The nurse is a member of health care team who provides primary care to the patients and their families, experiencing transition period. According to ANA “The nurse is responsible and accountable for individual nursing practice and determines the appropriate of tasks consistent with the nurse's obligation to provide optimum patient care”. The nurse is also responsible for the planning of transition of health care responsibilities to patients and their families. For childhood chronic diseases, planning and implementing interventions for the child and his family on transition from hospital to home should be part of nursing process. The child and his family should be acquired certain skills in order to manage the transition process appropriately. Also, some nursing interventions should be planned to help them overcome that complicated transition period. Those interventions are:

1. Assessment of the child and his family,
2. Determination of the sources to make the transition easier,
3. Gaining disease management skills

Recently, it has been shown that one-sided, education based strategies are not adequate for childhood chronic diseases so that multiple-sided interventions have gained importance in transition from hospital to home. The positive outcomes of multiple interventions such as phone-counselling, home visits have been promoted for management of childhood chronic diseases. The role of nurses in those multiple interventions should be motivating the patients and families to participate in disease management process and helping them about problems which might possibly be occurred during home visits and phone counselling.

Biography
Ayfer Ekim has completed her PhD at Marmara University Department of Pediatric Nursing. She is an Assistant Professor at Department of Nursing, Istanbul Bilgi University, Istanbul, Turkey. Her primary interests are childhood chronic diseases, pain management and nursing theory and models. She still works as a writer, researcher and educator in the field of pediatric nursing.

Notes: