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NURSE'S ACTIVITIES IN CARE TRANSITION: REALITIES AND CHALLENGES

ATIVIDADES DO ENFERMEIRO NA TRANSIÇÃO DO CUIDADO: REALIDADES E DESAFIOS

LAS ACTIVIDADES DEL ENFERMERO EN LA TRANSICIÓN DEL CUIDADO: REALIDADES Y DESAFIOS

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ABSTRACT

Objective: to analyze the activities performed by nurses in the transition of patient care with hospital discharge. ***Method:*** quantitative, cross-sectional and descriptive study, with 72 nurses from hospitalization units, selected from the snowball technique. Data collection occurred through an online structured questionnaire, using the tool of Google DocsOffline platform. The data were analyzed using descriptive statistics. ***Results:*** most activities regarded clarification of doubts during discharge guidance and guidelines on continuity of care with the healthcare team. Activities least performed were patient follow-up after discharge and communication with staff from the health unit of reference. The greatest difficulties related to the completion of referrals from hospital to Primary Health Care, communication between health professionals and little in-service training for qualification of professionals. ***Conclusion:*** the nurse plays a fundamental role in the care transition, with health education actions held with greater frequency. Efforts should be made to improve integration and articulation between professionals and hospital services and primary care. ***Descriptors*:** Patient Discharge; Continuity of Patient Care; Nursing Care, Health Education; Health Integrality; Nurse's Role.

RESUMO

***Objetivo*:** analisar as atividades realizadas pelo enfermeiro na transição do cuidado ao paciente com alta hospitalar. ***Método*:** trata-se de estudo quantitativo, transversal e descritivo com 72 enfermeiros de unidades de internação selecionados a partir da técnica de bola de neve. Realizou-se a coleta de dados por meio de questionário estruturado online, utilizando-se a ferramenta da plataforma Google DocsOffline. Analisaram-se os dados com estatística descritiva. ***Resultados*:** observou-se que a maioria das atividades foi quanto a esclarecimento de dúvidas durante as orientações de alta e orientações sobre continuidade dos cuidados com a equipe de saúde de referência. Viu-se que atividades menos realizadas foram: o acompanhamento do paciente após alta e a comunicação com equipe da unidade de saúde de referência. Viu-se que maiores dificuldades foram referentes: à realização de encaminhamentos ao hospital para a Atenção Primária à Saúde, comunicação entre os profissionais de saúde e pouca formação em serviço para qualificação dos profissionais. ***Conclusão*:** considera-se que o enfermeiro desempenha um papel fundamental na transição do cuidado, sendo as ações de educação em saúde realizadas com maior frequência. Devem-se ser feitos esforços para melhorar integração e articulação entre profissionais e serviços hospitalares e da Atenção Primária. ***Descritores*:** Alta do Paciente; Continuidade da Assistência ao Paciente; Cuidados de Enfermagem; Educação em Saúde; Integralidade em Saúde; Papel do Profissional de Enfermagem.

RESUMEN

Objetivo: analizar las actividades realizadas por los enfermeros en la transición del cuidado al paciente con el alta hospitalaria. ***Método:*** estudio cuantitativo, descriptivo y transversal, con 72 enfermeros de unidades de hospitalización, seleccionados a partir de la técnica de bola de nieve. La recolección de datos se realizó por medio de un cuestionario estructurado en línea, utilizando la herramienta de la plataforma Google DocsOffline. Los datos fueron analizados mediante estadística descriptiva. ***Resultados:*** la mayoría de las actividades era una aclaración de dudas durante las orientaciones de descarga y directrices sobre la continuidad de los cuidados con el equipo de salud. Actividades menos realizadas fueron el seguimiento de los pacientes tras el alta y la comunicación con el personal de la unidad de salud de referencia. Las mayores dificultades estaban relacionadas con la terminación de las remisiones del hospital a la atención primaria de la Salud, la comunicación entre los profesionales de la salud y la poca capacitación en servicio para la cualificación de los profesionales. ***Conclusión:*** el enfermero tiene un papel fundamental en la transición del cuidado, con acciones de educación para la salud con mayor frecuencia. Deben hacerse esfuerzos para mejorar la integración y articulación entre los profesionales y los servicios hospitalarios y de atención primaria. ***Descriptores*:** Alta del Paciente; Continuidad de la Atención al Paciente; Atención de Enfermería; Educación en Salud; Integralidad en Salud; Rol de la Enfermera.

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INTRODUCTION

During hospital discharge, the passage of patient care from the hospital to other health contexts occurs, which can be a fragile moment for the patient safety.[1] Studies have shown that there are often adverse events after discharge, as medication errors, use of emergency services and hospital readmissions.[2-3] Thus, efforts are necessary to ensure care continuity at home.

Care transition is defined as a set of actions aimed to ensure the coordination and continuity of care in the patient transfer between different sectors or health services.[4] This is an important strategy to ensure the integral care during hospitalization and after hospital discharge, increasing the use of primary care services and reducing hospital readmissions.[3-6]

The literature shows that the nurse has been one of the professionals most involved in care transition from the hospital to the domicile, developing activities in the care planning for discharge, aid for social rehabilitation, health education, articulation with other health services and post-discharge follow-up.[7-9] The nurse allows hospitalization to become a moment of learning, with an exchange of knowledge among patient, family and healthcare professional. Thus, in preparation for the discharge, actions focused on beyond the more acute health problems can be developed, providing meaningful and accurate information for the health self-care and self-management, favoring the return to the domicile and to family and social life.[10]

However, there are many differences between what the literature says that should be done and what is the daily clinical practice of nurses in the transition of patient care with hospital discharge to the home. In practice, the process played by nurses regarding discharge is disorganized, and the performance of the team is often restricted to withdrawal of invasive devices and rapid provision of simple and general guidelines, without considering each patient's needs, with little information and follow-up after hospital discharge.[11] A study carried out in São Paulo identified that the nurse performs technical and routine guidance to the patient and family, and, sometimes, he/she cannot provide guidance.[12] The lack of guidance by professionals results in frustrated patients, insecure to continue their treatment at home.[11]

Several factors hinder nurses' involvement in care transition, including the dedication to administrative activities, work overload and lack of time, ineffective communication between the nurse and the doctor and lack of support and structure in the health care system.[10-11] There was also little knowledge about the theme and lack of recognition that nurses are responsible for care transition.[12]

This theme is quite studied internationally. Studies have focused on interventions to ensure safe transitions from hospital to home and reduce adverse events after discharge. In Brazil, however, little progress has been made in relation to investigations on the topic.[7,13] There is a lack of studies that identify the activities performed by nurses at discharge from the hospital to the domicile in the country,[7,11] which justifies the realization of this research.

Therefore, this study aims to analyze the activities performed by nurses in transition of patient care with hospital discharge and identify the challenges to carry out these activities.

OBJECTIVE

- To analyze the activities performed by nurses in the transition of patient care with hospital discharge.

METHOD

This is a quantitative, cross-sectional and descriptive study. The population consisted of nurses in clinical hospitalization units of public, private or philanthropic hospital institutions of Rio Grande do Sul. The inclusion criteria were: being a nurse and performing assistance activity in clinical hospitalization unit of a hospital in the state of Rio Grande do Sul for at least six months. No exclusion criteria were established.

For selecting the subjects, the snowball technique was chose.[14] Initially, key informants identified by means of search of resumes in the Lattes Platform were selected. An e-mail was sent to invite the selected nurses. Seventy-five invitations were sent, but only 19 responded to the request to participate in the study. Of these, few indicated another nurse to participate in the study. Thus, the Facebook social network was used to disseminate the research and recruit participants. This tool was crucial, because it enabled respondents share and mark nurses. The final sample consisted of 72 nurses. The study did not consider essential to represent all regions of the State.

Data collection occurred in the months September and October 2017. A structured, self-applicable questionnaire was used, prepared by researchers from literature review about the nurse's role in care transition in patients' diacharge from the hospital to the home. The instrument was divided into three sections; the first one contained questions regarding characterization; the second one, nurse's activities in care transition and the third one, difficulties carrying out care transition. The second section presented the answers organized in frequency range, with alternatives ranging from never, rarely, sometimes, often and always. The responses of the third section were arranged in Likert scale with alternatives that ranged from "strongly disagree", "disagree", "don't disagree neither agree", "agree" and "totally agree". To enable the collection of research information, the questionnaire was available online, through Google Docs Offline® platform, which has been used as a tool for data collection in health research.[15] Before applying the instrument with the sample professionals, there was a pre-test with seven

nurses who made suggestions and evaluated the operation of the instrument over the web, being excluded from the study sample.

The information collected was transposed to a database in Microsoft Excel and analyzed by means of the software Statistical Package for Social Sciences (SPSS), version 21.08. Data analysis based on descriptive statistics, adopting frequency distribution. Quantitative variables were described by median and interquartile range, and the categorical variables, as absolute and relative frequencies. To evaluate the association between categorical variables, the Pearson's chi-square or Fisher's exact test were used. The level of significance was 5% ($p \leq 0,05$) and the analyses were performed in the program SPSS version 21.0.8.

The study is in accordance with the guidelines and regulatory standards for researches with human beings. The participants stated their acceptance to participate in the study in the Informed Consent Form. The project was evaluated and approved by the Research Ethics Committee of the University Center Ritter dos Reis (UniRitter), located in the municipality of Porto Alegre (CAAE n. 69014217.0.0000.5309).

RESULTS

The study sample consisted of 72 nurses who worked in units of hospital clinic. Table 1 shows the characterization of the profile of the study participants. The data demonstrate that 84.7% (n=61) are female, 50% (n=36) have a specialization course, 48.6% (n=35) are linked to public health institutions, 34.7% (n=25) have worked in the institution for more than ten years and 36.1% (n=26) work at the night shift. The median of patients that nurses assume in their work shift is 25 (20 - 35). In relation to the time of completion of the Nursing Graduate Course, the median is 8 years (3 - 13).

Table 1. Sample characterization. Porto Alegre (RS), Brazil, 2017.

Variables	n=72
Female – n(%)	61 (84.7)
Higher degree – n(%)	
Graduation	23 (31.9)
Specialization	36 (50.0)
Masters	12 (16.7)
Doctorate	1 (1.4)
Working area – n(%)	
Private hospital	18 (25.0)
Philantropic hospital	19 (26.4)
Public hospital	35 (48.6)
Work shift – n(%)	
Morning	14 (19.4)
Afternoon	18 (25.0)
Night	26 (36.1)
Weekend	3 (4.2)
Alternate	11 (15.3)
NUmber of patients assumed – median (P25 – P75)	25 (20 – 35)
Time of experience in current work – n(%)	
1 year	14 (19.4)
1-4 years	13 (18.1)
5-10 years	20 (27.8)
Over 10 years	25 (34.7)
Time after Nursing graduation (years) – median (P25 – P75)	8 (3 – 13)

Table 2 shows the activities developed by the nurse in care transition during patients' discharge.

Table 2. Data on nurses' activities in care transition. Porto Alegre (RS), Brazil, 2017.

Activities	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)	Missing n (%)
Talks with patient and family to identify needs and discuss post-discharge care plan	1(1.4)	4(5.6)	17(23.6)	25(34.7)	25(34.7)	0(0.0)
Elaborates a written, individualized discharge plan, describing the main necessary care to be performed at home	17(23.6)	26(36.1)	15(20.8)	8(11.1)	6(8.3)	0(0.0)
Carries out discharge planning together with the health team	10(13.9)	25(34.7)	19(26.4)	8(11.1)	10(13.9)	0(0.0)
Develops health education activities with patients and/or caregivers	3(4.2)	7(9.7)	13(18.1)	25(34.7)	24(33.3)	0(0.0)
Provides guidance on home medication use when the patient is preparing for discharge	1(1.4)	10(13.9)	17(23.6)	22(30.6)	20(27.8)	2(2.8)
Provides guidance on self-care of health problems at home	3(4.2)	7(9.7)	16(22.2)	29(40.3)	17(23.6)	0(0.0)
Clarifies patient and family doubts while providing discharge guidelines	0(0.0)	1(1.4)	7(9.7)	25(34.7)	38(52.8)	1(1.4)
Creates opportunities for patients to demonstrate what they have learned	3(4.2)	7(9.7)	12(16.7)	28(38.9)	21(29.2)	1(1.4)
Guides to continue the care with the health team that has reference	1(1.4)	7(9.7)	7(9.7)	19(26.4)	38(52.8)	0(0.0)
Communicates the patient's reference health team about admission and patient stay in the hospital and care continuity	29(40.3)	20(27.8)	12(16.7)	6(8.3)	3(4.2)	2(2.8)
Carries out patient follow-up after discharge	46(63.9)	15(20.8)	5(6.9)	1(1.4)	3(4.2)	2(2.8)

Table 2 shows that the items most performed by nurses, from the sum of responses "always" and "often", were: clarifying patients' and families' doubts while providing discharge guidelines (87.5%); guiding to continue the care with the health team that has reference (79.2%), talking with the patient and family to identify needs and discuss the post-discharge care plan (69.4%). The items regarding clarifying questions while providing discharge guidelines and guiding to continue the care with the team of the health unit of reference had the greates number of nurses' reporting always performing (52.8%).

The less performed items, as the sum of the responses "never" and "rarely", were: performing patient follow-up after discharge (84.7%); communicating the team of health care unit of reference on the patient's discharge (68.1%), and developing a discharge plan describing the main necessary care to be performed at home (59.7%). Follow-up after hospital discharge is never performed by 63.9% of nurses.

Regarding care guidelines provided during hospitalization (Table 3), there was a greater predominance of the guidelines with medical devices (81.9%), care in the administration of medications (78.9%) and care with food (70.8%).

Table 3. Data on care guidelines provided by nurses during hospitalization. Porto Alegre (RS), Brazil, 2017.

Provided guindelines	Yes n (%)	No n (%)
Care with hygiene and comfort	48(66.7)	24(33.3)
Care while administering medications	56(78.9)	15(21.1)
Crae with food	51(70.8)	21(29.2)
Care with medical devices	59(81.9)	13(18.1)
Care while performing Activities of Daily Life	43(59.7)	29(40.3)
Others	7(9.7)	65(90.3)

As shown in Table 4, the items with the highest agreement of professionals about the difficulties accomplishing care transition, as the sum of answers "I totally agree" and "I agree", related to weaknesses in the agreement between health services to perform the referral of patients from the hospital to the primary health care (90.3%), the difficulties of communication between health professionals to develop the transition of the care of patients with hospital discharge (88.8%) and low in-service training to qualify professionals to carry out care transition activities of patients with hospital discharge to the home (86.1%).The items with greater disagreement, from the sum of responses "I totally disagree" and "I disagree", were: inadequate nunrsing training to ensure that nurses are autonomous and have skills and knowledge to perform activities of care transition of patients with hospital discharge to the home (27.7%); physician or team carries out diascharge guidelines with little participation of nurses (26.4%), and difficulty guiding patients due to high turnover and hurry to release beds (20.9%).

Table 4. Data on nurses' difficulties to carry out care transition. Porto Alegre (RS), Brazil, 2017.

Difficulties	I don't agree neither disagree n (%)	I totally disagree n (%)	I disagree n (%)	I agree n (%)	I totally agree n (%)
Difficulties in communication between health professionals	'	0(0.0)	4(5.6)	32(44.4)	32(44.4)
There is no communicaiton in advance of patient discharge	5(6.9)	3(4.2)	12(16.7)	32(44.4)	20(27.8)
Discharge guidelines made by the staff with little participation of the nurse	8(11.1)	4 (5.6)	15(20.8)	33(45.8)	12(16.7)
HUrry when guiding patients due to high turnover and hurry to release beds	10(13.9)	3(4.2)	12(16.7)	25(34.7)	22(30.6)
Little time availability for care transition actions	7(9.7)	4(5.6)	12(16.7)	29(40.3)	20(27.8)
Insufficient time and professionals for care transition activities	9(12.5)	1 (1.4)	14(19.4)	21(29.2)	27(37.5)
Lack of protocols that help performing care transition	2(2.8)	2(2.8)	12(16.7)	32(44.4)	24(33.3)
Fragilities in the agreements between health services for referral of discharged patients for primary health care	5(6.9)	0(0.0)	2(2.8)	35(48.6)	30(41.7)
Little in-service training to qualify professionals to perform care transition	6(8.3)	0(0.0)	4(5.6)	30(41.7)	32(44.4)
Insufficient nursing training to carry out care transition activities	16(22.2)	5(6.9)	15(20.8)	25(34.7)	11(15.3)

When associating the sample characteristics with nurses' difficulties and activities, there was a significant association only between gender and the option of care with medical devices such as drains, food and vesical probes, catheters, etc. Women claim to do more this orientation than men (86,9% vs 54,5%; p=0,022).

DISCUSSION

This study allowed understanding nurses' role in clinical hospitalization units in care transition. The activities carried out by the respondents involve health education of patients and their families, from the guidance provided about the post-discharge care. Among the most frequente guidelines provided during hospitalization, care with medical devices, administration of medicines and food stand out.

These data are similar to other studies, which showed that nurses carry out health education of patients about various aspects at hospital discharge, including food, signs and symptoms of alert, who to look for in case of emergency, use of medication, exams and physical activity.[7,16] Health professionals, especially nurses, need to identify patients' needs at home and establish strategies to facilitate the recovery.[7] In preparation, discharge guidelines should be provided for both the patient as the caregiver, usually family, stimulating the potentialities of self-care at home. Such activities in preparation for discharge can increase patients' capacity of self-care at their homes and strengthen adherence to the proposed treatment, being important to prevent illness, hospitalizations and decrease the family stress.[10]

Nevertheless, guidelines should preferably be provided before hospital discharge, to avoid the accumulation of information, increasing the understanding regarding the information provided and the clarification of doubts. Techinical and routine guidelines shoudl also be avoided.[10] For this reason, nurses need to decide together with the multiprofessional team the most suitable time for patient discharge, or need to be communicated in advance. However, the findings of this study indicate that most respondents are not communicated in advance on patient discharge, which may hinder implementing care transition actions.

Despite this, most respondents clarify doubts while guiding the patient and his/her family during discharge and create opportunities for them to demonstrate what they have learned. These actions are important for health education, which is peculiar to the act of caring in nursing, being the nurse instrumentalised to carry out educational and health.[10] It is a necessary activity of nurses and fundamental to accomplish a safe

transition, contributing to transparency and enhancement of nursing care.

This research found that some activities are little performed in care transition, such as the discharge planning with the team and preparation of an individualized discharge plan describing the main necessary care at home, as well as the communication with the health team of reference of the patient and the follow-up after discharge. These results differ from the integrative review of literature that identified that these activities are often developed by nurses in the international context as a way of ensuring an adequate care transition.[7]

Surveys show that discharge planning is an important action to ensure a safe ans eficiente transition from hospital to home. The ideal is to start immediately after the patient's admission, identifying the individual's real and potential needs.[5,7] This is a complex action of assistance and should be part of the nursing process.[17] During the discharge planning, it is possible to assess patient's understanding about their health condition and medications used before, during and after hospitalization. Other activities of the nurse may be the establishment of goals from individual's preferences, evaluation of the psychosocial conditions and schedule the time of hospital stay.[7] Nevertheless, this study showed that only 13.9% of the respondents always perform this activity and 11.1% often perform it. Preparing a written adn individualized discharge plan is Always or often performed by only 19,4% of the nurses.

A finding that deserves to be highlighted is that most participants guide patients to continue the care with the healthcare team of reference after discharge, but few professionals communicate the health team of reference on admission, hospital stay and continuity of care in primary care. Furthermore, nurses' main difficulties to perform care transition are the weaknesses in the agréments between health services to perform the referral of patients from hospital to primary health care.

The articulation of network healthcare services is of utmost importance to ensure the follow-up after discharge and continuity of care. Once the primary care is considered a coordinator of care in the health system, the conter-reference for the individual's reference is essential to ensure na adequate care transition at hospital discharge. However, several studies indicate that the integration and articulation between services is still a great challenge of the healthcare network.[18-20] The formal counter-reference system is little frequent,[19-20] and the patient, many times, is responsible for transmitting the information of his/her admission to the primary care unit professional.[19]

Although the literature describes that, after hospital discharge, the professional also has the task of monitoring the patient for visits and phone calls,[7,17] these were not observed in this study. This differs from other international investigations showing that professionals who perform care transition interventions typically include the follow-up after discharge among their activities,[5-6] since it is important to strengthen the discharge guidelines and clarify any doubts that might arise at home. [7,17] Nonetheless, the organization of the Brazilian health system differs from other countries, because the post-discharge follow-up is expected to be done by the primary care team of reference. Thus, the importance of strengthening the formal flows and agréments in the articulation between hospital services and primary care stands out.

Other challenges shown by nurses in performing care transition in this study were the difficulties of communication between health professionals, little in-service training and lack of protocols that help professionals to carry out care transition activities. Ineffective communication between team members, especially doctor and nurse, was also shown as one of the biggest problems in the discharge planning in a study conducted in the state of São Paulo.[12]

The existence of protocols, guides or systematic instruments based on evidence can assist in the care standardization for the patient's hospital discharge for the domicile, equipping professionals to perform a precise and safe care transition for patients and their families. In this sense, systematized protocols or instruments ensure quality of life and excellence in the service, which corroborates that patients are able to adhere to the treatment proposed with more safety and quality at home.[10-11] However, few institutions have such strategies.

Moreover, nurses' tasks in care transition can be strengthened through education institutions, starting and stimulating during graduation the implementation of actions in the patient's discharge. In addition, continuing education at hospital institutions can help professionals to perform the systemized care with quality and safety.[11-12]

One of the factors described in the literature that hinder care transition is the dedication of nurses for administrative activities.[10] Nevertheless, this fact was of little relevance in this work, since only 22.3% of the participants believe that this is one of the difficulties for planning hospital discharge.

Despite the problems and challenges aforementioned, the nurse plays a fundamental role in achieving care transition, acting in the identification of the patient's needs, exercising health education and coordinating the process, being the professional who can ensure a better continuation and quality of the care provided.[7]

It is important to register some limitations inherent in the method of this study. The first refers to the difficulty following the chain of reference by means of indications of the participants, not reaching the initial expected result. Thus, an alternative was used in order to obtain greater adherence by nurses, being the use of social networks essential for achieving a greater number of participants for this research. Furthermore, the terminology of care transition is

little known in Brazil, which may have affected, initially, the interest of the participants in responding the data collection instrument. In addition, the discussion of the results was limited to comparisons with international studies or addressing aspects related to hospital discharge and not to care transition specifically, due to the scarcity of studies in the country on the topic.

CONCLUSION

The construction of this research allowed knowing the profile of assistance nurses working in inpatient units, as well as evaluating the frequency of the completion of the main activities assigned to this professional in care transition. Results and discussion of the data presented allowed a critical analysis when showing that the nurse plays a fundamental role in care transition and that the actions in health education are often performed. In general, the provision of discharge guidelines were the activities most performed by nurses.

However, some activities could be more developed, such as discharge planning in conjunction with the multiprofessional team, preparation of a written and individualized discharge plan, describing the main necessary care to be performed at home, as well as greater coordination between services and couter-reference of the patient in the country's health system. Most nurses do not perform patient follow-up after discharge.

The study revealed that the main challenges, in nurses' perception, in carrying out care transition include weaknesses in the agreements between health services to refer patients for primary healthcare, difficulties in communication between health professionals, little in-service training and lack of protocols that help professionals. Therefore, strategies need to be created to overcome such challenges, such as strengthening the care network and the integration of health services, from better organization of formal flows and instruments of communication between hospital services and primary care. The development of institutional protocols based on evidence can be an important strategy for improving the quality of care transition.

There should be future researches focused on the development of new models of hospital discharge planning feasible for the Brazilian reality, as well as a support in the health system suitable for patients and families after discharge, aiming at the quality of life and care continuity.

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