Review Article

Nursing team strategies for caring for older adults in the hospital-home transition: an integrative review

Estratégias da equipe de enfermagem para o cuidado de idosos na transição hospital-domicílio: revisão integrativa

Estrategias de equipos de enfermería para el cuidado de personas mayores en la transición hospital-domicilio: revisión integradora

Jéssica Lane Pereira Santos[1] https://orcid.org/0000-0001-6528-0689

Larissa Chaves Pedreira[1] https://orcid.org/0000-0002-6094-7218

Alyne Henri Motta Coifman[1] https://orcid.org/0000-0002-8714-6779

Jeferson Moreira dos Santos[1] https://orcid.org/0000-0001-7807-1341

Larissa Simões da Cruz Pessoa[1] https://orcid.org/0000-0002-6094-7218

Maria Antônia Alves de Souza[2] https://orcid.org/0000-0002-5100-9158

How to cite:
Santos JL, Pedreira LC, Coifman AH, Santos JM, Pessoa LS, Souza MA. Nursing team strategies for caring for older adults in the hospital-home transition: an integrative review. Acta Paul Enferm. 2024;37:eAPE01904.

DOI
http://dx.doi.org/10.37689/acta-ape/2024AR0019044

Abstract

Objective: To search the literature for strategies for nursing teams in the transition of care to older adults between the hospital and their home.

Methods: This is an integrative review of the literature with a search in the United States National Library of Medicine (PubMed), Latin American and Caribbean Literature in Health Sciences (LILACS), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus and Web of Science (WoS) databases via the CAPES Journal Portal. Original articles published in English, Spanish and Portuguese were included without delimiting the time of publication. MAXQDA software was used in qualitative data analysis to manage and code the data.

Results: The sample consisted of 14 articles. Two categories of articles were identified that address care strategies performed by nursing in the transition of care between hospital settings and the community.

Conclusion: Transitional care is a fundamental strategy for health promotion, continuity of care, disease prevention and rehabilitation of older adults. Nursing leads in this process.

Keywords
Transitional care; Nursing, team; Aged; Patient discharge

Resumo

Objetivo: Buscar na literatura estratégias para equipes de enfermagem na transição de cuidados a pessoas idosas entre o hospital e seu domicílio.

Métodos: Revisão integrativa da literatura com busca nas bases de dados United States National Library of Medicine (Pubmed), Literatura Latino-americana e do Caribe em Ciências da Saúde (LILACS), Cummulative Index to Nursing and Allied Health Literature (CINAHL), Scopus e Web Of Science (WOS), via Portal de Periódicos da Capes. Foram incluídos artigos originais publicados em inglês, espanhol e português sem delimitação no tempo de publicação. O *software* MAXQDA foi usado na análise de dados qualitativos para gerenciar e codificar os dados.

Resultados: A amostra foi constituída por 14 artigos. Foram identificadas duas categorias de artigos que abordam estratégias de cuidado desempenhadas pela enfermagem na transição de cuidados entre o ambiente hospitalar e a comunidade.

Conclusão: O cuidado de transição é uma estratégia fundamental para promoção da saúde, continuidade do cuidado, prevenção de agravos e reabilitação de pessoas idosas. A enfermagem é a protagonista neste processo.

Descritores
Cuidado transicional; Equipe de enfermagem; Idoso; Alta do paciente

Descriptores
Cuidado de transición; Grupo de enfermería; Anciano; Alta del paciente

Submitted
August 18, 2023

Accepted
March 21, 2024

Corresponding author
Jessica Lane Pereira Santos
E-mail: jessicalane84@gmail.com

Associate Editor
Meiry Fernanda Pinto Okuno
(https://orcid.org/0000-0003-4200-1186)
Escola Paulista de Enfermagem, Universidade Federal de São Paulo, São Paulo, SP, Brasil

Resumen

Objetivo: Buscar en la literatura estrategias para equipos de enfermería para los cuidados de personas mayores en la transición entre el hospital y su domicilio.

[1]School of Nursing, Universidade Federal da Bahia, Salvador, BA, Brazil.
[2]*Universidade do Estado da Bahia*, Guanambi, BA, Brazil.
Conflicts of interest: nothing to declare.

Métodos: Revisión integradora de la literatura mediante búsqueda en las bases de datos United States National Library of Medicine (Pubmed), Literatura Latinoamericana y del Caribe en Ciencias de la Salud (LILACS), Cummulative Index to Nursing and Allied Health Literature (CINAHL), Scopus y Web Of Science (WOS), a través del Portal de Revistas de Capes. Se incluyeron artículos originales publicados en inglés, español y portugués sin delimitación del tiempo de publicación. El *software* MAXQDA fue utilizado en el análisis de datos cualitativos para gestionar y codificar los datos.

Resultados: La muestra estuvo compuesta por 14 artículos. Se identificaron dos categorías de artículos que abordan estrategias de cuidado llevadas a cabo por enfermeros en la transición entre el ambiente hospitalario y la comunidad.

Conclusión: Los cuidados de transición son una estrategia fundamental para la promoción de la salud, continuidad del cuidado, prevención de agravios y rehabilitación de personas mayores. Los equipos de enfermería son los protagonistas en este proceso.

Open Science Framework: 10.17605/OSF.IO/5A2Z9.

Introduction

After experiencing hospitalization, older adults need rehabilitation and well-being strategies that promote continuity of care while minimizing the consequences of hospitalization. Therefore, the healthcare team must be sensitive to the specific needs of this population, promoting a better quality of life after hospital discharge.[1]

Continuity of care at home reduces (re)hospitalization and mortality rates. Therefore, it is necessary to prepare the affected people and those responsible throughout the hospitalization as hospital-home transition can be complex, permeated by weaknesses, difficulties and challenges for older adults.[2]

Transition movements involve changes in environment, condition or state, implying adaptation by the people who experience it. In turn, transitional care is actions planned for the continuity of care that can modify the health condition of these people, and must begin at admission, with follow-up until or after hospital discharge.[3]

In this context, nursing stands out for its ability to articulate professionals, older adults and caregivers, encouraging health promotion, action planning and care direction. Such measures are effective as they contribute to continuity of care after hospital discharge, reduce new hospitalizations and optimize older adults' health-disease process.[4]

However, this topic is still little addressed in Brazil, in contrast to its importance. Therefore, it is important that these professionals know the topic and develop skills to conduct this care in a safe and effective way with the care team to provide comprehensive care, continuity of care and increase in the quality of life of older adults hospitalized and after discharge.

Therefore, this study aimed to search the literature for strategies for nursing teams in the transition of care to older adults between the hospital and their home.

Methods

This was a bibliographical integrative literature review (ILR), in which six steps were followed: 1) Topic identification and research question selection, 2) Establishment of inclusion and exclusion criteria, 3) Pre-selection and selection of studies of interest, 4) Categorization of selected studies, 5) Analysis and interpretation of results and 6) Review/synthesis of knowledge.[5]

This investigation adopted the EQUATOR network guidelines and followed the recommendations of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) to select the studies and present the results.[6]

The mnemonic Population, Interest and Context (PICo) was adopted,[6] as follows: P = Population (Older adults), I = Interest (Transitional care performed by the nursing team) and Co = Context (between hospital and home). Thus, the research question was formed: What care strategies for older adults are performed by nursing in hospital-home transition?

The searches were carried out independently by three reviewers in July 2022 in the Virtual Health Library Regional Portal and United States National Library of Medicine (PubMed), Latin American and Caribbean Literature in Health Sciences (LILACS), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus and Web of Science

(WoS) databases, via CAPES Journal Portal (CAFe access).

Descriptors in Health Sciences (DeCs) in English, Spanish and Portuguese were used: "Transitional Care", "Nursing, Team", Aged; "Patient Discharge"; "*Cuidado de Transición*", "*Grupo de Enfermería*", *Anciano*, "*Alta del Paciente*"; "*Cuidado transicional*", "*Equipe de enfermagem*", *Idoso*, "*Alta do paciente*", exchanged with the Boolean operator "AND".

Original full-text articles available electronically, published in English, Spanish or Portuguese without limitation on publication time were included. Theses, dissertations, book chapters, opinions and expert consensus were excluded. Repeated studies were considered only once.

Screening of courses, abstracts and objectives of pre-selected articles was carried out by three reviewers independently. Then, those related to the object were organized in Excel (Microsoft Office, 2016). Afterwards, the articles were read in full by both reviewers to select a final sample considering those that answered the research question.

MAXQDA software (v. 2022), for qualitative data analysis, was used to manage and code the data. After selecting eligible studies, they were imported into the software where reading and data immersion began. This step allowed us to identify meanings that later defined the categories.

Exhaustive reading of the material enabled in-depth analysis, management, coding of data and formation of eight codes. These were grouped by similarity, originating the categories and directing analysis and discussion of the study.

The eight codes offered by the software were as follows: 1. Home medication review, 2. Post-discharge nutritional support, 3. Staff training, 4. Post-discharge follow-up, 5. Health education, 6. Community nurses/for continuity of care, 7. Assessment and planning for hospital discharge and 8. Communication among multidisciplinary team members.

Codes 4, 5 and 6 were subdivided: 4 (4.1. Multidisciplinary team, 4.2. Visits + phone calls, 4.3. Coordination with primary care); 5 (5.1. Involvement of patients and caregivers, 5.2. Family and informal support network) and 6 (6.1. Visits during hospitalization, 6.2. Home visit).

Initially, 10,235 articles were identified. After applying the filters and inclusion/exclusion criteria, 14 studies made up the sample (Figure 1).

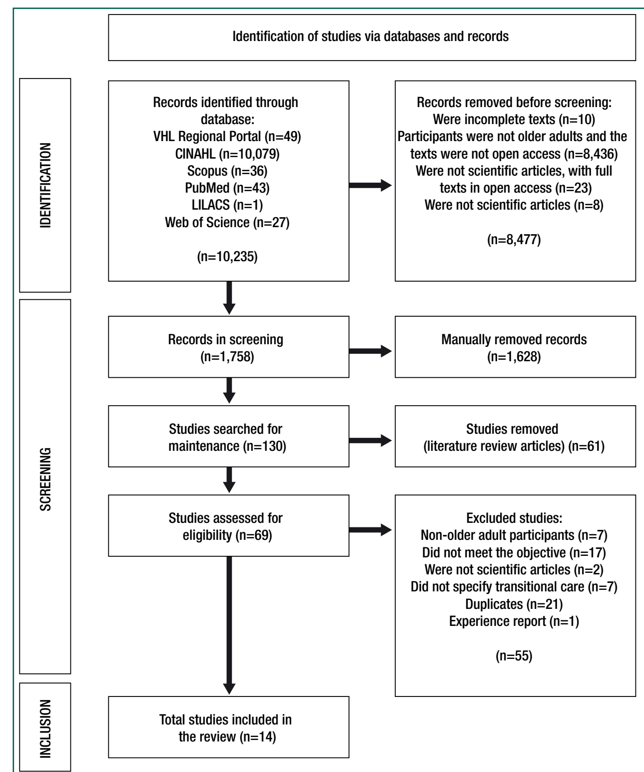

Figure 1. Study selection flowchart according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses

Results

The studies of interest were characterized according to the indicator to identify the selected article, title, author, year, database, journal and impact factor (Chart 1), in addition to study location and design, objective, participants, scope of study and main findings for this ILR (Chart 2).

The selected articles were published in English. The studies[16-18] with the highest impact factor (44.424) were published in JAMA Intern. Med. The exclusive participation of nurses occurred in five studies.[7-13-16-18-19] In nine studies,[8-9-10-11-12-14-15-17-20] there was also the participation of other healthcare professionals such as exercise physiologists, occupational therapists, physiotherapists, pharmacists,

Chart 1. Characterization of selected articles

Authors/year	Titles	Database	Journal	Impact factor
Sarzynski *et al.*, 2019[7]	Eliciting nurses' perspectives to improve health information exchange between hospital and home health care	CINAHL	Geriatr. Nurs.	2.525
Kim *et al.*, 2020[8]	Development of a senior-specific, citizen-oriented healthcare service system in South Korea based on the Canadian 48/6 model of care	CINAHL	BMC Geriatrics	4.070
Cheen *et al.*, 2017[9]	Evaluation of a care transition program with pharmacist-provided home-based medication review for elderly Singaporeans at high risk of readmissions	CINAHL	Int. J. Qual. Health Care	2.257
Hansen *et al.*, 2021[10]	Effects of a new early municipality-based *versus* a geriatric team-based transitional care intervention on readmission and mortality among frail older patients - a randomised controlled trial	Web of Science	Arch. Gerontol. Geriatr.	4.163
Wang *et al.*, 2019[11]	The Effectiveness of a Timely Discharge Plan in Older Adults: A Prospective Hospital-Based Cohort Study in Southern Taiwan	Web of Science	Aging Med. Healthcare	0.26
Allen *et al.*, 2020[12]	Communication and Coordination Processes Supporting Integrated Transitional Care: Australian Healthcare Practitioners' Perspectives	PubMed	Int. J. Integr. Care	2,913
Costa *et al.*, 2019[13]	The continuity of hospital nursing care for Primary Health Care in Spain	Scopus	Rev. Esc. Enferm. USP	1.123
Verweij *et al.*, 2018[14]	The cardiac care bridge program: design of a randomized trial of nurse-coordinated transitional care in older hospitalized cardiac patients at high risk of readmission and mortality	VHL Regional Portal	BMC Health Serv. Res.	2.908
Arbaje *et al.*, 2010[15]	The Geriatric Floating Interdisciplinary Transition Team	VHL Regional Portal	J. Am. Geriatr. Soc.	7.538
Buurman *et al.*, 2016[16]	Comprehensive Geriatric Assessment and Transitional Care in Acutely Hospitalized Patients: The Transitional Care Bridge Randomized Clinical Trial	VHL Regional Portal	JAMA Intern. Med.	44.424
Chareh *et al.*, 202[17]	Does a 12-Month Transitional Care Model Intervention by Geriatric-Experienced Care Professionals Improve Nutritional Status of Older Patients after Hospital Discharge? A Randomized Controlled Trial	CINAHL	Nutrients	6.706
Stauffer *et al.*, 2011[18]	Effectiveness and Cost of a Transitional Care Program for Heart Failure A Prospective Study With Concurrent Controls	CINAHL	JAMA Intern. Med.	44.424
Jepma *et al.*, 2021[19]	Experiences of frail older cardiac patients with a nurse-coordinated transitional care intervention - a qualitative study	CINAHL	BMC Health Serv. Res.	2.908
Finlayson *et al.*, 2018[20]	Transitional care interventions reduce unplanned hospital readmissions in high-risk older adults	CINAHL	BMC Health Serv. Res	2.908

general practitioners and geriatricians. The studies were carried out in Australia (14.2%) and the USA and Netherlands (21.4%), with the highest number of studies between 2019 and 2020. Most of studies developed transitional care in an in-hospital setting.[8-10-14] In five studies,[9-16-18-20] the follow-up method was used to monitor older adults at home after discharge. The two categories with studies that supported their construction, based on the codes offered by the software (Chart 3).

Discussion

The implementation of care strategies for the hospital-home transition of older adults requires understanding aging as a multidimensional process that encompasses diversities, singularities, subjectivities and multifactorial issues involved in the context of individual life.[21]

Such situations are linked to illness and must be identified upon admission, understood throughout hospitalization, enabling the health team to plan care individually and recognizing needs, preferences and possibilities in the context of people and their networks of relationships.[8]

In this ILR, nursing assessment and hospital discharge planning occurred during hospitalization,[8,10-16,19] and comprehensive geriatric assessment (CGA) was used to identify clinical and social needs.[13,14,16,19] In this assessment, one of the studies used Virginia Henderson's theory (14 components), making it possible to observe aspects of people's autonomy, independence, cognition and sociability.[10]

Assessment also involved the multidisciplinary team, considering clinical, functional, cognitive, social, mental, emotional factors, history of hospitalizations, degree of dependence, support network, self-management, etc.[11-13,15,16,19] It also considered the risk of falls, use of medications and the main geriatric syndromes.[15]

In Brazil, the Elderly Health Handbook was developed by the Ministry of Health in 2006,[22] and is used in primary care. It would be a good instrument for assessing and monitoring older adults in the transition to home as it considers CGA and allows monitoring in the community.

Chart 2. Characterization of selected articles

Authors/year	Country Study design	Participants	Nursing team strategies for hospital-home transition care
Sarzynski *et al.*, 2019[7]	USA, Mid-Michigan Qualitative study; focal group	Home care nurses (n=19)	Implementation of protocols for medication adjustment before the first outpatient follow-up appointment. Simplification of the medication regimen. Health guidance using materials with simple language; Screening for social determinants of health (financial, transport and home environment); Identification of caregiver and their contact information
Kim *et al.*, 2020[8]	South Korea Focus group interview and expert consultation	Nurses and doctors	Geriatric Screening for Care-10 screening and assessment, covering ten domains: Cognitive impairment, depression, delirium, polypharmacy, functional decline, dysphagia, malnutrition, urinary and fecal incontinence, pain.
Cheen *et al.*, 2017[9]	Singapore Retrospective observational study	Nurse care coordinators and pharmacists	Home visits by pharmacists and care and/or care coordinators (nurses) to provide information on disease management, comprehensive review and medication advice.
Hansen *et al.*, 2021[10]	Denmark Randomized controlled study	Nurses supported by a general practitioner	Comprehensive geriatric assessment based on the 14 components of nursing according to Virginia Henderson's theory. Review of the prescription list.
Wang *et al.*, 2019[11]	Thailand Prospective case-control study	Discharge specialist nurses, geriatricians and physiotherapists	Comprehensive geriatric patient assessment prior to hospital discharge by specialist discharge nurses. Promoting long-term care at home, communicating with providers before the patient is discharged.
Allen *et al.*, 2020[12]	Australia Qualitative study	Multi team, mostly composed of nurses (n=25)	Discussion between multidisciplinary teams for a quick and safe transition. Preparation of a hospital discharge plan for the home environment; Involvement of patients and caregivers in transitional care.
Costa *et al.*, 2019[13]	Spain Qualitative study	Hospital liaison nurses (n=19)	Assessment and verification of the need for care through consultation with the multidisciplinary team and interdisciplinary meeting. Assessment of patients before hospital discharge, including physical, cognitive, mental, social and emotional domains; Use of instruments such as Gordon, Barthel, Pfeiffer and Zarit to assess complex care (wounds), nutritional status and information about the caregiver. Social assessment; Application of a social risk questionnaire (TIRS).
Verweij *et al.*, 2018[14]	Netherlands Single-blind multicenter study with randomization	Nurses specializing in cardiology, geriatrics and community care and a physiotherapist	Discharge planning and preparation of care plans based on comprehensive geriatric assessment, current health condition and medication prescription. Primary care physiotherapist employment for cardiac rehabilitation at home before hospital discharge. Checking medications used at home and prescribed upon hospital discharge.
Arbaje *et al.*, 2010[15]	USA, Johns Hopkins Cohort study	Geriatric nurse and a geriatric doctor	Education of older adults and caregivers about medications and self-management skills before hospital discharge. Guidance provided 48 hours after discharge, via fax, describing the hospitalization and changes in the medication regimen. Use of phone calls to patients or caregivers reviewing symptoms, medication use, self-management skills.
Buurman *et al.*, 2016[16]	Netherlands Double-blind, multicenter, randomized clinical trial	Community care nurse	Comprehensive geriatric assessment Discussion about care plans, needs and treatments before discharge, involving nurses, older adults and informal caregivers Assessment of older adults' needs, medication reconciliation and clarification of doubts after hospital discharge.
Chareh *et al.*, 202[17]	Germany Secondary analysis of Non-Blinded Randomized Controlled Trial	Nurses (n=5), a case manager and an occupational therapist	Development of comprehensive individualized care plans involving healthcare professionals, older adults and family members. Assessment of nutritional problems, functionality, cognition, medication management, home environment conditions, difficulties in Basic Activities of Daily Living and self-care of older adults at home
Stauffer *et al.*, 2011[18]	USA, Dallas-Fort Worth, northern Texas Pilot study	Advanced practice nurses	Education of older adults and caregivers 72 hours after discharge to establish goals, guide them about the severity of heart failure, review behavior and general health skills.
Jepma *et al.*, 2021[19]	Netherlands Multicenter Randomized Controlled Trial	Nurse-led program	Comprehensive geriatric assessment to identify geriatric conditions and develop an integrated care plan. Delivery of the integrated care plan to older adults to prepare for discharge. Home visits for medication reconciliation, early warning of worsening, health complications and assessment of the care plan.
Finlayson *et al.*, 2018[20]	Australia Randomized Controlled Trial	Nurses and an exercise physiologist	Home visit 48 hours after discharge to assess: 1. Sufficient caregiver support for older adults 2. Safety of the home environment, 3. Access to medicines and dressings, 4. Understanding the medication regimen and treatment 5. Reinforcement of the exercise program and use of pedometer at home 6. Caregiver advice and support

Chart 3. Thematic categories and studies that addressed the content explored

Categories	Studies that addressed the content
Care strategies performed by nursing in the hospital environment for the transition from home care	(8-10-11-12-13-14-15-16-17-18-19)
Strategies performed by nursing for continuity of care in the community	(7-8-9-10-12-13-14-15-16-17-18-19-20)

The authors of studies included in this review pointed out the importance of community care nurses assessing and planning hospital discharge during hospitalization through hospital visits, continuing home visits after discharge.[12-14,16,19] In case of readmission, hospital visits must be resumed by them.[18]

This makes it possible to initiate an individualized care plan with other professionals, suggesting, questioning and contributing to discharge plan, ensuring that it is effective at home.[12,16] Furthermore, it allows the nurse to meet with older adults and their caregivers during hospitalization, initiating contact and discharge planning quickly and jointly, strengthening the informal support network.[16]

In the Netherlands, a study showed a transitional care program coordinated by nurses. In it, community care registered nurses visit older adult participants (all aged ≥70 years) at least one day before hospital discharge to discuss their care plan, ongoing interventions, current clinic, medication prescription and therapeutic recommendations.[14]

In South Korea, an integrated system of health services aimed at older adults allows care and discharge plan to be developed by doctors and nurses, based on the results obtained in the initial assessment. Nurses also assess before discharge, to monitor the clinical condition and develop a home care continuity plan, which is delivered to older adults and their caregivers.[8]

In a university hospital in Denmark, older adults receive from the geriatric department a plan and a letter before discharge containing test results, diagnoses, medications used and in use, rehabilitation plans, etc. An electronic version of the letter is also sent to the municipal health service and a copy is given to a family member when consent is obtained.[10]

In Brazil, this dialogue is provided for in the referral and counter-referral system, and is included in the Health Care Network.[23] However, movements in this direction are few in clinical practice, although safe discharge is described in an Ordinance in Brazilian Legislation.[24]

Considering the specificities of care for older adults, the authors highlighted health team training through continuing education for professionals' involvement in transitional care.[14,15,17]

Health education for hospitalized older adults and their caregivers is a strategy that should be employed by the nursing team, sharing information about health and best practices for maintaining it. About health education, the importance of involving older adults and their caregivers in planning the transition of care was highlighted by the authors, discussing the demands and necessary interventions with the care team,[12,15] incorporating accessible and effective communication between the people involved in care practice.[25]

Considering older adults' needs, such strategies promote a more effective and safe transition when combined. After hospital discharge, care must be continued through strategies to monitor and implement comprehensive and individualized actions, considering older adults' needs.

Continuity of care can be provided by older adults themselves, their family members or caregivers in hospitals, rehabilitation units, nursing facilities, etc. It is important that needs are shared between the hospital team and other health services.[8]

A bibliographic study that investigated the adaptation of long-lived people in their homes after hospitalization in the Intensive Care Unit concluded that the majority of them need specific and continued care for daily activities. With this, the importance of a transitional plan of individualized care during hospitalization was highlighted, aiming at its continuity, better recovery and rehabilitation at home.[26]

The primary health network's performance is essential for a safe continuity of care, and the coordination between the primary and tertiary care levels must begin during hospitalization.[8,13,14] However, contact with Basic Health Units in Brazil is usually made by the affected person or their caregiver after hospital discharge.

A care model used in the USA allows the team (nurse and geriatrician) to monitor older adults after discharge, maintaining communication with the primary care physician to ensure continuity of care.[15]

Another study highlighted the role of nurses in this process, carrying out counter-referral in a systematic and individualized way. To this end, it is important that nurses are aware of the resources available in the community and maintain contact with other healthcare professionals in the area of care for older adults.[13]

A program developed in Spain and coordinated by nurses, guarantees older adults a visit from a nurse or primary care doctor within 48 hours of returning home. Coordination between hospital and Primary Care is carried out by Primary Care nurses through an electronic platform.[13]

Visits carried out by nursing professionals in the homes of older adults who have been hospitalized are also an important strategy for continuity of care in the community.[7,9,10,12,14,16-20] Through these visits, the nurse can monitor the care plan developed at the hospital, reassess older adults, identify possible changes and new demands on the plan.[12]

There was divergence between studies regarding the frequency of home visits carried out by nurses in the community. Some authors noted this periodicity two days after discharge[14,16,20] in the first week[17] and two weeks later.[9] After the first visit, the others occurred in two, six, 12 and 24 weeks;[16] in one, three and six weeks and one more visit within 12 weeks after discharge if necessary according to identified demands;[14] or four visits in the first six weeks and one extra visit in the first three months after discharge when indicated.[19] Another study stated that at least eight home visits were carried out for each patient.[18]

The purposes of home visits were as follows: resolve outstanding problems;[9] review general health-related needs, identify the support network's availability;[18] perform the CGA, medication reconciliation, assess care plan and current clinical condition;[14,16,19] identify nutritional problems, physical and cognitive functionality, home environment conditions and self-care;[17] early warning of worsening or health complications.[19]

In the Netherlands, a project carried out in three hospitals with affiliated home care organizations confirmed that registered nurses in community care carried out the visit at the institution within two days of hospital discharge, even in cases where older adults were discharged to a nursing home.[16]

As observed during hospital admission, communication among multidisciplinary health team members was highlighted as essential to comprehensive care during home visits,[19] as it made it possible to discuss issues related to older adults' health in an integrated manner according to specific demands.

In a care transition program in Singapore, nurses and pharmacists carried out home visits to older adults with needs related to medication use, with the doctor contacted by the pharmacist when necessary.[9]

As observed in the study by Jepma *et al.* (2021),[19] home visits also offered an opportunity for health education actions with informal caregivers and promoted self-management skills to older adults. Older adults with chronic illnesses showed resourcefulness in self-management and were able to identify situations of deterioration in their health to consult with specialist nurses.

Telephone contact made by nursing professionals with patients and/or caregivers was another strategy used.[15,17,18,20] Telephone calls were made two days after discharge,[15] with tele-monitoring for 24 weeks[20] up to 12 months.[17] After discharge, the number of home visits and/or telephone contacts varied according to individual needs.[17,20] Through telephone calls, nurses review symptoms, medications in use and self-management skills, enabling instructions and adaptations to the care plan according to social changes and physical health.[15,17]

The studies included in this ILR did not indicate the participation of other nursing team members during bedside assistance and primary care, despite its importance due to its proximity to hospitalized people and their families and/or caregivers. Nursing technicians and assistants are rarely mentioned in studies on the subject, possibly because in many countries this division does not exist.

However, it is important to highlight that in Brazil these professionals experience a large part of

the direct care provided to older adults during hospitalization, being able and/or required to perform essential activities for a safe and adequate transition, such as discharge planning, guidance for the continuity of care at home, etc.[27]

Furthermore, little nursing action was observed with caregivers, who are important partners in this transition and also need attention. Often, they are directly responsible for the care provided to dependent older adults at home, making the role of nurses in training these people fundamental.[28]

Conclusion

In the hospital-home transition of older adults, the participation of nurses is the majority. During hospital stay, strategies consider individualized care for subsequent hospital discharge planning. We scored hospital visits carried out by community care nurses for joint discharge planning, care team training through continuing education and health education actions for hospitalized older adults and their caregivers. In the community, it is necessary to implement the plan for continuity of care, primary care articulated with tertiary healthcare, home visits for follow-up, assessment and review of needs with adjustment of plan, if necessary, health education for older adults and family members/caregivers, telephone contacts for follow-up and adjustments to care plan when necessary. Communication between the multidisciplinary team and primary and secondary care is important. Nursing leads in the transitional process, consolidating actions during hospitalization and after hospital discharge. It is necessary to map this reality in Brazil, giving visibility to Brazilian nurses' actions in transitional care.

Acknowledgments

To the Coordination for the Improvement of Higher Education Personnel - Brazil (CAPES - *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior*) - Finance Code 001.

References

1. Billett MC, Campanharo CR, Lopes MC, Batista RE, Belasco AG, Okuno MF. Functional capacity and quality of life of hospitalized octogenarians. Rev Bras Enferm. 2019;72(2):43-8.
2. Sousa LS, Pontes ML, Pereira RR, Leite MA, Nova FA, Monteiro EA. Older adult transition from hospital to home from caregivers'/ older adults' perspective: a scoping review. Acta Paul Enferm. 2023;36:eAPE03631. Review.
3. Meleis AI. Transitions theory: Middle-range and situation-specific theories in nursing research and practice. New York: Springer Publishing Company; 2010.
4. Menezes TM, Oliveira AL, Santos RA, Pedreira LC, Veras SM. Hospital transition care for the elderly: an integrative review. Rev Bras Enferm. 2019;72(2):294-301. Review.
5. Mendes KD, Silveira RC, Galvão CM. Uso de gerenciador de referências bibliográficas na seleção de estudos primários em revisão integrativa. Texto Contexto Enferm. 2019;28:e20170204.
6. Galvão TF, Pansani TS. Principais itens para relatar Revisões sistemáticas e Meta-análises: a recomendação PRISMA. Epidemiol Serv Saúde.2015;24(2):335.42.
7. Sarzynski E, Ensberg M, Parkinson A, Fitzpatrick L, Houdeshell L, Given C, et al. Eliciting nurses' perspectives to improve health information exchange between hospital and home health care. Geriatr Nurs. 2019;40(3):277-83.
8. Kim YS, Lee J, Moon Y, Kim HJ, Shin J, Park JM, et al. Development of a senior-specific, citizen-oriented healthcare service system in South Korea based on the Canadian 48/6 model of care. BMC Geriatr. 2020;20(1):32.
9. Cheen MH, Goon CP, Ong WC, Lim PS, Wan CN, Leong MY, et al. Evaluation of a care transition program with pharmacist-provided home-based medication review for elderly Singaporeans at high risk of readmissions. Int J Qual Health Care. 2017;29(2):200–5.
10. Hansen TK, Pedersen LH, Shahla S, Damsgaard EM, Bruun JM, Gregersen M. Effects of a new early municipality-based versus a geriatric team-based transitional care intervention on readmission and mortality among frail older patients - a randomised controlled trial. Arch Gerontol Geriatr. 2021;97:104511.
11. Wang YC, Lu YP, Wang JH, Liang CK, Choul MY, Lin YT. The Effectiveness of a Timely Discharge Plan in Older Adults: A Prospective Hospital-Based Cohort Study in Southern Taiwan. Aging Med Healthcare. 2019;10(3):104-8.
12. Allen J, Hutchinson AM, Brown R, Livingston PM. Communication and Coordination Processes Supporting Integrated Transitional Care: Australian Healthcare Practitioners' Perspectives. Int J Integr Care. 2020;20(2):1–10.
13. Costa MF, Andrade SR, Soares CF, Pérez EI, Tomás SC, Bernardino E. The continuity of hospital nursing care for Primary Health Care in Spain. Rev Esc Enferm USP. 2019;53:e03477.
14. Verweij L, Jepma P, Buurman BM, Latour CH, Engelbert RH, Ter Riet G, et al. The cardiac care bridge program: design of a randomized trial of nurse-coordinated transitional care in older hospitalized cardiac patients at high risk of readmission and mortality. BMC Health Serv Res. 2018;18(1):508.
15. Arbaje AI, Maron DD, Yu Q, Wendel VI, Tanner E, Boult C, et al. The geriatric floating interdisciplinary transition team. J Am Geriatr Soc. 2010;58(2):364–70.

16. Buurman BM, Parlevliet JL, Allore HG, Blok W, van Deelen BA, Moll van Charante EP, et al. Comprehensive Geriatric Assessment and Transitional Care in Acutely Hospitalized Patients: The Transitional Care Bridge Randomized Clinical Trial. JAMA Intern Med. 2016;176(3):302–9.
17. Chareh N, Rappl A, Rimmele M, Wingenfeld K, Freiberger E, Sieber CC, et al. Does a 12-Month Transitional Care Model Intervention by Geriatric-Experienced Care Professionals Improve Nutritional Status of Older Patients after Hospital Discharge? A Randomized Controlled Trial. Nutrients. 2021;13(9):3023.
18. Stauffer BD, Fullerton C, Fleming N, Ogola G, Herrin J, Stafford PM, et al. Effectiveness and cost of a transitional care program for heart failure: a prospective study with concurrent controls. Arch Intern Med. 2011;171(14):1238–43.
19. Jepma P, Latour CH, Ten Barge IH, Verweij L, Peters RJ, Scholte Op Reimer WJM, et al. Experiences of frail older cardiac patients with a nurse-coordinated transitional care intervention - a qualitative study. BMC Health Serv Res. 2021;21(1):786.
20. Finlayson K, Chang AM, Courtney MD, Edwards HE, Parker AW, Hamilton K, et al. Transitional care interventions reduce unplanned hospital readmissions in high-risk older adults. BMC Health Serv Res. 2018;18(1):956.
21. Manso ME, Camilo CG, Javitti GC, Benedito VL. Capacidade funcional no idoso longevo: revisão integrativa. Rev Kairós-Gerontol. 2019; 22(1), 563-74. Review.
22. Brasil. Ministério da Saúde. Envelhecimento e saúde da pessoa idosa. Brasília (DF): Ministério da Saúde; 2006. (Caderno de Atenção Básica nº 19) [citado 2022 Dez 10]. Disponível em: http://189.28.128.100/dab/docs/publicacoes/cadernos_ab/abcad19.pdf
23. Brasil. Ministério da Saúde. Portaria nº 4.279/2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS). Brasília (DF): Ministério da Saúde; 2010 [citado 2023 Maio 10]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2010/prt4279_30_12_2010.html
24. Brasil. Ministério da Saúde. Portaria nº 825/2016. Redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde (SUS) e atualiza as equipes habilitadas. Brasília (DF): Ministério da Saúde; 2016 [citado 2023 Maio 10]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2016/prt0825_25_04_2016.html
25. Midega TD, Oliveira HS, Fumis RR. Satisfaction of family members of critically ill patients admitted to a public hospital intensive care unit and correlated factors. Rev Bras Ter Intensiva. 2019;31(2):147-55.
26. Pessoa LS, Pedreira LC, Santos JL, Souza LM, Góes RP, Lopes AO. Adaptation of the elderly at home after intensive unit discharge ação de longevos no domicílio após alta da unidade intensiva. J Nurs UFPE On Line. 2019;13:e241635.
27. Valente SH, Zacharias FC, Fabriz LA, Schönholzer TE, Ferro D, Tomazela M, et al. Transition of elder care from hospital to home: nursing experience. Acta Paul Enferm. 2022;35:eAPE02687.
28. Melo R, Rua M, Santos C, Novais S, Mota L, Príncipe F, et al. Intervenção de enfermagem e coping na transição para cuidador familiar. Rev Invest Inov Saúde. 2021;4(1):61-73.