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FROM THE HOSPITAL TO THE COMMUNITY: THE (UN)SAFE TRANSITION

DO HOSPITAL PARA A COMUNIDADE: A TRANSIÇÃO (IN)SEGURA

DEL HOSPITAL A LA COMUNIDAD: LA TRANSICIÓN (IN)SEGURA

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Health care clients, especially the most dependent, are vulnerable to experiences of loss of continuity when there are changes in the health status or when moving between healthcare organizations. This, however, affects the evolution of functionality and quality of life[1]. Nevertheless, the guidelines for the clinical discharge are often scarce, performed on a routine basis and hasty, not individualized, without considering specific conditions and needs. In addition, they are often provided only when the patient leaves the hospital[1-2], not constituting an activity systematically integrated in the individualized care plan to the person and his/her family.

The fragmentation of care between the hospital and the community may result in confusing treatment guidelines for the patient, with a strong likelihood of errors and duplications, and an inadequate follow-up[3-4]. The causes of those difficulties reside in issues of difficult response and resolution, such as the time necessary for the proper planning of the return to home, the difficulties of communication between health professionals, unevaluated effectiveness of the intervention[1,4], lack of registration and non-systematization of protocols used[1]. Therefore, the nurse's action in the anticipation of the return to home should be a central concern in the care planning during the hospitalization period, to ensure safety, avoid breaks in care continuity and an effective measure to prevent readmissions in the immediate post-discharge period.

A research shows that the preparation of the return to home, as well as the education of the family caregiver[1,4] can contribute to the timely planning of the discharge, enabling the development of adaptive strategies of the patient and the family.

An integrative review carried out in 2017 shows five thematic categories that comprise nurses' main activities in the transition from hospital care to the community: care planning for the discharge, aid in social rehabilitation, health education, articulation with the different services and post-discharge

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follow-up[2]. Despite those guidelines of researchers, the planning of hospital discharge and the transition to the community continues to be a marshy area in health care, in which the system and the professionals have difficulties to ensure the effectiveness of care continuity[1], making it unsafe.

Undoubtedly, the complexity of the current health problems, coupled with the decreased average length of hospitalization and the economic retrenchment, requires a multidisciplinary and interinstitutional approach. Thus, the articulation between care levels requires a multi and interdisciplinary team intervention[3], to ensure the quality and safety, preventing the decline of functionality in the post-discharge and unnecessary readmissions by the appearance of risks and predictable complications. The dependent elderly person and his/her caregivers need to integrate the guidelines and develop specific skills to maintain the care started in the hospital. To achieve this, they must be empowered, allowing the acquisition and development of skills and resources for the self-care, in order to adapt and/or overcome the health problem and reacquire, whenever possible, the personal autonomy, with a view to resolving the problems identified and consequent satisfaction of affected needs. Nonetheless, this process can be disturbed by the difficulty to understand or accomplish the specific guidelines that result from this health-disease transition[4].

On the other hand, ensuring a safe transition from hospital to the community is an appropriate strategy for a policy to be followed by different health services[3], by the potential in the promotion of autonomy and independence for the self-care and prevention of readmissions and complications, making the health care provision more favorable from the cost-effectiveness point of view.

In this process, researchers stress that the obstacles that contribute to an unsafe transition between those care levels are also difficulties that contribute to the invisibility of the exercise of the profession[3]. These conditions provide the existence of gaps in the planning of the return to home and subsequent poor and uninformed transition between the different care contexts. The most informed clients are also those who have greater power, capacity for participation[1], adherence to the therapeutic regimen and claim.

In addition to this challenge, the criteria to assess the requirements of care continuity should provide a set of indicators associated with different transitions that the person, in the inpatient context, experiences; and that the informal caregivers, as a central element of the health team, along with the sick family member, should be the target of intervention of the health team in order to provide care continuity. In this sense, he/she needs appreciation, support and multiprofessional training, so that the transition from the hospital to the community occurs safely. The transition care begins at admission, follows during the discharge and remains in the return to home[5].

The nurse must only act together with the family member as a professional facilitator of the promotion of awareness and acceptance of his/her paper; diagnose needs; outline strategies that will enable the satisfaction of the needs of the family caregiver in the context of promotion of self-care of the sick person or in convalescence, in the monitoring and development of the commitment that involves the role of the family caregiver and support his/her needs[1].

This may be a priority area for the clinic and research in health care in favor of developing a transition from hospital to the community increasingly safe, satisfactory for all actors involved and, therefore, with quality.

Collaborations:

1 – conception, design, analysis and interpretation of data: Cristina Lavareda Baixinho and Óscar Ferreira;

2 – writing of the article and relevant critical review of the intellectual content: Cristina Lavareda Baixinho and Óscar Ferreira;

3 – final approval of the version to be published: Cristina Lavareda Baixinho and Óscar Ferreira.

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