Original Article

Transition of elder care from hospital to home: nursing experience

Transição do cuidado de idosos do hospital para casa: vivência da enfermagem

Transición del cuidado de adultos mayores del hospital a la casa: vivencia de enfermería

Silvia Helena Valente[1] https://orcid.org/0000-0002-3593-9590
Fabiana Costa Machado Zacharias[1] https://orcid.org/0000-0003-1150-6114
Luciana Aparecida Fabriz[2] https://orcid.org/0000-0001-7633-0127
Tatiele Estefâni Schönholzer[3] https://orcid.org/0000-0002-4294-8807
Denise Ferro[1] https://orcid.org/0000-0002-7025-9080
Marina Tomazela[1] https://orcid.org/0000-0001-8416-2901
Sara Maria Barbosa[1] https://orcid.org /0000-0002-4490-1068
Ione Carvalho Pinto[1] https://orcid.org/0000-0001-7541-5591

How to cite:
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.

DOI
http://dx.doi.org/10.37689/acta-ape/2022AO026877

Keywords
Transitional care; Nursing care; Aged; Patient discharge; Continuity of patient care; Licensed practical nurses

Descritores
Cuidado transicional; Cuidados de enfermagem; Idoso; Alta hospitalar; Continuidade da assistência ao paciente; Técnicos de enfermagem

Descriptores
Cuidado de transición; Atención de enfermería; Anciano; Alta del paciente; Continuidad de la atención al paciente; Enfermeros no diplomados

Submitted
September 12, 2021

Accepted
April 11, 2022

Corresponding author
Silvia Helena Valente
E-mail: silviavalente@usp.br

Associate Editor (Peer review process):
Edvane Birelo Lopes De Domenico
(https://orcid.org/0000-0001-7455-1727)
Escola Paulista de Enfermagem, Universidade Federal de São Paulo, São Paulo, SP, Brasil

Abstract

Objective: To understand how the transition of care from hospital to home of older adults occurs in the experience of nursing technicians who work in a clinical inpatient unit.

Methods: This is an observational, descriptive, cross-sectional research, with a qualitative approach, composed of 15 nursing technicians who provide direct care to older adults hospitalized in a medium-sized public hospital in the countryside of the state of São Paulo. Four Dialogical Conversation Circles were held, guided by questions based on the Care Transition Intervention pillars and the Ideal Care Transition model main components, with an average duration of 30 minutes. Subsequently, participant observation was carried out in the place where these professionals work. After transcription of speeches, thematic analysis and data systematization followed using the Atlas.ti Qualitative Data Analysis.

Results: Nursing technicians showed a lack of knowledge about the meaning of care transition; however, in practice, they experience important aspects that permeate their concept, such as continuity of care, discharge planning and medication reconciliation. The strengthening of communication with the health care network services, the importance of family and health education were axes in the discussions regarding the transitions of older adults from hospital to home together with these professionals.

Conclusion: Professionals pointed to potentialities in the development of safe transitions in their care practice, in line with the Care Transition Intervention pillars and Ideal Care Transition model components, as long as they are aligned with the institution's care guidelines.

Resumo

Objetivo: Compreender como ocorre a transição do cuidado do hospital para casa de idosos na vivência de técnicos de enfermagem que atuam em uma unidade de internação clínica.

Métodos: Pesquisa observacional, descritiva, transversal, com abordagem qualitativa, composta por 15 técnicos de enfermagem que prestam assistência direta aos idosos internados em um hospital público, médio porte, no interior do estado de São Paulo. Realizadas quatro Rodas de Conversas Dialógicas, conduzidas por questões fundamentadas nos pilares do *Care Transition Intervention* e os principais componentes do modelo de Transição do Cuidado Ideal, com duração média de 30 minutos. Posteriormente realizada observação participante no local de atuação desses profissionais. Após transcrição das falas, seguiu-se análise temática e sistematização dos dados utilizando-se o Atlas.ti *Qualitative Datas Analysis*.

Resultados: Os técnicos de enfermagem demonstraram desconhecimento sobre o significado de transição do cuidado, contudo na prática vivenciam aspectos importantes que permeiam o seu conceito, como continuidade do cuidado, planejamento de alta e reconciliação medicamentosa. O fortalecimento da comunicação com os

[1]Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, Ribeirão Preto, SP, Brazil.
[2]Universidade Estadual do Oeste do Paraná, Foz do Iguaçu, PR, Brazil.
[3]Faculdade de Tecnologia do Vale do Ivaí, Ivaiporã, PR, Brazil.
Conflicts of interest: nothing to declare.

serviços da rede de atenção à saúde, a importância da família e educação em saúde foram eixos nas discussões referentes às transições de idosos do hospital para casa junto com estes profissionais.

Conclusão: Os profissionais apontaram para potencialidades no desenvolvimento de transições seguras na sua prática assistencial, consonantes com os pilares do *Care Transition Intervention* e componentes do modelo de Transição do Cuidado Ideal, desde que alinhadas a diretrizes assistenciais da instituição.

Resumen

Objetivo: Entender cómo ocurre la transición del cuidado del hospital a la casa de adultos mayores en la vivencia de técnicos de enfermería que actúan en una unidad de internación clínica.

Métodos: Investigación de observación, descriptiva, transversal, con enfoque cualitativo, compuesta por 15 técnicos de enfermería que brindan atención directa a adultos mayores internados en un hospital público, de tamaño mediano, en el interior del estado de São Paulo. Se realizaron cuatro Rondas de Conversaciones Dialógicas, conducidas por cuestiones fundamentadas en los pilares del *Care Transition Intervention* y los principales componentes del modelo de Transición del Cuidado Ideal, con una duración promedio de 30 minutos. Posteriormente se realizó la observación del participante en el lugar de actuación de esos profesionales. Después de la transcripción de los relatos, se siguió al análisis temático y a la sistematización de los datos utilizando el Atlas. ti *Qualitative Datas Analysis*.

Resultados: Los técnicos de enfermería demostraron una falta de conocimiento del significado de transición del cuidado, sin embargo, en la práctica vivencian aspectos importantes que penetran en su concepto, como continuidad del cuidado, planificación del alta y reconciliación medicamentosa. El fortalecimiento de la comunicación con los servicios de la red de atención a la salud, la importancia de la familia y la educación en salud fueron ejes en las discusiones referentes a la transición de adultos mayores del hospital a la casa junto con estos profesionales.

Conclusión: Los profesionales apuntaron las potencialidades en el desarrollo de transiciones seguras en su práctica asistencial, consonantes con los pilares del *Care Transition Intervention* y componentes del modelo de Transición del Cuidado Ideal, siempre y cuando estén alineadas a directivas asistenciales de la institución.

Introduction

Care transition (CT) can be defined as the time interval that begins with the preparation of individuals for discharge and ends when they are received at the next service. It is based on a care plan that includes logistical arrangements, communication between professionals, health education and care coordination. It covers activities related to discharge preparation, medication monitoring, social and community network, management of symptoms after discharge and follow-up in outpatient services.[1,2]

CT can be especially important for older adults with multiple chronic conditions and complex therapeutic regimens, as they generally receive care at various points in the Health Care Network (RAS) and often move in health care environments.[3,4]

The most common problems when there are failures in CT of older from hospital to home are: increased mortality and morbidity; delays in receiving treatment and support from the community; additional care; duplicate or missed examinations and unplanned readmissions.[3,5]

The nursing team constitutes an important group for carrying out safe CT in the RAS, as they actively participate in the therapeutic plans established for older adults, whether developed in basic health units, specialty centers or hospitals.

According to data from Federal Nursing Council (Cofen), in the Unified Health System (SUS - *Sistema Único de Saúde*), nursing is responsible for 60 to 80% of actions in Primary Health Care (PHC) and 90% of health processes in general. Technicians account for 75% of the category and exceed the mark of 1,800,000 people. Most of them work on the front line, and most of the time remain together with patients. Moreover, they participate in the planning of admission, hospitalization and perform together with other professionals hospital discharge.[6,7]

In this perspective, the following research question was elaborated: how does CT from hospital to home of older adults occur in the experience of nursing technicians working in a clinical hospitalization unit? Thus, the objective was to understand CT in the experience of these professionals. It is hoped that the research can contribute to reflections inherent to the nursing team's care process in CT and collaborate with discussions about continuity of care in the RAS.

Methods

This study was extracted from the results of a doctoral research, observational, descriptive and

cross-sectional, with a qualitative approach.[8] It was carried out in a clinical inpatient unit of a medium-sized public hospital, a reference for 26 municipalities, located in the countryside of the state of São Paulo. This hospitalization unit has 42 beds, of which 22 are intended for the care of patients with worsening clinical conditions, having as profile the hospitalization of older adults with chronic diseases.

Of the 25 nursing technicians (NT) working in the clinical hospitalization unit, 15 participated in the study. The invitation to NT was made by one of the researchers, by direct contact, according to the scale of duty. The inclusion criterion adopted was to work in the unit for more than six months.

For data collection, the Dialogical Conversation Circle (DCC) technique was used, recorded in audio, using a semi-structured script, with questions based on the Care Transition Intervention (CTI) (preparation for self-management; understanding about medications; assured preferences; care plan) pillars and the main ideal CT model main components (discharge plan; comprehensive communication and information about illness and care; drug safety; patient education; promotion of autonomy; social support; advanced care plan; care coordination; post-discharge symptom management; monitoring in outpatient services), which allowed participants to discuss the proposed theme in a reflective way, articulated with their experiences in care practice.[1,2,9] Participants, when starting the DCC, filled out an individualized form of characterization, containing data on age, gender, marital status and working time in the hospital. During the DCCs, the researchers made alignments on terms and concepts unknown to NT.

Four DCCs were performed in February 2021, with the participation of NT of all work shifts, with an average duration of 30 minutes. A physical education professional with experience in data collection applied the questionnaire directly in the classrooms. After the DCCs, participant observation was performed in all shifts, using a observation script contemplating care activities related to CT, being possible to identify convergences of what was observed with NT's statements. The audios were transcribed, preserving the fidelity of language, gestures and nonverbal expressions and identity of participants, and the observations were recorded in a field diary.

The collected data were analyzed, as proposed by the thematic analysis, in its six phases: familiarization with the data; definition of initial codes; topic research; topic review; denomination of themes and report production.[8]

Data systematization occurred with aid of Atlas.ti Qualitative Analysis Dates, version 9.1.5, and, at the end, an analytical table was built in Microsoft Excel 2019 to summarize the results.[8]

The research followed Resolution 466/2012 of the National Health Council, and was approved by the Research Ethics Committee of the *Escola de Enfermagem de Ribeirão Preto*, *Universidade de São Paulo* (EERP-USP), Opinion 4,368,291 and CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 36391420.8.0000.5393. The subjects were identified with the letters "CC", referring to the Conversation Circle, followed by the work shift and the numeral generated in the data analysis by Atlas.ti.

Results

Of the 25 professionals active in the sector, 19 were on duty on the dates defined for data collection and, of these, 15 agreed to participate in the study. The participants' mean age was 38 years, 13 (87%) were female and two (13%) were male; five (33%) were married, five (33%) were single, five (20%) were divorced and two (13.3%) were in a stable relationship; the average time of work in the hospital was two years. In data analysis, five thematic categories emerged in line with the CTI pillars and the ideal CT components, namely: *Meaning of care transition*; *Continuity of care*; *Discharge planning*; *Drug-Related Problems*; and *Care transition protocol*. They consisted of 14 subthemes, as presented in Figure 1.

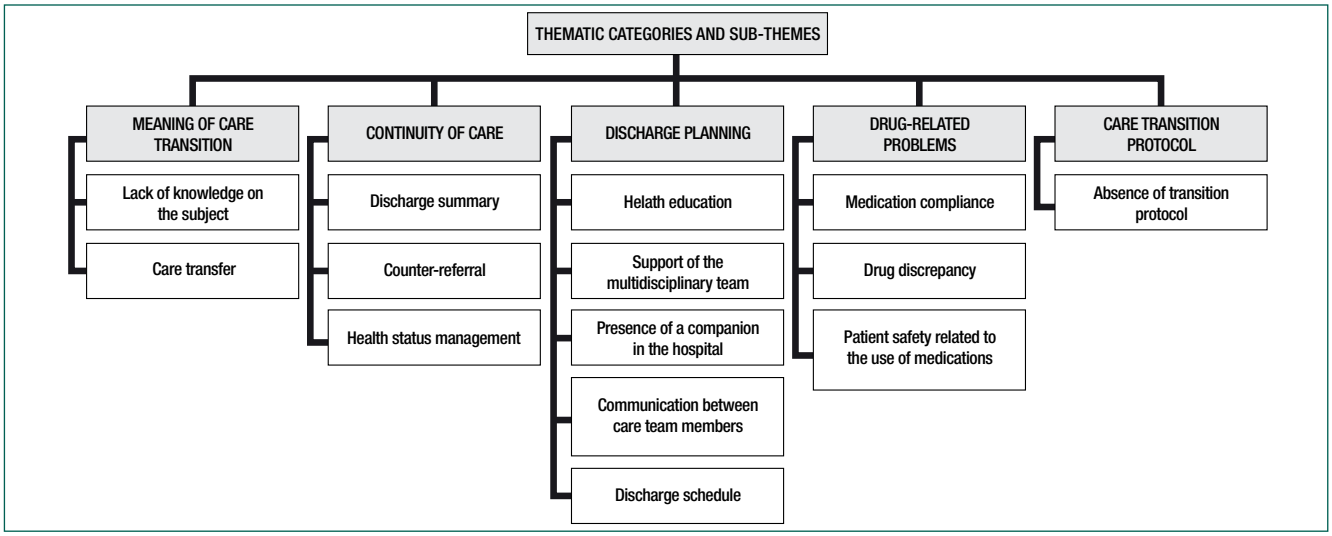

Figure 1. Thematic categories and sub-themes of care transition

Meaning of care transition

The first investigative question referred to the meaning of CT. Most NT showed a lack of knowledge on the subject, only one professional related it to the concept of CT.

> *It is the transfer of a patient from one institution to another, from one shift to another. Yeah... Maintain care or improve care… (Night CC 1, 3,1).*

Continuity of care

According to the CTI pillar (preparation for self-management) and CT model components (care coordination, post-discharge symptom management and follow-up in outpatient services), NT point to the importance of continuity of care and consider it a relevant aspect in CT, being evidenced in the statements related to the counter-referral to PHC and the provision of discharge summary, standardized by the hospital.

> *Referrals to BHU or then to an outpatient clinic. It is important for continuity of treatment (Morning CC, 1:121).*

> *Discharge report, two copies. […] He signs a copy, one with us and the other stays with him (Afternoon CC, 2:30).*

Although they consider the importance of bureaucratic communication between the hospital and other health services, they believe that there is no guarantee of access to the RAS.

> *How it works abroad, I don't know, but we give instructions everything right and referral ... That we do! Now, if they do outside, there is no way we could know (Morning CC, 1:45).*

As formal communication is not effective, they highlight the weaknesses in managing older adults' health after discharge.

> *[...] Our good and stable, it is different from the family's view... There was a patient in the ICU [Intensive Care Unit] who spent three months in intubation. Was discharged (Inpatient Unit), went home ... was oriented that could not give water... Ended up at ECU, bronchoaspirated and died... (Afternoon CC, 2:54).*

The lack of ability to manage the health status is evidenced in the observation of hospital readmissions, which generate costs for SUS.

> *There's a patient who leaves today, in three days and he will come back. Wow, why did you leave? Spending on this... (Night CC 1, 3:35).*

A strategy to improve continuity of care emerged from the work experience in another institution, in which post-discharge follow-up calls were used.

We don't need to assemble this multidisciplinary team that we had in São Paulo, which we monitored at home. But in one call, you get a lot of good information. "Don't do like this: take him to a BHU, to an ECU to see how he is, if anything happens, they transfer him to here". It is a prevention care (Night CC 1, 3:34).

Discharge planning

Discharge planning was the most discussed topic and considered an important resource for safe CT, as well as the ICU pillar (care plan) and ideal CT model components (discharge plan, communication and comprehensive information about the disease) and care, patient education, autonomy promotion, advanced care plan). Although the reports point to failures in its execution, such as difficulties in communication between the care team and with the family, absence of discharge schedule and gaps in the preparation of older adults for home care, there is consensus on health education as a significant strategy in discharge planning.

The most important thing is the family to be prepared. For example, there is a patient who arrives walking and then the family receives him bedridden. [...] Many end up not caring for themselves due to lack of instruction (Morning CC 1:105).

Health education is presented in a more systematic way when the older adult needs specific care at home, such as the use of nasoenteral tube, indwelling urinary catheter, oxygen therapy, dressings, among others.

She was intubated for 10 days in the ICU. The family is coming to know how treatment is going to be, how to make dressing. It's been a week since they've been there (Morning CC, 1:83).

In these cases, NT from day shifts observe that the multidisciplinary team participates more actively in discharge planning.

A discharge like this, everyone follows up (Morning CC, 1:85).

NT of night shifts are unaware of the actions carried out by the multidisciplinary team due to the lack of standardization of discharge planning in the hospital.

Especially at night, we do not see (multidisciplinary team). It may be during the day, but I can't talk because I'm not here (Night CC 2, 4:20).

The presence of a companion during hospitalization was identified as a relevant point in discharge planning. In the context of the COVID-19 pandemic, there was a restriction of visits and companions in the hospital, this absence was signaled as a complicating factor in CT, due to the challenges to think about the guidelines for caregivers.

[...] Before the pandemic, there were more companions, it was easier to give guidance, because it was passed according to hospitalization (Afternoon CC, 2:19).

Communication failures among the care team members, regarding the discharge schedule, were identified as negative aspects in the planning. The moment of discharge is perceived by the NT, due to their professional experience in observing patients' clinical evolution.

This planning belongs to the doctor, if he will discharge or not. [...] This patient I'm with today, I didn't know she was leaving. [...] I learned now, because I took the paper in my hand (Morning CC, 1:96).

It is because we know more or less. Did you call the family? Turned off the catheter, will undergo arterial gasometry exams... (Night CC 1, 3:31).

Drug-Related Problems

Understanding medications and drug safety can be considered strategic axes in CT and highlights in the conceptual basis of this study. In this sense, the speeches pointed to PRD, such as medication compliance (MC), medication discrepancy and medication safety during care transfers.

MC was related to the older adults' difficulty in self-managing the medication, resulting in readmissions.

> *There are some who don't even take medication. The thinks he took it here and doesn't need to take it at home. Back to hospital… Did you buy medication? No (Morning CC, 1:107).*

Medication discrepancies were evidenced by not checking the medications at admission-hospitalization-discharge and providing the medical prescription at hospital discharge.

> *We enter the room: "See, but my mommy takes Alzheimer's medicine." "But did you talk to the doctor?" Then you take the medicine, take it to the prescription room (Afternoon CC, 2:36).*

> *Sometimes there is also a divergence that happens, a patient has his medications... Then, at discharge, in the prescription, the medications for hypertension, diabetes are different... (Afternoon CC, 2:37).*

Care transition protocol

The standardization of care activities related to the older adults' CT from hospital to home was evidenced by the absence of a protocol at the institution.

> *There is no protocol. [...] We go according to the moment's needs (Night CC 2, 4:10).*

Discussion

The discussion about CT, especially older adults from hospital to home, is still embryonic in Brazil, both in terms of research development and the existence of specific public policies.[10,11] In this study, most NT presented ignorance about the concept of CT. These professionals make up the multidisciplinary team, actively participate in care and shift change, interacting with patients and families, health professionals, support services and other groups, for the purpose of continuity of hospital care.[6] In this way, the importance of knowing the subject and developing skills to conduct safe CT together with the care team is highlighted.

Only one NT spoke about the meaning as a transfer of care, understood as the safe delivery of patients to another health service. Some authors, when discussing this definition, deal with important aspects to be considered during transitions, such as effective communication, teamwork, person-centered care and continuity of care.[12,13]

Continuity of care was pointed out as relevant to solve problems faced by older adults after hospital discharge, which is corroborated by some authors, when they define continuity as fundamental in the integrality of care, especially in the relationship between user and RAS.[14,15]

Carrying out the counter-referral and providing the discharge summary, in a standardized way, were considered as activities used by the hospital for continuity of care. According to some studies, as long as associated with a comprehensive communication program, these features are powerful tools that guide older adult access in RAS through information transition.[16,17]

Although NT considers the importance of bureaucratic communication of the hospital to other health services, they consider that this cannot be considered as a guarantee of access. This fragility may be related to the difficulties of older adult adulthood in spontaneous search for health services, the problems faced by PHC in the active search, communication failures and organizational deficiencies in the RAS.[18,19]

As the communication between the hospital and the RAS services was highlighted as inefficient, participants pointed to the weaknesses of older adult in the management of their health status: a fundamental attribute for performing safe CT, as pointed out by researchers in the area of knowledge.[1-3]

This inability to monitor the health situation was demonstrated in the observations of unscheduled hospital readmissions. Readmission can bring burden to the health system, discomfort to older adult and family members. In this regard, as pointed out by some studies, CT programs can contrib-

ute to the development of skills in older adults and family members to perform health status management after hospital discharge.[20-22]

Discharge planning was considered as a CT pillar by NT. A theme widely discussed in the hospital area and a fundamental resource in transition programs, aiming to reduce hospitalization time, improve coordination between post-hospital discharge services and perform health education.[1,23,24]

Thus, health education was emphasized by NT, in the preparation of older adults to perform health self-management after discharge and in the family adaptation to a new reality of life. This subject, highlighted as a CT pillar, has strong potential for development by the nursing team, because it is an activity inherent to the profession and attribution recognized by different health systems.[1,25]

According to the participants of this study, discharge planning is hampered by gaps in the care process, such as the absence of the family in hospitalization follow-up. In high-level CT programs such as the ICU, the family's participation in active discharge planning is considered as a strategic axis for continuity of treatment of older adult at home.[2,26-28] In this sense, the implementation of a care guideline for the involvement of these actors in care management can contribute to decision-making in post-discharge care.

Regarding the communication failures among the care team members identified in this investigation, corroborate studies in which failures contribute to medical errors, adverse events and decreased quality of care. For these studies, for assistance safety, it is crucial to establish communication resources among team members, such as active listening, confirmation of the transmitted message, clear leadership and situational awareness.[29- 31]

MC, drug discrepancies and drug safety were indicated as DRP during CT. Authors point out that drug reconciliation programs can be a useful strategy to reduce these problems and the implementation of drug conference activities, the use of checklists and education on self-management of medications may enhance the nursing team's actions, favoring safety of medicines in CT.[32-34]

The lack of standardization of care activities was highlighted by the absence of a CT protocol in the institution. These practice-guide documents can be considered important tools for solving different problems in care. In this regard, the study brings advantages in use of care protocols that are related to the safety of users and professionals involved in care, reduction of the variability of care actions, improvement in the qualification of professionals for decision-making, care innovation, rational use of available resources and cost control.[35]

The limitation study refers to being carried out only with NT.

Conclusion

NT are the professionals who spend the most time in direct care to older adult during hospitalizations and experience important aspects that permeate the expanded concept of CT, such as continuity of care, discharge planning and drug reconciliation. In this study, potentialities for the development of CT were evidenced in a clinical hospitalization unit, integrated with care guidelines. The strengthening of RAS, of which the hospital is a part, can be a fundamental resource for the development of quality CT for older adults after hospital discharge. It is considered that the study contributes to reflections inherent to the care process of nursing team in CT from hospital to home and in the RAS, referring to the coordination, continuity of care and health education in SUS. Further research can be developed with the objective of quantifying and qualifying nursing performance in CT.

Collaborations

Valente SH, Zacharias FCM, Fabriz LA, Schönholzer TE, Ferro D, Tomazela M, Barbosa SM and Pinto IC contributed to study conception, data analysis and interpretation, article writing, relevant critical review of intellectual content and approval of the final version to be published.

References

1. Burke RE, Kripalani S, Vasilevskis EE, Schnipper JL. Moving beyond readmission penalties: creating an ideal process to improve transitional care. J Hosp Med. 2013;8(2):102-9. Review.
2. Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. 2006;166(17):1822-8.
3. Naylor MD, Hirschman KB, McCauley K. Meeting the transitional care needs of older adults with COVID-19. J Aging Soc Policy. 2020;32(4-5):387-95.
4. Hunt-O'Connor C, Moore Z, Patton D, Nugent L, Avsar P, O'Connor T. The effect of discharge planning on length of stay and readmission rates of older adults in acute hospitals: a systematic review and meta-analysis of systematic reviews. J Nurs Manag. 2021;29(8):2697-706.
5. Schapira M, Outumuro MB, Giber F, Pino C, Mattiussi M, Montero-Odasso M, et al. Geriatric co-management and interdisciplinary transitional care reduced hospital readmissions in frail older patients in Argentina: results from a randomized controlled trial. Aging Clin Exp Res. 2022;34(1):85-93.
6. Conselho Federal de Enfermagem (COFEN). Enfermagem em números. Brasília (DF): COFEN; 2021.
7. Silva MC, Machado MH. Sistema de saúde e trabalho: desafios para a Enfermagem no Brasil. Cien Saude Colet. 2020;25(1):7-13.
8. Braun V, Clarke V. Using thematic analysis in Psychology. Qualit Res Psychol. 2006;3(2):77-101.
9. Pereira ES, Silva MR. Rodas de conversas dialógicas: aqui tem a força da palavra. Curitiba: Brasil Publishing; 2019.180 p.
10. Gheno J, Weis AH. Transição do cuidado na alta hospitalar de pacientes adultos: revisão de literatura. Texto Contexto Enferm. 2021;30:e20210030.
11. Siqueira TH, Vila VS, Weiss ME. Adaptação transcultural do instrumento Readiness For Hospital Discharge Scale – Adult Form. Rev Bras Enferm. 2018;71(3):1046-54.
12. Merten H, Galen LS, Wagner C. Safe handover. BMJ. 2017;359:j4328. Review.
13. Sanjuan-Quiles Á, Hernández-Ramón MD, Juliá-Sanchis R, García-Aracil N, Castejón-de la Encina ME, Perpiñá-Galvañ J. Handover of patients from prehospital emergency services to emergency departments: a qualitative analysis based on experiences of nurses. J Nurs Care Qual. 2019;34(2):169-74.
14. Utzumi FC, Lacerda MR, Bernardino E, Gomes IG, Aued GK, Sousa SM. Continuidade do cuidado e o interacionismo simbólico: um entendimento possível. Texto Contexto Enferm. 2018;27(2):e4250016.
15. Ribas EM, Bernardino E, Larocca LM, Neto PP, Aued GK, Silva CP. Nurse liaison: a strategy for counter-referral. Rev Bras Enferm. 2018;71(1):546-53.
16. Andrade LS, Francischetti I. Referência e contrarreferência: compreensões e práticas. Saúde Transf. Soci. 2019;10:54-63.
17. Rattray NA, Sico JJ, Cox LA, Russ AL, Matthias MS, Frankel RM. Crossing the communication chasm: Challenges and opportunities in transitions of care from the hospital to the primary care clinic. Jt Comm J Qual Patient Saf. 2017;43(3):127-37.
18. Mendes EV. Entrevista: a abordagem das condições crônicas pelo Sistema Único de Saúde. Cien Saude Colet. 2018;23(2):431-36.
19. Östman M, Bäck-Pettersson S, Sundler AJ, Sandvik A. Nurses' experiences of continuity of care for patients with heart failure: a thematic analysis. J Clin Nurs. 2021;30:276–86.
20. Acosta AM, Lima MA, Marques GQ, Abreu AP, Sanseverino AX, Oelke N. Intervenções em saúde para a redução da readmissão hospitalar em 30 dias em pacientes clínicos: uma revisão integrativa. RSD. 2022;11(2):e2011225273. Review.
21. 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;18:956.
22. Finlayson K, Chang AM, Courtney MD, Edwards HE, Parker AW, Hamilton K, et al. Transitional care interventions reduce unplanned hospital readmissions in highrisk older adults. BMC Health Serv Res. 2018;18:956.
23. Mennuni M, Gulizia MM, Alunni G, Amico AF, Bovenzi FM, Caporale R, et al. ANMCO Position Paper: hospital discharge planning: recommendations and standards. Euro Heart J Suppl. 2017;19(Suppl D):D244-55.
24. Costa MF, Oliveira LS, Santos JL, Lanzoni GM, Cechinel-Peiter C. Hospital discharge planning as a continuity care strategy for primary care. RSD. 2020;9(10):e3709108518.
25. Souza N, Vilhena A, Santos M, Monteiro N. Planejamento da alta hospitalar para pacientes submetidos a revascularização do miocárdio: desafios à atuação do enfermeiro. Cogitare Enferm. 2020;25:e71602.
26. Coleman EA, Roman SP, Hall KA, Min S. Enhancing the care transitions intervention protocol to better address the needs of family caregivers. J Healthc Qual. 2015;37(1):2–11.
27. Coleman EA, Roman, SP. Family caregivers' experiences during transitions out of hospital. J Healthc Qual. 2015;37(1):12-21.
28. Rodakowski J, Rocco PB, Ortiz M, Folb B, Schulz R, Morton SC, et al. Caregiver integration during discharge planning of older adults to reduce resource utilization: a systematic review and meta-analysis of randomized controlled trials. J Am Geriatr Soc. 2017;65(8):1748–55. Review.
29. Farias ES, Santos JO, Góis RM. Comunicação efetiva: elo na segurança do paciente no âmbito hospitalar. Cien Biol Saude Unit. 2018;4(3):139.
30. Sousa JB, Brandão MJ, Cardoso AL, Archer AR, Belfort IK. Comunicação efetiva como ferramenta de qualidade: Desafio na segurança do paciente. Braz J Health Rev. 2020;3(3):6467-79.
31. Santos TO, Lima MA, Alves VS, Ribeiro MC, Alves RS, Souza MR, et al. Comunicação efetiva da equipe multiprofissional na promoção da segurança do paciente em ambiente hospitalar. Rev Psicol. 2021;15(55):159-68.
32. Valente SH, Barbosa SM, Ferro D, Fabriz LA, Schönholzer TE, Pinto IC. Problemas relacionados a medicamentos na transição de idosos do hospital para casa. Rev Bras Enferm. 2019;72(Suppl 2):361-69.
33. Aquino GA, Cruz DT, Silvério MS, Vieira MT, Bastos RR, Leite IC. Fatores associados à adesão ao tratamento farmacológico em idosos que utilizam medicamento anti-hipertensivo. Rev Bras Geriatr Gerontol. 2017;20(1):116-27.
34. Mortelmans L, Goossens E, Dilles T. Beliefs about medication after hospital discharge in geriatric patients with polypharmacy. Geriatr Nurs. 2022;43:280–7.
35. Sakamoto VM, Moraes LC, Blatt CR, Caregnato RC. Validation methods of nursing protocols: an integrative review. Rev Bras Enferm. 2020;73(Supl 5):e20200050. Review.