Background and Significance: Readiness for hospital discharge (RHD) and the associated transition from hospital to home is an under-investigated topic in the pediatric solid organ transplant (SOT) population. The time immediately following SOT is crucial as families face the new challenges of managing the child’s continued recovery following surgery and the emotional shift to managing a chronic illness. A successful transition with the help of the transplant team lowers risk of post-operative complications, thus lessening the burden to the family and medical community as a whole and significantly impacting outcome including family psychosocial adjustment and quality of life.

Purpose of Study: The purpose of this study is to address a gap in knowledge regarding parent’s perspective of discharge transition care and adaptation to chronic illness during the first six months following hospital discharge.

Sample: 51 parents of pediatric heart, kidney, liver, lung and multivisceral transplant recipients participated.

Framework: Meleis’ Transitions Theory provided an organizing framework for conceptualizing the transition from hospital to home and chronic illness care.

Setting: Parents were recruited at five pediatric transplant centers in the United States.

Method/Approach: The study was a prospective, correlational and longitudinal design. Participants completed questionnaires on the day of hospital discharge and 3 telephone interviews in the first six months following hospital discharge at 3-week, 3-month and 6-month time points. Quantitative methodologies were used to determine associations of: 1) discharge teaching and care coordination on parent RHD at hospital discharge and 2) parent RHD with coping difficulty, utilization of healthcare resources, and family impact in the first six months following hospital discharge.

Results: Linear and logistic regression analyses were used to identify significant relationships. Care coordination (p = .03) and quality of discharge teaching (p ≤ .001) were independently associated with RHD. RHD was subsequently associated with post-discharge coping difficulty (p = 0.01) and impact on family (p = 0.01) at 3-weeks post discharge, but significance was not maintained at 3 or 6-months post-discharge. RHD was not associated with readmission to the hospital or emergency department visits.

Conclusions and Implications: RHD is influenced by care team process quality of discharge teaching. RHD was associated with subsequent post-discharge outcomes including post-discharge coping difficulty and impact on family for parents of pediatric SOT recipients. Identifying parents who are not ready to go home from the hospital
following their child’s SOT provides an opportunity to offer additional transitional services to effectively manage recovery and continuing care at home. We recommend further investigation targeting nursing and health interventions to enhance parent RHD and subsequent chronic illness management in the home environment to maximize child and family psychosocial adjustment and quality of life.