DOI 10.18471/rbe.v37.47254 Original Article

TRANSITIONAL CARE OF PEOPLE WITH CHRONIC DISEASE AT HOSPITAL DISCHARGE: PERSPECTIVE OF NURSES

TRANSIÇÃO DO CUIDADO DA PESSOA COM DOENÇA CRÔNICA NA ALTA HOSPITALAR: PERSPECTIVA DE ENFERMEIROS

TRANSICIÓN DEL CUIDADO DE LA PERSONA CON ENFERMEDAD CRÓNICA EN EL HOSPITAL: PERSPECTIVA DE ENFERMEROS

Gabriela Marcellino de Melo Lanzoni[1]
Aliny Fernandes Goularte[2]
Marina Miotello[3]
Caroline Cechinel-Peiter[4]
Cintia Koerich[5]
Laísa Fischer Wachholz[6]

How to cite this article: Lanzoni GMM, Goularte AF, Miotello M, Cechinel-Peiter C, Koerich C, Wachholz LF. Transitional care of people with chronic disease at hospital discharge: perspective of nurses. Rev baiana enferm. 2023; 37: e47254.

Objective: to understand the perspective of nurses on the transitional care of the person with chronic non-communicable disease from hospital to home. Method: qualitative, exploratory and descriptive study. The study scenario was a University Hospital in southern Brazil. Data collection occurred through semi-structured interviews with 28 nurses and managers, between July 2018 to May 2019, in which the analyses were made by the themes. Results: The nurses point out some strategies of transition of the care, as the inclusion of the caregiver in the orientations and the telephone contact. They also indicate the need for recognition of the health network by professionals and the challenge of articulation between different services. Final considerations: the transitional care goes beyond the reductionist logic of simple individualized orientation to hospital discharge. The nurse can lead the change and promote the consolidation of safe and qualified practices, due to its insertion in the various scenarios of health care.

Descriptors: Nursing. Continuity of Patient Care. Nursing Care. Chronic Disease. Unified Health System. Transitional Care.

Corresponding Author: Gabriela Marcellino de Melo Lanzoni, gabriela.lanzoni@ufsc.br

[1] Universidade Federal de Santa Catarina. Florianópolis, SC, Brazil. https://orcid.org/0000-0001-5935-8849
[2] Universidade Federal de Santa Catarina. Florianópolis, SC, Brazil. https://orcid.org/0000-0001-8739-6025
[3] York and Scarborough Teaching Hospital. York, North Yorkshire, England. https://orcid.org/0000-0003-4863-921X
[4] Universidade Federal de Santa Catarina. Florianópolis, SC, Brazil. https://orcid.org/0000-0003-0032-6791
[5] Universidade Federal de Santa Catarina. Florianópolis, SC, Brazil. https://orcid.org/0000-0002-6147-415X
[6] Universidade Federal de Santa Catarina. Florianópolis, SC, Brazil. https://orcid.org/0000-0001-9841-9798

Objetivo: compreender a perspectiva de enfermeiros sobre a transição do cuidado da pessoa com doença crônica não transmissível do hospital para o domicílio. Método: estudo qualitativo, exploratório e descritivo. O cenário do estudo foi um Hospital Universitário no Sul do Brasil. A coleta de dados ocorreu mediante entrevistas semiestruturadas com 28 enfermeiros assistenciais e gestores, entre julho de 2018 a maio de 2019, em que foram feitas as análises pelas temáticas. Resultados: Os enfermeiros apontam algumas estratégias de transição do cuidado, como a inclusão do cuidador nas orientações e o contato telefônico. Indicam, ainda, a necessidade de reconhecimento da rede de saúde pelos profissionais e o desafio da articulação entre diferentes serviços. Considerações finais: a transição do cuidado extrapola a lógica reducionista de simples orientação individualizada para alta hospitalar. O enfermeiro pode protagonizar a mudança e promover a consolidação de práticas seguras e qualificadas, devido sua inserção nos diversos cenários de atenção à saúde.

Descritores: Enfermagem. Continuidade da Assistência ao Paciente. Cuidados de Enfermagem. Doença Crônica. Sistema Único de Saúde. Cuidado Transicional.

Objetivo: comprender la perspectiva de enfermeros sobre la transición del cuidado de la persona con enfermedad crónica no transmisible del hospital al domicilio. Método: estudio cualitativo, exploratorio y descriptivo. El escenario del estudio fue un Hospital Universitario en el Sur de Brasil. La recolección de datos se realizó mediante entrevistas semiestructuradas con 28 enfermeros asistenciales y gestores, entre julio de 2018 y mayo de 2019, en las que se realizaron los análisis por las temáticas. Resultados: Los enfermeros apuntan algunas estrategias de transición del cuidado, como la inclusión del cuidador en las orientaciones y el contacto telefónico. Indican, además, la necesidad de reconocimiento de la red de salud por los profesionales y el desafío de la articulación entre diferentes servicios. Consideraciones finales: la transición del cuidado extrapola la lógica reduccionista de simple orientación individualizada para alta hospitalaria. El enfermero puede protagonizar el cambio y promover la consolidación de prácticas seguras y cualificadas, debido a su inserción en los diversos escenarios de atención a la salud.

Descriptores: Enfermería. Continuidad de la Atención al Paciente. Cuidados de Enfermería. Enfermedad Crónica. Sistema Único de Salud. Cuidado Transicional.

Introduction

Chronic non-communicable diseases (CNCDs) have significant prominence in relation to national and international morbidity and mortality with the four most prevalent causes, which are: cardiovascular, respiratory, cancer and diabetes that together, account for 70% of deaths worldwide. Thus, for countries to continue to develop, the health of the population must be a priority and the reduction of CNCDs, globally, a necessity[1].

People living with CNCD are more susceptible to frequent hospitalizations and for long periods due to episodes of worsening of the disease. In addition, the treatment initiated in the hospital needs to be continued at home and, therefore, integration between professionals from different points of the health network is necessary in order to provide integrated and continuous care to these people[2].

In Brazil, the organization of Health Care Networks (RAS - *Redes de Atenção à Saúde*) is a strategy for integrating the health system and promoting comprehensive care[3]. However, gaps in the integration between the points of the care network interfere in the access to specialized services both in the process of reference and counter-reference of the population, that this represents one of the major bottlenecks of the Unified Health System (UHS) and reflects negatively on the continuity of care in RAS and the promotion of the principle of integrality[3]. In view of this text, the transitional care is an important strategy for achieving and operationalizing continuity of care among different health services[2].

The transitional care refers to coordinated interventions between health services at the time of patient transfer, and its purpose is the continuity of care for the user[4]. Thus, the transitional care through the articulation of services of greater technological density with Primary Health Care (PHC) aims at the quality of care in the home environment and reducing the costs of the health system, especially through the prevention

of repeated preventable hospitalizations. Thus, in order to ensure continuity of care, the patient's transition should begin with the patient's admission to the hospital, be enhanced during the hospitalization period and continue after discharge[5].

The nurse, for its insertion in the different health services, available in the RAS, and for the involvement with the direct care to the is the professional with the greatest possibility of creating bonds and establishing a successful care plan together with the multidisciplinary team[6-7]. A study with nurses in PHC in Brazil points to positive professional experience in the exercise of leadership and trust between professionals and the community to build a bond[8], from the perspective of continuity of care.

International experiences also show the importance of nurses in the transitional care. In Spain, this professional has been a reference in the articulation of the hospital service with PHC since the 1970s in Europe. The so-called liaison nurses are responsible for the elaboration of care plans in a shared way with the multidisciplinary team, patient and family, aiming at the continuity of care after hospital discharge[9]. This experience is repeated in countries such as Canada and Portugal, which, despite using other terminologies, comprise the contribution of nurses in the transitional care as a strategy for continuity of care[6].

Thus, the role of nurses in the transitional care can provide adequate conditions, through the interaction between high complexity and PHC, so that this care happens in a coordinated and effective way at home level. For this, he stands out as a facilitator in the consolidation of continuity of care through a set of actions that consider the patient, their reality and their needs[6-7,9].

Despite the growing interest on the subject in Brazil and abroad, there is still little literature on the mechanisms and strategies used to transition the care of people with CNCD from hospital to home, especially from the perspective of nurses[6-7]. Thus, this study was outlined with the following research question: how do nurses understand the transitional care from the person with chronic non-communicable disease from the hospital to the home?

Thus, this study aimed to understand the perspective of nurses on the transitional care of people with chronic non-communicable disease from hospital to home.

Method

This is a descriptive-exploratory study with a qualitative approach, which allows the construction of knowledge from the experiences that subjects experience in their daily lives[10].

The study participants were care nurses and managers, linked to two units of medical clinic, two of surgical clinic and an adult emergency of a university hospital located in southern Brazil. The approach of the participants took place personally or via institutional telephone contact provided by the chief nurses of the hospitalization units. At this first moment, the researchers presented the research proposal and questioned about the interest in participating in the study. For those who answered affirmatively, a time was scheduled for the interview in the workplace in a private room.

The following inclusion criteria were considered: to be a care nurse or in charge of managing the medical, surgical and emergency clinic units, with at least six months of experience in the sector. Professionals on leave of any kind were excluded during the research period. In this sense, 33 nurses were approached, of which five refused to participate in the research due to lack of time and 28 nurses participated in the study. As the data were collected and analyzed, there was repetition of information in front of the elements sought to achieve the objective of the study and, considering the absence of new incidents relevant to the research, it was understood that data saturation was achieved and data collection was ended with 28 participants.

Data collection was performed between July 2018 and May 2019, using semi-structured interviews, recorded by digital voice recording

and transcribed in full, with an average duration of 15 minutes, in a reserved place indicated by the participant in their work unit. The question used to start the interview with the participants was the following: "tell me, from your experiences, how you perceive the transition from care to the person with CNCD from the hospital to PHC or home". From this triggering question, the interview was followed by questions, according to the answers of the participants.

Data analysis was performed in three stages: pre-analysis, material exploration and treatment of the results obtained[10]. The first stage, the pre-analysis, comprised the general reading of the material to be analyzed, generating the approximation and organization of the data. The exploration of the material, second stage, consisted in the codification of the data, classifying them for the essential understanding of the interviews. The text was reduced to meaningful expressions to later form groupings. Finally, in the third stage, the treatment and interpretation of the results occurred, in which the study categories were originated. For the analysis of the results, the theoretical framework of transition and continuity of care was adopted[11-12], in addition to the national and international literature relevant to the theme.

It is noteworthy that the study is an integral part of a Nursing Graduation Work entitled "Continuity of care in transition: nurse strategies for consolidation of counter-reference"[13]. The research met the ethical aspects of Resolution 466/2012 of the National Health Council. The project was submitted and approved by the Ethics Committee in Research with Human Beings, with opinion number 2,537,096. All participants were informed of the objectives of the research and the conduct of the interviews was conditioned to the signing of the Informed Consent Form. The participants' speeches were identified by the letter N followed by the number corresponding to the order of the interviews (N1, N2, N3...), ensuring the anonymity of the participants.

Results

The analysis of the data led to the construction of three thematic categories interrelated among themselves: actions and strategies of nurses for the transitional care; organizational challenges for the transitional care; continuity of care in the Health Care Network, which are presented below.

Actions and strategies of nurses for the transitional care

This category showed the interventions performed by nurses to promote the transitional care from hospital to home. Guidance for discharge was highlighted as an essential tool for continuity of care.

The guidelines for discharge, in most cases, are taken over by the medical team and, in some cases, there is the participation of professionals from the multidisciplinary team such as nutrition, psychology, pharmacy and social service.

> *They* [medical team] *go by and say that the patient is discharged and many times they have already given the guidelines, they are just communicating with us.* [...] *Usually, when the patient is about to be discharged, he* [doctor] *has already given the guidelines or he is going there to deliver what he needs* (N19).

In this sense, the nurse's orientation happens punctually in specific cases, such as guidance on the performance of procedures and manipulation of devices at home. Nursing stands out for being the closest profession to the patient, making the nurse the required professional in the face of doubts from patients and companions about the continuity of care in the household.

> *Some guidelines like that, for example, doubts that the companions have about some procedure like a tube, the tube diet, we also end up giving some guidelines,* [...] *we also end up solving some doubts* (N20).

> *We sometimes guide the things that they* [patients and companions] *were in doubt, like, if you have to go home using a tube, how you are going to do with this tube, if it is a nasogastric tube, how you do it, how you administer the medication, how you feed. More in these cases, we go into discharge guidance, but in the rest, it ends up being medicine, to guide medication, and sometimes they come just to ask if there was any doubt* (N24).

It should be noted that patients in use of certain invasive devices require guidance from nurses throughout hospital stay, even before the expected discharge, understanding the guidelines on the use and handling of the device to promote self-care. In this sense, nurses use strategies such as verbal guidance, pamphlets with guidelines for home and the repetition of procedures to confirm understanding. Professionals seek to direct the guidelines, adapting them to the language of the patient, using words of easy understanding, in order to facilitate understanding.

> *Since when he* [the patient] *comes from the surgery, we have already started to provide care guidelines for the device, especially handling. Because he and his family have to leave already knowing how to use the equipment* (N07).

> *It's no use getting there and talking about a catheter, probe, diet, many of them don't know what a diet is. They know what food is, what diet is. So I think the main thing in communication is adapting to the patient's intellectual, cultural level, and making sure that he really understands* (N13).

In the case of injuries, when performing the guidelines, the nurse takes into account who will perform the dressing of the patient at home, if a family caregiver or a professional of the health team. In addition, it is considered what materials the health center has to offer and the socioeconomic reality of the patient. According to the answers, the nurse reorganizes the care plan, changing the coverage of the injury or seeking an outpatient referral for better evolution. In the case of referral to PHC, the nurse prepares a document of the hospitalization unit to be taken by the patient. This is a strategy for the PHC nurse to be aware of the materials being used to treat the injury.

> *We have more special cases, for example, a patient who goes home with a more extensive wound or who has a more fragile condition, we do it in writing, but it is more in the dressing, that we write the prescription in writing for he takes it to the health center, so that the nurse there knows*. (N01).

The guidelines are carried out with both patients and their relatives or companions. Nurses emphasize that in cases where the family is present in the care of the patient, there is greater adherence to guidelines, such as seeking follow-up in PHC after hospital discharge. Therefore, they invest efforts to include the family caregiver in the dynamics of care, seeking to strengthen the mechanisms that promote continuity of care.

Organizational challenges for the transitional care

In this category, nurses revealed that the high demand for care and administration in hospital units leads to work overload, which impairs their performance in activities for the transitional care.

> *I think there is much more that could be done that the nurse does not do because of that, because we are involved in other demands and maybe also because of custom, cultural, of "ah, they never did"*. (N01).

> *It's too much*. [...] *We have a lot of work overload. We are responsible for a lot of things, most of which are bureaucratic and end up leaving the patient a little aside*. (N15).

Thus, for an adequate transitional care from hospitalization, professionals identified the need for tools and organizational strategies that would help in the transitional care, as electronic medical records shared between the different services in the RAS, shared discharge guidelines among professionals and telephone contact. Such mechanisms would facilitate communication with other points of the network.

> *I think it's ideal to have a system, even to pull up medical records, to see what the hospital itself is doing, it would make our lives a lot easier. We never know anything, so we have to do everything again, keep tracking the patient. Sometimes he* [the patient] *has to undergo an ultrasound, something, or there is some data from a doctor, from a previous exam, and we don't even know*. (N18).

Nurses also highlighted the absence of an instrument standardized by the institution for guidance at hospital discharge. In this sense, the patient receives only from the doctor the discharge summary, containing the summary of the medical conduct adopted during his hospitalization.

> *There is no type of form, he [the patient] usually leaves the hospital with a discharge summary that is prepared by the doctor, leaves with some test results that the patient requests and the doctor provides, leaves with a prescription for medication to be used at home and sometimes it has some medical guidance. But the nursing part does not have any type of record. Anything. I've never done it in these three years of emergency and I've never seen anyone doing it*. (N21).

Nurses point out that the reference letter for PHC is prepared only for patients considered more complex from a clinical and social point of view. Thus, the suggestion of creating a standardized counter-reference instrument throughout the institution could sensitize nurses to the continuity of care. They emphasize that, like the instrument, the discharge summary itself could be sent by e-mail to the PHC and delivered only to the patient.

Continuity of care in the Health Care Network

With regard to this category, although they are not able to develop all stages of the transition from care to inpatients, nurses understand that adequate guidance during hospitalization until discharge leads to a decrease in the return of this patient to service. This happens from the promotion of self-care, which leads to the reduction of episodes of exacerbation, as for education, regarding the functioning of the health system, prioritizing the link with PHC.

> *Often the returns they have, they should not necessarily come to the hospital. There is a health center close to their house, they often solve it there and they end up returning that way. This is perhaps an orientation that we could improve.* [...] *Maybe that was the point that I think could be worked on.* (N24).

Nurses demonstrate to understand that episodes of exacerbation are part of the evolution of chronic disease, making readmissions cannot be completely avoided. However, they understand that adequate management in the transitional care can prevent exacerbations of chronic diseases, when possible, and reduce the frequency of these readmissions.

> [The readmissions] *are also due to lack of guidance because sometimes treatment management or some guidelines for lifestyle changes, this would also help these patients to, perhaps, improve their quality of life a little.* (N20).

Communication with PHC, either through telephone contact or other communication with health center teams, could improve the counter-referral process and allow the flow of information and, consequently, the continuity of patient care. Since the patient, when leaving the hospital without referral, ends up not having a health follow-up and, therefore, becomes susceptible to complications and readmissions.

> *Most of them come back because they didn't take the medication correctly, because they can't understand that prescription properly, so most of them end up coming back here. If there was an effective monitoring of the health unit, they would definitely come back here less times.* (N12).

In this sense, three main aspects were highlighted by nurses, as initiatives to improve continuity of care from the transition from hospital to home: adequate guidance of the patient and family caregiver, adequate monitoring by PHC and multidisciplinary support.

Discussion

The findings of this study reveal the interface between the difficulties and strategies of nurses for the transitional care of patients with CNCD from hospital to home. The transitional care comprises actions aimed at consolidating continuity of care and involves aspects related to: 1) information transfer; 2) patient and caregiver preparation; 3) self-management support; 4) empowerment to affirm preferences[11-12].

In this study, regarding the guidelines for discharge, the individual action of each professional of the multiprofessional team stood out, each one in front of their interventions, acting in their specific area, highlighting fragility in communication between the multiprofessional team. It is evident that both in the home follow-up and in the hospital, it is expected that the professionals act in an integrated way, articulated interdisciplinary, that they carry out case discussions and the decision-making is jointly, including the patient and his relatives[14]. The establishment of a relationship of trust between patient, family and health professionals, whose actions are directed to the health needs of the patient, configures the continuity of relational essential to promote patient engagement in the home care process[12].

Scientific evidence points to the contribution of nurses to the continuity of care[12]. Although the results do not present the nurse as the

main professional responsible for the guidelines of hospital discharge, this is responsible for encouraging the self-management of the clinical condition, especially in cases where the patient and/ or family caregiver need to learn to handle equipment, materials and technological devices and, therefore, seeks to use appropriate language that favors the understanding of information. Corroborating these findings, this study highlights that education for self-management of the disease should involve clear guidelines, in a language comfortable to the patient and, if possible, accompanied by visual resources, such as printed materials, that help reinforce verbal instructions[15].

Therefore, it is appropriate to highlight the contribution of the family caregiver in the transitional care, and its inclusion by health professionals as active agents in the preparation of the care plan after hospital discharge[11]. A review of the literature on the transitional care in Latin American countries showed that self-management activities predict the inclusion of caregivers, since they are more able to care for patients after discharge, since at that moment they are equipped with the knowledge and skills they acquired during hospitalization with the patient[16], supporting the efforts invested, in this sense, by the nurses included in this research.

Therefore, the data of this research indicated the need to develop a care plan for discharge. Similar results are described in the study, which points out the importance of the use of a care plan by the nurse that adjusts the way to transmit information during the discharge planning to the patient and caregiver, so that they understand the recommendations to be followed after discharge, either by the self-management of the disease by the patient, or by the management of this process by the caregiver, regardless of the scenario in which they are inserted[17].

In this sense, it is worth mentioning the importance of planning the transitional care to reduce the length of hospital stay, which is responsible for the considerable increase in health costs. Guidelines when performed from the beginning of hospitalization, avoid delays in hospital discharge. A randomized clinical trial conducted in the United States found that 30% of hospital discharges are postponed for non-medical reasons, i.e., health needs outside the hospital or social assistance[18].

The present study pointed out that the high demand of the nurse's duties in the hospital unit, sometimes not specific to this professional, ends up hindering the implementation of the care transition. Thus, it is perceived that in the face of numerous assignments, nurses tend to prioritize essential care in order to ensure safe and qualified care in the hospital context. On the other hand, the actions that would enhance the transition between services are in a second corroborating with the results of national studies that point to the fragility in the counter-reference process of patients who are discharged from the hospital and not properly referred to PHC[19].

Given this, it is important to highlight the importance of the managerial dimension of continuity of care, essential for the provision of high-quality care through the coordination of care in the transition between the different ensuring access and avoiding duplication of health actions[12].

It is important to measure that the function of organizing work processes in the hospital requires initiative and management investment, since it goes beyond the governance of professionals directly involved in patient care. In this sense, there is a need for efforts to start from the superior management of the organizational structure, subsidizing the since the transitional care from one service to another in RAS represents a moment subject to fragmentation of care and therefore requires special attention from professionals and managers[6].

Tools such as information systems, in the case of electronic medical records and computerized agenda, are facilitating tools for the development of health actions of medium/high complexity and consequent optimization of the service and promotion of integrality[20], strategies also cited by the participants of this study. The provision of mechanisms that ensure the storage and sharing of patient health information promotes

the continuity of informational care, providing subsidies to health professionals for safe decision making[12].

The implementation of information systems is an important strategy for the integration of medium/high complexity services to other points of attention. These tools allow managers to know and monitor demand, which enables the definition of clinical priorities and development of strategies for qualification of care[20]. For professionals, this resource has a prominent potential to qualify care, considering that the detailed record of each professional and conduct throughout the patient's life allows the continuity of informational care[21].

Among the strategies proposed by the interviewed professionals, there is also the monitoring of patients after discharge through telephone calls. This strategy can be used, for example, to analyze the use of the health service by elderly patients after discharge, enabling the follow-up of care, identification of risk situations and prevention of complications that may lead to readmission[22].

Similarly, another strategy described in the literature is post-discharge follow-up by nurses. The follow-up is performed by telephone by hospital nurses to the PHC nurse, as well as for patients and caregivers in the home context, with immediate intervention during the call. The results, identified from a literature review, pointed to the sharing of computerized systems between the hospital and PHC and a discharge plan that is delivered to the patient at the time of this, which is shared with the PHC team electronically[23].

The lack of standardization of hospital discharge was cited as a challenge for the transitional care, since the standardization of care processes is considered a facilitator when starting the preparation for discharge. Faced with this, instruments such as the check list for verification can help nurses at the time of discharge, considering that they standardize information and tend to increase patient satisfaction with the care received[18].

In this sense, one can also cite an instrument developed in the USA, the Readiness for Hospital Discharge Scale (RHDS), which can identify, in the planning and coordination of hospital discharge, patients who are not prepared to return home and present risks of readmission. With this evaluation, the multiprofessional team can establish therapeutic plans with goals, as well as prepare the patient and his family members for the return home. The instrument includes educational interventions with patient and family, referral to PHC and monitoring of this through telephone calls and home visits[24].

Follow-up in PHC becomes essential after discharge of the person with CNCD considering situations such as early hospital discharge, insecurity or unpreparedness of the patient and his family members to home care, difficulty in adhering to the therapeutic regime, changes in lifestyle and self-care[19]. In this scenario, matrix support is configured by the support given by specialized professionals from different areas of operation to a FHS team, through shared construction processes, reaching pedagogical and technical dimensions to promote comprehensive care and qualify the assistance provided[25].

Thus, for the transitional care, especially for people with CNCDs, there is a need for collaboration between professionals for the implementation of an integrated and continuous care[2]. Whereas the articulation between the different points of the network, composed of devices of different technological densities, ensures the patient access to the health system, effective communication between the RAS points and the multidisciplinary team is fundamental to ensure continuity of care.

In the national context, although some initiatives are verified empirically, the role of nurses in various hospital institutions for strengthening counter-referral is not yet consolidated. In this context, even if linked to the individual sphere, the relevance of the nurse's performance in promoting comprehensive and qualified care to ensure integration between the points of care in the network is emphasized[26].

Study that sought to assess the quality of the transitional care in the discharge of the emergency service of patients with CNCD showed the importance of using protocols for the planning of hospital discharge and the strengthening of the role of nurses in coordinating the transition care, participating in discharge planning, providing guidance for self-management in health, as well as assisting in the articulation between hospital and PHC services[27]. The literature review conducted in Latin American countries on the transitional care, presented the use of communication protocols between hospital and PHC and action conducted by nurses, considered coordinators of patient monitoring plans, with the multidisciplinary team in PHC[16].

An integrative review identified the effectiveness of post-discharge patient follow-up by a case manager nurse. This nurse provided assistance to the patient, leading to self-management of medication, offering health education and facilitating access to outpatient clinics when necessary[2]. In this perspective, the recognition and legitimation of the function of the liaison nurse stands out as a possibility of qualification of the transition processes of care, increasing the quality of life after discharge, as well as reducing hospitalizations and optimizing health system resources[6,9].

As a limitation of the study, it is pointed out that the data collection included care nurses and managers, although the important interface of the multiprofessional team and nursing technicians in the transition process of care has not been explored. Thus, new studies can be performed, including these professionals, in order to seek new strategies that can be rethought together.

Final Considerations

The study makes it possible to contribute to an understanding that the transitional care goes beyond the reductionist logic of simple individualized orientation to hospital discharge. It requires the construction of a joint work with the health team, including the patient and caregiver, as well as the recognition of the health network by professionals and appreciation of the articulation between professionals and actions in the different points of the RAS. Faced with this challenge, nurses can lead the change and promote the consolidation of safe and qualified practices, considering their inclusion in all health care scenarios.

From the perspective of nurses, the transitional care faces many challenges for its consolidation, highlighting the high demand for assignments of nurses in hospital units, the need for tools, standardization for hospital discharge by the hospital institution and disarticulation among health services professionals at different points of the RAS.

Despite this, some strategies are perceived by nurses as essential for the implementation of the transitional care, such as the creation of standardized instruments that assist the nurse in the process of guidance for discharge and referral of the patient to PHC, inclusion of the caregiver in the guidelines for hospital discharge and self-management of the patient. The stimulus to effective multiprofessional communication, both in-hospital and intersectoral, was also highlighted, considering the different points of the RAS, the use of technologies such as telephone contact, for monitoring the patient with CNCD after hospital discharge, systems, such as the shared electronic medical record, aiming at the continuity of care of these patients in articulation with PHC.

Collaborations:

1 – Conception and planning of the project: Gabriela Marcellino de Melo Lanzoni, Aliny Fernandes Goularte and Marina Miotelo.

2 – Analysis and interpretation of data: Gabriela Marcellino de Melo Lanzoni, Aliny Fernandes Goularte and Marina Miotelo;

3 – Writing and/or critical review: Gabriela Marcellino de Melo Lanzoni, Aliny Fernandes Goularte, Marina Miotelo, Caroline Cechinel Peiter, Cintia Koerich and Laísa Fischer Wachholz.

4 – Approval of the final version: Gabriela Marcellino de Melo Lanzoni, Aliny Fernandes Goularte, Marina Miotelo, Caroline Cechinel Peiter, Cintia Koerich and Laísa Fischer Wachholz.

Conflicts of interest

There are no conflicts of interest.

Funding sources

This work was supported by the Coordination for the Improvement of Higher Education Personnel - Brazil (CAPES) - Financing code 001.

References

1. Malta DC, Bernal RTI, Lima MG, Araújo SSC, Silva MMA, Freitas MIF, et al. Noncommunicable diseases and the use of health services: analysis of the National Health Survey in Brazil. Rev saúde pública. 2017;51(Suppl 1):4s. DOI: https://doi.org/10.1590/s1518-8787.2017051000090
2. Regge MD, Pourcq KD, Meijboom B, Trybou J, Mortier E, Eeckloo K. The role of hospitals in bridging the care continuum: a systematic review of coordination of care and follow-up for adults with chronic conditions. BMC health serv res. 2017;17(1):1-24. DOI: https://doi.org/10.1186/s12913-017-2500-0
3. Vieira EW, Gazzinelli A. Degree of integration of Primary Health Care of a small municipality in the Health Services Network. Saúde Soc. 2017;26(2):448-61. DOI: https://doi.org/10.1590/S0104-12902017170100
4. Weber LAF, Lima MADS, Acosta AM, Marques GQ. Transição do cuidado do hospital para o domicílio: revisão integrativa. Cogitare Enfermagem. 2017;22(3)e47615. DOI: http://dx.doi.org/10.5380/ce.v22i3.47615
5. Menezes TMO, Oliveira ALB, Santos LB, Freitas RA, Pedreira LC, Veras SMCB. Hospital transition care for the elderly: an integrative review. Rev bras enferm. 2019;72(Suppl 2):294-301. DOI:https://doi.org/10.1590/0034-7167-2018-0286.
6. Ribas EN, Bernardino E, Larocca LM, Poli Neto P, Aued GP, Silva CPC. Nurse liaison: a strategy for counter-referral. Rev bras enferm, 2018:71(1):546-553. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0490
7. Aued GK, Bernardino E, Lapierre J, Dallaire C. Liaison nurse activities at hospital discharge: a strategy for continuity of care. Rev latinoam enferm. 2019;27:e3162. DOI: http://dx.doi.org/10.1590/1518-8345.3069.3162
8. Lanzoni GMM, Meirelles BHS, Cummings G. Práticas de liderança do enfermeiro na atenção básica à saúde: uma teoria fundamentada nos dados. Texto contexto enferm. 2016;25(4):e4190015. DOI: http://dx.doi.org/10.1590/0104-07072016004190015
9. Costa MFBNA, Andrade SR, Soares CF, Pérez EIB, Tomás SC, Bernardino E. The continuity of hospital nursing care for Primary Health Care in Spain. Rev Esc Enferm USP. 2019;53:e03477. DOI: https://doi.org/10.1590/s1980-220x2018017803477
10. Minayo MCS. Pesquisa social: Teoria, método e criatividade. 34. ed. Petrópolis: Editora Vozes, 2015.
11. Coleman EA, Roman SP. Family caregivers' experiences during transitions out of hospital. Journal for Healthcare Quality. 2015;37(1):12–21. DOI: https://doi.org/10.1097/01.JHQ.0000460117.83437.b3
12. Bahr SJ, Weiss ME. Clarifying model for continuity of care: A concept analysis. International Journal of Nursing Practice. 2018;25(2):e12704. DOI: https://doi.org/10.1111/ijn.12704
13. Miotello, Marina. Continuidade do cuidado na transição: estratégias do enfermeiro para consolidação da contrarreferência [Trabalho de Conclusão de Curso]. Florianópolis. Universidade Federal de Santa Catarina. 2018. 63p.
14. Hermann AP, Lacerda MR, Nascimento JD, Gomes IM, Zatoni DCP. Enhancing the process of teaching and learning homecare. Rev. Bras. Enferm. 2018;71(1):156-62. DOI: http://dx.doi.org/10.1590/0034-7167-2016-0541
15. Donihi AC. Practical recommendations for transitioning patients with type 2 diabetes from hospital to home. Curr diab rep. 2017;17(52) :1-11. DOI: https://doi.org/10.1007/s11892-017-0876-1
16. Lima MADS, Magalhães AMM, Oelke ND, Marques GQ, Lorenzini E, Weber LAF, et al. Care transition strategies in Latin American countries: an integrative review. Rev gaúcha enferm. 2018;39:e20180119. DOI: https://doi.org/10.1590/1983-1447.2018.20180119
17. Menezes TMO, Oliveira ALB, Santos LB, Freitas RA, Pedreira LC, Veras SMCB. Cuidados de transição hospitalar à pessoa idosa: revisão integrativa. Rev. Bras. Enferm. 2019;72:294-301. DOI: https://doi.org/10.1590/0034-7167-2018-0286.
18. Shakir G, Gaddis J, Mariga NN, Obanor F, Okafor OT, Thornton A, et al. Use of a Daily Discharge Goals Checklist for Timely Discharge

and Patient Satisfaction. Medsurg nurs [Internet]. 2017 [cited 2021 Nov 28];26(4):236-41. Available from: https://www.thefreelibrary.com/Use of a daily discharge goals checklist for timely discharge and...-a0503466842

19. Cunha KS, Erdmann AL, Higashi GDC, Baggio MA, Kahl C, Koerich C, et al. Myocardial revascularization: unveiling strategies in reference and counter reference in primary health care. Rev baiana enferm. 2016;30(1):295-304. DOI: http://dx.doi.org/10.18471/rbe.v1i1.16039

20. Sockolow P, Hellesø R, Ekstedt M. Digitalization of patient information process from hospital to community (home) care nurses: International perspectives. Stud Health Technol Inform. 2018;250:227-9. DOI: https://doi.org/10.3233/978-1-61499-872-3-227

21. Kuusistoac A, Asikainen P, Sarant K. Contents of Informational and Management Continuity of Care. Stud Health Technol Inform. 2019;264:669-73. DOI: https://doi.org/10.3233/shti190307

22. Pinheiro F, Santos FHE, Sousa RM, Santana RF, Silva J, Pestana LC, et al. Phone monitoring on the elderly post hospital discharge. Revista enfermagem atual in derme [Internet]. 2017 [cited 2021 Nov 28];83(1):48-53. Available from: https://revistaenfermagematual.com.br/index.php/revista/article/view/284/175

23. Weber LAF, Lima MADS, Acosta AM, Maques GQ. Care transition from hospital to home: integrative review. Cogitare enferm. 2017;(22)3:e47615. DOI: http://dx.doi.org/10.5380/ce.v22i3.47615

24. Siqueira TH, Vila VSC, Weiss ME. Cross-cultural adaptation of the instrument Readiness for Hospital Discharge Scale - Adult Form. Rev bras enferm. 2018;71(3):983-991. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0241

25. Oliveira RCC, Adário KDO, Sá LD, Videres ARN, Souza SAF, Pinheiro PGOD. Managers' discourse about information and knowledge related to directly observed treatment of tuberculosis. Texto contexto enferm. 2016;25(2):e3210015. DOI: http://dx.doi.org/10.1590/0104-07072016003210015

26. Ferreira ML; Vargas MAO; Marques AMFB, Andrade SR, Vargas CP. Atuação do enfermeiro no referenciamento e contrarreferenciamento de pessoas com amputação. Cogitare enferm. 2017;(22)3:e50601. DOI: http://dx.doi.org/10.5380/ce.v22i3.50601

27. Acosta AA, Lima MADS, Pinto IC, Weber LAF Care transition of patients with chronic diseases from the discharge of the emergency service to their homes. Rev gaúcha enferm. 2020;41(esp):e20190155. DOI: https://doi.org/10.1590/1983-1447.2020.20190155

Received: March 31, 2022

Approved: December 28, 2022

Published: May 24, 2023