Revista Brasileira de Enfermagem
REBEn

THEMATIC ISSUE:
MENTAL HEALTH

RESEARCH

Project K: Training for hospital-community safe transition

Projeto K: Kapacitar para uma transição segura hospital-comunidade

Proyecto K: Kapacitar para una transición hospital-comunidad segura

David Valsera Paniagua[I], Maria Paula Homem Ribeiro[I], Ana Marta Correia[II], Carla Rosa Ferreira e Cunha[II], Cristina Lavareda Baixinho[III], Óscar Ferreira[III]

[I] *Hospital de Vila Franca de Xira. Vila Franca de Xira, Portugal.*
[II] *Agrupamento Centros de Saúde do Estuário do Tejo. Vila Franca de Xira, Portugal.*
[III] *Escola Superior de Enfermagem de Lisboa. Lisboa, Portugal.*

How to cite this article:
Paniagua DV, Ribeiro MPH, Correia AM, Cunha CRF, Baixinho CL, Ferreira O. Project K: Training for hospital-community safe transition. Rev Bras Enferm [Internet]. 2018;71(Suppl 5):2264-71. [Thematic Issue: Mental health] DOI: http://dx.doi.org/10.1590/0034-7167-2018-0190

Submission: 04-06-2018 **Approval:** 05-19-2018

ABSTRACT

Objective: To define the safe transition process from hospital to community of patients with chronic mental disorders and their families. **Method:** This was an action research study included in the constructivist paradigm. The participants in the study were nurses from a psychiatry service and from primary healthcare services. **Results:** After the identification of causes of continuity fragmentation, the following items emerged from the participants' speeches: a) two criteria categories for safe transition (those associated with health status, dependence level, and self-care capacity of patients, and those associated with knowledge and competence level of informal caregivers); b) the design of an algorithm to facilitate clinical decision-making. **Final considerations:** In order to promote adherence to therapeutic treatment in the hospital-community transition, treatment plans must include patients and their families, and improve communication networks and support among care levels.
Descriptors: Mental Health; Nursing; Continuity to Patient Care; Medication Adherence; Caregivers.

RESUMO

Objetivo: Definir o processo de transição segura do hospital para a comunidade da pessoa com doença mental crônica e sua família. **Método:** Este é um estudo de investigação-ação, inserido no paradigma construtivista. Teve como participantes os enfermeiros de um serviço de psiquiatria e dos cuidados de saúde primários. **Resultados:** Após a identificação das causas da fragmentação da continuidade, emergiram do discurso dos participantes: a) duas categorias de critérios para a transição segura (os associados à condição de saúde, ao grau de dependência e à capacidade de autocuidado do cliente e os associados ao conhecimento e ao nível de competência do cuidador informal); b) o desenho de um algoritmo para facilitar a tomada de decisão clínica. **Considerações finais:** Para promover a adesão ao regime terapêutico na transição hospital-comunidade, o projeto terapêutico tem de incluir a pessoa e a sua família e melhorar as redes de comunicação e suporte entre níveis de cuidado.
Descritores: Saúde Mental; Enfermagem; Continuidade da Assistência ao Paciente; Adesão à Medicação; Cuidadores.

RESUMEN

Objetivo: Definir el proceso de transición segura del hospital a la comunidad de la persona con enfermedad mental crónica y su familia. **Método**: Estudio de investigación-acción, inserto en el paradigma constructivista. Participaron los enfermeros de un servicio de psiquiatría y de atención primaria de salud. **Resultados**: Luego de identificarse las causas de fragmentación de la continuidad, surgieron del discurso de los participantes: a) Dos categorías de criterios para la transición segura (los asociados a condición de salud, grado de dependencia y capacidad de autocuidado del paciente, y los asociados al conocimiento y nivel de competencia del cuidador informal); b) El diseño de un algoritmo para facilitar la toma de decisión clínica. **Consideraciones finales**: Para estimular la adhesión al régimen terapéutico en la transición hospital-comunidad, el proyecto terapéutico debe incluir a la persona y a su familia, y mejorar las redes de comunicación y soporte entre niveles de cuidado.
Descriptores: Salud Mental; Enfermería; Continuidad de la Atención al Paciente; Cumplimiento de la Medicación; Cuidadores.

CORRESPONDING AUTHOR **Cristina Lavareda Baixinho** E-mail: crbaixinho@esel.pt

INTRODUCTION

The purpose of hospital discharge instructions is the patient's compliance with the treatment proposed by the healthcare team, since hospitalization up to home[1]. However, the transition from hospital to community is not always safe and does not ensure that patients and their families will have support and assistance for the needs felt when they return home. This is a reality for all patients with self-care dependence, cognitive alterations, and loss of autonomy[1-4].

In case of patients with mental disorders, assurance of continuity of care is of utmost importance, because they are rarely able to ensure continuity of care by themselves, whether due to risk of frailty, difficulties associated with self-care dependence, or lack of autonomy.

Caregivers themselves (family members or informal caregivers) face these difficulties, associated with the embarrassment over the lack of knowledge about the illness and the lack of ability to follow instructions associated with other limitations[1].

Nurses have a key role in the choice of appropriate interventions that ensure continuity of care between hospital and community. Early and appropriate planning of home return minimizes collateral effects and secondary disabilities on illness and medication, promotes knowledge and abilities for the adaptive confrontation with the disorder, and enables the inclusion of the family as a target and partner in care[2].

The planning of hospital discharge is still problematic in several areas, with difficulties in ensuring the effectiveness of continuity of care. Some authors state that issues such as time spent on this activity, methodology, difficulties of communication among healthcare professionals, non-evaluation of the effectiveness of the interventions[1,3], lack of records, and their non-systematization contribute to their invisibility in the practice of the profession, thus contributing to the gaps in the planning of hospital discharge[1] and subsequent safe and informed transition among different care contexts.

One recent study showed that information sharing among healthcare services in Portugal is nonexistent or scarce[4], with clear implications for the quality of services provided to the population.

In the mental healthcare area, researchers warn that the appropriate use of the medications prescribed is necessary to achieve clinical benefits and reduce risks of relapse or recurrence of mental disorders[2]. An example of this reality is the taking of antidepressants and antipsychotics. Half of patients with mental disorders interrupt the treatment in the first six months from the prescription of the drug therapy[5-8] or administer it inappropriately[2]. This phenomenon represents a particularly serious problem in psychiatric chronic disorders, whose rates of adherence to treatments are still lower than in other disorders[6].

Non-adherence to medications includes a range of behaviors, from refusal of treatment to an irregular use, partial alteration of the daily medication[8-9], or its regular interruptions[6,9].

Potential factors for non-adherence may be related to patients' attitude in the face of illnesses and behaviors towards their management, knowledge on illnesses, severity of signs and symptoms, comorbidities, cognitive functioning, relationship with medications[6,9-10], treatment, personal characteristics, external environmental factors[9], attitudes regarding medication, experiences lived with their illnesses and treatments[10], or even therapeutic support. In particular, risks perceived and benefits of the treatment and illness (that is, "illness insight") play an important role in adherence[10].

Some sociodemographic characteristics have been described as determinants of non-adherence, such as the beginning of early treatment, younger age at the beginning of the illness, alcohol addiction and other illicit drugs, lack of housing, low levels of involvement in social activities, independent housing, and financial restrictions with consequent inability to pay the medication[7,10].

Difficulties in adherence to the therapeutic treatment prescribed have a negative effect on the result of the illness, increase recurrence and hospitalization rates, worsen signs and symptoms, and increase hospital costs[2,6-7,9].

The issue regarding inappropriate or non-adherence is particularly important in the first stages of severe mental disorders, because non-treatment is critical for these patients' prognosis and quality of life[6].

Family involvement is of utmost importance for the maintenance of care and resocialization of patients with mental health disorders. In the same way that it affects and influences patients, it is also influenced and affected by them[11], which justifies that families of patients with mental disorders are prepared in advance to their family member returning home.

The family develops actions to maintain self-care, encourage, be present, be a reliable and trustful support[11].

Although nurses adopt the role of coordinating the home return planning process, in practice, the instructions written and provided to patients and their family members, especially to family caregivers, have been too simple to ensure this continuity of care[1], and mostly provided by the medical team[3].

In addition to the medication, patients must know and be able to manage other elements related to their illnesses, especially their treatment, management of symptoms, and healthy lifestyle[2].

It is nurses' responsibility to ensure that both patients and families, especially caregivers, leave the hospital properly prepared and supported, which is possible through a better interaction and communication among professionals, patients, caregivers, and healthcare services[12].

OBJECTIVE

To define the safe transition process from hospital to community for patients with chronic mental disorders and their families, with the purpose of promoting and maintaining adherence to the therapeutic treatment.

METHOD

Ethical aspects

The present study initiated after approval of the three institutions involved and was agreed by means of signature of a partnership protocol. In order to ensure data anonymity and confidentiality, the researchers who collected data in the community and hospital codified the data regarding observation (O), interviews (I), and records (R), without identifying patients and their families.

The institutions authorized the present study in partnership with the Higher School of Nursing of Lisbon.

Study design

This was a study with a qualitative approach included in the constructivist paradigm, carried out from 2015 to 2017, involving researchers of a higher education institution and nurses from the psychiatry service of a hospital and from healthcare centers in the coverage area of the hospital, totaling 38 professionals.

The action-research methodological choice was due to its flexibility as a participatory research method, with involvement of praxis, allowing the interaction between researchers and the research subjects, that is, between formal and informal knowledge, between theory and practice[13], maximizing participants' individual qualities and abilities.

Scientific methods must be used to promote the resolution of problems, improve knowledge, and quickly translate it into the final users (healthcare professionals) and beneficiaries (healthcare patients)[14]. The action-research method was selected due to its dynamic process that enables to combine the data collection process with analysis, reflection, and action to change clinical practice, promoting the translation of knowledge.

Authors strengthen the following essential characteristics of this method: search for solutions for problems in practice; collaborative work between professionals and researchers; and change and development of theory[15].

Methodological procedures

Based on the guiding question "How to ensure a safe transition from hospital to community for patients with mental disorders and their families?", data collection was carried out by means of participant observation, semi-structured interviews, consultation on clinical processes and notes made by the professionals of the institutions, and team meetings with the presence of researchers and professionals from both contexts of clinical practice.

The present study is part of a more comprehensive project entitled "Safe transition from hospital to community", which comprises nursing interventions to other types of health/nursing care patients and includes the identification phases of the problem, planning, treatment and data analysis, action, and evaluation. The present study shows the results of the three first stages of the research process regarding project K: Training.

Meetings with all participants in the study were essential to share information and clarify the gap between speech and daily practice, connect formal and informal knowledge, and establish communication between the two cultural worlds: experts and general practitioners participants[13], based on decision-making on how to ensure that the planning of hospital discharge may provide continuity of care, refocusing the group on the central issue of the study.

Data source

The study participants were nurses from the hospital and healthcare centers in the coverage area of the hospital.

Data collection and organization

The data collected were recorded in a logbook. The diversity of techniques and sources facilitated the inductive work, because it brought the perspective of the different participants in the process, which enriched interpretation and guided the emergence of new issues and solutions to reveal the complexity of the phenomenon in study.

Data analysis

Participant observation was carried out in the hospital and community context by two researchers. The result from professionals' interviews guided observation, issues that were placed at times of presence, and record of interactions in the logbook.

The interviews were not recorded because the researchers were present during their interaction with the professionals[15]. The data were organized, categorized, and analyzed for the collection of responses regarding the issue of study.

RESULTS

Discussion meetings on practice enabled the diagnosis of the situation. The establishment of difficulties and opportunities for a safe transition, with discussion between community and hospital nurses, enabled the explanation of the model in use, organizational constraints, difficulties of communication and circulation of information between the two care levels, as well as the perception that many patients with mental disorders did not undergo medical follow-up after clinical discharge when they returned home, due to the lack of referral to primary healthcare professionals.

Regarding the phase of identification of the problem, on the matter of sending hospital discharge letters, it was evidenced that these were not effective to ensure continuity of care:

> *Hospital discharge letters do not always reach the healthcare center. They are personally delivered to patients and their families. In some cases, patients do not have economic conditions to go to places. In other cases, the social stigma attached to illnesses is so high they feel embarrassed, which makes it difficult to ask for help. Some patients do not want the support of community nurses because of previous negative experiences.* (I37)

The lack of an instrument able to predict the risk of non-adherence was another adversity identified for discontinuity of care:

> *In the clinical process, we have extensive data about patients. However, how can we guess the adherence behavior after hospital discharge? Patients themselves lie about taking medications.* (I4)

> *Regarding pressure ulcers, there is a more objective way to predict the risk development, and this guides community nurses. With regard to mental disorders, we are not used to evaluate non-adherence risk. We have already used the MARS scale. However, at the time of hospital discharge, we forget that its filling may help to guide the intervention of community nurses.* (R13)

In the analysis of the participants' speeches, the following difficulties in the process were identified: 1) lack of organization, systematization, and dissemination of best practice in different services; 2) lack of education structure to provide patients with

mental disorders and family caregivers with elements in three key areas: understanding of the therapeutic treatment, undertaking of activities of daily living, and training of family caregivers; and 3) difficulties in communication and circulation of information for continuity of care between hospital and community, without a definition of information content and circulation.

It is worth mentioning that the professionals observed some difficulties self-perceived by patients themselves and their families that determine the failure of a safe transition such as low level of literacy; low adherence of family caregivers to training at the hospital and primary healthcare centers; and obstacles to changed imposed by healthcare professionals.

In the phase of planning the resolution of the problems identified, analysis of the notes written by nurses and data collected in team meetings enabled the emergence of the criteria for continuity of care.

The discussion on clinical cases of rehospitalization due to non-adherence to therapeutic treatments led team members to reflect on their own practice, which clarified and motivated them to change their practice.

In the content analysis of nurses' speeches and reports, two major categories related to the criteria for continuity of care emerged: those associated with patients with mental disorders and those established by knowledge and competence of family caregivers. Chart 1 presents subcategories and units of enumeration (UE) of each category.

After distinguishing the problem, the first step for change was planning a safe transition process with the establishment of eligibility criteria for patients and their families to ensure continuity of care.

The participants established that in a first phase, priority to ensure continuity of care according to the problem and based on the availability of human resources in the community and existing community support networks ensuring equity and justice, would be given to patients with mental disorders and their families with: partial or absent insight of patients with severe mental disorders (psychotic disorders) and family caregivers; dysfunctional family dynamics (conflicts/abusive relationships/expressed emotion levels); lack of resources/structures of support for patients/families; poor social and family support network for patients with severe mental disorders.

The use of a non-adherence assessment and prediction instrument was agreed. The instrument negotiated between researchers and physicians was the MARS scale (Medication Adherence Rating Scale), because it was already used by the hospital nurses, and validation of this self-administered scale to the Portuguese population in 2011 had shown it can be easily and fastly administered, with satisfactory applicability and reliability[16].

In order to ensure a safe transition followed by the binomial patient/family, the design of an algorithm was required to facilitate decision-making, where from evidence, the circuit of intervention, information, and communication between the two care contexts could be graphically recreated (Figure 1). The use of algorithms in clinical practice promotes faster learning and internalization, allows the introduction of evidence into clinical practice in a faster and more uniform way, and facilitates the definition of individual strategies to be introduced in the information systems of support to documentation, that is, nursing documentation[17].

Chart 1 – Criteria for continuity of care of patients with mental disorders and their families, Vila Franca de Xira, Portugal, 2017

Category	Subcategory	UE[a]
Criteria for continuity of care when patients with mental disorders are referred to the community, associated with health status, dependence level, and self-care capacity	Capacity for management of therapeutic treatments	23
	Degree of dependence	17
	Patient training and cognitive status	13
	Need for care	10
	Family support	8
	Need for technical and rehabilitation assistance	8
	Need for home care	5
Criteria for continuity of care associated with knowledge and competence level of family caregivers	Need for training caregivers	13
	Socioeconomic and family conditions	10
	Evaluation of caregivers' cognitive capacity	8
	Internalization of the importance of role/responsibility	6
	Caregivers' physical capacity	5
	Community resources and support network	7
	Capacity for management of therapeutic treatments	4
	Psychological capacity	4
	Caregivers' availability	4

Note: [a] Units of enumeration

Guidelines of the Society for Medical Decision Making, which regards to the development of algorithms, were applied for its development[17].

The main concern with the treatment plan of patients and their families focuses on the control of symptoms and patient reintegration, which requires two approaches in the opinion of the participants: drug therapy and psychosocial therapy. Drug therapies are made with antipsychotics or neuroleptics, which are used in the acute phase of illnesses to relieve psychotic symptoms, and in periods between crises to prevent risk of relapse. Physicians try to keep the medication in the lowest possible dose to prevent risk of relapse and potential adverse effects. Due to the risk of non-adherence to the therapeutic treatment, all professionals' interventions aim at promoting adherence to the therapeutic treatment, by means of a good therapeutic alliance and psychoeducation together with patients and their families.

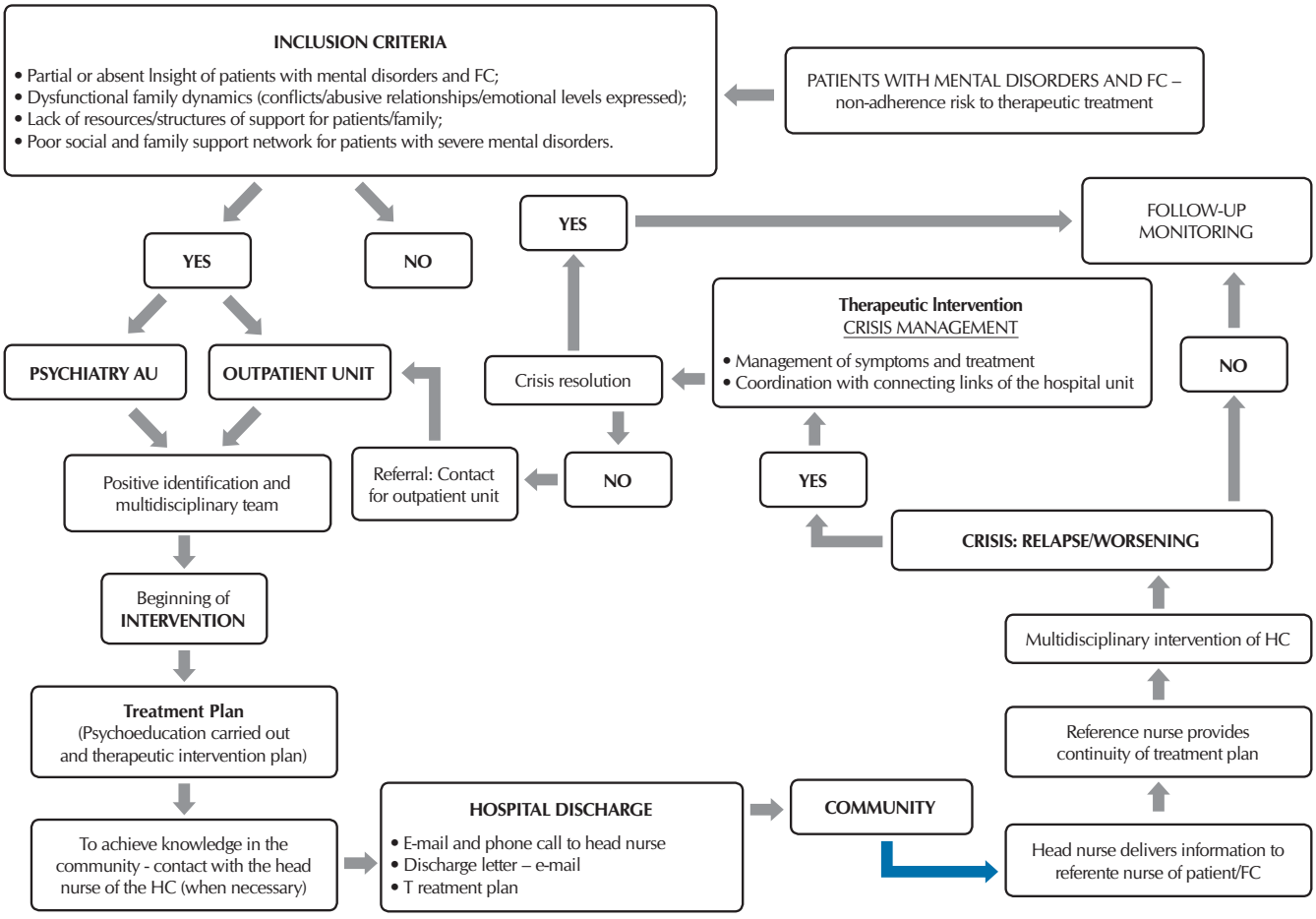
Reference nurses in the hospital and community were defined for each clinical situation and to facilitate alliance.

After returning home, the community reference nurse gives continuity to the treatment plan with biweekly follow-up during the first month. Then, follow-up is carried out once a month to keep therapeutic adherence. Status of patients and their family is determined in the first evaluation.

The MARS scale is applied both at the hospital and in the community. At the hospital, it is applied at the time of admission and on the day of hospital discharge. In the community, it is applied on the third, sixth, and 12th month after returning home.

In situations of difficult adherence and symptomatic control, coordination with connecting links at the hospital is of utmost importance. In these cases, a crisis must be managed and a plan is required to revert any worsening of psychotic symptoms, as well as to reduce delirious thoughts. At this time, patients and other family members must receive immediate protection and support. The following warning signs were recognized by patients and their families: insomnia; ritualistic concern with specific activities; being suspicious; unexpected outbursts; search for quietness or isolation; mood swings; and demonstration of bizarre behaviors.

Crisis management must be preferably made in the community in coordination with the outpatient unit of the hospital to prevent hospitalization. It includes all activities that allow stress management (management of the context and situation itself); management of symptoms and treatment (for example: sleep, deliriums, hallucinations); management of emotions (anxiety, irritability, aggressiveness, lability); management of communication and coordination with connecting links of the hospital unit.



Note: AU – Autonomous unit; HC – Healthcare center; FC – Family caregivers

Figure 1 – Algorithm for a safe transition from hospital to community for patients with mental disorders and their families, Vila Franca de Xira, Portugal, 2017

DISCUSSION

Non-adherence to treatments stands out as a potentially modifiable factor that may lead to relapses and pharmacological resistance[2].

The main problem and starting point for the present study was the discontinuity of care and its potential impact on non-adherence to treatments.

Patients are vulnerable to experiences of loss of continuity when their health status is altered or when they have to move between healthcare services, which leads to implications for their functionality and quality of life. Continuity of care ensures improvement in the quality of care provided, contributes to the reduction of costs, and presents itself as an appropriate strategy and a policy to be followed by healthcare services[4].

The fragmentation of continuity of care may result in confusing treatment instructions for patients with a significant probability of errors and duplications, inappropriate follow-up, as well as lack of preparation/information for themselves and family caregivers[17].

The results in the present study indicate the need for a reliable evaluation of the adherence to medications of patients with chronic disorders and measurement of risk associated with the vulnerability criteria that these patients and their families present, in order to ensure continuity and manage community resources. However, establishing non-adherence risk is a challenge. In spite of being a concern, its measurement is difficult[10,16]. Professionals spend time in the evaluation of non-adherence predictors, and patients may eventually not express their intentions regarding medication. Even with a type of "non-adherent personality", there are no patterns universally accepted for a worthwhile and reliable approach to evaluate adherence behavior[10].

The main evaluation methods are patients' reports and information of professionals, counting of drug tablets/capsules, and biological methods (such as the dosing of drugs through blood or urine tests), with advantages and disadvantages inherent to each method[16].

The present study showed that the reports of patients with mental disorders are not always reliable, even though the cost/efficiency and cost/time relationship of this method is more favorable. However, it can overestimate adherence to medication in 30%[16]. The counting of drugs is not reliable because patients and their families may remove them from blisters, which does not mean intake[16].

The study participants chose the MARS scale, with establishment of evaluation times in the hospital and community, in order to keep an evaluation and comparison of the adherence behavior.

The treatment plan initiated at the hospital and to be continued in the community relies on psychoeducation of patients and their families. Among the interventions with impact on the adherence to therapeutic treatments, authors highlight psychoeducation, cognitive-behavioral therapies, and motivational interviews[16] with the potential to increase adherence[10,18].

The purpose of psychoeducation is to teach a better understanding of illnesses, medications, and potential collateral effects. It may involve counseling techniques, sessions, and writing and audiovisual material[10]. In spite of being the main pillar of strategies to improve adherence over the years, the results of studies are not consistent with its use, because its effectiveness is considered poor[10].

These behavioral approaches include conditioning, rewards, tips, reminders, and training of skills[18]. Psychosocial and pharmacological aspects, and even technological approaches must complement themselves to resolve this issue[10].

Many of the difficulties result from the lack of information on what to expect from treatments in terms of risk and specific collateral effects, response time of medications, or degree of impact of a treatment on specific dimensions. The nature and extension of psychoeducation combined with the therapeutic alliance with patients may be an important predictor of behavioral adherence[10].

Some studies have focused on the importance and effectiveness of teleconsultations, telemonitoring, telecare, or telenursing, considered as an increasing modality of communication in the nursing care area[1]. In order to ensure and improve access to health care, information exchange is essential, because it provides bond and psychosocial and affective safety in the communication between professional and patients[1]. Telenursing consultations have demonstrated adherence to therapeutic treatments through the significant increase in 83.4% by means of outpatient medical follow-up, use of prescribed medications, and continuity of instructions carried out[1].

Follow-up by reference nurses of healthcare centers includes the possibility of telemonitoring for patients with lower risk of non-adherence, but always complemented with regular consultations by the multidisciplinary team.

This regular follow-up corroborates results of other studies that show that symptomatic patients may have serious impairments in self-care and maintenance of the drug treatment, and may even make use of medications to commit suicide[2]. Non-adherence to therapeutic and drug treatments itself has a negative impact on the course of illnesses, which may lead to hospitalization recurrence and increase in time for remission of symptoms, with psychotic outbreaks and suicide attempts[9].

Regular contact contributes to the development of a trustful relationship and provides safety. Therapeutic alliance leads to a better adherence. Therefore, professionals must help patients and their families in establishing goals[18]. Empathetic willingness is required, in addition to a collaborative and partnership structure where patients feel active, participative, and respected in this relationships[18].

Family support is a predictor of adherence[7]. Researchers of a study that evaluated the training of family members observed that their supervision increased adherence to treatment[19].

The characteristics of the care system must also be considered[10]. Authors indicate that this system includes the time spent to evaluate factors that may influence adherence, providing psychotherapy (to patients and family members, if appropriate), and enabling continuity of care[10]. The characteristics of family caregivers must be considered to evaluate their capacity for management of treatments and symptoms. Knowledge, beliefs, attitudes, and the nature of their relationships influence their role as potential facilitators of adherence to therapeutic treatments[10].

Another aspect to be considered is related to social, cognitive, and behavioral perspectives. Non-compliance/adherence often represents a rational decision for some patients, determined by factors such as their opinions/beliefs on taking medications, life circumstances and available resources, competing priorities,

and the need to ensure their independence and carry out their lives, even when undergoing long-term treatments[8].

Therefore, interventions must be developed to meet the challenges of non-adherence to treatments, with improvement in training environments of patients and their families, sharing of decision-making, and accountability for the management of illnesses[10].

Although not presented in the results of the present study, it is worth mentioning that indicators were defined for evaluation of the treatment plan. It is important to strengthen the idea that organizations, when evaluating the quality of care provided in healthcare services, must make use of indicators in the preparation of patients to return home, health education of these patients and families, support provided for continuity of care at home, and follow-up carried out after hospital discharge[12].

Encouragement and increase in networking among healthcare professionals of hospitals and community, and the resource to case managers or peer advisers may also be valuable to facilitate the process[10].

Integrative reviews carried out regarding the transition from hospital to community showed that the instructions made available by nurses are essential so this transition is effective, as they promote adherence to medications, self-care management, increase adherence to treatments, and reduce rehospitalization, comorbidities, and mortality rates[12].

Study limitations

The present study presented limitations involving the intentionality in the choice of contexts, participants, method, and analysis carried out, which do not allow generalizations for the population.

Contributions to the nursing, healthcare, or health policy areas

In spite of the limitations abovementioned, the present study contributes to discussions on continuity of care, safety in the adherence to therapeutic treatments, and raises issues on the role of nurses as managers of clinical cases and leaders in the management of the transition that patients experience over their life cycle and in different contexts. Some of the results may be used in undergraduate and graduate programs for healthcare professionals to discuss the importance of the role of nurses as managers of clinical cases in patients who need continuity of care, contributing to the development of more effective solutions to adopt evidence-based decision making in clinical practice and development of healthcare policies.

FINAL CONSIDERATIONS

The present study brings significant contributions to continuity of care among care levels. In the content analysis of nurses' speeches and reports, two major categories related to the criteria for continuity of care patients with mental disorders emerged: those associated with patients and those established by knowledge and competence of family caregivers.

It is worth mentioning the importance of improving communication networks and empowering patients and their families with knowledge and adaptive strategies in the face of adversity and symptomatic alterations.

The algorithm designed over the action research process aims to ensure a hospital-community safe transition, which is only possible with the definition of criteria for continuity of care associated with clinical condition, and training and motivation of patients and family caregivers.

Safe transition insurance with adherence to therapeutic treatments involves early planning of home return, participation of patients and their families, establishment of non-adherence risk, information sharing, and accountability of all parties involved. Communication among care levels must be simple, objective, continuous, and with feedback.

In order to achieve improvement in continuity of care between hospital and community, information content and circulation must be defined.

Further studies must be carried out to evaluate the effectiveness of the change in adherence to therapeutic treatments.

REFERENCES

1. Pereira SK, Santana RF, Morais VSC, Soares TS, Silva DM. Discharge planning in post-operative of elderly: multiple cases study. Rev Pesqui: Cuid Fundam[Internet]. 2016[cited 2018 Mar 02];8(4):4949-55. Available from: http://dx.doi.org/10.9789/2175-5361.2016.v8i4.4949-4955
2. Ibanez G, Mercedes BPC, Vedana KGG, Miasso AI. Adherence and difficulties related to drug treatment in patients with depression. Rev Bras Enferm[Internet]. 2014[cited 2018 Mar 07];67(4):556-62. Available from: http://dx.doi.org/10.1590/0034-7167.2014670409
3. Mata LRF, Napoleão AA. Nursing interventions for patients discharged from prostatectomy: an integrative review. Acta Paul Enferm[Internet]. 2010[cited 2018 Feb 27];23(4):574-9. Available from: http://www.scielo.br/pdf/ape/v23n4/en_21.pdf
4. Mendes F, Gemito MLP, Parreirinha C, Cladeira EC, Serra IC, Casas-Novas MV. Continuity of care from the perspective of users. Ciência Saúde Colet[Internet]. 2017[cited 2018 Feb 27];22(3):841-53. Available from: https://dx.doi.org/10.1590/1413-81232017223.26292015
5. Párraga Martinez I, Lopez-Torres Hidalgo J, Del Campo Del Campo JM, Villena Ferrer A, Morena Rayo S, Rabadan F, et al. Adherence to patients antidepressant treatment and the factors associated of non-compiance. Aten Primaria[Internet]. 2014[cited 2018 Mar 05]:S0212-6567(13)00308-9. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0212-6567(13)00308-9
6. García S, Martínez-Cengotitabengoa M, López-Zurbano S, Zorrilla I, López P, Vieta E, et al. Adherence to antipsychotic medication in bipolar disorder and schizophrenic patients: a systematic review. J Clin Psychopharmacol[Internet]. 2016[cited 2018 Feb 28];36(4):355-71. Available from: http://dx.doi.org/10.1097/JCP.0000000000000523

7. El-Mallakh P, Findlay J. Strategies to improve medication adherence in patients with schizophrenia: the role of support services. Neuropsychiatric Dis Treat[Internet]. 2015[cited 2018 Mar 05];11:1077-90. Available from: https://doi.org/10.2147/NDT.S56107

8. Chakrabarti S. What's in a name? compliance, adherence and concordance in chronic psychiatric disorders. World J Psychiatr[Internet]. 2014[cited 2018 Feb 28];4(2):30-6. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4087153/pdf/WJP-4-30.pdf

9. Higashi K, Medic G, Littlewood KJ, Diez T, Granström O, De Hert M. Medication adherence in schizophrenia: factors influencing adherence and consequences of nonadherence, a systematic literature review. Ther Adv Psychopharmacol[Internet]. 2013[cited 2018 Mar 17];3(4):200-218. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805432/pdf/10.1177_2045125312474019.pdf

10. Kane JM, Kishimoto T, Correll CU. Non-adherence to medication in patients with psychotic disorders: epidemiology, contributing factors and management strategies. World Psychiatry[Internet]. 2013[cited 2018 Feb 28];12(3):216-26. Available from: https://www.ncbi.nlm.nih.gov/pubmed/24096780

11. Nascimento KC, Kolhs M, Mella S, Berra E, Olschowsky A, Guimarães AN. The family challenge in for people care suffering from mental disorder. Rev Enferm UFPE[Internet]. 2016[cited 2018 Mar 07];10(3):940-8. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/viewFile/11044/12449

12. Weber LAF, Lima MADS, Acosta AM, Marques GQ. Care transition from hospital to home: integrative review. Cogitare Enferm[Internet]. 2017[cited 2018 Mar 07];22(3):e47615. Available from: http://dx.doi.org/10.5380/ce.v22i3.47615

13. Silva JC, Morais ER, Figueiredo MLF, Tyrrell MAR. Action research: concepts and applicability in Nursing studies. Rev Bras Enferm[Internet]. 2011[cited 2018 Mar 08];64(3):592-5. Available from: https://dx.doi.org/10.1590/S0034-71672011000300026

14. Baixinho CL, Ferreira Ó, Marques FM, Presado MH, Cardoso M. Transição segura: um projeto da transferência do conhecimento para a prática clínica. In: Costa AP, Sánches-Gómez MC, Cilleros MVM. A prática na Investigação Qualitativa: exemplos de estudos. Oliveira de Azeméis: Ludomédia, 2017; pp.57-80.

15. Streubet HJ, Carpenter DR. Investigação Qualitativa em Enfermagem: avançando o imperativo humanista. 5ª ed. Loures: Lusociência; 2013.

16. Vanelli I, Chendo I, Gois C, Santos J, Levy P. Medication adherence rating scale. Acta Med Port [Internet]. 2011[cited 2018 Mar 08];24:17-20. Available from: http://www.actamedicaportuguesa.com/revista/index.php/amp/article/view/348/118

17. ACP. Proposal for Clinical Algorithm Standards: Society for Medical Decision Making Committee on Standardization of Clinical Algorithms. Medical Decision Making. 1992.

18. Ehret MJ, Matthew W. How to increase medication adherence: What works? MHC[Internet]. 2013[cited 2018 Mar 09];2(8):230-2. Available from: http://mhc.cpnp.org/doi/full/10.9740/mhc.n132973?code=cpnp-site

19. Farooq S, Nazar Z, Irfan M, Akhter J, Gul E, Irfan U, et al. Schizophrenia medication adherence in a resource-poor setting: randomised controlled trial of supervised treatment in out-patients for schizophrenia-STOPS. Br J Psychiatry[Internet]. 2011[cited 2018 Mar 19];199(6):467-72. Available from: https://www.ncbi.nlm.nih.gov/pubmed/22130748