable.

**Clinician burden.** Nurses describe transitions as one of the most stressful parts of their role. Fragmented communication, duplicate documentation, and unclear handoffs lead to increased errors and burnout. Transitional care programs not only help patients, they also give nurses more transparent processes and reduce strain (Tyler et al., 2023).

**Methodologies and Gaps**

Most studies utilize numerical data, including readmission rates, mortality rates, and hospital costs. These show impact but miss the human experience. Some studies employ interviews and surveys to capture the experiences of patients and caregivers, although these methods are less commonly used. What is missing is research that combines both outcomes and voices. Another gap is technology. Telehealth, virtual nursing, and AI-driven tools are expanding, but there is little evidence on how they truly affect transitions.

**Human Rights Protection**

Safe transitions should be viewed as a basic patient right. Every patient deserves clear and understandable education, access to necessary supplies, and follow-up care that prevents avoidable harm. These rights are often compromised when discharges are rushed or when information is not shared. Patients may be discharged without the necessary equipment or instructions in their own language (Wang et al., 2023). Nurses frequently act as advocates, protecting patients when systems and policies fail to meet their needs.

**Evidence-Based Practice**

Evidence shows that transitions are safer when nurses lead the process. A recent review found that nurse-led models reduced hospital readmissions and also improved the quality of life for patients, demonstrating that consistent follow-up is crucial long after discharge (Sakashita et al., 2025). Transitional care programs with varying levels of support also reduced hospital use, demonstrating that even moderate structure can help keep patients out of the hospital (Tyler et al., 2023). In heart failure programs, nurses coordinating care lowered both rehospitalization and death rates, which is critical for patients who are already at high risk (Koontalay et al., 2024). Research also shows the importance of equity. Programs that included caregiver education and culturally appropriate teaching improved outcomes for patients who usually face more barriers (Marini et al., 2025). Technology has also played a role. When structured follow-up was combined with technology-based tools, patients who left surgery adjusted more safely at home (Wang et al., 2023). Taken together, these findings suggest a common conclusion: when nurses guide patients through transitions, they are safer and outcomes improve.

**Implications for Health Equity**

The U.S. healthcare system is structured around Medicare guidelines, which set the rules for reimbursement and drive organizational behavior. Hospitals and agencies are pressured to discharge quickly to reduce costs and maintain throughput. These incentives often come at the expense of patient safety, especially for those who are frail or lack resources. When care is rushed, patients without caregivers, transportation, or internet access face the most significant risk. Poor transitions also trigger financial penalties under Medicare’s Hospital Readmissions Reduction Program, resulting in lower reimbursement and potentially damaging accreditation status. This cycle not only widens inequities for patients but also fuels burnout among nurses who are left to manage unsafe discharges. The implications are clear: safe and equitable transitional care is tied to both patient rights and the financial stability of healthcare systems (Tyler et al., 2023; Marini et al., 2025).

**Recommendations for Further Research**

Future studies should explore the impact of Medicare-driven incentives on the quality of discharges and long-term outcomes. Research is also needed on how fragmented EMRs and communication failures contribute to costly errors. Studies should evaluate the link between poor transitions, clinician burnout, and turnover to capture the full economic burden. Additional work is also needed to test technology-supported interventions, such as virtual nursing and AI-driven discharge planning, to determine whether they can improve outcomes without increasing staff workload.

**Proposed Research Question and Method**

A strong future research question would be:
**“How do nurse-led transitional care models influence patient safety, health equity, and healthcare system costs within Medicare-driven structures?”**

A mixed methods design would capture both outcomes and experiences. Quantitative analysis could measure readmission rates, penalties avoided, and cost savings. Qualitative interviews with patients, caregivers, and nurses would reveal the challenges of fragmented systems and policy pressures. This approach would provide a comprehensive understanding of the issue.

**Impact on Nursing Practice**

Transitions in care have a significant impact on patient safety, health equity, and the financial stability of organizations. Poorly managed discharges increase readmissions, trigger financial penalties, and lower accreditation scores. These outcomes directly impact hospital revenue and stability. At the same time, nurses shoulder the burden of bridging gaps in unsafe discharges, which fuels burnout and turnover. Strengthening transitional care not only protects patients but also supports nursing practice and the sustainability of healthcare systems. Nurse-led models demonstrate how transitional care can improve outcomes, protect rights, and reduce costs. This makes transitions one of the most critical areas for advancing safe, equitable, and sustainable nursing practice.

**Conclusion**

Transitions in care remain a vulnerable point in healthcare, but one with significant opportunity for improvement. Recent evidence shows that nurse-led and interdisciplinary models reduce readmissions, improve patient outcomes, and support caregivers. Safe transitions protect patient rights and reduce inequities while also preserving organizational stability. With more substantial research and evidence-based practices, nurses can continue to lead changes that turn fragmented handoffs into coordinated and safe care journeys. Based on models, transitions can shift from being points of failure to becoming points of strength in the healthcare system.

References

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