Review

CARE TRANSITION FROM HOSPITAL TO HOME: INTEGRATIVE REVIEW

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ABSTRACT: The present study aimed to identify nurses' activities in the transition of care from hospital to home based on literature evidence. Integrative review conducted in August 2015, through search of PubMed, Cumulative Index to Nursing and Allied Health Literature, Web of Science, SCOPUS and Latin American and Caribbean Health Sciences Literature databases. Twenty-two (22) articles that met the inclusion criteria were selected. Interventional, experimental and quasi-experimental studies with elderly and patients with chronic diseases were identified. The results showed five thematic categories related to the main activities of nurses in transitional care: planning for discharge; assistance in social rehabilitation; health education; coordination with other services; post-discharge follow-up. It is concluded that improvement of care practices and organization of nurses' activities is needed, to ensure the coordination of care focused on transition from hospital to home.
DESCRIPTORS: Transitional care; Patient discharge; Continuity of Patient Care; Nursing.

TRANSIÇÃO DO CUIDADO DO HOSPITAL PARA O DOMICÍLIO: REVISÃO INTEGRATIVA

RESUMO: Objetivou-se identificar atividades dos enfermeiros na transição do cuidado do hospital para o domicílio a partir de evidências na literatura. Trata-se de revisão integrativa, realizada em agosto de 2015, mediante busca nas bases de dados PubMed, *Cumulative Index to Nursing and Allied Health Literature, Web of Science, SCOPUS* e Literatura Latino-Americana e do Caribe em Ciências da Saúde. Foram selecionados 22 artigos que atenderam aos critérios de inclusão. Identificaram-se estudos de intervenção, pesquisas experimentais, quase-experimentais, em idosos e com doenças crônicas. Os resultados evidenciaram cinco categorias temáticas com as principais atividades dos enfermeiros na transição do cuidado: planejamento de cuidados para a alta; auxílio na reabilitação social; educação em saúde; articulação com os demais serviços; acompanhamento pós-alta. Conclui-se que há necessidade de aprimoramento das práticas assistenciais e organização das atividades dos enfermeiros, promovendo coordenação do cuidado com foco na transição do hospital para o domicílio.
DESCRITORES: Cuidado transicional; Alta do paciente; Continuidade da assistência ao paciente; Enfermagem.

TRANSICIÓN DEL CUIDADO DEL HOSPITAL PARA EL DOMICILIO: REVISIÓN INTEGRATIVA

RESUMEN: Estudio cuya finalidad fue identificar actividades de los enfermeros en la transición del cuidado del hospital para el domicilio considerándose evidencias en la literatura. Es una revisión integrativa, realizada en agosto de 2015, por medio de búsqueda en las bases de datos *PubMed, Cumulative Index to Nursing and Allied Health Literature, Web of Science, SCOPUS* y Literatura Latinoamericana y de Caribe en Ciencias de la Salud. Se seleccionaron 22 artículos de acuerdo a los criterios de inclusión. Se identificaron estudios de intervención, investigaciones experimentales, casi experimentales, en ancianos y con enfermedades crónicas. Los resultados apuntaron cinco categorías temáticas con las principales actividades de los enfermeros en la transición del cuidado: planeamiento de cuidados para el alta; ayuda en la rehabilitación social; educación en salud; articulación con otros servicios; acompañamiento despues del alta. Se constata que hay necesidad de perfeccionamiento de las prácticas asistenciales y organización de las actividades de los enfermeros, para promover coordinación del cuidado con énfasis en la transición del hospital para el domicilio.
DESCRIPTORES: Cuidado transicional; Alta del paciente; Continuidad de la asistencia al paciente; Enfermería.

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INTRODUCTION

Care transition concerns the actions aimed to ensure coordination and continuity of care as patients move between different settings or different units of the same setting[1]. Given population aging, the increasing prevalence of chronic diseases, the trend toward reduced length of hospital stay and increased community care, care transition is a way to overcome e fragmentation of care and ensure permanent care to patients[2].

Transition occurs in a context that includes patient, family members and caregivers the former carers and those who will provide care to the patient at home[1]. Therefore, it is a complex process that requires coordination and communication between people of different backgrounds, experiences and skills.

Hospital discharge is a challenging moment in patients' daily lives, which involves more drugs to take and home care. These changes are sometimes not effectively addressed during hospitalization, resulting in post discharge fragmentation of care[3]. Thus, hospital discharge requires planning, preparation and health education of the patient and the family, especially when the patients are elderly and people with chronic diseases, who have persistent and continuous health needs[1]. However, discharge instructions are mostly delivered mechanically and hurriedly, without taking each patient's needs into consideration[4], and are often delivered only at the time of hospital discharge[5].

Even those patients who feel confident at hospital discharge[6], may have doubts about treatment and recovery when they return to their homes[7]. Lack or insufficient planning of hospital discharge may lead to distress and anxiety[2], adverse events and medication errors[8], poor adherence to treatment and poor quality of life[9].

Suitable transition processes can improve the quality of care and influence the quality of life of patients, helping to avoid unnecessary hospitalizations and reduce the cost of health care[5,10]. Nurses are responsible to ensure that patients return home safely and receive the necessary support, contributing for better coordination and communication among professionals, patients, carers and health services, in order to provide continuous care, through the use of successful care transition strategies[11].

Often, due to their numerous activities, nurses provide information only during routine activities of their care practice[2], sometimes hurriedly and delivering too much information over a short period of time[12]. Also, the high hospital bed turnover rate makes the exchange of information on home care during the discharge process difficult[2].

Nurses can play an active role in care transition strategies through its coordination, as well as by providing health education support and guidelines for the prevention and control of diseases and health promotion and maintenance[5] to improve the hospital discharge process and ensure continuity of care at home. This process is under construction and adaptation in different countries and needs investigation, especially in Brazil.

The quality of care transitions has been used as a component for assessing hospital performance. Ensuring safe and efficient transitions from hospital services to home has been the focus of interest of health researchers and managers globally[5,10]. Therefore, this article aims to identify the activities conducted by nurses in care transition from hospital to home, based on evidence from the literature.

METHOD

This is an integrative review conducted in five recommended steps: problem formulation, data collection or literature search, evaluation of data, data analysis, and synthesis of knowledge[13].

The guiding question was: what are the activities of nurses in care transition from hospital to home described in the literature?

Field search was based on PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Science, Overview (SCOPUS) and Latin American and Caribbean Health Sciences

(LILACS) databases.

Controlled Health Sciences (DeCS) descriptors and uncontrolled descriptors, all in English, were used in database search. The following combinations were made: 1) (patient discharge) AND (care transitions) AND (best practices) AND (nursing); 2) ((care coordination) OR (care transition)) AND (patient discharge) AND (nursing); 3) ((care coordination) OR (care transition)) AND (patient discharge) AND (nursing) AND (best practices); 4) ((care coordination) OR (care transition) OR (patient discharge)) AND (nursing) AND (best practices).

Inclusion criteria were full-text articles available in English, Spanish and Portuguese languages, published between January 2005 and August 2015. Theoretical articles, integrative, narrative and systematic reviews, experience reports, editorials, theses, dissertations, monographs, abstracts, documents and annals of events were excluded. Collection was made in August 2015.

A total of 2,279 articles were found, and after removal of duplicates, 1,419 publications, were obtained, of which 105 were pre-selected through title and abstract reading. After careful reading of texts, the final sample was composed of 22 items, as shown in Figure 1.

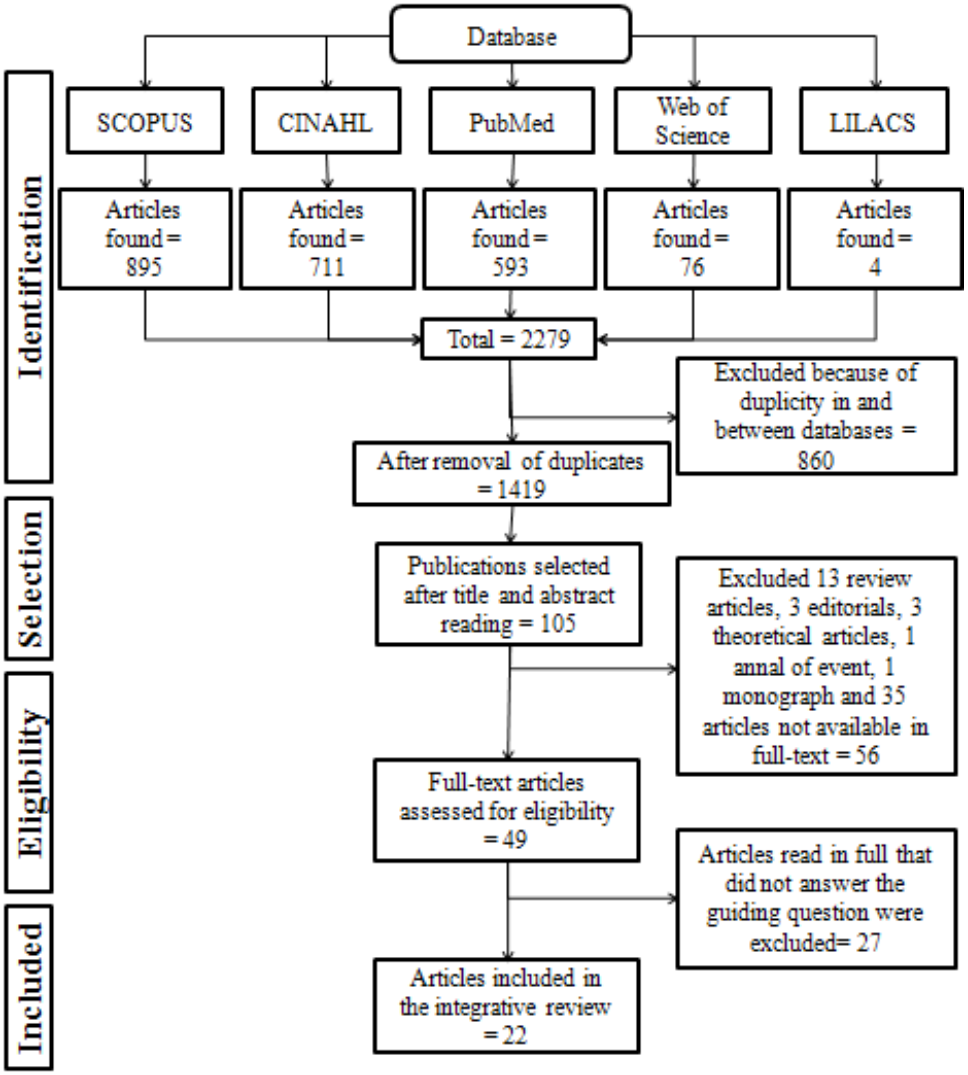

Figure 1 - Flowchart of data collection and selection of the studies that compose the sample. Porto Alegre, 2015

Data extraction was based on a guide with information on year of publication, authors, title, journal, country, methodological design, objectives, results, activities of nurses and conclusions. The reference management tool EndNote X7 was used to organize the publications and remove duplicates.

Data analysis was performed through simple and relative frequency calculations. The activities of the nurses described in the articles were classified by similarity and grouped into categories, using NVivo software, version 10.

RESULTS

The sample of this review consisted of 22 studies describing activities or proposing interventions to be performed by nurses, in order to qualify care transition from hospital to home. The articles with their respective authors, years of publication, objectives and activities developed are shown in Table 1.

Table 1 - Description of the articles included in the review. Porto Alegre, RS, Brazil, 2015 (continues)

Authors and year of publication	Objectives	Care transition activities developed by nurses
Gunady S, Upfield S, Pham ND, Yea J, Schmiedeberg MB, Stahmer GD. 2015[14]	To describe the development and implementation of a care transition program with focus on medication reconciliation for patients with heart failure.	Medication instructions.
Ulin K, Olsson LE, Wolf A, Ekman I. 2015[15]	To assess the efficiency of the care planning model of a Gothenburg Care Center compared to the usual care provided to patients with heart disease.	Elaboration of discharge plan, assistance in social rehabilitation, guidelines on signs and symptoms and self-care at home, coordination of hospital nurses with primary health care and home visit.
Young Young L, Barnason S, Hays K, Do V. 2015[16]	To assess the effects of care management in drug reconciliation on discharge from a rural hospital and transition to home care.	Medication instructions.
Berry DL, Cunningham T, Eisenberg S, Wickline M, Hammer M, Berg C. 2014[17]	To improve patient's understanding of their medications at hospital discharge.	Medication instructions and follow-up telephone contact.
Biese K, Lamantia M, Shofer F, McCall B, Roberts E, Stearns SC, et al. 2014[18]	To investigate whether telephone follow-up improves elderly adherence to the care plan after emergency care and reduces hospitalizations after 35 days.	Preparation of discharge planning, medication instructions, follow-up telephone contact, home visit.
Black JT, Romano PS, Sadeghi B, Auerbach AD, Ganiats TG, Greenfield S, et al. 2014[19]	To assess the effectiveness of intervention in care transition with pre-discharge education intervention and post-discharge phone calls.	Preparation of discharge planning, medication instructions, follow-up telephone contact, home visit
Englander H, Michaels L, Chan B, Kansagara D. 2014[20]	To assess the impact of a care transition program on 30-day hospital readmissions, on emergency service use, transition quality, and mortality	Elaboration of discharge plan, assistance in social rehabilitation, medication instructions, follow-up telephone contact, home visit.
Harrison JD, Auerbach AD, Quinn K, Kynoch E, Mourad M. 2014[21]	To determine the effect of post-discharge telephone calls on the causes of 30-day hospital readmissions	Instructions on medications, signs and symptoms and self-care at home, follow-up telephone contact.
Li J, Wang H, Xie H, Mei G, Cai W, Ye J, et al. 2014[22]	To assess the effectiveness of nurses' phone calls on patients with peritoneal dialysis in mainland China	Elaboration of discharge plan, social rehabilitation assistance, medication instructions and self-care at home, follow-up telephone contact.

Graham J, Gallagher R, Bothe J. 2013[23]	To examine nurses' understanding of discharge planning, adherence and barriers.	Elaboration of discharge plan, assistance in social rehabilitation, instructions for self-care at home.
Bradley EH, Curry L, Horwitz LI, Sipsma H, Wang Y, Walsh MN et al. 2013[24]	To identify strategies adopted by hospitals to reduce hospital readmission rates of patients with acute myocardial infarction (AMI).	Elaboration of discharge plan, medication instructions.
Keeping-Burke L, Purden M, Frasure-Smith N, Cossette S, McCarthy F, Amsel R. 2013[25]	To identify whether a telehealth program, accompanied by standardized education, reduces the anxiety of caregivers and patients in need of coronary artery bypass surgery.	Elaboration of discharge planning, social rehabilitation assistance, instructions on medications, signs and symptoms, follow-up telephone contact, home visit.
Kind J, Jensen L, Barczi S, Bridges A, Kordahl R, Smith MA et al. 2013[26]	To assess a transition care protocol for war veterans after hospital discharge in transition to home care.	Instructions on medications, signs and symptoms and self-care at home, coordination of hospital nurses with primary health care, telephone follow-up, home visit.
Meisinger C, Stollenwerk B, Kirchberger I, Seidl H, Wende R, Kuch B et al. 2013[27]	To assess a care management intervention at hospital discharge in elderly with acute myocardial infarction (AMI).	Assistance in social rehabilitation, instructions on signs and symptoms and self-care at home, telephone follow-up, home visit.
Barnason S, Zimmerman L, Hertzog M, Schulz P. 2010[28]	To assess the impact of a transition care intervention from hospital to home in elderly post-AMI patients using multiple medications.	Elaboration of discharge planning, social rehabilitation assistance, instructions on diet, medications, signs and symptoms, self-care at home, follow-up telephone contact.
CF, Setter SM, Daratha KB, Neumiller JJ, Wood LD. 2010[29]	To describe the main drug discrepancies identified by nurses in care transition hospitalized adults to their homes.	Medication instructions, home visit
Portillo MC, Corchón S, López-Dicastillo O, Cowley S. 2010[30]	To assess the effectiveness of a social rehabilitation program for neurological patients and their caregivers.	Elaboration of discharge planning, assistance in social rehabilitation, signs and symptoms, self-care at home.
Balaban RB, Weissman JS, Samuel PA, Woolhandler S. 2008[31]	To assess an intervention to immediately reconnect patients in home care after hospital discharge.	Elaboration of discharge plan, coordination of nurses of a primary health care hospital, follow-up telephone contact.
Setter SM, Corbett CF, Neumiller JJ, Gates BJ, Sclar DA, Sonnett TE. 2009[32]	To assess the collaboration of nurses in the resolution of drug discrepancies in adult and elderly patients in transition from hospital to home.	Medication instructions, home visit.
Chow SK, Wong FK, Chan TM, Chung LY, Chang KK, Lee RP. 2007[33]	To assess the services of community nurses for patients with chronic diseases in transition from hospital to home.	Elaboration of discharge plan, assistance in social rehabilitation, instructions on diet, medications and signs and symptoms, home visit.
Tarling; Jauffur. 2006[34]	To produce an intervention protocol based on best practices to a standardize multidisciplinary discharge plan.	Elaboration of discharge plan, assistance in social rehabilitation.
Wong FK, Mok MP, Chan T, Tsang MW. 2005[35]	To compare the results obtained in the telephone follow-up of patients with early discharge to those who received routine instructions at hospital discharge.	Instructions on diet, medications, signs and symptoms, self-care at home, follow-up telephone contact.

Regarding the methodology used in the publications, there were several intervention studies. Eight (36.4%) randomized clinical trials, three (13.6%) pre and post-intervention quasi-experimental studies, two (9.1%) intervention protocols, one (4.5%) non-randomized controlled trial study, one (4.5%) pilot

intervention study and one (4.5%) action design research study were identified. Other designs identified were four (18.3%) descriptive quantitative studies and two (9.1%) qualitative exploratory studies.

Regarding the year of publication, one article was published per year in 2005, 2006, 2007 and 2008. Three articles were published in 2010, five in 2013, six in 2014 and three in 2015. Most studies were focused on elderly and people with chronic diseases, such as diabetes, cardiovascular, pulmonary and neurological diseases, and cancer.

The nursing activities described in the 22 articles were classified into five thematic categories: Planning of hospital discharge care; Assistance in social rehabilitation; Health education; Coordination with other services; Follow-up care after hospital discharge.

Category 1 – Planning of discharge care

This category includes the activities described in 13 articles of the sample. Discharge planning was jointly performed by hospital nurses[18-19,22-23,28,31], patient and family members[25] or with the multidisciplinary team[15,20,32,35] and reshaped during hospital stay, according to medical and psychosocial changes in the patient[15]. The discharge plans contained information on previous diagnoses[24-25], mode of medication administration[18,20,24-25,31,33], past medical history, assessment of psychosocial conditions[20,22-23,25,33], financial and housing conditions[31] and follow- up care after hospital discharge[24-25,31,33]. The plan was delivered to the patient at the time of hospital discharge[15].

Category 2 – Assistance in Social Rehabilitation

The activities included in this category were identified in 10 articles. Social rehabilitation intends to make the patients able to resume their daily activities after hospital discharge[30]. It is focused on the interaction between family and community, promoting positive attitudes, acceptance and adaptation of the disease to daily living activities, mitigating the feeling of abandonment, encouraging favorable expectations o of rehabilitation[15,30]. The nurses rated assessed aspects that might improve or impair patient recovery, such as physical[22,27,30,33], social[15,22,33,34], psychological[20,22-23,25,28,30,33] and motivational[28] conditions of the patient and family.

Category 3 – Health Education

This activity prevailed in all the studies identified in this review. It was described in 20 articles. Nurses conduct health education activities in several ways: changes in diet and possible restrictions on food[27-28,33,35], physical exercises[25,35], correct use of medications such as dosage, frequency of administration and times[14,17-19,21-22,25-26,28-30,33], interactions of continuous use medications[14,16,20,26,32,35], recognition of signs and symptoms of the current disease[19-20,22-23,25-28,30,35] and self-care at home[15,22,35]. Some nurses perform medication reconciliation, assessing the effects of drugs used before hospitalization and drugs prescribed in the hospital setting[16,20,24]. Others use support informational handouts to strengthen care instructions[25,26,28] and simple, concise language, as well as feedback from information to check the patient's understanding about the information provided[19,30].

Category 4 – Coordination with the other services

This activity was described in three studies of the sample. Nurses convey information about the patient's discharge plan to primary health care teams, managing the care transition between different points of the healthcare network. Such coordination between services can be done through notifications of hospital nurses on patient discharge to the referral service[15].

It can also be done by phone calls through which hospital nurses suggest primary care nurses visit the patients at home and clarify their doubts[26]. The computerized hospital system interconnected to the local health network is also used. The discharge plan is sent electronically to the primary health

care service and used by the healthcare team for monitoring home care[31].

Category 5 – Post-discharge follow-up

The activities of follow-up care after discharge were described in the first 16 articles. Telephone calls or home visits were carried out in order to assess the discharge plan and address the instructions provided in the hospital setting and clarify any doubts about this information[21,33]. The main points are: to identify and guide aspects of the treatment[18,27-28,31], signs and alarm symptoms[25,33,35], drug administrations[17,25-26], check patient's understanding of self-management activities of care[20,21,33], clarification on the suitable sites for assistance[33] and follow-up consultations[25,27,31].

The phone contacts allowed to identify doubts of patients and caregivers in home care[18-19,22] define home visits to at risk patients[20], and prompt intervention during the phone call[31].

DISCUSSION

Nurses perform multiple activities, of varying degrees of complexity, in care in the transition from hospital to home, which starts during hospitalization and are concluded when the patient is transferred to the home environment.

The planning of discharge care initiated upon admission set goals for short-term and long-term treatment, and stimulate the establishment of bonds and the participation of patients and family members in the different types of care[2]. The development of targets for the treatment favored the provision of the care needed to meet patient's needs, ensuring safe and effective recovery[15]. Shared discharge planning facilitates the work performed by nurses and the hospital team, benefitting patients and families. Data collection by health professionals clarifies the reason for hospital admission and possible difficulties of home treatment, resulting in the management of individualized care during hospital admission and promoting post-discharge health.

In continuous home care, it is important to monitor patient's adaptation[5] and interaction with family, which is essential in the resumption of daily activities[30]. Therefore, nurses can assess patients' physical and psychosocial conditions and promote high quality care to vulnerable patients to help them cope with the disease while performing their daily routine activities[22,28]. This assessment contributes to the promotion of patient rehabilitation, aimed to seek his/her integration with his/her family.

Health professionals should assess patients' ability to accept changes and identify psychological and cognitive aspects that may assist in this process[23]. Aid programs in social rehabilitation programs are valuable for effective care transitions, especially for more vulnerable patients, who feel safe and find it easier to adapt to disease and perform their daily activities at home[6].

The integrative review showed that health education was the most prevalent activity performed by nurses related to care transition from hospital to home. Just like social rehabilitation and discharge planning, it requires the participation of patients in the construction of their care based on shared information.

Educational strategies that use clear and concise language, informational handouts and feedback from information make it easier for patients and families to understand care transition[5-6,11]. The instructions provided by nurses are essential for successful care transition, as they favor the use of medications and self-care management[17], increase adherence to treatment[35], reduce hospital readmission[15,21,26-27] and mortality[20,27] rates.

The number of articles focused on health education indicates concern with the inclusion of patients and families in care transition, in order to improve dietary aspects, physical activity execution, proper use of medications and early recognition of signs and symptoms. Comprehensive and individualized care should be considered, and health education should not merely involve medication prescription, but also clarification. Thus, investing in activities that stimulate self-care and support to medication management empowers patients and caregivers, avoiding unnecessary search and use of health

services available in the health care network.

Follow-up care after discharge is necessary to identify doubts about after treatment prescribed at the hospital and seek appropriate care in the event of an unexpected problem[25]. This objective has been implemented by telephone monitoring, home visits and consultations after hospital discharge, with positive outcomes[26,31].

So far there is little coordination of the hospital with the other services of the health care network, demonstrating that despite the concern about follow-up care after hospital discharge, this activity is usually performed by primary care services. Three studies[15,26,31] used coordination between services, emphasizing that communication between different levels of care contributed to the implementation of best practices in care transition and made it possible to ensure continuous care after discharge.

More effective care transition processes require focus on the individual needs of patients and families and on shared care[5,9,15]. Thus, health professionals, patients and families become partners in care from hospital admission until the days subsequent to home return after hospital discharge.

The activities related to the coordination of transition care from hospital to home, performed by nurses, include medication reconciliation, instructions to patients and/or caregivers, follow-up care after discharge, effective communication between the hospital and other health services, and community support. However, nurses should be well-trained and stimulated to perform these activities to be more able to promote more effective transitions.

CONCLUSION

The findings of this study allowed identifying the main care transition activities performed by nurses. Over the last five years, there was an increase in the number of articles on this subject, indicating the growing importance of the issue. Most studies included in this review were experimental and quasi-experimental, suggesting interest in the improvement of effectiveness and quality of care transitions, especially in more severe chronic diseases.

Several studies identified in the review used multiple interventions to analyze the effects of nurse - led initiatives, but the results do not elucidate which aspects of the intervention were responsible for the favorable effect.

Aspects related to the preparation of discharge care, health education of patients and families, support to continuity of care in the home environment and follow-up care after discharge are indicators to assess the quality of care provided in health services. Therefore, the present study provides useful information for the improvement of care practices and the organization of the activities of nurses, in order to promote the coordination of care in hospital discharges, with focus on care transition.

According to the results obtained, there are few studies on routine activities of nurses in care transition. Further studies on the referred subject in Brazil are needed, as care transition is a strategy that can contribute to the implementation of integrated health systems.

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