Perceptions of hospitalized older adults regarding the transition of care from hospital to home

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Abstract

Objective: To analyze the perceptions of older adults hospitalized regarding the transition of care from hospital to home. *Method*: A qualitative, descriptive-exploratory research was conducted in a clinical inpatient unit of a medium-sized public hospital in the interior of São Paulo state, Brazil. Twenty-two older adults participated in the study through semi-structured interviews, guided by questions based on the pillars of the Care Transitions Intervention (CTI). Subsequently, participant observation was conducted at the study site, with recording in a field diary and transcription of speeches. Thematic analysis and data systematization followed through specific software for qualitative data analysis. *Results*: The mean age of the participants was 68 years (SD±5.4); 16 (77%) had one or more chronic diseases; 14 (64%) were using one or more continuous medications. The primary International Classification of Diseases code for hospitalization was Covid-19. The average length of hospital stay was 9 days (SD±5.7), with a maximum of 31 days and a minimum of two days, with four (18%) experiencing severe disease. From the perception of older adults, four themes of analysis emerged: medication-related problems; preparation for hospital discharge; continuity of care; and family network. *Conclusion*: From the perspective of older adults, it is necessary to organize the care plan during hospitalization through medication reconciliation, preparation for home care, family presence during hospitalization, and recognition of Primary Health Care in continuity of care during the transition from hospital to home care.

Keywords: Transition of care. Older Adults. Hospital Discharge. Continuity of Patient Care.

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INTRODUCTION

The care transitions (CT) can be defined as the interval of time that begins with the individual's preparation for discharge and ends when they are received in the next service. It is associated with a set of actions aimed at ensuring the continuity of health care during patient transfers between points of the Health Care Network (HCN) or from a health service to home care and self-care[1,2].

The CT includes logistical arrangements, communication, health education, and encompasses activities related to discharge planning, medication management, social and community network, symptom management post-discharge, and follow-up in outpatient services[1,2].

The strategy for successful CT development comprises a comprehensive care plan, carried out by trained healthcare professionals, aimed at ensuring care coordination during patient transfers between various healthcare services and interfaces between primary, specialized, hospital, and community care [3,4].

CT is particularly important for older adults with multiple chronic conditions and complex therapeutic regimens because they often receive care at various points in the Health Care Network and move frequently within care settings; thus, they are more vulnerable to care discontinuity [5,6].

Inadequate transfers between healthcare services for older adults may be associated with adverse events and low satisfaction with care. When there are failures in hospital-to-home CT, there can be increased mortality and morbidity; delays in receiving treatment; additional healthcare encounters; duplicated or lost tests; unplanned readmissions; emotional and physical distress; and dissatisfaction among patients, caregivers, family members, and professionals involved in care coordination [5-7].

During the Covid-19 pandemic, with the rise in hospital admissions of older adults, issues related to transitional care from hospital to home may have escalated, considering the burden on the healthcare system and diversion of attention towards urgent and emergency care[8].

The organization of safe transitional care practices within the HCN, focusing on the older adult population, may promote a reduction in hospitalization time, prevent hospital readmissions, and decrease costs for the Unified Health System (Sistema Único de Saúde - SUS)[1-7].

In this perspective, the following research question was formulated: What are the perceptions of older adults who are hospitalized regarding care transitions from hospital to home? The objective was to analyze these perceptions among older adults hospitalized in a public hospital in the interior of São Paulo.

METHOD

A descriptive-exploratory study with a qualitative approach was conducted in the adult clinical inpatient unit of a medium-sized public hospital serving as a reference for 26 municipalities in the interior of São Paulo, Brazil. This healthcare unit had 42 inpatient beds during the data collection period from March 22nd to May 27th, 2021.

Older adults hospitalized with the International Classification of Diseases (ICD) code for coronavirus infection of unspecified location participated, considering that data collection took place during the second wave of Covid-19 in the year 2021. All precautionary measures recommended by the Hospital Infection Control Service of the institution were taken to ensure there was no risk of virus transmission.

The participants were identified by the lead researcher through visits to the inpatient unit and consultation of the Electronic Patient Record (EPR), based on inclusion criteria: being aged 60 years or older, having a discharge forecast registered in the medical record, having the conditions and expressing interest in participating in the interview by signing the Informed Consent Form.

The form for characterizing older adults was filled out, containing data on age, gender, marital status, education level, primary diagnosis for hospitalization, time since diagnosis, and pre-existing chronic diseases.

The invitation to participate in the research was extended by a nurse, the principal researcher of the study, through direct contact during hospitalization on the day scheduled for discharge, with or without the presence of companions, followed by the interview.

The decision was made to employ the interview technique, using a semi-structured script containing questions based on the pillars of the Care Transitions Intervention (CTI): patient-centered recording; self-management of medications; follow-up in Primary Health Care (PHC) and specialized care; and awareness of events suggesting deterioration of health status. These questions enabled participants to discuss the topic reflectively, articulating it with their experiences during hospitalization[9].

The questions that guided the interview were: 1. How was your hospitalization in this hospital?; 2. How do you anticipate your transition home will be?; 3. Have you received any guidance related to hospital discharge up to this point in your hospitalization?; 4. Do you know which medications you will be taking at home upon discharge? If so, how do you plan to take them?; 5. Do you have any follow-up appointments scheduled at the specialty outpatient clinic or at the health center?; 6. Are you aware of the situations in which you should seek healthcare services again?; 7. Do you possess a health card containing information about your health status?

For the enhancement of the guiding script, three pilot interviews were conducted (discarded from the study), which proved relevant for adapting the language to the participants' profile and refining skills in approaching the experiences of older adults generated during hospitalization[10].

A total of 25 interviews were conducted, with 22 deemed valid for data analysis. Three interviews were discarded, two due to difficulties in transcribing speech (low voice tone) and one due to challenges related to family circumstances.

Four companions, present during the interviews, participated in the study in a complementary manner, providing information regarding the health and hospitalization of the older adults.

The interviews were recorded in audio format using a smartphone, with an average duration of 22 minutes each. They were transcribed immediately after each interview, preserving the fidelity of the speech. Data collection was concluded when the interviews were deemed sufficient to address the proposed objective, as they did not yield new reflections on the topic and the data became repetitive[11].

Subsequent to the interviews, participant observation was conducted, guided by a script based on the conceptual framework of the research. Impressions and perceptions were systematically recorded in a field diary at the end of each activity to compose material for data analysis. The data collected in this stage were subjected to analysis together with the interviews, contributing to a deeper understanding of the study site as well as to a greater comprehension of the older adults' discourse on the CT.

The data were analyzed according to the proposed thematic analysis in six phases: a. Familiarization with the data, aiming to achieve depth and breadth of content through repeated reading, searching for meanings, and patterns in the discourse. b. Initial coding, defining initial codes by identifying the characteristics of the data (semantic or latent content) that could be considered in relation to the phenomenon; c. Theme exploration, involving the screening of different codes into potential themes; d. Theme review, where coded extracts are reviewed and themes are refined; e. Theme naming, with final refinements and titling of the themes; f. Report production, where the fully processed dataset is analyzed, and the report is written in a coherent and logical manner[12].

The data were systematized with the aid of specific software for qualitative data analysis, and ultimately, an analytical framework was constructed to synthesize the results. The older adults were identified with the letter "I," representing "Idoso" (older adult), followed by a sequential number according to the chronological order of data collection.

The research adhered to Resolution number 466/2012 of the National Health Council and was approved by the Research Ethics Committee of the Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, under Opinion number

4.368.291 and CAAE: 36391420.8.0000.5393, respecting the respiratory protocol guidelines established during the Covid-19 pandemic.

DATA AVAILABILITY

All data supporting the findings of this study are available upon request from the corresponding author [Silvia Helena Valente].

RESULTS

A total of 22 older adults participated in the interviews, with 16 (73%) being female and six (27%) male. The mean age was 68 years (SD±5.4). Fourteen (63%) were married, six (27%) were widowed, one (5%) was divorced, and one (5%) was in a stable union. One older adult reported being illiterate (5%); 10 (45%) reported incomplete primary education; six (27%) reported completing primary education; two (9%) reported incomplete secondary education; one (5%) reported incomplete higher education; one (5%) reported completing higher education; and one (5%) reported having postgraduate education.

Seventeen (73%) older adults had one or more chronic diseases, with systemic arterial hypertension being the most common, followed by diabetes mellitus. Regarding medication use, 14 (64%) were taking one or more medications regularly, and among them, three (14%) were taking more than four medications at home.

The average length of hospital stay was nine days (SD±5.7), with four individuals (18%) experiencing severe forms of the disease, with a maximum stay of 31 days and a minimum of two days.

In the data analysis, four thematic categories emerged consistent with the pillars of CTI (Medication-related problems; Hospital discharge preparation; Care continuity; and Family network), comprised of eight subthemes, as presented in Figure 1.

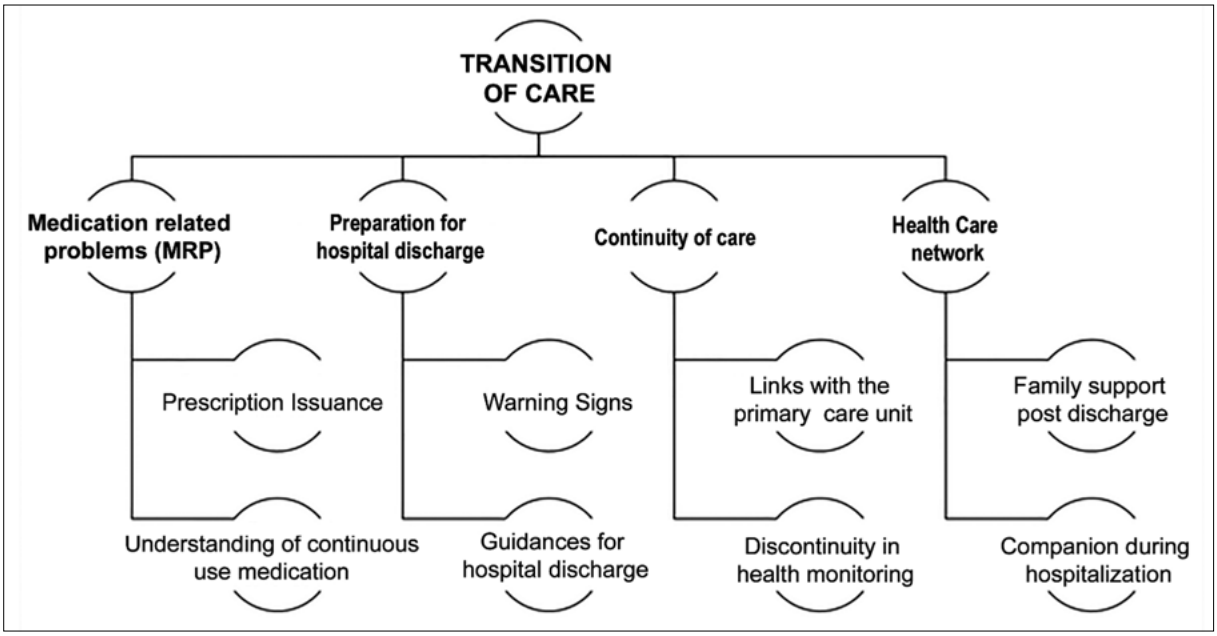

Figure 1. Themes and subthemes of the transition of care for older adults from the hospital to home. São Paulo, SP, Brazil, 2021.

Medication-related problems

Understanding the medications to be used at home by older adults can be considered an important aspect in care transition and is highlighted in the conceptual framework of the research.

Regarding the continuous use medications, some participants expressed knowledge of those used prior to hospitalization.

> "I know. The blood pressure medication, which is losartan, and the one for the thyroid, which is for control." (I 2)

> "I take compounded carvedilol. Here, I'm taking the regular one." (I 5)

Others showed difficulties in describing which medications they used daily.

> "To remember the name, it's tough..." (I 7)

> "I don't remember, I know it's 10 mg. [...] I know it's not very strong because it's not that kind of pressure." (I 16)

During participant observation, it was possible to identify that there are records of continuous use medications in the medical records, especially upon admission. However, this is an isolated record, without documentation in the medication reconciliation (MR) therapeutic plan.

Regarding MR at hospital discharge, participants expressed weaknesses in the team's instructions, which reflected in difficulties understanding which medications would be continued after hospital discharge.

> "I don't know if these boxes of medicine are to take with me. They are here in my drawer (bedside table)." (I 5)

> "Do I need any medication or not? (Doubts about what I will take at home)." (I 9)

An older adult emphasized that, despite not having received guidance on MR until discharge, they will continue using the same medications as before hospitalization.

> "Not yet, they haven't passed on to me, I only know the ones I was already taking (Referring to the medications prescribed for home use on the day of discharge)." (I 14)

Others expressed uncertainty about the continuation of continuous medication treatment:

> "So, I don't know if they will keep the ones that are at home. The doctor said he would look into it, if anything is going to change." (I 19)

> "There are plenty of medicines there, but I don't know what I'll be able to take now." (Continuous use medications left at home) (I12)

In participant observation, while witnessing the hospital discharge process, it was evident that the instructions were delivered swiftly, not exceeding five minutes, which could potentially affect the guidance regarding medication usage at home.

Additionally, chart reviews were conducted post-discharge for the interviewees, confirming that only medications related to the primary disease treatment during hospitalization were prescribed for these patients, without encompassing documentation of continuous medication usage.

Hospital Discharge Preparation

The preparation of older adults and their families during the CT period is considered a strategic pillar in CTI and aims to enhance self-management capacity, minimize unnecessary healthcare seeking, and prevent future hospital readmissions.

For participants with low care needs, their statements reveal a lack of perception regarding the work of the healthcare team, particularly regarding guidance and preparation for care to be carried out at home after hospital discharge:

> "No, they haven't said anything yet (Regarding discharge instructions)." (I 2)

> "No (Regarding discharge instructions). The doctor came and said I'm discharged. The nurse said she would come back because I have an IV now, so I guess she'll come back." (I 14)

During the interview, doubts about post-discharge care were evident:

> "I have a question for you: 'Will I have to wear a mask at home?'" (I6)

> "And how long does it take to recover before I can start working or doing something?" (I 9)

When older adults were asked about warning signs indicating a deterioration in their health status after hospital discharge, the majority were unable to provide precise responses regarding health management:

> "May God grant me the grace not to go back there anymore. I want to get home and recover properly, take good care of myself, and have my girls (daughters) take good care of me." (I 4)

> "I believe everything will be fine, in God's hands." (I 6)

Some participants indicated, in a non-specific manner, seeking help from healthcare services in case of any changes, which may encourage unnecessary visits to emergency services:

> "If I have to go... if I'm forced to go, what can I do, right? I have to go..." (I 4)

> "If we're not feeling well, we already have to seek help, but I don't know why there are so many reasons." (I 10)

Participant observation also identified weaknesses in the organization of the healthcare team for the discharge preparation of older adults and their families, as evidenced by the absence of a therapeutic plan in the Electronic Health Record, as well as the lack of protocols to guide clinical practice.

Continuity of Care

Timely follow-up in Primary Health Care (PHC) post-hospital discharge is an important aspect to be considered in CT and forms the conceptual basis of the study. Interviewees report established ties with the reference Basic Health Unit (BHU), which may facilitate the continuity of care from the hospital to the Health Services Network (HSN).

> "They are very good to us there. Every week, they come by, they check on us to see how we are doing (Regarding appointments at the reference BHU). [...] at the clinic, they have everything sorted out. I also go to meetings. Every three months, there's a meeting to pick up medication." (Hypertension Group at the Basic Health Unit) (I 4)

> "I had a breast exam, what else did I have done? I know I had some tests. [...] Pap smear. [...] imagine, it hasn't even been a year since I had it done." (Regarding health follow-up) (I 10)

Participants, despite reporting a connection with healthcare services, highlighted that during the Covid-19 pandemic, there was a discontinuation in the follow-up of chronic illness:

> "Because of this Covid, I used to schedule appointments every six months and go. Now, at home, when things get better, when everything is normal, I'll seek out the cardiologist, have an echocardiogram done. [...] ah... It's been a while... [...] well before Covid, I just didn't go back anymore." (Regarding the follow-up of chronic illness) (I 2)

> "I had scheduled routine exams, cholesterol, those kinds of things, but they canceled because of the pandemic, so they are focusing more on Covid cases. The others were postponed for later, as they're not as urgent. [...] this year I had an appointment scheduled for April, I think for the 24th. They called to cancel because they were starting vaccinations." (I 22)

Family Support Network

According to the conceptual framework used in this study, family plays a central role in ensuring

quality and safety in CT. In this regard, hospitalized older adults emphasized the importance of family support in post-discharge care.

> "A lot of emotion, one of my daughters lives in Hortolândia. The other one lives here; she'll be the one coming to pick me up when I'm discharged. For sure, she'll want to take me to her place (daughter's house)." (I 16)

> "My husband will cook for me. [...] he (Referring to the companion grandson), I believe he will take care of me, because if he gets sick, I'll take care of him." (I 21)

Nonetheless, there were also statements about the difficulty of family assistance in post-discharge care.

> "She's working, she can't help me." (Regarding the daughter) (I 16)

> "They have their chores (About family members). He doesn't know much about these things, but he helps a little. He tries to do his best, but he is not fit for it." (Regarding the husband) (I 26)

DISCUSSION

The understanding of older adults regarding medication usage during admission, hospitalization, and discharge revealed issues related to medications in CT from hospital to home, as evidenced by difficulties in describing continuous-use medications used before admission and a deficit in understanding those prescribed for home use.

Studies indicate that older individuals are more vulnerable to medication-related problems, as aging alters the effects of drugs on organs and tissues, impairing pharmacokinetics and pharmacodynamics. Additionally, due to the high prevalence of chronic diseases and comorbidities in this population, they frequently transition between different healthcare services and are more exposed to medication management failures by healthcare professionals[13-15].

The lack of understanding of medications to be continued at home may be associated with difficulties in self-management of post-discharge medications and can lead to adverse reactions, drug interactions, medication resistance, resulting in seeking emergency care, hospital readmissions, health complications, and even death[13-15].

The majority of participants had one or more chronic diseases, were using one or more medications, and demonstrated difficulties in understanding the medications to be continued at home. Nevertheless, the medical prescription provided at hospital discharge only pertained to medications related to the treatment of the primary disease of hospitalization, without encompassing those for continuous use.

Research indicates that healthcare professionals in hospitals play a crucial role in the medication therapy used by older individuals during hospitalization, discharge, and CT. They highlight that reconciliation programs can prevent difficulties in medication self-management at home[15-17].

There is scientific evidence that in-hospital preparation, discharge planning (DP), and enhanced communication can prevent issues in medication self-management at home. The effectiveness of these measures may be further enhanced when combined with home follow-up strategies[14,18].

Although some participants identified actions by the healthcare team aimed at hospital discharge preparation, the majority of older adults' statements pointed to difficulties in understanding the care to be performed at home, whether they were of greater or lesser complexity. This indicated failures in health education and communication deficits among healthcare professionals, patients, and their families.

Regarding hospital discharge preparation, health education and promotion of patient autonomy can be considered essential for qualified transitional care and should be part of the discharge planning process[2,4,19].

There are recommendations that discharge planning should commence upon hospital admission, ensuring that the patient leaves the hospital at the appropriate time and with adequate organization of post-discharge needs[19-21]. However, it is observed that in practice, the process conducted upon discharge appears disorganized, and the team's involvement is limited to the removal of invasive devices and

the provision of simplistic and general health status instructions. This may foster treatment discontinuity, frequent visits to the emergency department, and hospital readmissions [5,6]. In this sense, the absence of a guiding document regarding the practice on the topic within the institution can hinder the systematization of care. Authors emphasize that protocols can be important resources to guide healthcare practices, as well as their quality [22-24].

To enhance CT for older adults from hospital to home, researchers recommend: developing a care plan centered on the older person; ensuring patient safety through medication reconciliation throughout the admission, hospitalization, and discharge processes; integrating the discharge process with the delivery of structured reports; and ensuring accurate communication between different levels of healthcare [5,6,19,20].

The continuity of care in PHC emerged as a relevant theme in the participants' discourse and could be an important resource to address issues faced by older adults post-hospital discharge. This is corroborated by some authors, who define continuity as planned, integrated health actions over time, across different healthcare settings, with primary care serving as the coordinator and organizer of care during patient transfers[25,26]. Studies emphasize that continuity of care practices depend on effective communication among all social actors involved, as well as the integration of knowledge and information to meet the uniqueness of users. Therefore, it is within the context of social interactions and understanding of human actions that continuity of care occurs [27,28].

It is worth noting that since the research was conducted during the second wave of Covid-19 in Brazil, participants pointed out discontinuity in health monitoring and delays in PHC appointments, as well as changes in the routine of healthcare services regarding the follow-up of chronic diseases. Research indicates losses and delays in healthcare appointments during the pandemic, leading to the postponement of chronic disease treatment[29].

The suspension of chronic condition appointments during the Covid-19 pandemic in PHC, the lack of assistance caused by access restrictions, and the fear of seeking healthcare services may have exacerbated the severity of diseases and destabilized previously controlled and monitored clinical conditions. In this sense, there is a need for a review of health policies for older adults focusing on projecting future scenarios related to new health emergencies[4].

Regarding the family support network during CT from hospital to home, participants emphasized the importance of family members in post-discharge rehabilitation. Research indicates that older adults with multiple chronic conditions are less capable of engaging in and participating in their own care and often require family caregivers for post-hospital discharge rehabilitation[2,30].

In Brazil, the family of older adults with some level of dependency assumes caregiving responsibilities informally in over 90% of cases. Despite the magnitude of their role in facilitating healthcare, these family caregivers often perform caregiving activities without the necessary preparation and without the support of healthcare team members[31,32]. A study exploring the experiences of family caregivers during transitional care for individuals with diabetes and concurrent chronic conditions identified two significant themes regarding unsafe transition (unplanned discharge, inadequate communication, lack of post-discharge follow-up, and unavailable healthcare team) and erosive effort (financial burden, psychological stress, physical exhaustion, and lack of support network). Findings underscored the importance of developing a discharge plan and preparing family caregivers for CT[33].

In this perspective, it is essential for healthcare professionals to recognize the diversity of family situations in which older adults are involved, as well as to understand the complexity surrounding transitional care from hospital to home from the caregiver's perspective. Thus, aware of these challenges, it is recommended that healthcare professionals work collaboratively with families through actions that assess their perspectives and needs, fostering shared decision-making regarding the older adults care plans through reciprocal and respectful relationships. The importance of policies and programs supporting older adults health is emphasized, as they can play a fundamental role in ensuring continuity of care and necessary support during the critical transitional care phase from hospital to home [8,30-33].

The research is limited by being conducted in a region in the interior of São Paulo during the second wave of the Covid-19 pandemic, when imposed health restrictions may have hindered access to hospitalized older adults. From this perspective, new studies in other periods and locations in Brazil are suggested.

CONCLUSION

Care transitional requires a care plan during hospitalization comprised of medication reconciliation, preparation for home care, involvement of the family during hospitalization, discharge process, and recognition of PHC in continuity of care.

The study enabled the analysis of gaps in the care provided by healthcare professionals in the transition of older adults from hospital to home, highlighting the need to develop a CT protocol that can instrumentalize healthcare practice, grounded in the pillars of safety and quality of care.

AUTHORSHIP

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REFERENCES

1. Acosta AM, Lima MADS, Pinto IC, Weber LAF. Care transition of patients with chronic diseases from the discharge of the emergency service to their homes. Rev Gaucha Enferm [online]. 2020 [Access December 18, 2023];41(spe). Available at: https://doi.org/10.1590/1983-1447.2020.20190155
2. Sousa LS, Pontes MLF, Pereira RR, Leite MAP, Vila Nova FAL, Monteiro EA. Transição do idoso do hospital para o domicílio na perspectiva do cuidador/idoso: revisão de escopo. Acta Paul Enferm [online]. 2023 [Access December 18, 2023];36. Available at: https://doi.org/10.37689/acta-ape/2023ar03631
3. Buikstra E, Strivens E, Clay-Williams R. Understanding variability in discharge planning processes for the older person. Safety Sci [online]. 2020 [Access December 18, 2023];121:137-46. Available at: https://doi.org/10.1016/j.ssci.2019.08.026
4. Lee JY, Yang YS, Cho E. Transitional care from hospital to home for frail older adults: a systematic review and meta-analysis. Geriatr Nurs [online]. 2022 [Access December 18, 2023];43:64-76. Available at: https://doi.org/10.1016/j.gerinurse.2021.11.003
5. Lenaghan NA. Transitional care and empowerment of the older adult. Geriatr Nurs [online]. 2019 [Access December 18, 2023];40(2):148-53. Available at: https://doi.org/10.1016/j.gerinurse.2018.07.005
6. Hunt-O'Connor C, Moore Z, Patton D, Nugent L, O'Connor T, Avsar P. The effect of discharge planning on length of stay and readmission rates of older adults in acute hospitals: a systematic review and meta-analysis of systematic reviews. J Nurs Manag [online]. 2021 [Access December 18, 2023]. Available at: https://doi.org/10.1111/jonm.13409
7. Ferreira OMR, Baixinho CL. Strategies to implement the safe hospital-community transition and mitigate hospital readmissions. Rev Cien Saúde [online]. 2021 [Access December 18, 2023];11(1):2-3. Available at: https://doi.org/10.21876/rcshci.v11i1.1120
8. Naylor MD, Hirschman K, Mccauley K. Meeting the transitional care needs of older adults with covid-19. J Aging Soc Policy [online]. 2020 [Access December 18, 2023];32(4-5):387-95. Available at: https://doi.org/10.1080/08959420.2020.1773189

9. Coleman EA, Parry C, Chalmers S, Min S. The care transitions intervention: results of a randomized controlled trial. Arch Internal Med [online]. 2006 [Access December 18, 2023];166(17):1822–8. Available at: https://doi.org/10.1001/archinte.166.17.1822

10. Minayo MCS, Assis SG, Souza ER. Avaliação por triangulação de métodos: abordagem de programas sociais. Rio de Janeiro: Fiocruz; 2005.244p. ISBN:85-89697-06-1

11. Fontanella BJB, Ricas J, Turato ER. Saturation sampling in qualitative health research: theoretical contributions. Cad Saude Publ [online]. 2008 [Access December 18, 2023];24(1):17-27. Available at: https://doi.org/10.1590/s0102-311x2008000100003

12. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol [online]. 2006 [Access December 18, 2023];3(2):77-101. Available at: https://doi.org/10.1191/1478088706qp063oa

13. Valente SH, Barbosa SM, Ferro D, Fabriz LA, Schönholzer TE, Pinto IC. Drug-related problems in the transitional care of the elderly from hospital to home. Rev Bras Enferm [online]. 2019 [Access December 18, 2023];72(suppl 2):345-53. Available at: https://doi.org/10.1590/0034-7167-2018-0848

14. Mortelmans L, Goossens E, Dilles T. Beliefs about medication after hospital discharge in geriatric patients with polypharmacy. Geriatr Nurs [online 2022 [Access December 18, 2023];43:280-7. Available at: https://doi.org/10.1016/j.gerinurse.2021.12.007

15. Hoel RW, Giddings Connolly RM, Takahashi PY. Polypharmacy Management in Older Patients. Mayo Clin Proc [online]. 2021 [Access December 18, 2023];96(1):242-56. Available at: https://doi.org/10.1016/j.mayocp.2020.06.012

16. Aljasmi F, Almalood F, AlAnsari A. Prevalence of medication errors in primary health care at Bahrain Defence Force Hospital – prescription-based study. Drug, Healthc Patient Saf [online]. 2018 [Access December 18, 2023];10:1-7. Available at: https://doi.org/10.2147/dhps.s147994

17. Costa JM, Silva KL. Pharmaceutical counter-referencing in the transition care process: experiences of health professionals in a teaching hospital . Rev Enferm Cent Oeste Min [online]. 2021 [Access December 18, 2023];11. Available at: https://doi.org/10.19175/recom.v11i0.3942

18. Aquino GA, Cruz DT, Silvério MS, Vieira MT, Bastos RR, Leite ICG. Factors associated with adherence to pharmacological treatment among elderly persons using antihypertensive drugs. Rev Bras Geriatr Gerontol [online]. 2017 [Access December 18, 2023];20(1):111-22. Available at: https://doi.org/10.1590/1981-22562017020.160098

19. Aboumatar H, Naqibuddin M, Chung S, Chaudhry H, Kim SW, Saunders J, et al. Effect of a hospital-Initiated program combining transitional care and long-term self-management support on outcomes of patients hospitalized with chronic obstructive pulmonary disease. JAMA [online]. 2019 [Access December 18, 2023];322(14):1371. Available at: https://doi.org/10.1001/jama.2019.11982

20. Eggen AC, Jalving M, Bosma I, Veenhuis DJ, Bosscher LJ, Geerling JI, et al. A methodology to systematically analyze the hospital discharge of terminally ill patients. Medicine [online]. 2018 [Access December 18, 2023];97(46):e12953. Available at: https://doi.org/10.1097/md.0000000000012953

21. 21.Barbosa SM, Zacharias FCM, Schönholzer TE, Carlos DM, Pires MEL, Valente SH, et al. Hospital discharge planning in care transition of patients with chronic noncommunicable diseases. Rev Bras Enferm [online]. 2023 [Access December 18, 2023];76(6):e20220772. Available at: https://doi.org/10.1590/0034-7167-2022-0772

22. Engle RL, Mohr DC, Holmes SK, Seibert MN, Afable M, Leyson J, et al. Evidence-based practice and patient-centered care: doing both well. Health Care Manag Rev [online]. 2019 [Access December 18, 2023];46(3). Available at: http://doi.org/10.1097/HMR.0000000000000254

23. Krauzer IM, Dall'Agnoll CM, Gelbcke FL, Lorenzini E, Ferraz L. A construção de protocolos assistenciais no trabalho em Enfermagem. REME[online]. 2018 [Access December 18, 2023];22:e–1087. Available at: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-905215?lang=en

24. Vieira TW, Sakamoto VTM, Moraes LC, Blatt CR, Caregnato RCA. Validation methods of nursing protocols: an integrative review. Rev Bras Enferm [online]. 2020 [Access December 18, 2023];73:(Suppl 5). Available at: https://doi.org/10.1590/0034-7167-2020-0050

25. Freitas LFC, Moreira DA, Brito MJM. The continuity of care from the perspective of the being cared for. Cogitare Enferm [online]. 2014 [Access December 18, 2023]; 19(4):694-700. Available at: http://dx.doi.org/10.5380/ce.v19i4.35993

26. Ribas EN, Bernardino E, Larocca LM, Poli P Neto, Aued GK, Silva CPC. Nurse liaison: a strategy for counter-referral. Rev Bras Enferm [online]. 2018 [Access December 18, 2023];71(1):546-53. Available at: https://doi.org/10.1590/0034-7167-2017-0490

27. Utzumi FC, Lacerda MR, Bernardino E, Gomes IM, Aued GK, Sousa SM. Continuity of care and the symbolic interactionism: a possible understanding. Texto & contexto [online]. 2018 [Access December 18, 2023];27(2):e4250016. Available at: https://doi.org/10.1590/0104-070720180004250016

28. Belga SMMF, Jorge AO, Silva KL. Continuidade do cuidado a partir do hospital: interdisciplinaridade e dispositivos para integralidade na rede de atenção à saúde. Saúde Debate [online]. 2022 [Access December 18, 2023];46:551–70. Available at: https://www.scielosp.org/article/sdeb/2022.v46n133/551-570/

29. Gonzalez D, Karpman M, Kenney GM, Zuckerman S. Delayed and forgone health care for nonelderly adults during the covid-19pandemic. Washington: The Urban Institute [online]; 2021 [Access February 02, 2024]. Available at: https://www.urban.org/research/publication/delayed-and-forgone-health-care-nonelderly-adults-during-covid-19-pandemic

30. Aires M, Fuhrmann AC, Mocellin D, Pizzol FLFD, Sponchiado LF, Marchezan CR, et al. Burden of informal caregivers of dependent elderlies in the community in small cities. Rev Gaucha Enferm [online]. 2020 [Access December 18, 2023];41(Spe):e20190156. Available at: https://doi.org/10.1590/1983-1447.2020.20190156

31. Garbaccio JL, Tonaco LAB. Characteristics and difficulties of informal caregivers in assisting elderly people. Rev Fund Care Online[online]. 2019 [Access December 18, 2023];11(3):680-6. Available at: https://dx.doi.org/10.9789/2175-5361.2019.v11i3.680-686

32. Arruda MS, Macedo MNGF, Ottaviani AC, Nunes DP, Cardoso JFZ, Santos KC, et al. Correlation of family functionality and burden of informal caregivers of hospitalized older adults. Rev Gaucha Enferm [online]. 2022 [Access December 18, 2023];43:e20210081. Available at: https://doi.org/10.1590/1983-1447.2022.20210081.en

33. Nikbakht-Nasrabadi A, Mardanian-Dehkordi L, Taleghani F. Abandonment at the transition from hospital to home: family caregivers' experiences. Ethiopian J Health Sci [online]. 2021 [Access December 18, 2023];31(3). Available at: https://www.ajol.info/index.php/ejhs/article/view/207624