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TRANSITIONAL CARE FOR IMPROVING HEALTH CARE QUALITY IN HOSPITAL: A LITERATURE REVIEW

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ABSTRACT
The transition of care from hospital to home is a critical period for patients, especially those with chronic conditions such as heart failure. During the transition period, patients often experience difficulties managing their disease, which can lead to an increased risk of rehospitalization. This literature review aims to analyze scientific evidence about the effectiveness of transitional care interventions in improving the quality of health care in hospitals, especially for patients with chronic conditions. The method of this study is a literature review. This study used electronic databases such as PubMed, ScienceDirect and Google Scholar. The selected articles are quantitative research articles published within the last 5 years available in full text and not the result of a review. The results of the review show that transitional care interventions have a significant positive impact on the quality of health care. This intervention can increase self-management, treatment adherence and patient satisfaction with heart failure. Some components of effective interventions include patient education, care coordination, outpatient follow up and social support. Transitional care interventions are an effective strategy to improve the quality of health care, especially in patients with chronic conditions. The implementation of a comprehensive transitional care program in hospitals needs to continue to be improved to achieve optimal results.

Keywords: hospital; improving health care quality; transitional care

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INTRODUCTION

Transitional care is the process of moving a patient from one level of care to another and this process often involves moving the patient from the hospital to a continuing care facility or home. Transitional care involves a broad range of conditions and services to ensure continuity of care and prevent negative effects in vulnerable individuals who are affected by any changes in care settings or caregivers (Meleis, 2010). Transitional care was initially used as a multidisciplinary model to empower parents with vulnerable low-birth-weight neonates who had early discharge and received part of hospital care at home and then gradually used in other vulnerable groups (Meleis, 2010). Although care transition is an integral part of the patient care process, it is often a critical point that can have an impact on the overall quality of health care (Legallois dkk., 2019)

Many studies have shown that ineffective transitional care can increase the risk of readmissions, complications and even death and a decrease mortality rate and patient's quality of life (Baecker dkk., 2020; Blumer dkk., 2021; Alcoberro dkk., 2023; Basso dkk., 2024). This is due to several factors, such as lack of coordination between healthcare providers, lack of information provided to patients, non-compliance with therapy management, as well as lack of follow-up while at home and adequate social support (Nakahara-Melo dkk., 2022; Cui Xiaoning, 2019). Besides that, qualitative studies say that

there was a lack of holistic plan in the healthcare system towards transitional care and the continuance of care resulting decreased quality of care (Dolu dkk., 2021). Seeing the importance of transitional care in improving the quality of health services, this study aims to conduct a systematic literature review of various transitional care strategies that have been implemented in hospitals and their impact on the quality of health services. This literature review aims to analyze scientific evidence about the effectiveness of transitional care interventions in improving the quality of health care in hospitals, especially for patients with chronic conditions. Thus, it is hoped that a more comprehensive understanding of best practices in transitional care and its implications for the development of hospital intervention policies and programs can be obtained.

METHOD

This study used a scoping review design outlined by (Arksey, H., & O'Malley, 2005) which consists of the following steps: (1) formulating research questions, (2) identifying relevant studies, (3) selecting studies, (4) mapping data, and (5) compiling, summarizing, and reporting results. A literatures search was carried out using various electronic databases such as PubMed, ScienceDirect, and Google Scholar using the keywords transitional care, improving health care quality, hospital. The criteria for selecting articles were based on inclusion criteria based on PICO analysis (population, intervention, comparison, outcomes), with the provisions P: Population is a patient receiving treatment in a hospital I: Intervention is an intervention by providing transitional care; C: Comparison is an intervention given to patients in a hospital; and O: Outcomes are the results or effects of the intervention, namely quality of life, readmission rate, therapeutic adherence, self-care management and patient satisfaction. Inclusion criteria in the literature search included articles reviewed which were research articles in international journals, published at least in the last 5 years, available in full text in English, and studies related to transitional care in the hospital. The exclusion criteria were articles that were the result of a literature review. Appropriate literature selected based on topics related to transitional care for improving health care in hospitals.The author checked each abstract thouroughly by using inclusion criteria. Studies were excluded if they were not relevant to the topic of transitional care for improving health care quality in hospital either quantitatively or qualitatively. Data analysis in this research includes reading the entire contents of each article systematically, labeling meaningful parts of a collection of texts, analyzing, and mapping each context, and grouping them into categories. Combining qualitative and quantitative study findings. Next, the author analyzes the content of significant findings from reviews related to transitional care and concludes the results of the analysis to support these findings.

RESULT

The selected articles are summarized and presented in figure 1. Based on the results of a review conducted of the 16 articles, they are explained in the figure attached below. The results of the study search researchers concluded that transitional care is a continuous care strategy to improve the quality of health care in hospital and ensure a safe patient transition from hospital to home. This is important for nurses and other health workers to be given to patients and their families/caregivers, especially in chronic diseases such as heart failure which affect the quality of life and patient satisfaction.

Picture Description

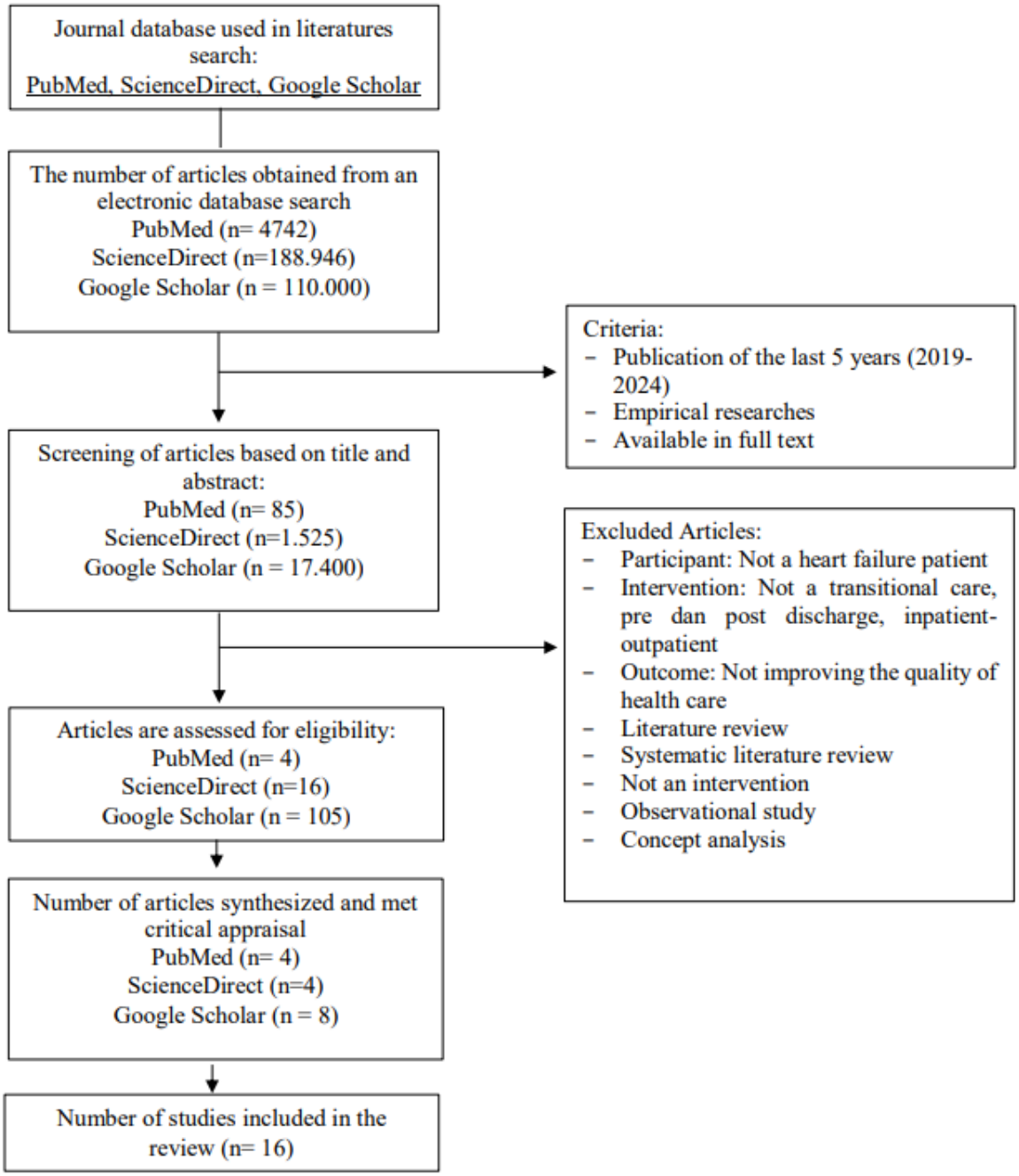


Figure 1. Prisma flowchar

Table 1.
Literature analysis result

No	Author (s)	Journal title	Objective	Population and sample	Research Methods	Results and discussion
1	(Aileen Baecker, PhD, et al, 2020)	Evaluation of a Transitional Care Program After Hospitalization for Heart Failure in an	This research was conducted to examine the association of the individual	The study population were 28.693 and samples of the study were 2565	Cohort study	HF-TCP was not associated with a reduction in 30-day readmissions overall, although a follow-up clinic visit within 7 days of discharge may be

No	Author (s)	Journal title	Objective	Population and sample	Research Methods	Results and discussion
		Integrated Health Care System	HF-TCP components and their bundle with the primary outcome of all-cause 30-day inpatient or observation stay readmissions	participants		helpful. These findings highlight the importance of continued quality improvement and refinement of existing clinical programs.
2	(Blumer, V MD, et al, 2021)	Effect of patient centered transitional care services on patient reported outcomes: sex specific analysis of the PACT-HF Randomized Controlled Trial	This research aims to assessed the effect of transitional care on patient reported outcomes (PROs) in women and men hospitalized for heart failure (HF).	The study samples consisted of 986 patients (47.4% women)	A stepped-wedge cluster randomized controlled trial in 10 hospitals in Ontario, Canada	A patient-centered transitional care model improved discharge preparedness, transition quality, and HRQOL in the weeks following HF hospitalization, with effects largely consistent in women and men. However, women reported lower HRQOL and experienced greater treatment benefit than men at hospital discharge.
3	(Jeffrey L Schnipper, et al. 2021)	The Effects of a Multifaceted Intervention to Improve Care Transitions Within an Accountable Care Organization: Results of a Stepped-Wedge Cluster-Randomized Trial	This research aims to develop, implement, and refine a multifaceted care transitions intervention and evaluate its effects on post discharge adverse events.	The samples in the study, 692 were assigned to usual care and 987 to the intervention	A Stepped Wedge Cluster Randomized Trial	Patients in the intervention arm had a 45% relative reduction in post discharge adverse events (18 vs 23 events per 100 patients; adjusted incidence rate ratio, 0.55; 95% CI, 0.35- 0.84). Significant reductions were also seen in preventable adverse events and in new or worsening symptoms, but there was no difference in readmission rates
4	(Patricia Jepma, et al 2021)	The nurse-coordinated cardiac care bridge transitional care programmed: a randomized clinical trial	The cardiac care bridge (CCB) transitional care programmed evaluated the impact of combining case management, disease management and home-	The samples in this research were cardiac patients ≥ 70 years were eligible if they were at high risk of functional	Single-blind, randomized clinical trial	In total, 306 participants were included. Mean age was 82.4 (standard deviation 6.3), 58% had heart failure and 92% were acutely hospitalized. 67% of the intervention key-elements were delivered. The composite outcome incidence was 54.2% (83/153) in the intervention group and 47.7% (73/153) in the control group (risk

No	Author (s)	Journal title	Objective	Population and sample	Research Methods	Results and discussion
			based cardiac rehabilitation (CR) on hospital readmission and mortality	loss or if they had had an unplanned hospital admission in the previous 6 months		differences 6.5% [95% confidence intervals, CI −4.7 to 18%], risk ratios 1.14 [95% CI 0.91–1.42], P = 0.253). The study was discontinued prematurely due to implementation activities in usual care. In high-risk older cardiac patients, the CCB programmed did not reduce hospital readmission or mortality within 6 months.
5	Huynh, Quan L, et al, 2019	Influence of Risk on Reduction of Readmission and Death by Disease Management Programs in Heart Failure	Disease management programs (DMPs) may reduce short-term readmission or death after heart failure (HF) hospitalization. We sought to determine if targeting of DMP to the highest-risk patients could improve efficiency.	The samples in the research were 412 (197: control group, 215: intervention group)	Randomized controlled trial	Readmission or death occurred in 74/197 (37%) usual care and 50/215 (23%) DMP patients within 30 days (relative risk [RR] 0.62, 95% confidence interval [CI] 0.460.84), and 113/ 197 (57%) usual care and 78/215 (36%) DMP patients within 90 days, (RR 0.63, 9%% CI 0.510.78). The predicted risk of death and readmission (estimated from our previously developed risk score) was similar between treatment groups (mean predicted risk 38.6 § 22.2% vs 39.4 § 21.9%; P =73) and similar across categories of predicted risk between the treatment groups. For 30-day readmission or death, patients from the 2 highest risk quintiles showed a benefit from intervention, and there was an interaction between intervention and predicted risk (P = .02). For 90-day readmission or death, most patients other than those in the lowest-risk quintile benefited from the intervention. Intensive DMP may reduce short-term readmission or death, particularly in high-risk patients
6	(Cui Xiaoning,	A nurse led structured	This study was	The samples in	Randomized	The mean score of medication adherence,

No	Author (s)	Journal title	Objective	Population and sample	Research Methods	Results and discussion
	et al, 2019)	education program improves self-management skills and reduces hospital readmission in patients with chronic heart failure a randomized and controlled trial in China	designed to evaluate the impact of a nurse-led education program on patient self-management and hospital readmissions in rural Chinese patients with CHF.	the research were 96, intervention group (48) and control group (48)	controlled trial	dietary modifications, social support, and symptom control in the intervention group was higher than in the control group at the end of the study ((p<0.01). The readmission rates for HF in the intervention and control group were 10.4% and 27.1%, respectively (p=0.036). this program was associated with a significant reduction in hospital readmission. This study indicates that implementation of a nurse-led education program improves self-management and clinical outcomes of rural CHF patients, who may not have regular access to cardiac management services as per metropolitan populations.
7	(Lidia Alcoberro, et al, 2022)	Breaking the 30-day barrier: Long-term effectiveness of a nurse-led 7-step transitional intervention program in heart failure	This study was evaluated whether the impact of a new nurse-led coordinated transitional HF program extends to longer periods of time, including 90 and 180 days after discharge.	The samples in this study were 440 participants, usual care (n=123), HF Program (n=317)	Natural experiment	There were more females in Period #2 (p = 0.025), with no other significant differences between periods. The primary endpoint was significantly reduced in the HF program group, at 90 [adjusted OR 0.31 (0.18–0.53), p < 0.001 and at 180 days [adjusted OR 0.18 (CI 0.11– 0.32), p < 0.001). Such a decrease was due to a reduction in cardiovascular (CV) and HF hospitalization. All-cause death was reduced when a double check discharge planning was implanted compared to usual care [0 (0%) vs. 7 (3.8%), p = 0.022]. A new nurse-led coordinated transitional bundle of interventions model reduces the composite endpoint of all-cause death and all-cause hospitalization both at 90 and 180 days after a discharge for HF, also in

No	Author (s)	Journal title	Objective	Population and sample	Research Methods	Results and discussion
						high-risk populations. Such a decrease is driven by a reduction of CV and HF hospitalization. Reduction of all-cause mortality was also observed when the full model including a more exhaustive discharge planning process was implemented.
8	(Negarandeh, Reza, et al, 2019)	Evaluating the Effect of Monitoring through Telephone (Tele-Monitoring) on Self-Care Behaviors and Readmission of Patients with Heart Failure after Discharge	The research aims to reduce patients' complications, readmission rates, and health care expenditures, it is necessary to design interventions, which are culturally appropriate and based on community needs	The samples in this research were 80 patients, intervention group (n= 40), control group (n= 40).	Randomized clinical trial	The mean scores for self-care behaviors of the two groups showed significant difference at the baseline (p ¼ 0.045). The results of the analysis of covariance that was used to control the differences in the pretest scores of self-care behaviors showed that the difference between both groups after the intervention was still significant (p < 0.001). The percentage of patients' readmissions in the intervention group (20%) was less than that in the control group (42.2%); however, the results were not statistically significant (p ¼ 0/066). This study showed that tele-monitoring improved self-care behaviors in Iranian patients with heart failure but did not reduce their readmission rates.
9	(Somsiri, Vasinee, 2020)	Effects of a Transitional Telehealth Program on Functional Status, Rehospitalization, and Satisfaction With Care in Thai Patients with Heart Failure	The aim of this study is to investigate the effectiveness of a TTP on functional status, rehospitalization, and satisfaction with care in Thai patients with HF	The samples size was calculated by using the formula for repeated measures design based on Naylor et al, this study, with a significanc	This study employed a quasi-experimental design.	Functional status and satisfaction with care scores in the TTP group were significantly higher than those of the control group, and rehospitalization rates in the TTP group were significantly lower than those of the control group at 6- and 8-weeks post-enrollment. Thus, the TTP effectively improved functional status, increased satisfaction with care, and reduced

No	Author (s)	Journal title	Objective	Population and sample	Research Methods	Results and discussion
				e level of .05, power of .80, and sample size adjusted for a 10% attrition rate. The calculations led to a sample size of 146. Experimental group (n=73), control group (n=73)		rehospitalization rates in Thai patients with HF. TTP implementation could be considered to improve the quality of transitional care in Thailand.
10	(Nakahara, M, et al, 2021)	Transitional care from the hospital to the home in heart failure: implementation of best practices	Assess the compliance of the implementation of better evidence in the transitional care of the person with heart failure from the hospital to the home	The samples in this research were 14 nurses and 22 patients	Implementation project that used the JBI method and using the tools: Practical Application of Clinical Evidence System - (PACES), an online tool for recording the processes of audit (basic and follow-up); and Getting Research into Practice (GRiP)	In the baseline audit, compliance was null with five of the six criteria. Strategies: training of nurses; reformulation of the hospital discharge form and guidance on self-care in care contexts; and making telephone contact on the 7th, 14th and 21st days after discharge. In the follow-up audit, there was 100% compliance with five of the six criteria. The project made it possible to increase the compliance of transitional care practices in people with heart failure with the recommendations based on the best evidence.
11	Mills A, et al. 2021	Impact of Heart Failure Transitions of Care Program: A Prospective Study of Heart Failure	The purpose of the study is to evaluate the impact of heart failure medication education on	The samples were 222 patients. Divided 2 group, control,	This single-center pilot study	For the primary endpoint, there were 222 patients in the treatment group compared with the control group of 941 patients. The treatment group resulted in 30 (13.5%) of the 222

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		Education and Patient Satisfaction	30-day all-cause readmission rates and patient-reported satisfaction scores	and interventio n.		patients being readmitted within 30 days compared with the control group where 186 (19.6%) of the 941 were readmitted (P = .0395). The risk reduction in odds ratio and relative risk of readmission was 0.63 (confidence interval [CI] = 0.42-0.96) for the treatment group and 0.68 (CI = 0.48-0.98) for the control group. For the secondary endpoint, 56 patients were called 1 week after discharge, and there was no significant difference in overall patient satisfaction between groups. This study demonstrated that heart failure medication education provided by the pharmacist or pharmacy student resulted in improved patient outcomes and ultimately a reduction in 30-day all-cause readmission rates.
12	(Basso I, 2024)	A nurse-led coaching intervention with home telemonitoring for patients with heart failure: Protocol for a feasibility randomized clinical trial	The primary aim of the study is to investigate the feasibility and acceptability of a home telemonitori ng program combined with telephone-delivered nurse-led coaching intervention. The secondary aim is to explore the feasibility of a randomized controlled study to assess the effectiveness	The samples in this research were 45 patients (15 will be allocated to the interventio n arm and 30 to the control arm)	Mix methode, Randomi zed clinical trial and qualitativ e	Quantitatif Supportive programming will be provided in addition to standard care, consisting of 1) pre-discharge educational meetings, 2) nurse-led training sessions via telephone and 3) monitoring of vital signs via telemonitoring at home.

No	Author (s)	Journal title	Objective	Population and sample	Research Methods	Results and discussion
			of the supportive intervention.			
13	(Isabelle, M, 2019)	Discharge guidance and telephone follow-up in the therapeutic adherence of heart failure: randomized clinical trial	To evaluate the effectiveness of the behavioral intervention of discharge guidance and telephone follow-up in the therapeutic adherence, re-hospitalization, and mortality of patients with heart failure.	The samples in this research were 201 patients diagnosed with heart failure, control group (n=101), intervention group (n=100)	Randomized clinical trial	One-hundred and one patient were randomly sorted in the Control Group and in the Intervention Group, their average age being 62.6±15.2. The Intervention Group had higher drug and nondrug therapeutic adherence compared to the Control Group ($p<0.001$) and there were lower re-hospitalization and death rates in the intervention group after 90 days. Discharge guidance with telephone follow-up was effective and resulted in greater therapeutic adherence, as well as in decrease of re-hospitalization and death rates in patients with heart failure.
14	(Legallois, D, 2019)	Improving quality of care in patients with decompensated acute heart failure using a discharge checklist	This research aims to evaluate the usefulness of a checklist in patients hospitalized for heart failure, in terms of mortality, cardiovascular mortality and readmission rates, and quality of care, including therapeutic optimization and care planning	The samples in this research were 103 patient (prospective), quality care and outcomes were compared with retrospective cohort of 137 patients with the same inclusion criteria.	Prospectively and retrospective cohort	At 6 months, there were no differences between the checklist and control cohorts in the rates of all-cause mortality (10.7% vs. 13.1%; P = 0.57), cardiovascular mortality (8.7% vs. 10.9%; P = 0.58) and readmission (29.1% vs. 32.1%; P = 0.62). Follow-up after discharge was better planned in the checklist group. The use of the checklist yielded therapeutic optimization with a higher dose of beta-blockers and renin-angiotensin-aldosterone system blockers, especially in patients with a reduced left ventricular ejection fraction (< 50%) (P = 0.03 and P = 0.02, respectively. The use of a simple discharge checklist in patients with acute heart failure showed no benefit in terms of readmission and mortality rates;

No	Author (s)	Journal title	Objective	Population and sample	Research Methods	Results and discussion
						however, it yielded better quality of care, including therapeutic optimization and care planning.
15	(Veenis, J.F, et al, 2020)	Remote monitoring of chronic heart failure patients: invasive versus non-invasive tools for optimizing patient management	This research aimed to prevent HF-related to hospitalizations by keeping stable HF patients out of the hospital and focusing resources on unstable HF patients	The samples size (25 studies, 9332 patients) or non-invasive telemonitoring (18 studies, 3860 patients) compared with standard HF care	Randomized clinical trial	Results of telemonitoring to date are inconsistent, especially those of telemonitoring with traditional non-hemodynamic parameters. Recently, the Cardio MEMS device (Abbott Inc., Atlanta, GA, USA), an implantable hemodynamic remote monitoring sensor, has shown promising results in preventing HF-related hospitalizations in chronic HF patients hospitalized in the previous year and in New York Heart Association functional class III in the United States. This review provides an overview of the available evidence on remote monitoring in chronic HF patients and future perspectives for the efficacy and cost-effectiveness of these strategies.
16	(Dolu, et al, 2021)	A Qualitative Study of Older Patients' and Family Caregivers' Perspectives of Transitional Care from Hospital to Home	This study aimed to explore the perspectives of patients aged 65 years and over and their family caregivers transitioning from hospital to home in an urban area of Turkey	This samples were 14 patients, with at least one chronic disease and admitted to the hospital for a minimum of 3 days, and family caregivers were 11 participants	Qualitative design	Main themes were 'confused feelings of safety and stress;' 'worried about being left alone;' and 'disrupted healthcare journey.' The proactive rehabilitation model was used to elaborate on the study findings and interpret the perspectives and experiences of older patients and their family caregivers, which can be used for improving the quality of care after discharge from hospital.

DISCUSSION

Transitional care was initially used as a multidisciplinary model to empower parents with vulnerable low-birth-weight neonates who had early discharge and received part of hospital care at home and then gradually used in other vulnerable groups (Meleis, 2010). An interesting finding in this literature review is the inconsistency of the relationship between

transitional care and decreased patient readmission rates These findings provide a lesson that we need to evaluate, continuously improve, and refine patient transition clinical programs in optimizing health services, especially in chronic and complex diseases such as heart failure (Baecker dkk., 2020). Although many studies show a positive correlation between the two(Huynh dkk., 2019; Oscalices dkk., 2019; Mills dkk., 2021; Somsiri dkk., 2021), some studies do not find a significant relationship (Legallois dkk., 2019; Negarandeh dkk., 2019; Baecker dkk., 2020; Jepma dkk., 2021; Schnipper dkk., 2021). These mixed results indicate that the success of transitional care in reducing readmissions may be influenced by a variety of complex factors that are not yet fully understood.

Some factors that may explain this inconsistency include the definition and implementation of diverse transitional care, patient characteristics, environmental factors, and data quality. One of the unsuccessful programs is due to the large number of patients who are elderly and have many comorbidities (Jepma dkk., 2021). For the implementation of transitional care to be optimal, full family involvement in caring for patients is needed, self-efficacy and able to manage self-care adequately (Dolu, 2021). Moreover, poor treatment adherence and lack of self-care behaviors are significant contributors to hospital readmissions of people with heart failure (HF) (Basso dkk, 2024).Findings from the studies we reviewed consistently show that effective communication between health care providers, comprehensive discharge planning, coordination of care and outpatient follow up are important components of transitional care. If these components are implemented adequately, not only will the number of readmissions decrease, but also patient satisfaction and quality of life will increase (Oscalices dkk., 2019; Mills dkk., 2021). This is in line with Meleis' theory which emphasizes the importance of healthy transitions which are related to the effective mastery of roles for patients and families which are influential in the healing process (Meleis, 2010). Comprehensive transitional care interventions have been shown to increase readmission-free time and reduce mortality in older adults with heart failure. In addition, these interventions have also had a positive impact on healthcare cost efficiency, providing new hope in the management of this complex chronic disease (Naylor dkk., 2004). Other studies have concluded that supporting patients and caregivers to take a more active role in managing their care after discharge from the hospital can reduce the frequency of readmissions (Coleman dkk, 2004)

Most studies in these literatures define transitional care as a comprehensive strategy that is carried out when the patient is hospitalized and followed up during outpatient treatment with effective communication and coordination.Protocols to investigate the feasibility of the program transitional care in developing countries such as in Italy consist of pre-discharge education, nurse-led training sessions over the phone and monitoring of vital signs when patients are already home. After the patient is stable, nurses and other health workers provide material related to self-care management, the importance of activity, quality sleep, psychological problems, formal and informal support. Next, the nurse will observe and evaluate the patient's motivation to change using the transtheoritical theory model of behaviour change (Prochaska dan Velicer, 1997), which consists of 5 stages, namely pre-contemplation: the patient is not yet aware of a problem that needs to be changed, contemplation: is aware of the problem but is not yet sure or able to make a change, determination: starting to prepare to make changes, action: taking action to change, maintenance: maintaining behavior changes. Next, follow-up is carried out in the form of a telephone session with the patient and their family. In addition, to improve the health status of patients, it is necessary to increase patient involvement in self-care management, which can be achieved through self-empowerment that focuses on developing self-efficacy and self-esteem (Woodall dkk., 2010). Moreover, nurses carry out home telemonitoring to measure

body weight, blood pressure, O2 saturation in the morning before breakfast (Basso dkk., 2024).

However, there are still variations in communication practices, content of education, coordination, intensity of effective follow-up in various care settings and diversity of health workers providing education. Besides that, our literature review shows a significant gap in research on transitional care for patients with heart failure. Although many studies have explored the physical, psychological, and social aspects, very few have explicitly addressed the spiritual dimension. A qualitative study shows that spiritual beliefs play an important role in the transition process, hope and belief in God's help are strong supporting factors in dealing with change (Mora-López dkk., 2016). Based on previous research findings, spiritual nursing interventions have been shown to be effective in improving mental health. The group receiving spiritual interventions showed a more significant decrease in levels of depression, stress, and anxiety compared to the control group (Yun dkk, 2017). Some examples of religious and spiritual interventions suggested by nurses in the past decade include prayer practices, mantra repetition, Quran recitation, religious support, meditation, and strengthening relationships with God (Babamohamadi dkk., 2020). The results of these interventions have shown significant reductions in patient distress and depression, as well as increases in life expectancy and spiritual well-being (Ichihara dkk., 2019).

One study stated that the education provided included the causes and consequences of heart failure, symptoms, treatment goals, fluid restrictions and risk factors for heart failure using leaflets and instructional videos where follow-up was carried out once a week, 1 home visit within 10 days after discharge (Huynh dkk., 2019). Nursing staff who complete heart failure management training are given 1 hour. Education sessions for each participant whose condition is stable. Education sessions provided prior to repatriation include self-care management measures, with families encouraged to be present to discuss patient support requirements. There are six areas of intervention, related to education, self-management skills, positive feedback and interviews, social support, training, and rehabilitation. Intervention programs developed according to the theory of self-management carried out every 8 weeks after discharge. In addition to this, the patients in the intervention group received a 15 - 30-minute telephone or face-to-face consultation every 4 weeks, before the routinely scheduled heart failure clinics until 12 months (Cui dkk., 2019).

This review of the literature shows that there is strong agreement that transitional care programs can have a positive impact on the quality of health care, self-management, and patient satisfaction with heart failure. In line with the American Heart Association (AHA) scientific recommendations, transitional care interventions should be widely implemented, both in research and clinical practice contexts, in an effort to address the complexity of heart failure and improve patient outcomes (Albert dkk., 2015). Transitional care management study has demonstrated that this approach has a strong scientific basis with further refinement, this method has the potential to have a significant positive impact on the Medicare beneficiary population transitioning from the hospital to the home (Coalition for evidance-based policy, 2010). The implementation of transitional care programs in various countries has shown consistent results in improving patients' knowledge of their disease, self-management skills, and adherence to treatment. This is in line with nursing theories that emphasize the importance of patient empowerment and social support in the healing process (Negarandeh dkk., 2019; Blumer dkk., 2021; Mills dkk., 2021; Somsiri dkk., 2021).

Implications for nursing practice

The findings of this literature review have important implications for nursing practice. Nurses have a crucial role in the implementation of transitional care programs. Some of the implications of the practice include patient empowerment: nurses need to focus on patient empowerment by providing comprehensive health education and encouraging active patient participation. Care coordination: Nurses need to work closely with interdisciplinary healthcare teams to ensure continuity of care and good coordination. Lastly, Social support: Nurses need to provide social support to patients and their families.Future research needs to focus on the development and evaluation of more effective and efficient transitional care programs by considering factors that affect the success of the program such as knowledge and skills, motivation, age, cultural factors, economics, and social support.

CONCLUSION

Transitional care interventions are an effective strategy to improve the quality of health care, especially in patients with chronic conditions. The implementation of a comprehensive transitional care program in hospitals needs to continue to be improved to achieve optimal results.

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