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REVIEW

Transitional rehabilitation care and patient care continuity as an advanced nursing practice

Cuidado transicional de reabilitação e continuidade da assistência ao paciente como prática avançada de enfermagem

Cuidado transicional de rehabilitación y continuidad de atención al paciente como práctica avanzada de enfermería

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ABSTRACT

Objective: To analyze the needs and facilitating and hindering elements related to transitional rehabilitation care. **Methods:** Integrative literature review oriented toward answering the question "What nursing interventions guarantee transitional rehabilitation care to dependent adult or elderly people when they return home after hospitalization?". **Results:** The patients did not participate much in the planning of hospital discharge and decision-making when they had to return home. Informal caretakers reported that professionals showed detachment during hospitalization and delayed guiding instructions. Health professionals mentioned lack of time to offer this care modality as a difficulty. **Final considerations:** Ensuring training, follow-up, and coordination between care levels is essential. Care integration can reduce hospital stay and the impact of post-discharge complications. Transitional care contributes to a sustainable health system, higher care quality, and client satisfaction.
Descriptors: Transitional Care; Continuity of Patient Care; Advanced Practice Nursing; Hospitalization; Patient Discharge.

RESUMO

Objetivos: Analisar as necessidades, elementos facilitadores e dificultadores, de cuidados transicionais de reabilitação **Métodos:** Revisão integrativa da literatura para responder à questão "Quais as intervenções de enfermagem que garantem a continuidade dos cuidados de reabilitação à pessoa adulta/idosa dependente no regresso a casa, após hospitalização?". **Resultados:** Existe uma baixa participação da pessoa no seu planejamento da alta e na tomada de decisão no regresso a casa. Os cuidadores informais referem distanciamento dos profissionais durante a internação e que a realização de orientações é tardia. Os profissionais de saúde envolvidos apontam como dificuldade a falta de tempo da equipe para este cuidado. **Considerações Finais:** *É* fundamental garantir formação, acompanhamento e coordenação entre níveis de cuidados. A integração de cuidados pode reduzir o tempo de internação e as complicações pós-alta. O cuidado transicional contribui para um sistema de saúde sustentável, o incremento da qualidade dos cuidados e a satisfação dos clientes.
Descritores: Cuidado Transicional; Continuidade da Assistência ao Paciente; Prática Avançada de Enfermagem; Hospitalização; Alta do Paciente.

RESUMEN

Objetivos: Analizar las necesidades, elementos facilitadores y dificultadores de cuidados transicionales de rehabilitación. **Métodos:** Revisión Integrativa de Literatura, respondiendo la pregunta: "¿Cuáles intervenciones de enfermería garantizan la continuidad de cuidados de rehabilitación al adulto/anciano dependiente en su regreso luego de una internación?". **Resultados:** Existe baja participación de la persona en la planificación de su alta y en la toma de decisiones al regresar a casa. Los cuidadores informales refieren distanciamiento de los profesionales durante la internación, y que la transmisión de enseñanzas es tardía. Los profesionales de salud alegan como dificultad la falta de tiempo del equipo para estos cuidados. **Consideraciones Finales:** Resulta esencial garantizar la formación, seguimiento y coordinación entre niveles de cuidados. La integración de cuidados puede reducir el tiempo de internación y las complicaciones postalta. El cuidado de transición favorece un sistema de salud sostenible, un aumento cualitativo del cuidado y la satisfacción de los pacientes.
Descriptores: Cuidado de Transición; Continuidad de la Atención al Paciente; Enfermería de Práctica Avanzada; Hospitalización; Alta del Paciente.

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INTRODUCTION

The increasing incidence of chronic or disabling diseases leads to the need for hospitalization and adaptation in the process of returning home, as well as transition between care levels. The need to adapt the response of health systems so they can fight the possible care fragmentation is indisputable. This problem can manifest as confusing guidance on treatment (with high chances of mistakes and duplications), inadequate follow-up, and lack of preparation and information of the people involved and informal caretakers. Therefore, decreasing the information asymmetry between users and health professionals and making more information available to the former are fundamental measures[1-2].

The World Health Organization has been warning about this problem since 2016. It suggests strategies and intervention policies to consolidate patient-centered health services, namely by: training people individually and as a community; reinforcing management and responsibility (whether to the participation of citizens in the reformulation of care policies or the alignment of strategies in the public and private sectors, for instance); reorganizing the care model; coordinating multisectoral services according to people's needs and demand; and promoting an environment favorable to the implementation of previous transformation strategies[3]. To achieve these goals, the World Health Organization emphasizes the development of transitional care based on advanced practice nursing as a priority, because the impact of this care model is clear. By applying this strategy, it is possible to decrease hospital costs and readmission rates and offer and manage care at home (for instance, achieve identical or more satisfactory outcomes compared to those obtained in inpatients). It was shown that the strategy of favoring home care over hospital care reduced costs by 17%[3].

In this context, transitional care stands out as a response to health needs. It can be defined as a set of actions that aim to ensure care continuity when different care levels or transfers from the place where care is offered are involved. In this situation, there may be alterations in the clients' functional status or health condition, especially in elderly people, which means that patients have to be prepared for their new situation[4].

Health-disease transitions that originate dependence and preclude functional recovery to pre-hospitalization levels imply a process of adaptation of patients and their families to their new dependence status to guarantee self-care after they return home[5].

Studies have shown the benefits associated with care continuity, which include greater capacity of integration of physical, psychological, social, and economic dimensions and, therefore, adequate care individualization; improvement of the relationship between health professionals and clients and their relatives; decrease in undue use of health services, which results in cost reduction; and increased satisfaction of clients and health professionals with services and work, respectively[1,4-5].

Another consensus is the necessity to introduce instruments that assess people's needs[5-6] so it is possible to individualize the interventions of caregivers that ensure care of dependent people over this transition period. Interestingly, studies tend to focus on two well-defined contexts, hospital or community, without discussing care continuity related to the transition between these two care levels[6].

There are few studies on transitional care to support care continuity in the rehabilitation context and they have not systematized professionals' interventions, which impacts the development of health policies oriented toward transitional rehabilitation care. Actually, few studies have addressed rehabilitation care.

OBJECTIVES

Analyzing the needs and facilitating and hindering elements related to transitional rehabilitation care.

METHODS

Ethical aspects

This was a literature review that used articles rather than human beings as its sample. Therefore, a report by a research ethics committee was not requested. However, the researchers carried out the study by following integrity principles. Formulation of the guiding question and the study protocol observed the principles of clarity, accuracy, objectiveness, and delimitation, which allowed the researchers to obtain rigor in the results and use the findings in clinical practice and health policies about the subject. Specifically, rigor was guaranteed in different methodological procedures to ensure the study validity. Two independent researchers extracted and analyzed data in the bibliographic sample by respecting other researchers' studies and findings. Referencing of the authors whose work allowed the development of the present review followed the recommendations of good academic and scientific practices.

Study type

This was a literature review[7]. Consequently, the authors applied a predefined protocol with six steps: (1) identification of the subject and selection of the hypothesis or research question; (2) establishment of study inclusion and exclusion criteria; (3) definition of the information to be extracted; (4) evaluation of the included articles; (5) results interpretation; and (6) presentation of the review or synthesis of knowledge[7].

The PICo mnemonic was used to answer the research question "What nursing interventions guarantee transitional rehabilitation care to dependent adult or elderly people when they return home after hospitalization?".

Inclusion criteria and research strategy

The defined eligibility criteria were: quantitative or qualitative studies with adults and/or elderly people, that is, people 18 years old or older; identification of patient home as the destination after hospital discharge; presence of Barthel index scores equal to or lower than 90; articles that reported at least one reassessment of the interventions up to 30 days after clinical discharge; and articles published between 2015 and 2020, with free full texts in English, Spanish, or Portuguese. This period was chosen to guarantee that the results were recent.

Article search was carried out in the electronic databases EBSCOhost (CINAHL and MEDLINE), PubMed and Web of Science,

because they were considered the most appropriate to the study objective, since they include publications in the health and social science areas.

The descriptors, adjusted to each database, were: *transitional care, patient transfer, rehabilitation, rehabilitation nursing, physical and rehabilitation medicine, aged and adult* (for search in CINAHL and MEDLINE) and *transitional care, readiness discharge, discharge planning, patient discharge, continuity of care, continuity of patient care, continuous care, patient rehabilitation, rehabilitation nursing, rehabilitation care, physical rehabilitation, rehabilitation, rehabilitation health, rehabilitation therapy, rehabilitation treatment, rehabilitation medicine, rehabilitative intervention, rehabilitative, dependent patients, dependent person, adult, elderly, elderly adults, elderly patients, elderly person, aged, aged human, nurs** (for search in PubMed and Web of Science).

The articles' titles, abstracts, and full texts were analyzed by two independent researchers to guarantee that the relevant studies were considered according to the defined inclusion criteria.

Data collection and organization

The present study was carried out between October and December 2020 based on the guiding question.

The quantities of identified articles were: 138 in EBSCOhost, 1,044 in PubMed, and 56 in Web of Science, which totaled 1,238 potentially relevant articles. No duplicates were found. By applying the inclusion criteria, 1,038 articles were excluded.

The set of 200 articles that remained were analyzed by the two independent researchers, who excluded 152 articles after reading their titles, and three after reading the abstracts. After full-text reading, 11 articles that answered the research question were selected to be the sample of the present study.

Results analysis

Thematic synthesis was used in the present study to explore the research question. Each article was summarized and had the following information tabulated: study identification (author, publication year, country), study objective, study type, sample, and outcomes.

The results reported in the articles were extracted and analyzed to systematize the data. Bardin's content analysis[8] was applied to the findings. Two researchers carried out the codification, which was subsequently assessed by the research team, made up of two members, to increase reliability.

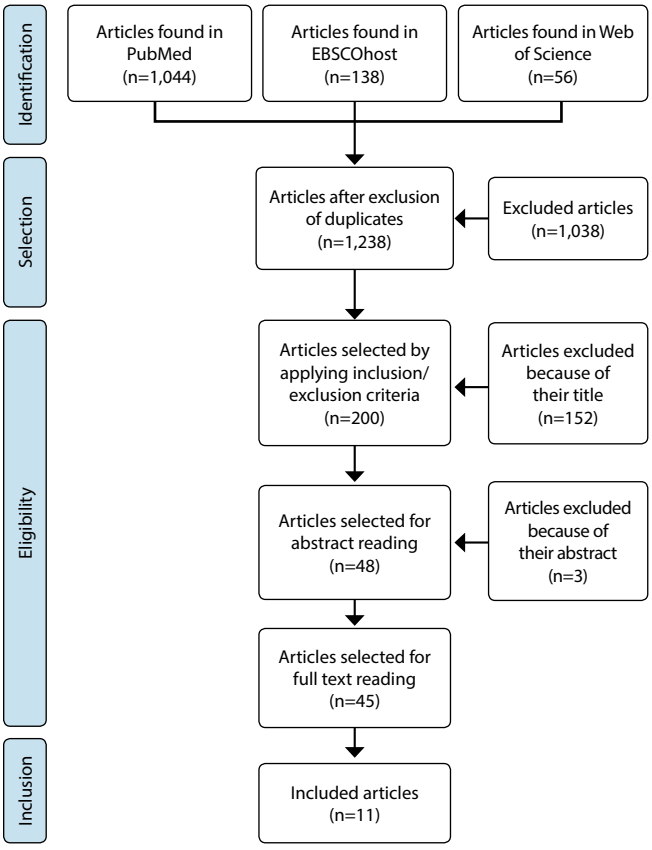

Figure 1 – Flowchart showing the article selection process, Lisbon, Portugal, 2021

RESULTS

In the examined bibliographic sample (Chart 1), three articles were published in 2015[9-11], four in 2017[12-15], one in 2018[16], and three in 2019[17-19]. Two were literature reviews with a scientific methodology[9,13]. In the subset of primary studies, both qualitative[12,16-17] and quantitative approaches were used, with the latter including observational longitudinal studies[11,18] and randomized clinical trials[10,14-15,19]. Despite the differences between the approaches and methodologies, interpreting the sources allowed to answer the research question.

The geographic variety of the studies was remarkable. Two were carried out in Norway[9,18], two in Canada[16,19], two in the United Kingdom[13-14], two in the United States[11,17], one in China[10], one in Australia[12], and one in Singapore[15].

Chart 1 – Studies included in the bibliographic sample, Lisbon, Portugal, 2021

Reference	Country/ Year	Study type Sample	Objectives	Outcomes
S1[9]	Norway 2015	Literature review n=30 articles	Offering an overview of the studies, which addressed the participation of elderly people in transitional care.	The level of participation of elderly people in the planning of hospital discharge and decision-making was low, although people wanted to be included in these processes. The authors recommended considering the implementation of tools to support patient participation to improve transitional care of elderly people.
S2[10]	China 2015	Randomized clinical trial n=108 participants	Testing the effectiveness of a transitional care program developed over four weeks and carried out by a nurse.	The intervention group showed better spiritual, religious, and personal results, greater satisfaction, higher scores in the modified Barthel index, lower depression scores, and lower hospital readmission and urgency service admission rates compared to the control group.

To be continued

Chart 1 (concluded)

Reference	Country/ Year	Study type Sample	Objectives	Outcomes
S3[11]	United States 2015	Longitudinal observational quantitative study n=44,473 participants	Testing whether the risk of readmission was associated with the probability of receiving the benefit of early follow-up at home.	Follow-up within 14 days after discharge was associated with a reduction of 1.5% and 19.1% in readmission rate in lower risk strata and higher risk strata, respectively. Follow-up within seven days after discharge was associated with a reduction of more than 20% in the chances of readmission in people with multiple chronic pathologies.
S4[12]	Australia 2017	Qualitative study n=26 participants	Describing the experience of patients and caretakers in the transition from hospital to community.	All participants reported the need to become independent over the transition. They realized that a number of social processes helped them get their independence at home: supporting relationships with caretakers and health professionals, search for information, discussion of and negotiation on the transitional care plan, and learning of self-care.
S5[13]	United Kingdom 2017	Systematic literature review n=17 articles	Comparing conventional care offered to people who had cerebrovascular accident and programs with early hospital discharge and rehabilitation carried out in the community.	The services with a policy of early discharge, adequate resources, and contribution of a coordinated multidisciplinary team offered to a selected group of people who had cerebrovascular accident reduced their long-term dependence, rate of admission to care institutions, and hospital stay.
S6[14]	United Kingdom 2017	Randomized clinical trial n=250 participants	Comparing the clinical effectiveness and cost-benefit of rehabilitation in the community and transitional care with traditional hospital rehabilitation care.	There was no significant difference regarding length of stay in the two groups. Among the participants who were discharged from hospital, 17% and 13% were readmitted within 28 days, respectively. There were no significant differences between the groups in any secondary results. The cost difference between the two intervention strategies was estimated at 144 pounds.
S7[15]	Singapore 2017	Randomized clinical trial n=840 participants	Evaluating the effectiveness of a model that incorporates pre-hospital discharge transitional care in reducing the use of hospital services by people at a higher risk of readmission.	By applying the concept of practice unit integrated into the online nursing program, which incorporates pre-hospital discharge transitional care, the hospitalization rate was reduced by one third. Combining compatible concepts in care integration can produce synergic results, and more studies would be useful to confirm this idea. Care integration projects must adapt new concepts with the potential to be suitable for the settings under consideration and evaluate the results by designing controlled studies.
S8[16]	Canada 2018	Qualitative study n=27 participants	Exploring the factors that affect people's ability to understand and follow indications.	Caretakers played an important role in the transition experienced by patients with chronic diseases and impacted people's ability to understand and follow indications for discharge. The authors highlighted opportunities for managers and institutions to make the engagement of caretakers in the transition from hospital care to home care effective.
S9[17]	United States 2019	Qualitative study n=20 participants	Exploring the experiences of caretakers in the management of home care needs in post-acute health condition situations, regarding the functioning sphere.	Caretakers played an active and critical role in the management of elderly people's needs when they returned home after hospitalization. Delivery of home care by nurses focused on supporting and training caretakers. Understanding caretakers' perception regarding their activities and their role in the management of elderly people's needs in all care transitions can provide resources for new studies and future practices in post-acute health condition situations.
S10[18]	Norway 2019	Longitudinal observational quantitative study n=3,060 participants	Comparing readmission and mortality rates in two groups of people who had a cerebrovascular accident: one that received follow-up at home after hospital discharge and a control group that did not receive it.	There were no significant differences between the groups regarding readmission rate, despite early follow-up. The patients who got nursing support at home and/or rehabilitation care showed higher readmission rates after 90 and 365 days after hospital discharge in comparison with the control group. There were no significant differences regarding mortality rate. People who received rehabilitation care had a higher mortality rate, whereas those who were offered nursing support at home showed a rate similar to that obtained for the control group.
S11[19]	Canada 2019	Randomized clinical trial n=2,494 participants	Testing the effectiveness of person-centered transitional care offered to inpatients with heart failure.	In the analyzed people with heart failure from Ontario, Canada, comparison between an implemented model of person-centered transitional care and traditional care indicated no improvements in clinical results. It is necessary to carry out more studies to test the effectiveness of this type of intervention. It may be effective in other systems or places.

Application of content analysis to the articles in the bibliographic sample allowed to identify the following categories: people who are the target of transitional care; families involved in care transition; health professionals; and action strategies and health policies.

People who are the target of transitional care

Dependent people's participation and decision-making were two common focuses in several studies in the sample of the present review. Although patient participation is included in health

policies and many users expressed their wish to be involved in care transition, the level of participation of elderly people in discharge planning and decision-making was low. In some described situations, the clients did not have the chance to participate in meetings with their relatives, and there was neither informed consent nor clarity about the purpose of these meetings. In contrast, meetings with clients and their relatives were marked by a feeling of gratitude, because the users could understand the objective of coordinating resources and increasing their own engagement, despite the discomfort caused by the exposure of their inabilities. An integrated study reported that half the participants declared that they did not receive useful information on their self-care, which showed a lack of concern about their preparation in health education programs that include attention to warning signs which can lead to readmission, therapy management plan, and education about its proper use[9].

Independence was one of the main wishes of the patients, whose response involves integrated efforts at different care levels, since it is related to a need of continuous care and aims at recovery. Independence proved equally relevant for the community-dwelling elderly population, regardless of existence of previous support[12].

Another study showed that the transition period was characterized by anxiety and that there were different perceptions regarding education and training times. People with acute pathologies mentioned excessive information and training at hospital discharge, whereas people with chronic diseases declared that their ability to memorize, understand, and fulfill the instructions was an indication of a successful transition. The authors of this study reported that success in health education seems to be associated with caretaker engagement. Both clients and relatives recognized the importance of being involved in care transition. People with no informal caretakers had more difficulty adhering to follow-up appointments and often pointed out bad experiences and despair when talking about their realities in post-acute situations[16].

Families involved in care transition

Engagement of family caretakers can be characterized according to the several roles in which they stand out: offering care (related to medical tasks such as therapy management and household chores such as cooking or helping move around), acting as the patient's lawyer (by playing an advocate role so as to guarantee the fulfillment of the person's needs and wishes and question a medical decision or resource request), carrying out surveillance (by identifying warning signs and symptoms), providing comfort (by means of a pleasant environment and experience, which helps reduce the person's anxiety), and functioning as a translator (by adjusting the language between the person and health professionals)[16].

Some authors, who recognize the importance of an active and critical role in the management of needs, claimed that, although informal caretakers acknowledge the evolution of the elderly person's status and a possible worsening of their condition, they identify identical care needs, to which an increased dependence is added. Caretakers themselves described that they had more roles and challenges after hospitalization and that these tasks were related to the person's motor disability, with lack of balance, strength limitation, pain, and the person's preferences standing out (specific situations of elderly people who have always said that they would not like to be taken care of by others). Caretakers also emphasized the feeling of isolation and described the need to look after the person first and then themselves, as a result of an obligation or retribution of love[17].

Regarding interaction with health professionals, caretakers reported that their concern originated in previous experiences. They highlighted health teams' detachment during hospitalization, lack of written information, and the facts that they felt unable to ask questions about health condition and care to be delivered and that they classified knowledge transmission as overdue. After the patients returned home, the caretakers felt the need to go after health professionals so they could intervene when necessary and played attention to the professionals' work during home care to understand the real health needs (for instance, elimination of architectonic barriers or selection of gait support items, such as sticks or Zimmer frames)[16-17].

Health professionals

A study published in 2015 identified that success in transitional care relied on reintegrating care fragments as patients get past phases in the care cycle. Professionals declared that multidisciplinary teams proved to not be enough and that they needed education and training to effectively implement patients' participation in their empowerment process[9].

Considering that patients cite independence as one of their needs and wishes, ideal transitional care must focus on it and on communication between the involved health professionals, oriented toward assessment at hospital discharge, care planning, preparation of patients and caretakers for the transition, home therapy management, and education of patients that allow them to carry out self-management. Some patients and caretakers mentioned negative experiences with health professionals and admitted these events may have led to care incoordination. The examples they cited were nonintroduction of physicians and nurses involved in care delivery, nondisclosure of the diagnosis, and nonapproach of treatment continuity. These situations contributed to reducing patients and caretakers' trust in health teams[12].

The health professionals pointed the following factors as problems that hindered care integration and coordination and family engagement: health teams' lack of time to devote to these investments and patients' health and post-discharge care complexity[16].

Action strategies and health policies

A literature review identified some tools and interventions for transitional care that boost patient participation in their discharge plan and rehabilitation, and family meetings stood out as a strategy to integrate patients into their care program and discharge plan. Regarding this aspect, studies have shown that it is necessary to include subjects such as therapy management, response by primary health care, capacity to carry out follow-up,

and education about warning signs and symptoms that indicate worsening of the situation. Health education programs proved a facilitating tool that must include education about warning signs and symptoms that can lead to readmission, self-management of the health condition, and therapy management[9].

Checklists also emerged as tools to be applied to transition between care levels. They must include topics such as ensuring safe transportation from hospital to home, economic capacity to buy therapy items, access to health care, need for support products, and existence of a close reference person that has responsibility and ability to guarantee care[9].

The participants of the selected studies often considered that their discharge occurred too early and reported difficulty managing their health situation when they returned home. Home visits to promote engagement of family and informal caretakers and inclusion of patients' wishes in decision-making showed positive results in the process of readapting when they returned home and suggested a care model defined by patients that allows them to make decisions and facilitates their participation in everyday life[9].

A Chinese study showed the effectiveness of a four-week transitional care program headed by nurses and in which the existence of a comprehensive care management nurse, with proper education and training, was advocated. The program encompassed pre-discharge comprehensive evaluation and structured care planning over the four weeks that followed hospital discharge, including meetings with relatives (even before discharge), weekly home visits (preferably paid at the beginning of the week), and phone calls (preferably made at the end of the week). The study reported marked differences in the physical and mental domains of quality of life, although only the former showed an association between time and intervention effect. The group of people who received the transitional care proposed by the program had better spiritual and religious results, greater satisfaction, greater gain assessed by applying the Barthel scale, lower score in the depressive state assessment, lower readmission rate, and less frequent use of urgency services[10].

The benefits associated with home follow-up can vary according to the health condition complexity. Follow-up over a period of seven days was associated with substantial reduction of risk of readmission in people with high clinical complexity, a characteristic that would be related to higher chances of this event to occur. In situations for which the predicted risk of readmission was higher than 20%, it was shown that one readmission could be prevented out of every five people who have had follow-ups over 14 days. Still, it is important to emphasize that the study had the limitations of not contextualizing readmission predictors such as functional status, health literacy, social context, and support by relative and/or caretakers[11].

An early hospital discharge program with adequate and properly coordinated resources allows health teams to offer effective action plans, especially for people who had cerebrovascular accident, suggesting that units specialized in care of people with this problem should be included as extra care, since they proved their effectiveness when their results were compared to those obtained after application of standard care actions. According to the authors of the study that addressed this subject, the benefit of early discharge programs resulted from work by multidisciplinary teams, which must be coordinated by means of regular meetings. The composition of these teams must include professionals from several intervention areas, such as physical therapy, occupational therapy, speech therapy, medical support teams, nurses, and social workers. Although it was not possible to find evidence that the structure of hospital services or communities influenced results (except for length of stay, for which there seemed to be no significant difference regarding elderly population's rehabilitation), all teams described in this study had one cerebrovascular accident specialist or one rehabilitation specialist or both[13-14].

A study in Norway compared a group of people who had had this health problem and were in its post-acute phase and had access to follow-up after discharge and a group of patients who were recovering from the same disease but did not have access to this strategy. It concluded that hospital readmission was not impacted by access to follow-up (it was noteworthy that the reasons for readmission were not directly related to cerebrovascular accident). However, there was a significant difference in mortality rate. Similar to what happened in the previously discussed study, and despite strengths, this study also had limitations, including lack of detail about information on home care (characterized simply as present or absent) and lack of information on reasons for readmission[18].

A Canadian study showed no significant differences in readmission rate, use of urgency services, and death after three months of clinical discharge after comparing groups of people who had acute myocardial infarction, with one of the groups admitted to a transitional care program in addition to receiving regular care. However, several limitations were identified by the authors, namely including only hospitals in urban areas linked to a single health system and not monitoring neither the use of communities' resources after patients returned home nor patients' adherence to discharge planning[19].

DISCUSSION

The present literature review showed that, despite the frequent transition between care levels, transitional rehabilitation care is not always applied, and this implies an increased risk of fragmented care, adverse effects, and post-discharge complications. The four categories that emerged in content analysis were people who are the target of transitional care; families involved in care transition; health professionals; and action strategies and health policies.

Regarding the category people who are the target of transitional care, the studies pointed out the chronicity of several pathologies, motor and cognitive disability, and polymedication as factors that result in the need for complex care and for adult and elderly patients to be followed up at different care levels. Consequently, this can lead to an increased risk of fragmented care and the possibility of developing adverse events. Therefore, the challenge of keeping interaction, coordination, and integration between care deliverers who work at different care levels prevails so it is possible to guarantee safe discharge planning and posterior follow-up[9,18], with the engagement of patients and their caretakers in all steps of transitional care[2,5-6].

Nevertheless, transition between care levels often cannot be planned, which leads to consequences in the preparation of

patients and caretakers and contributes to hospital readmissions. The reasons for readmission vary, but one of the most important components are assessment of community resources and whether they can fit patients' needs[9,14,20]. A study in France estimated that, for patients 75 years old or older, hospital readmission rate within 30 days after discharge was 14%, and that one fourth of these events was preventable[20].

Once the need for and the contribution of transitional care are recognized, it becomes important to fully explore the experience of care transition. A study in Australia highlighted six topics identified in this experience: patients' need to become independent, learning about self-care, support relationship with caretakers, relationship with professionals, search for information, and discussion and negotiation of the transitional care plan[12].

Among the results, participation, decision-making, and autonomy were themes identified by patients themselves as fundamental. Some of the selected studies reported that, although these people intended to be involved in care transition, their level of participation in discharge planning and decision-making was low, and it must be stressed that they did not receive useful information[2,5,9].

Regarding the category families involved in care transition, family and informal caretakers reported that their preparation came from previous experiences and emphasized the detachment of health professionals during hospitalization. This lack of attention materialized in the caretakers' difficulty asking questions about the situation and care to be offered. The marked delay to transmit knowledge and the lack of written information also stood out as negative aspects[16].

In some studies, patients and caretakers mentioned negative experiences with health professionals, which negatively impacted care coordination and caused the trust in the process as a whole to be reduced. Professionals, in turn, cited lack of time of health teams and the complexity observed in patients' health condition and post-discharge care as the main difficulties in the transition process[12,16].

Transitioning into the role of informal caretaker is complex and implies physical, cognitive, and emotional efforts. This is the reason why this transition is often associated with increased incidence of diseases, which many times is combined with a set of economic, social, and community needs triggered by giving up work, which, among other problems, makes the source of income to cease to exist and leads to isolation from friends and social support networks. Additionally, caretakers may also experience health-disease transitions themselves and require nursing interventions, since most are women over 65 years old with chronic diseases that they have to manage together with delivering care to their sick and dependent relative[18].

An integrative literature review that had the objective of identifying the transitional care needs of caretakers grouped these necessities into five categories: needs in the transition into the role of caretaker, self-care needs of caretakers, health needs, economic needs, and social and community needs[5]. Other studies have pointed emotional support as the intervention that was probably the most cited in the literature as being priority for caretakers, since its lack can hinder adaptation to the new role and contribute to an increase in the overload and a reduction in their own well-being and health, problems that can decrease the quality of care offered to dependent elderly people[21-22].

The health professionals involved in care transition identified that success in transitional care depends on reintegrating care fragments as patients get past different care levels. However, the consulted professionals mentioned barriers to care integration and coordination and to family engagement, including lack of time of health teams to invest in these activities and the complexity observed in patients' health and post-discharge care[16]. Other studies have cited difficulties of communication and coordination between care levels as an obstacle to obtain a response compatible with the needs of the population who has complex health-disease problems[23-24].

Some transitional care tools and interventions stood out for boosting the participation of patients in their discharge and rehabilitation planning: meetings held with relatives that included the participation of patients; design of a discharge plan; existence of a checklist that took into account the care needs identified by patients and caretakers, available community resources, and need for support products, among other items; establishment of a health education program (including information on warning signs and symptoms that may indicate the possibility of hospital readmission, health condition self-management, and therapy management); and home visits that can include patients' decision-making, engaging relatives and caretakers and facilitating their participation in everyday life[9].

The results are a warning that action strategies and health policies are necessary to increment coordination and vertical integration of care in both the community and hospital contexts. This integration remains a challenge, with proven consequences in the tendency toward reduction of length of stay and home follow-up, and, thus, decrease in hospital bed occupation rates. Guaranteeing this coordination between care levels (considering the risks in different phases of the cycle) and ensuring transitional care is imperative for developing a more sustainable health system[15,18].

According to the bibliographic sample, a direct conclusion that allows to state that transitional care integration translates into reduced readmission or mortality rates does not seem to exist. In contrast, most studies reported that the development of transitional care programs had positive impacts, such as better spiritual and religious results, greater satisfaction, higher noticeable gain in independence and better identification of patients' specific inabilities as per application of Barthel scale, lower score in the depressive state assessment, lower readmission rate, and less frequent use of urgency services[10].

The authors of the present review corroborate the opinion of the researchers who have claimed that interventions that bridge the gap between hospital and home and involve an assigned professional (usually a nurse) are the most effective in reducing risk of readmission[20,23-24], but it is necessary to carry out more studies on the details of their effectiveness and the role played by nurses as managers of the process.

Study limitations

The limitations of the present study resulted from the characteristics of its method and the study eligibility criteria, because

selection of studies with different methodologies and levels of evidence does not allow to extract a unique level of evidence. Additionally, inclusion of exclusively free studies in three languages only (English, Spanish, and Portuguese) can have excluded articles that could have helped answer the research question.

Contributions to the area

The results can contribute to health professionals' education and training and to the implementation of patients' and relatives' or caretakers' participation in the process of transition from hospital to community, qualifying them. Health professionals must facilitate transitional care by resorting to practices that place patients in the center of care, valuing active listening, and using adequate language to facilitate training and participation of users and family caretakers in decision-making. These two groups of people must be informed about their right to participate in decisions related to their needs and the level of follow-up to be received. Scientific evidence provides tools and interventions that promote care transition, with nurses playing an important role as the coordination link. By applying advanced practice, nurses act as leaders in the process of care continuity and have the responsibility of integrating transitional care as a priority practice, since its structured implementation facilitates care continuity, optimizes available health resources, increases care quality, and encourages the development of a more sustainable health system.

FINAL CONSIDERATIONS

There is a limited amount of studies on transitional rehabilitation care, which have identified risks but have not assessed the effectiveness of rehabilitation interventions. It was noteworthy that the bibliographic sample of the present review included no Portuguese studies. The selected studies showed that the countries that have rehabilitation nursing as an established specialty (such as Canada, England, and United States) apply the principle that it is a care philosophy (in which rehabilitation is implicit in professional practice) rather than a knowledge field or professional area.

The present literature review showed that elderly people's participation in transitional care is often related to discharge planning and return home. The findings indicated that the elderly population did not participate regularly in the discussion about their discharge planning, and even when they were present at meetings to discuss their care plan, their opinions, whishes, and objectives were neither requested nor valued.

The present study allowed to identify several implemented strategies and tools to support the participation of the elderly population in transitional care and minimize the risk of care fragmentation. Some actions that stood out in this area were programs headed by nurses, regular multidisciplinary meetings, checklists to prepare for discharge, and monitoring by means of follow-ups.

Coordination and integration of care received in the community and hospital settings remains a challenge and show a tendency to reduce length of stay and home follow-up and, consequently, hospital bed occupation rates. Multidisciplinary teams in isolation proved not to be enough. It is necessary to guarantee training, follow-up, and coordination between care levels.

It is concluded that transitional care is imperative for developing a sustainable health system and increasing care quality and clients' and professionals' satisfaction.

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