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Nurses' perception about the transition of care at hospital discharge

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Abstract

There is a clear gap in the transition between Hospital Care (HC) and Primary Health Care (PHC). The effectiveness of the Care Transition (TC) depends on an excellent communication ability between professionals and services, with hospital discharge being a critical moment. The objective of this study was to investigate the perceptions of HC and PHC nurses on aspects of hospital discharge. This is a cross-sectional and quantitative study carried out with data from nurses working in HC and PHC in the state of Santa Catarina. Data was collected between December 2020 and January 2021, using an electronic form. Descriptive and inferential analysis were performed. Pearson's chi-square test was used for comparison between groups. There are some overlapping positions in the perceptions of HC and PHC nurses on the subject, considering that patient follow-up after hospital discharge is important (54; 91.5%), they understand that there is little and weak communication between health services (52; 88%). Also, verbal guidelines are given to patients and family members at discharge (32; 54.2%), little information is understood by patients (47; 79.7%) and the discharge plan is not individualized (30; 50.8%), in most cases. Communication is a major weakness in hospital discharge, which is expressed in this study, by the nurses' perception of poor communication between HC and PHC, by the fragility of the discharge plan and verbally given guidelines. Improving the care transition process, especially hospital discharge, allows for more integrated, safe and patient-centered healthcare. Investment in strategies that improve this process is essential for the quality of care.

Keywords: Care Transition. Primary Health Care. Hospital Care. Health Communication. Nursing.

INTRODUCTION

Actions that guarantee the coordination and continuity of care for people who move between different health services or different units in the same location encompass the Care Transition (TC)[1]. This can be incorporated as one of the strategies to overcome the fragmentation of care and ensure continuity of care. This process includes, in the context of care, patients, family members, health professional caregivers, at different points of care. However, it is necessary to consider its complexity as it involves high levels of organization, articulation of services, in addition to the number of professionals with different backgrounds, experiences and skills[2,3].

The CT model includes nine components: screening, team, maintenance of the relationship, engagement of patients and caregivers, assessment and management of risks and symptoms, education and promotion of self-management, collaboration, promotion of continuity, promotion of coordination[4].

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The effectiveness of CT is based on an excellent ability to communicate between professionals and services[5]. Instruments that facilitate communication between teams may be able to facilitate continuity of care, thus reducing gaps in continuity of care and contributing to comprehensive care[6]. However, to be an effective device, it must be performed by professionals, in a way that goes beyond the simple act of forwarding, that is, advanced skills are needed for effective collaboration between professionals, family and other services, to coordinate complex treatments, promote education in health and ensure that the needs of the health service user are met[5,7].

There is an evident gap in the transition between Hospital Care (HC) and Primary Health Care (PHC)[8]. Underlying causes of hospital discharge problems are complex and require strategies to improve CT[9]. A study that combined different CT strategies demonstrated a reduction in hospital readmissions in 30 days, a reduction in the search for an emergency unit in seven days, better physical and mental health, greater participation in activities of daily living and reduction in pain[10].

Some strategies used for care transition in the United States include timely follow-up, urgent care plan, multidisciplinary follow-up, transition team, shared decision, referral to services, identification of high-risk patients and intervention, medication reconciliation, teach back , coordination of care and exchange of information about critically ill patients among caregivers[6]. Meanwhile, in Latin American countries, transitional care strategies focus on discharge planning, advance care planning, patient education and promotion of self-management, medication safety, and outpatient follow-up[12]. Nurses play a central role in the successful transition of patients, as they have competencies to promote health education and clinical skills to manage these patients[5].

In Brazil, an instrument that evaluates CT from the perspective of patients was validated[12], and it can point to ways for the improvement process of CT. However, it is known that the different perspectives in which professionals and patients operate are diverse. Given this context, in which nurses play a central role in CT and hospital discharge is an important step in this process, the objective of the present study was to investigate these professionals' perception of communication, guidance to patients and/or family members, satisfaction of professionals and organization of teams in relation to hospital discharge, both in hospital care and in primary health care.

METHODOLOGY

This is a cross-sectional study, which included two groups of nurses: the first composed of professionals working in HC and the second composed of professionals working in PHC, both in the state of Santa Catarina. Participants were invited to participate in the survey through a link available on the website and official social networks of the Regional Nursing Council of Santa Catarina (Coren-SC), between December 2020 and January 2021. To participate in the survey, the professional who accessed the Coren-SC website or social networks could click on the link with the invitation to the survey and was directed to a Google® form, first presenting the Term of Free and Informed Consent, in case of acceptance to participate in the research, the participant was directed to the questionnaire, first identifying their area of expertise (HC or PHC).

The present study had as a dependent variable the environment in which nurses work,

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which is classified into two categories: HC and PHC. For data collection, two instruments were used with equivalence of questions for the two work environments of the nurses, so that the same aspects could be observed from different perspectives. After identifying the area of expertise, the participant was directed to the equivalent questionnaire, which was composed of a block of questions for the characterization of professionals (gender, age, time of training and time of work) and another block of questions that addressed nurses' perception of communication, guidance and satisfaction, using a Likert scale for responses.

Before the research was released, a pre-test was carried out with three nurses, by sending the instrument by email, in order to improve the questionnaire and receive suggestions for adaptation. It is worth mentioning that the pre-test responses were not included in the study, and these professionals did not participate in the step with results presented here. Finally, the professionals were not contacted directly and individually, which may explain the low response rate. The answers automatically formed a database, from which the statistical analysis was carried out, using the SPSS 20.0 software. Age is presented as median and interquartile range, the difference between groups was analyzed using the Mann-Whitney U test, preceded by the Kolmogorov-Smirnov test. Sociodemographic and care transition data are presented with relative and absolute frequency. Comparison between groups was performed using Pearson's chi-square test. A statistically significant difference is considered when p value <0.05.

The study complies with CNS/MS resolution nº 466, of December 12, 2012, and was approved by the Human Research Ethics Committee of the University of the Extreme South of Santa Catarina (UNESC), under opinion nº 4.410.063/2020.

RESULTS

Coren-SC was implemented in 1975 and until December 2022 it reports 18,790 records of nurses and 48,584 nursing technicians in Santa Catarina. In 2016, the Outstanding Nursing Professional Award was created, in celebration of the 40th anniversary of Coren-SC, which takes place annually, with the aim of valuing nursing in its areas of activity[13].

The present study included 59 nurses, of whom 25 (42.4%) work in HC and 34 (57.6%) in PHC in the state of Santa Catarina, most of whom are female (n= 50, 84.7%), with a median age of 33 years. Most of the nurses participating in the research have specialization (n= 30, 50.8%), have at least five years of training (n= 33, 55.9%) and between one and four years of experience (n= 23, 39.0%) (Table 1).

Most nurses (n= 54, 91.5%) understand how important it is to monitor the patient after hospital discharge and that there are weaknesses in agreements between health services (n= 56. 94,9%). Communication between services about hospital discharge never or rarely (n= 52, 88.1%) happens, however, when it happens it is via telephone (n= 32, 54.2%), and 30 (50.8%) nurses consider the quality of communication between HC and PHC weak (Tabela 2). It is noted that in none of the aspects related to communication there is a statistically significant difference between the responses of HC and PHC professionals.

HC professionals advise on the continuity of care in PHC and PHC professionals confirm that there is demand for the PHC service by patients and/or their families (n=19, 76%; n=32, 94.1%, respectively; p =0.045). Even though guidance is provided regarding

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the use of medications at home at hospital discharge (n=23, 92%), PHC nurses state that patients have doubts about the prescribed medications (n= 34, 100%). At the time of hospital discharge, guidelines are given verbally to patients and/or family members (n=43, 72.9%). Although HC professionals clarify doubts at the time of hospital discharge (n=23, 92%), in PHC, professionals perceive doubts from patients and their families regarding the continuity of care (n=34, 100%). Regarding the information understood by the patient and/or family members at the time of hospital discharge, the perceptions of HC and PHC professionals showed differences: while most PHC professionals (n= 32, 94.2%) consider that little information is understood, only 15 (60.0%; p=0.001) HC professionals have this perception (Table 3).

Both nurses working in AH and those working in PHC consider themselves satisfied with the care and guidance given in the hospital discharge process (n=13, 52%) and the care offered by PHC after hospital discharge (n=21, 61.8%), respectively (Table 4).

As for the organization of health teams for hospital discharge, in table 5 we find that most nurses, both HC and PHC, state that a written discharge plan is available (n=44, 74.6%). However, it is not individualized and does not describe the main care needed for the patient's recovery (n=30, 50.8%). Just over half of the nurses understand that there is an established flow of referrals and counter-referrals between HC and PHC (n=32, 54.2%). Most PHC nurses (n=32, 94.2%; p=0.001) understand that there are few guidelines provided at hospital discharge to adequately support care after hospital discharge, while only 15 (60%) nurses from AH perceive the same way. The main information described in the discharge plan is related to the current treatment plan (n= 36, 61%), the less frequent information is related to patient follow-up (n=12, 20.3%).

Table 1 - Sociodemographic characteristics of nurses working in HC and PHC in Santa Catarina, 2021

Characteristics	HC	PHC	Total	P Value
Sex, n (%)[1]				
Female	20 (80.0)	30 (88.2)	50 (84.7)	0.385
Male	5 (20.0)	4 (11.8)	9 (15.3)	
Age, median (IQR)[2]	28 (13.5)	35 (14.8)	33 (13.0)	0.385
Training Time n(%)[1]				
<1 year	2 (8.0)	0 (0.0)	2 (3.4)	0.102
1 to 4 years	13 (52.0)	11 (32.4)	24 (40.7)	
5 to 10 years	4 (16.0)	11 (32.4)	15 (25.4)	
Over 10 years	6 (24.0)	12 (35.2)	18 (30.5)	
Activity Time n(%)[1]				
3 months to 1 year	6 (24.0)	9 (26.5)	15 (25.5)	0.805
1 to 4 years	11 (44.0)	12 (35.3)	23 (39.0)	
5 to 10 years	3 (12.0)	7 (20.6)	10 (16.9)	
Over 10 years	5 (20.0)	6 (17.6)	11 (18.6)	

*IQR: Interquartile range; HC: Hospital Care; PHC: Primary Health Care.

1 – Pearson's chi-square test

2 – Mann-Whitney U test for independent samples

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Table 2 - Communication of health teams at hospital discharge, Santa Catarina, 2021.

Perceptions about communication at hospital discharge, n (%)[1]	HC	PHC	Total	P value
It is important that the team accompanying the patient in HC communicates with PHC after their discharge				
Completely or partially disagree	2 (8.0)	2(5.9)	4 (6.8)	
Neutral	1 (4.0)	0 (0.0)	1 (1.7)	0.717
Totally or partially agree	22 (88.0)	32 (94.1)	54 (91.5)	
There are weaknesses in agreements between health services to refer discharged patients to PHC				
Completely or partially disagree	1 (4.0)	1 (2.9)	2 (3.4)	0.801
Neutral	1 (4.0)	0 (0.0)	0 (0.0)	
Totally or partially agree	23 (92.0)	33 (97.1)	56 (94.9)	
There is communication between the HC and the patient's reference health team about hospital discharge and the necessary care				
Never or rarely	18(72.0)	27 (79.4)	45(76.3)	0.375
Always or sometimes	7 (28.0)	6 (17.6)	13(22)	
After the patient's hospital discharge, the services (HC and PHC) communicate				
Never or rarely	22(88.0)	30(88.2)	52 (88.1)	0.673
Always or sometimes	2(8.0)	4 (11.8)	6 (10.2)	
How do you or a member of your team communicate with HC/PHC (yes/no)				
Verbal communication over the phone, yes	12 (48.0)	20 (58.8)	32 (54.2)	0.410
Written communication, yes	5 (20.0)	4 (11.8)	9 (15.3)	0.385
Electronic communication, yes	2 (8.0)	6 (17.6)	8 (13.6)	0.285
There is no communication, yes	6 (24.0)	12 (35.3)	18 (30.5)	0.352
Others	1 (4.0)	0 (0.0)	1 (1.7)	0.240
Evaluation of the quality of communication between hospital care and primary care during the transition of patient care				
Good	1 (4.0)	2 (5.9)	3 (5.3)	
On average	8 (32.0)	2 (5.9)	10 (16.8)	0.070
Weak	10 (40.0)	20 (58.8)	30(50.8)	
Bad	6 (24.0)	10 (29.4)	16 (27.1)	

HC: Hospital Care; PHC: Primary Health Care; [1]Pearson's chi-square test. [a] = more than one option could be chosen.

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Table 3 - Guidance for patients and/or family members at AH and APS hospital discharge, Santa Catarina, 2021.

Perceptions about the guidance provided to patients and/or family members in the transition of care, n (%)[1]	AH	APS	Total	P value
HC - Guidance is given to the patient and/or family members about the continuity of care with their reference unit.				
APS - Patients who are discharged from the hospital or their relatives seek the health unit to continue the care.				
Never or rarely	6 (24.0)	2 (5.9)	8 (13.6)	0.045*
Always or sometimes	19 (76.0)	32 (94.1)	51 (86.4)	
HC - Guidance is provided on the use of medications at home when the patient is preparing for discharge.				
PHC - Patients and/ or family members have doubts about the prescribed drugs, dosage and duration of treatment.				
Never or rarely	2 (8.0)	0 (0.0)	2 (3.4)	0.093
Always or sometimes	23 (92.0)	34 (100.0)	57 (96.6)	
HC - The guidelines given at hospital discharge are passed on verbally to the patient and/or family members.				
PHC - In the PHC, patients and/or family members report the guidelines given verbally by the HC team.				
Never or rarely	5 (20.0)	10 (29.4)	15 (25.4)	0.375
Always or sometimes	20 (80.0)	23 (67.5)	43 (72.9)	
HC - Questions of the patient and family are clarified at the time of discharge.				
APS - The patient who was discharged from the hospital and/or family members have doubts regarding the continuity of care and services that they should seek.				

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Perceptions about the guidance provided to patients and/or family members in the transition of care, n (%)[1]	AH	APS	Total	P value
Never or rarely	2 (8.0)	0 (0.0)	2 (3.4)	0.093
Always or sometimes	23 (92.0)	34 (100.0)	57 (96.6)	
HC/PHC - Understanding the information provided at discharge by the patient and/or family.				
None	0 (0.0)	1 (2.9)	1 (1.7)	0.001*
Little	15 (60.0)	32 (94.2)	47 (79.7)	
Fully or most part	10 (40.0)	1 (2.9)	11 (18.6)	

HC: Hospital Care; PHC Primary Health Care; [1]Pearson's chi-square test.
*statistically significant difference between responses of HC and PHC nurses in Pearson's chi-square test.

Table 4 - Satisfaction of professionals about the process of hospital discharge from HC and PHC, Santa Catarina, 2021.

Nurses' satisfaction with transitional care, n (%)[1]	AH	APS	Total	P value
HC - Level of satisfaction with the care and guidance given in the hospital discharge process of patients				
PHC - Level of satisfaction with the care offered by primary care in the period after hospital discharge of patients.				
Satisfied	13 (52.0)	21 (61.8)	34 (57.6)	0.748
Neutral	4 (16.0)	4 (11.8)	8 (13.6)	
Insatisfied	8 (32.0)	9 (26.5)	17 (28.8)	

HC: Hospital Care; PHC Primary Health Care; [1]Pearson's chi-square test.

Table 5 - Organization of health teams in the discharge process between HC and PHC, Santa Catarina, 2021.

Perceptions about the organization of health teams, n (%)	AH	APS	Total	P value
There is an established reference and counter-reference flow between the AH and the APS for patient follow-up				

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... continuation table 05

Perceptions about the organization of health teams, n (%)	AH	APS	Total	P value
Completely or partially disagree	7 (28,0)	17 (50,0)	24 (40,7)	
Neutral	2 (8,0)	1 (2,9)	1 (1,7)	0.147
Totally or partially agree	16 (64,0)	16 (47,1)	32 (54,2)	
The hospital discharge plan is a written, individualized discharge plan, with a description of the main care necessary for the patient's recovery.				
Never or rarely	14 (56.0)	16 (47.1)	30 (50.8)	0.397
Always or sometimes	10 (40.0)	18 (52.9)	28 (47.5)	
A written discharge plan is provided to the patient to support appropriate care				
Never or rarely	3 (12.0)	11 (32.4)	14 (23.7)	0.082
Always or sometimes	21 (84.0)	23 (67.6)	44 (74.6)	
Guidance provided at hospital discharge to support proper patient care after hospital discharge				
No information	0 (0.0)	1 (2.9)	1 (1.7)	
Little information	15 (60.0)	32 (94.2)	47 (79.7)	0.001*
All or most information	10 (40.0)	1 (2.9)	11 (18.6)	
HC - Information that the nurse or other staff member provides in the discharge plan				
PHC - Information described in the discharge plan (yes/no)				
Summary of events that occurred, yes	12 (48.0)	19 (55.9)	31 (52.5)	0.549
Summary of current medical conditions, yes	13 (52.0)	13 (38.2)	26 (44.1)	0.293
Current treatment plan, yes	15 (60.0)	21 (61.8)	36 (61.0)	0.891
Follow-up information, yes	4 (16.0)	8 (23.5)	12 (20.3)	0.478

HC: Hospital Care; PHC Primary Health Care; [1]Pearson's chi-square test.
*statistically significant difference between responses of Hospital Care and PHC nurses in Pearson's chi-square test.

DISCUSSION

The perceptions of HC and PHC nurses about hospital discharge are presented in this study. It is noteworthy that, while the nurses understand the importance of accompanying the patient after hospital discharge, they recognize that there are weaknesses in the pacts between the health services. Such weaknesses are evidenced throughout the results, in which nurses point out that communication between services is weak, persistence

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of doubts regarding medications after hospital discharge, absence of an individualized discharge plan, guidelines at hospital discharge in little quantity and little understanding of this information. Paradoxically, both HC and PHC nurses feel satisfied with the transitional care they provide.

The search for comprehensive health care is not an easy task, considering the complexity of the system, which encompasses different levels of care, diversified sources of funding, professionals with different backgrounds and specialties, disparity in structure and technological resources, in addition to the users from different sociodemographic scenarios. Furthermore, the very formations of a care network, with their various intersections, must be included in this complex phenomenon, as each connection has its own characteristics[14].

Hospital discharge marks a sign of significant challenge for patients and their families. When the guidelines provided by the Hospital Care team are successful and clinical care is well performed, the probability of complications after hospital discharge decreases. This process can be facilitated by transition programs – the reality practiced in other countries – which consist of care transition programs that include follow-up consultations after hospital discharge, scheduled with the patient in primary care. This follow-up guarantees compliance with the discharge plan, health monitoring and is an opportunity to diagnose problems that may occur at an early stage, even before symptoms and clinical signs appear. There are care transition models that carry out face-to-face care from the hospital to home care, as well as models with telephone monitoring[2,5,12].

The study shows a fragile communication between AH and APS. The hospital team's communication with the patient's reference team is an activity that is rarely performed, but essential for the discharge plan[2]. For the implementation of CT strategies, both those used in the USA[6], and those used in Latin American countries[11], the ability of health professionals to communicate is essential. Still, this communication must be considered in different directions: professional-professional, professional-patient, professional-family. A meta-analysis suggested that communication interventions at hospital discharge are significantly associated with fewer hospital readmissions, greater adherence to treatment and greater patient satisfaction and, therefore, are important for facilitating the transition of care[15].

Implementing the use of electronic discharge summaries improves the quality of communication time with primary care and generates satisfaction among primary care physicians in this regard[16]. The use of tools such as teach-back and any method using mobile technology shows positive effects in reducing hospital readmissions[17]. In a study on the preferences of HC and PHC professionals on how to communicate hospital discharge, there is an overlapping preference for a shared electronic medical record, in addition to both groups reporting concerns about patient safety and continuity of care. The defense of a shared electronic medical record is due to the possibility of guaranteeing a safer care transition[18]. On the other hand, it must be considered that, in addition to systems that guarantee greater security, professionals must be committed to complete information, which allows a reduction of noise among those who access the information. Ineffective communication has repercussions on unsafe care, being a contributing factor to unfavorable outcomes, just as effective communication reflects positively on care processes, on the quality of services and patient care[5,19]. Readmission may be related to loss of continuity of care, due to the fragility of the system and problems in the patient's self-care behavior, thus recognizing the benefit of an integrated care system for continuity of care. It was found in this research that HC professionals

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carry out follow-up guidance at the health unit for continuity of care and that patients usually seek the service, which is a positive point for the transition process.

Continuity of care must be carried out in a network, and it is essential to create linking strategies between services so that communication and information take place, avoiding discontinuity of care. In addition, international nursing networks describe the role of nurses as a communication strategy that articulates people and organizations[20]. However, a rather large gap is perceived in the transition of care. It is understood that information and guidance are not enough for the discharged patient's reference health unit. There needs to be, in fact, communication between these two spaces of care with effective exchange of information, which can collaborate in patient care after hospital discharge[2].

Despite presenting a written discharge plan, it is not individualized and concentrates information on the current treatment plan, but less frequent information is on patient follow-up. The low reliability of the information received in the hospital discharge plan is a challenge, although discharge summaries are used based on evidence, the use of templates ensures that all necessary components are included. The variation in quality can be attributed to the practice of "copying and pasting", that is, a document is created with the same information, regardless of the patient[21].

The care plan directly impacts the collaboration and engagement of patients and caregivers[4]. In the United States, in pediatrics, for example, a quarter of discharge instructions do not meet the standards recommended for the country. In this case accessibility was often limited by literacy or discordant language of instructions[22]. A study involving children used a CT model, SAFER Care, which employs Plan-Do-Study-Act (PDSA) cycles, and included several initiatives for efficient discharge planning, demonstrating improvement in caregivers' understanding of discharge instructions[23]. The use of discharge plan templates can be a valuable tool to improve the content of discharge instructions and accessibility[22].

A study conducted in 2018 pointed out that the lack of sending or the presence of discrepancies in patient information, as well as the ineffectiveness of referral and counter-referral mechanisms, result in failures in communication between the different levels of health care. These failures contribute to the fragmentation of care and, consequently, to a decrease in the quality of care provided to patients[24].

Ensuring that all of an individual's specific information is clear at transition is crucial to a successful care process. Patients who are in a trauma or rehabilitation setting typically receive care provided by many professionals using an interdisciplinary team approach. Thus, there is a need for detailed information to be shared between teams during any transition[25].

This study shows that 40% of HC professionals point out that all information provided is understood by the patient and/or family at the time of discharge, while 94.2% of PHC professionals point out that patients understand little of the information provided. This finding raises concern, since the hospital discharge period can represent a fragile moment for the patient and their family members. A network meta-analysis on the CT service among patients with heart failure at hospital discharge showed that home visits by nurses and clinical management of the disease (follow-up visits with multidisciplinary management of heart failure) decrease the overall mortality of these patients, and the case management by the nurse reduces readmissions, and these services reduce the cost to the health system[26].

Regarding the limitations of this study, it works with a limited sample. However, different dissemination strategies were used. The pandemic period is a factor that impacts the

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rate of return to research, considering the high demand and workload of these professionals. However, this is an emerging issue, especially in Brazil, and it deserves to gain space for discussion and implementation of new strategies in this context.

CONCLUSION

The study points to communication as a major weakness in hospital discharge, which is expressed in this study, by the perception of poor communication between HC and PHC, by the fragility of the discharge plan and instructions given verbally. This allows us to suggest that it leads to a greater number of doubts after hospital discharge and that it may lead to difficulties in the clinical management of CT.

Considering that this is a scarcely discussed in national literature, it is important to broaden the discussion about it. This study presents some elements that can be used to guide new research in the area, in addition to allowing us to rethink our health practices, such as the strengthening of interprofessional communication, with the implementation of strategies that improve communication between HC and PHC, guaranteeing an exchange of effective patient information, the use of shared electronic medical records and appropriate communication tools can facilitate the secure transmission of important data between healthcare professionals; individualization of discharge plans, considering the specific needs of each patient, including clear information on post-discharge follow-up, prescribed medications and guidelines for home care; the implementation of care transition programs, such as follow-up consultations after hospital discharge, can significantly contribute to the continuity of care and reduction of post-discharge complications, these programs must involve HC and PHC, to ensure a smooth and integrated transition; investment in training professionals; encouraging the engagement of patients and caregivers, providing clear and accessible information about the care plan; as well as creating integrated care networks, in which the different levels of care work collaboratively, in a coordinated and articulated way.

Improving the care transition process, especially hospital discharge, allows for more integrated, safe and patient-centered healthcare. Investment in strategies that improve this process is essential for the quality of care.

Author Statement CREdiT

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