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DEFRAGMENT OR INTEGRATE CARE? A CHALLENGE FOR THE INTERNATIONAL YEAR OF THE NURSE

DESFRAGMENTAR OU INTEGRAR CUIDADOS? UM DESAFIO PARA O ANO INTERNACIONAL DO ENFERMEIRO

¿DESFRAGMENTAR O INTEGRAR CUIDADOS? UN DESAFÍO PARA EL AÑO INTERNACIONAL DEL ENFERMERO

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The continuity of care between the different levels of care, namely the discharge after a hospitalization or the transfer to another unit, it is not always carried out with safety and ensuring communication and information sharing about the person's clinical situation. This defragmentation of care may lead to changes in the person's functional or health status, mostly if the person is elderly [(1)].

Difficulties in communication and articulation between primary and differential health care are an obstacle to responding in an integrated way to the needs of the population with complex health-disease problems[(2-3)]. This issue extends not only to the person who is admitted to a hospital, but also to their caregiver family member. The double aging of the population and the increase in the incidence of chronic diseases and the degree of dependence affect the capacity for self-care and create new needs for support and social support, for a large percentage of elderly people, often dependent on a family member to ensure their daily living activities.

On the other hand, the transition to the role of informal caregiver of a family member with a commitment to mobility, cognitive changes and/or the state of consciousness leads to difficulties associated with the demand for care, but can generate financial problems, changes in social life and consequent relational problems, lack of family support, bad reaction to care and lack of social resources[(3)].

Some authors advocate that the potential problems that may arise in the transition from hospital to home justify an immediate continuity of care, to prevent risks and avoid complications associated with immobility processes and difficulties in managing the therapeutic regime[(2)] in the elderly person, and

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as well as an intervention with caregivers, sustaining their transition to paper, identifying risks to their health and preventing complications.

The lack of sustained support from primary health care professionals, timely, and with a permanence maintained in time, causes unnecessary readmissions, increasing health care costs and promoting the onset of complications such as infections and functional decline. In light of this, we agree with a study[1] that defends the need for more action by health professionals in transition care and that involves the person and their family.

For the year that the World Health Organization (WHO) has declared as the International of the Nurse, we challenge colleagues to reflect on this emergence of integration care, centered in the citizen, not in the place where it is provided. Nurses should lead this integration, because the discharge from hospital is synonymous with discharge by stabilizing the patient's clinical condition. However, the person may be discharged in worse functional and psychological conditions than when they were admitted[4].

This leadership function passes by coordination and planning of care transfer to be realized in out-of-hospital environment, fostering understanding between all those involved in the therapeutic process, through secure communication, monitoring its effectiveness and encouraging health promotion[1].

During hospitalization, needs should be identified and risks corrected inherent in the hospital-community transition process[2]. Preparing for discharge should be a central concern in the hospital and community, and the action, in that sense, should be initiated at the early phase of admission and stimulate the coordination/communication of the hospital-community dyad in the accompaniment of the person and their caregiver[1-3].

In this way, it becomes necessary to articulate with other services/institutions in order to ensure the continuity of care and to articulate with the different community services that guarantee health support, social and material support and the necessary equipment for the continuity of care[1-2].

The integration of transitional care into global health care planning implies anticipating, from the time of admission to hospital to the time of return home[1], the intervention continuity by health professionals and support for patients and their families in the different transitions they may be experiencing.

The integration of transitional care has as its central pillar the needs of the population most vulnerable to its discontinuity, however, the commitment to a safe hospital-community transition, ensuring continuity of care, also contributes to the reduction of health costs, presenting itself as an appropriate strategy and policy to be followed by the health services[1-3].

The challenge is to transform the International Year of the Nurse into the year of the resolution of the defragmentation of care, betting on the nurses' leadership to ensure a safe, ethical and cost-effective transition to the health of the populations.

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