



Transitional care: analysis of the concept in hospital discharge management

Cuidados de transição: análise do conceito na gestão da alta hospitalar

Atención transicional: análisis de concepto en gestión de alta hospitalaria

Elizabeth Bernardino¹

Solange Meira de Sousa¹

Jaqueline Dias do Nascimento¹

Maria Ribeiro Lacerda¹

Danelia Gomez Torres²

Luciana Schleder Gonçalves¹

1. Universidade Federal do Paraná, Programa de Pós-graduação em Enfermagem. Curitiba, PR, Brasil.

2. Universidad Autonoma Del Estado de México, Facultad de Enfermería y Obstetricia. Toluca de Lerdo, México.

ABSTRACT

Objective: to analyze the concept of Transitional Care in the context of hospital discharge management. **Method:** analytical reflection using the Walker and Avant's conceptual analysis: concept selection; definition of the objective, identification of the use of the concept (literature search and dictionaries between September-December/2019 in the databases: PubMed, Virtual Health Library and SCOPUS. A total of 77 articles that contemplated the concept and other terms that corroborated the study were considered; for methodological purposes, 12 studies enabled the analysis); definition of attributes; description of model case; description of additional cases; definition of antecedents and consequents; definition of empirical indicators. **Results:** the fragmented care and readmission antecedents are common to the concept. The attributes integrated care, professional collaboration, coordination, discharge planning, communication, professional integration, and case management were identified. **Conclusion and Implications for practice:** it was opportune to analyze the concept together with terms related to the context of hospital discharge. Transitional Care is coordinated and effective practices for the Continuity of Care in the transference of the user at hospital discharge; in this context, Liaison Nurses are potential protagonists to be ahead in this Integration process. The specificities of the concept may favor its understanding and the construction of knowledge that has repercussions on coordinated and continuous care.

Keywords: Patient Discharge; Transitional Care; Continuity of Patient Care; Intersectoral Collaboration; Nurses.

RESUMO

Objetivo: analisar o conceito Cuidados de Transição no contexto da gestão da alta hospitalar. **Método:** reflexão analítica utilizando-se a análise conceitual de Walker e Avant: seleção do conceito; definição do objetivo, identificação do uso do conceito (busca na literatura e dicionários entre setembro-dezembro/2019 nas bases de dados: PubMed, Biblioteca Virtual em Saúde e SCOPUS. Consideraram-se 77 artigos que contemplaram conceito e outros termos que corroboraram o estudo; para fins metodológicos, 12 estudos possibilitaram a análise); definição dos atributos; descrição de caso modelo; descrição de casos adicionais; definição de antecedentes e consequentes; definição de indicadores empíricos. **Resultados:** os antecedentes cuidados fragmentados e reinternação são comuns ao conceito. Identificaram-se atributos cuidado integrado, colaboração profissional, coordenação, planejamento da alta, comunicação, integração profissional e gerenciamento de casos. **Conclusão e implicações para a prática:** foi oportuno analisar o conceito em conjunto com termos relacionados ao contexto da alta hospitalar. Cuidados de Transição são práticas coordenadas e eficazes para a *Continuidade dos Cuidados* na transferência do usuário na alta hospitalar; nesse contexto, as *Enfermeiras de Ligação* são potenciais protagonistas para estar à frente nesse processo de *Integração*. As especificidades do conceito poderão favorecer a sua compreensão e a construção de conhecimentos que repercutam no cuidado coordenado e contínuo.

Palavras-chave: Alta Hospitalar. Cuidados de Transição. Continuidade da Assistência ao Paciente. Integração dos Serviços de Saúde. Enfermeiras e Enfermeiros.

RESUMEN

Objetivo: analizar el concepto de Atención Transicional en el contexto de la gestión del alta hospitalaria. **Método:** reflexión analítica utilizando el análisis conceptual de Walker y Avant: selección de conceptos; definición del objetivo, identificación del uso del concepto (búsqueda en la literatura y diccionarios entre septiembre-diciembre / 2019 en las bases de datos: PubMed, Virtual Health Library y SCOPUS. Se consideraron 77 artículos que contemplaban el concepto y otros términos que corroboraban el estudio; a efectos metodológicos, 12 estudios permitieron el análisis); definición de atributos; descripción del caso modelo; descripción de casos adicionales; definición de antecedentes y consecuencias; definición de indicadores empíricos. **Resultados:** la atención fragmentada y los antecedentes de readmisión son comunes al concepto. Se identificaron los atributos atención integral, colaboración profesional, coordinación, planificación del alta, comunicación, integración profesional y manejo de casos. **Conclusión e implicaciones para la práctica:** fue apropiado analizar el concepto junto con términos relacionados con el contexto del alta hospitalaria. Transition Care son prácticas coordinadas y efectivas para la *Continuidad de la Atención* en el traslado del usuario al alta hospitalaria; en este contexto, las *Enfermeras de Enlace* son potenciales protagonistas para estar a la vanguardia de este proceso de integración. La especificidad del concepto puede favorecer su comprensión y la construcción de conocimientos que inciden en la atención coordinada y continuada.

Palabras clave: Alta del Paciente; Cuidado de Transición; Continuidad de la Atención al Paciente; Colaboración Intersectorial; Enfermeras y Enfermeros.

Corresponding author:

Solange Meira de Sousa.

E-mail: solangesmj@gmail.com

Submitted on 11/04/2020.

Accepted on 08/17/2021.

DOI: <https://doi.org/10.1590/2177-9465-EAN-2020-0435>

INTRODUCTION

Concepts are expressed through language (terms or words), allowing ideas to be communicated and experiences to be classified in a meaningful way¹. They can be considered concrete or abstract, enabling the description of any situation². Established over time by certain circumstances, concepts allow knowledge to be expanded. In nursing, they are essential so that the care provided can be executed with quality and, considering the various contexts, be visualized in a way that does not generate ambiguity in the assistance³⁻⁷.

The need for hospitalization is determined primarily by the presence of an acute health condition of sufficient severity that therapeutic or diagnostic intervention or careful monitoring is required. Inherent in this, hospital discharge is a complex and challenging process³. Therefore, hospital discharge management is an administrative tool, aimed at promoting more effective and planned interventions, in a perspective of Integration with other health care points⁶.

In this perspective, the Continuity of Care to the patient after hospital discharge prevents the user from getting lost in the care network due to lack of knowledge of the services to which he/she can resort in case of need. The deficits in the counter-reference mechanisms leave the users and their families helpless and insecure, leading them to search for inadequate services, such as the Emergency Care Units (ECU), which are destined to the care of urgencies and emergencies⁴.

The search for information and actions that support discharge planning in the hospital environment and its responsible action constitutes the final product of a path that has concepts that crosscut the entire care network of the complexity levels of the Unified Health System (UHS)⁸.

Transitions between healthcare services can be a vulnerable period, especially for users with multiple comorbidities, complicated treatment regimens, or limited caregiver support. In this sense, practices that aim to improve discharge management can ensure continuity of patient care and show a close look at the transition of care⁹.

In this scenario of multiple needs and scarce resources, nurses present themselves as strategic professionals in both resource management and care coordination, and there is no alternative without being heavily involved. Their contribution comprises integration, transition, and liaison practices, aiming at the Continuity of Care, meeting not only a UHS principle, but also the citizen's right to be assisted in their individual and collective health needs⁴⁻⁷.

Thus, the Liaison Nurse is the professional who has the function or assignment of coordinating the transition of patients between units in the care network, reconciling the care needs and the network's ability to meet them with a view to the Continuity of Care⁴⁻⁶.

Therefore, the transition of patients with complex situations from hospital to primary care services depends on effective communication and requires greater care with the whole context involved in the care and discharge of each individual¹⁰.

These, among other aspects, contribute to the understanding of a complex dynamic involved in the context of hospital discharge and the responsibility attributed to professionals, services, as well as to the entire Health System. However, many concepts related to this subject are found in the literature from various perspectives and, therefore, it becomes necessary to clarify them in order to make the theoretical discussions more consistent and, consequently, favor the care provided.

For this reason, in order to promote knowledge related to the subject and to provide reflection about some terms deemed pertinent to the context of hospital discharge management, this study aimed to analyze the Transitional Care concept in order to determine its critical attributes, antecedents, and consequents. It was observed through other studies⁴⁻⁶, a proximity between the intended concept of Transitional Care with other terms, among which are Liaison Nurse, Continuity of Care, and Integration. In this way, besides clarifying the use of the concept Transitional Care, it is intended to ratify or not this relation or to sustain a differentiation between the terms.

METHOD

This is an analytical reflection about the concept of Transitional Care in the context of hospital discharge management. To achieve this, a theoretical analysis was performed using the conceptual analysis method of Walker and Avant, which includes eight steps that can occur sequentially or simultaneously: selection of the concept; definition of the objective; identification of the use of the concept; definition of attributes; description of a model case; description of additional cases; definition of antecedents and consequents; definition of empirical indicators¹.

The first step is the selection of the concept. The term Transitional Care reflects part of the professional and research experience of the authors of this study and has attracted attention and concern in recent years. The second step corresponds to the objective of this study.

In the third step, the use of the concept is identified through database and dictionary searches to elucidate it in the scientific field and common sense¹. Thus, a search of the literature was conducted between September and December 2019 in the Virtual Health Library, MEDLINE/PubMed and SCOPUS. Terms in English and Portuguese were used by combining the descriptors identified in Medical Subject Headings (MeSH), Descriptors in Health Sciences (DeCS) and keywords with the Boolean operators AND and OR.

The decision was made to conduct a review for each of the terms considered pertinent to the same context as the concept addressed in this study in order to promote a theoretical and reflective analysis that would provide, in addition to understanding the concept, an understanding of its relationship with terms that are commonly related to it. Thus, it was used as a guiding question: "How does the Transitional Care concept relate to hospital discharge management?". Chart 1 shows the search strategies in the databases with the combinations made to cover the search.

Chart 1. Search strategies. Curitiba, PR, Brazil, 2021.

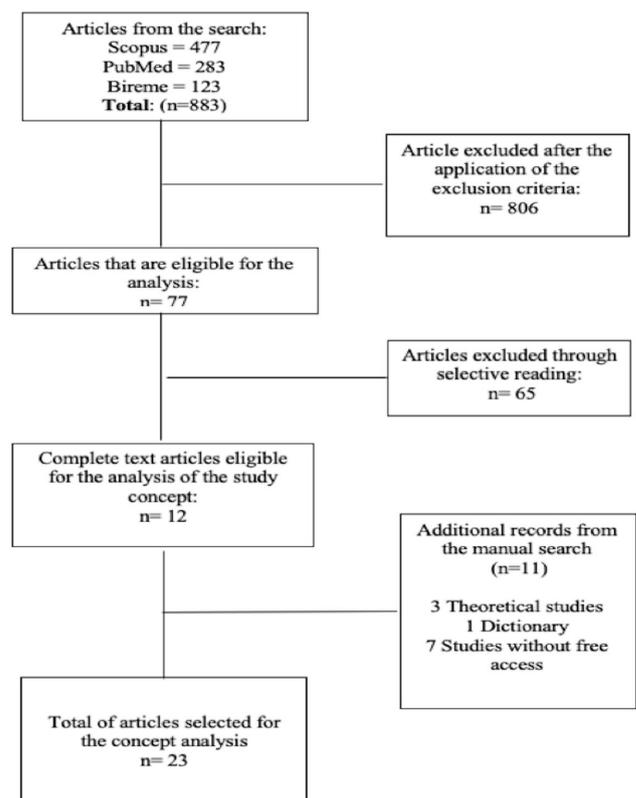
1) Transitional Care
-“Transitional Care”[MeSH Terms] AND “Patient Discharge”[MeSH Terms] AND “Organization and Administration”[MeSH Terms]
-(tw:(“transitional care”)) AND (tw:(“patient discharge”)) OR (tw:(“hospital discharge”)) OR (tw:(“discharge management”)) AND (“Nursing” OR “male nurse” OR “female nurse”)
2) Continuity of Care:
-“Continuity of Patient Care” [MeSH Terms] AND “Nurses” [MeSH Terms] AND “Patient Discharge” [MeSH Terms] AND “Organization and Administration”[MeSH Terms]
-“continuity of care” AND (“patient discharge ” OR “ hospital discharge ” OR “ discharge management “) AND (“Nursing ” OR “ male nurse ” OR “ female nurse “)
3) Liaison Nurse:
-“Liaison nurses” [All Fields] AND (“nurses” [MeSH Terms] OR “nurses”[All Fields] OR “nurse”[All Fields])) AND “Patient Discharge”[MeSH Terms] AND “Organization and Administration” [MeSH Terms]
-“ liaison nurses ” AND “ discharge management ” OR “ hospital discharge “
4) Integration:
-“integrated”[All Fields] OR integration [Text Word] AND “Patient Discharge”[MeSH Terms] AND “Organization and Administration” [MeSH Terms] AND “integrated”[All Fields] OR integration [Text Word] AND “Int J Integr Care”[Journal]
-(tw:(“ hospital discharge “)) OR (tw:(“ discharge management “)) OR (tw:(“ patient discharge “)) AND (tw:(integration)) OR (tw:(“ integral health care”)) OR (tw:(“ integral care “)) AND (tw:(Nursing))

Source: Elaborated by the authors (2021).

This search obtained a total of 883 articles. Then, the inclusion criteria were applied: primary research articles; in Portuguese, English or Spanish; complete texts available online in full, without date delimitation, in which the focus was on each of the four main terms (Chart 1) in hospital discharge management. Exclusion criteria were: editorial publications, dissertations, theses and abstracts. Two reviewers selected the articles independently and analyzed the titles and abstracts of the identified publications applying the eligibility criteria. The articles selected for reading presented, in their abstracts, a direct approach related to the subject. A total of 77 articles were considered for analysis, considering all the terms listed. For didactic and methodological purposes, numerically, only the studies that reflected the concept of this research were considered, which resulted in 12 articles^{4-6,9,11-18}. In addition to these, 11 records were added through manual search (Figure 1)^{10,19-28}.

In the fourth step, the attributes are determined, that is, words or expressions that constitute the essence of the concept and are pertinent to the analysis. The fifth step consists of formulating a model case, which translates into an example of a fictitious case created by the researchers, based on the actual context of the concept's use, covering the identified attributes. In the sixth step, additional cases are identified. To this end, a case contrary to the concept was selected that contributed to the construction of essential characteristics¹.

In the seventh step, the identification of antecedents and consequences of the concept occurs. This is a survey of incidents or events that happen before the concept occurs and events or

**Figure 1.** Flowchart of the selected studies. Curitiba, PR, Brazil, 2021.

Source: Elaborated by the authors (2021).

situations that arise after the concept is present. Therefore, it was necessary to consider the social context in which the concept is used. In the eighth step, the empirical referents are defined, observable phenomena that confirm the occurrence of the concept and allow a functional meaning for it. Attributes can often be similar to empirical referents¹ and, during the course of this study, it was found that the attributes identified coincide with the consequences of the concept and with the empirical referents, which may be common during the development of this methodology².

RESULTS AND DISCUSSION

The uses of the concept Transitional Care, from the health area perspective, and its dictionary definition, as well as the antecedents, attributes, consequences and empirical referents, are synthesized in Chart 2.

Antecedents

The antecedents of fragmented care^{4,12,20} and readmission^{14-16,23,26} are cited in several studies from different contexts, comprising general aspects that instigated the studies. They are events that motivate not only Transitional Care, but are also related to the terms Integration, Continuity of Care and Liaison Nurse.

Fragmented care is closely related to changes from fragmented to integrated processes²⁰. Such changes require the integration of professional practices of services in various domains and for different subgroups, e.g., people with diabetes, cardiovascular diseases, etc.,¹³ thus enabling care in different settings to be continued.

Readmissions are by far another important antecedent to be analyzed as a comprehensive determinant. They are the object of study of several authors, who seek to understand, mainly, the effect of practices that enable a safer transition and the importance of professionals that support them^{14-16,23}.

According to these studies, the practices carried out generate positive associations, with a decrease in hospitalizations and

user satisfaction due to an improvement in their quality of life. However, it is worth noting that all this discussion should occur in parallel with the implementation of a structured Transitional Care pathway that identifies safe discharge¹⁶. This, of course, can be achieved by working as a skilled and often cited Liaison Nurse in many settings and countries for several decades^{4-6,23,24}.

Attributes, consequences, and empirical referents

From the dictionary search, it was found that the concept has a meaning that is close to the main focus of the study¹⁹. Transitional Care are actions with the purpose of ensuring coordination and Continuity of Care for individuals transferring between different services or levels of care complexity. Transitions of care are based on level of care and health care availability and encompass the sending and receiving aspects of transfer and are essential for individuals with complex care needs²².

In the context of transition of care, the international literature highlights that adequate hospital discharge planning with a focus on Continuity of Care results in fewer hospital readmissions^{26,27}. This context is detailed in several studies, especially in American contexts where there is a concern to meet the imperatives of the Affordable Care Act, passed in 2010, which, among other things, encourages no hospital readmissions in less than 30 days^{26,27}.

Broadly speaking, Continuity of Care is what a patient experiences over time as coherent and connected; it is the outcome of good information flow, good interpersonal skills, and good care coordination. Thus, Continuity of Care occurs when the separate and discrete elements of care are connected and when these elements, which endure over time, are maintained and supported²¹.

In this process, the Liaison Nurse is the professional who can enable the reduction of hospitalization time and the Continuity of Care after discharge¹¹. This is the professional with the capacity to coordinate and follow the users' entire path, and must be able to transfer information from the hospital to primary care,

Chart 2. Uses of the concept, antecedents, attributes, consequences, and empirical referents. Curitiba, PR, Brazil, 2021.

<i>Uses of the concept</i>	Health: are actions with the purpose of ensuring coordination and Continuity of Care for individuals in transfer between different sites or levels of care in the same location ²² .
	Dictionary: act or effect of transiting. Path, trajectory. Passage from one place, subject, tone, treatment, etc. to another ¹⁹ .
<i>Antecedents</i>	Fragmented care ^{4,12,20}
	Rehospitalization ^{14-16,23,26}
<i>Attributes, consequences, and empirical referents</i>	Integrated Care ^{12,13} , professional collaboration ^{4,13,17} , coordination ^{5,6,12,13,17} , discharge planning ^{5,17} , communication ^{4-6,12} , professional integration ^{5,6,12} , case management ^{5,12,13}

Source: Elaborated by the authors (2020).

reconciling the care needs with the network's capacity to meet them in a continuous perspective¹¹.

During the review process, a juxtaposition of the terms Integration, Continuity of Care and Liaison Nurse to the concept Transitional Care was found, denoting the use of the concept.

The analysis of the main uses of the concept allowed us to highlight the following attributes: integrated care; professional collaboration; coordination; discharge planning; communication; professional integration; case management.

The integrated care attribute expresses care with a person centered focus and an approach that prioritizes the health of the population. This involves changes in all services and in the entire network to ensure that care is coordinated according to the needs of each individual, overcoming fragmentation in health care. As a result, there is a guarantee of Integration, which results in improved access, quality, and Continuity of Care¹³.

One can presume a consistent linkage of the concept under analysis together with the other terms mentioned beforehand. Similarly, integrated and quality care, offered unconditionally to the individual, resulting in his/her discharge from the hospital and anticipating all his/her needs, may be considered the key element for the current discussion. In this strict sense, the concept of Transitional Care, related to the terms Liaison Nurse and Continuity of Care, has elements that ensure integrated care and could be didactically allocated to a condition in which Integration permeates the whole context, as the scope of the whole process (Figure 2).

In the context of a transfer between health services or from health services to the home, enhanced collaboration between professionals should be prioritized. Therefore, the provision of services in a seamless manner in the transition from one service to another demonstrates a clear transfer of responsibilities between professionals¹⁷. For such professional collaboration, open communication channels, such as electronic medical records between organizations, can enable the effective transfer

of information. This becomes necessary as professionals, most notably nurses, have an understanding of the collaboration that exists. This recognition is a key part of effective collaboration and facilitates discharge planning¹⁷.

In this context, the attribute of coordination is introduced. Professionals in charge of coordinating hospital discharge are extremely valuable, since they can offer support to collaborating nurses, facilitating a safe and smooth transition between the hospital and primary care¹⁷. The role of coordinators between hospital and primary care, to support collaborating nurses, is extremely helpful. Collaboration and Continuity of Care can be improved with Liaison Nurses to coordinate and organize discharge planning and communication between the hospital and primary care organizations¹⁷.

Other relationships between the concept of Transitional Care and the terms Liaison Nurse, Continuity of Care, and Integration may be pointed out. For example, the activities developed by the Liaison Nurse for the Continuity of Care suggest that the articulation with services minimizes discontinuity in care^{6,23} or, that the problems related to Transitional Care from hospital care to home care led to the strong recommendation of the introduction of the Liaison Nurse role⁶. The Liaison Nurses are essential at hospital discharge and ensure adequate care planning in an articulated and coherent manner with all professionals⁶.

Effective hospital discharge planning is strongly related to integrated care and care transition, resulting in improvements in Integration. In a study developed in Iran, it was pointed out that the identification and provision of aspects that favor discharge planning are favorable to the reduction of avoidable hospital readmissions, causing an improvement in the quality of care¹⁸. Other settings show successful results in decreasing hospital readmission rates^{14,15}. In Singapore, a transitional home care program operated by a hospital was analyzed for its effectiveness in reducing hospitalizations. In the study, 259 patients received an assessment by a physician and a nurse case manager in the home setting, followed by an individualized care plan that included medical and nursing care, patient education, and coordination of care with hospital specialists and community services. The results indicated, among other things, a reduction in emergency department visits, hospitalizations, comprehensive assessment of patients' needs in the home environment, and the formulation of an individualized care plan, optimizing post-discharge care in complex situations¹⁴.

Successful transition is ideal in many settings, especially those related to chronic illness. Evidence suggests that a coordinated Transitional Care plan can result in reduced length of stay and readmission rates for adults with complex medical needs^{14,15}. Discharge planning aims to define the needs of individuals regarding the transition from one level of care to another, observing the context that encompasses discharge from the hospital to the community, and can be a central axis in the provision of Nursing care. In this sense, Transitional Care is inserted as interventions, usually of a multidisciplinary nature, whose proposal consists in

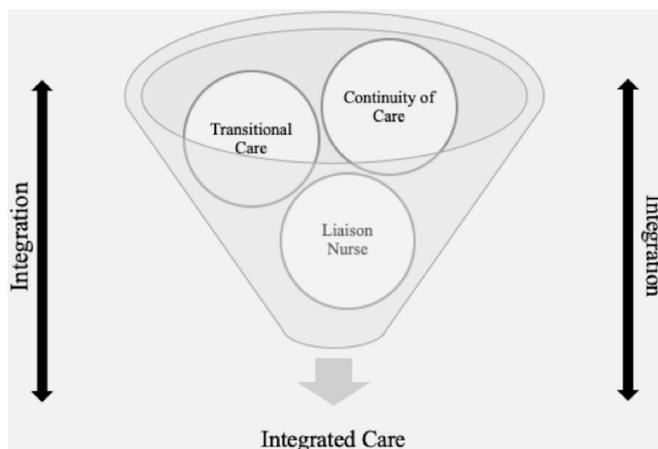


Figure 2. Concept under analysis and its relationship with other terms. Curitiba, PR, Brazil, 2021.

Source: Elaborated by the authors (2021).

improving health care through better coordination and Continuity of Care when individuals move between different services¹⁴.

In the study of integrated care programs in Australia, Canada, the Netherlands, New Zealand, Sweden, the United Kingdom, and the United States¹³, it was possible to clarify the attributes communication, professional integration, and case management. In order to align work processes, and therefore the time and effort required by some professionals to the detriment of others for the specific care of older adults with dementia, one initiative allowed case managers to meet and discuss periodically about all their clients, which favored professional integration¹³. This has made it possible to understand that care integration is not about finding formal, structural solutions for everything¹⁴. Trust and good working relationships seem to have played an important role in overcoming the fragmentation that challenges established work processes¹³. While the integration of functional structures and processes played indispensable facilitating roles in service delivery, the small teams and low hierarchy allowed communication among all, while still considering the user's situation as the starting point¹³.

In many analogous ways, these attributes go together and have technical and practical elements for the scope and glimpse of the concept of this research^{5,6,10}.

As part of the proposed methodology, Chart 3 exemplifies the concept of Transitional Care and establishes the connection with the terms Liaison Nurse, Continuity of Care and Integration through a fictional context in which the attributes are present: integrated care; professional collaboration; coordination; discharge planning; communication; professional integration and case management.

It is perceived, in the described event, that the concern with a quality hospital discharge can prevent eventual readmissions, thus promoting a continuous care. For this, professionals engaged in guaranteeing this process are needed in a context in which several services work to guarantee quality and integrated care.

It is worth noting that the discussion about comprehensive, continuous and coordinated care that meets the health needs of individuals also includes the perspective of reference and counter-reference and that an adequate organization for medium and high complexity referrals can favor the transition of care.

As an example of an additional case, a contrary case is shown in Chart 4²⁸.

In this case, it is not possible to identify the attributes related to the concept under analysis, but opposite information, contributing to the understanding of the concepts' characteristics.

Chart 3. Model case. Curitiba, PR, Brazil, 2021.

A.C.M, female, cashier operator, 51 years old, married. She was admitted to a teaching hospital after acute myocardial infarction (AMI) and underwent emergency cardiac catheterization followed by angioplasty for treatment. History of hypertension, diabetes and hypercholesterolemia. She was in consultation with the nurse at her neighborhood Health Unit when she presented unspecific signs of AMI (intermittent jaw and scapular pain and mild stomach pain). She is promptly attended to by the nurse and the doctor of the unit, who identify a possible more complex condition and call the Mobile Emergency Care Service (MECU). Before sending the patient to the hospital, the doctor and nurse make some observations about their condition, vital signs, and the measures taken at the time of the symptoms. Care continues in the Intensive Care Unit (ICU). The next day, the ICU nurse contacts the nurse at the health care facility seeking additional information about the patient. The contact is made and the hospital nurse obtains additional information that helps her to prepare discharge planning. In the midst of this, in the hospital, some professionals meet twice a month to discuss some cases and, on one of these occasions, A.C.M.'s case was discussed in order to outline her best therapeutic plan, since, during hospitalization, she presented again symptoms that would need to be re-discussed to outline a new conduct. At the moment of hospital discharge, the hospital nurse contacted the health unit again and reported, to the health unit nurse, the pertinent information about A.C.M.'s hospitalization.

Source: Elaborated by the authors (2021).

Chart 4. Contrary case. Curitiba, PR, Brazil, 2021.

A 73-year-old African-American man, Mr. W., admitted to a large urban teaching hospital with blood glucose of 560 mg/dL, dehydration, and confusion. He improved with insulin and hydration and was able to give the hospital staff his wife's phone number. After a discussion between the hospital staff and his wife, Mr. W. was sent home with a referral for home care services and the same diabetic regimen he had before the hospital visit. His primary care physician was not contacted. Five days later, Mr. W. returned to the Police Department after police found him wandering the streets. Further testing revealed moderate vascular dementia, hyperglycemia, and dehydration. In addition, his wife is disabled, attends daycare, and cannot help him with his diabetic regimen or diet. Such aspects pointed out require several emergency visits and hospitalizations. This patient's concerns clearly point to the need for better transitions²⁸.

Source: Burke²⁸.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

It was appropriate to analyze the concept of Transitional Care together with the terms Liaison Nurse, Continuity of Care and Integration, as they are all intertwined in the context of hospital discharge. The characterization of the concept was possible through the attributes discussed, that is, integrated care, professional collaboration, coordination, discharge planning, communication, professional integration and case management make up important aspects of the concepts, making it possible to define a meaning.

By way of conclusion, it is conceptualized, based on this study, that Transitional Care is a coordinated practice, proven effective to guarantee safety and Continuity of Care during the user's transfer at hospital discharge in an attempt to guarantee quality of life and, consequently, avoid hospital readmissions. In this context, the professionals called Liaison Nurses are potential protagonists to be ahead of these practices, contributing to the management of hospital discharge and to the Integration process.

The specificities related to the concept under study may favor its understanding in a precise manner and the construction of knowledge that will result in a coordinated and continuous care. The affinity between the concept and the terms described is emphasized, especially regarding the Liaison Nurse, in the context of hospital discharge management.

As a limitation, the study did not contemplate all the contexts inherent to the care network.

Therefore, as a possibility for new studies, research carried out in different contexts would originate other attributes and definitions. Furthermore, it is important to mention that the methodology was opportune, making it possible to reach the objective. However, the results obtained from other concept analysis techniques may add more knowledge.

FINANCIAL SUPPORT

Project funded by Edital nº 09/2018, from Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq), granted to Prof. Dr. Elizabeth Bernardino. Case No. 307642/2018-6. Title of the research project: "From admission to discharge: concepts and strategies for continuity of care actions in nursing in a teaching hospital".

AUTHOR'S CONTRIBUTIONS

Design of the reflection study Elizabeth Bernardino. Solange Meira de Sousa. Jaqueline Dias do Nascimento.

Survey of sources/information, Elizabeth Bernardino. Solange Meira de Sousa. Maria Ribeiro Lacerda.

Analysis. Elizabeth Bernardino. Solange Meira de Sousa. Luciana Schleder Gonçalves

Interpretation of results. Elizabeth Bernardino. Solange Meira de Sousa. Jaqueline Dias do Nascimento. Maria Ribeiro Lacerda. Danelia Gómez Torres.

Writing and critical revision of the manuscript. Elizabeth Bernardino. Solange Meira de Sousa. Jaqueline Dias do Nascimento. Maria Ribeiro Lacerda. Danelia Gómez Torres. Luciana Schleder Gonçalves.

Approval of the final version of the article. Elizabeth Bernardino. Solange Meira de Sousa. Jaqueline Dias do Nascimento. Maria Ribeiro Lacerda. Danelia Gómez Torres. Luciana Schleder Gonçalves.

Responsibility for all aspects of the content and integrity of the published article. Elizabeth Bernardino. Solange Meira de Sousa. Jaqueline Dias do Nascimento. Maria Ribeiro Lacerda. Danelia Gómez Torres. Luciana Schleder Gonçalves.

SCIENTIFIC EDITOR

Ivone Evangelista Cabral 

ASSOCIATE EDITOR

Rodrigo Nogueira da Silva 

REFERENCES

- Walker LO, Avant KC. *Strategies for theory construction in nursing*. 6th ed. Nova York, NY (USA): Editora Person; 2019.
- Fernandes M, da Nóbrega MM, Garcia TR, Macêdo-Costa KN. Conceptual analysis: methodological considerations. *Rev Bras Enferm*. 2011;64(6):1150-6. <http://dx.doi.org/10.1590/S0034-71672011000600024>. PMID:22664616.
- Kuo YF, Goodwin JS. Association of hospitalist care with medical utilization after discharge: evidence of cost shift from a cohort study. *Ann Intern Med*. 2011;155(3):152-9. <http://dx.doi.org/10.7326/0003-4819-155-3-201108020-00005>. PMID:21810708.
- Ribas EN, Bernardino E, Larocca LM, Poli P No, Aued GK, Silva CPCD. Nurse liaison: a strategy for counter-referral. *Rev Bras Enferm*. 2018;71(Suppl 1):546-53. <http://dx.doi.org/10.1590/0034-7167-2017-0490>. PMID:29562010.
- Costa MFBNAD, Andrade SR, Soares CF, Pérez EIB, Tomás SC, Bernardino E. The continuity of hospital nursing care for Primary Health Care in Spain. *Rev Esc Enferm USP*. 2019;53:e03477. <http://dx.doi.org/10.1590/s1980-220x2018017803477>. PMID:31291396.
- Aued GK, Bernardino E, Lapiere J, Dallaire C. Atividades das enfermeiras de ligação na alta hospitalar: uma estratégia para a continuidade do cuidado. *Rev Lat Am Enfermagem*. 2019;27:e3162. <http://dx.doi.org/10.1590/1518-8345.3069.3162>. PMID:31432917.
- Sousa SM, Bernardino E, Crozeta K, Peres AM, Lacerda MR. Integrity of care: challenges for the nurse practice. *Rev Bras Enferm*. 2017;70(3):504-10. <http://dx.doi.org/10.1590/0034-7167-2016-0380>. PMID:28562797.
- Portaria nº 3390 de 30 dezembro de 2013 (BR). Institui a Política Nacional de Atenção Hospitalar (PNHOSP) no âmbito do Sistema Único de Saúde (SUS), estabelecendo-se as diretrizes para a organização do componente hospitalar da Rede de Atenção à Saúde (RAS). *Diário Oficial da União [periódico na internet]*, Brasília (DF), 2013 [citado 2020 out 15]. Disponível em: https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2013/prt3390_30_12_2013.html
- Reidt SL, Holtan HS, Larson TA, Thompson B, Kerzner LJ, Salvatore TM et al. Interprofessional collaboration to improve discharge from skilled nursing facility to home: preliminary data on postdischarge hospitalizations and emergency department visits. *J Am Geriatr Soc*. 2016;64(9):1895-9. <http://dx.doi.org/10.1111/jgs.14258>. PMID:27385197.
- Rattray NA, Sico JJ, Cox LM, Russ AL, Matthias MS, Frankel RM. Crossing the communication chasm: challenges and opportunities in transitions of care from the hospital to the primary care clinic. *Jt Comm*

- J Qual Patient Saf. 2017;43(3):127-37. <http://dx.doi.org/10.1016/j.jcjq.2016.11.007>. PMID:28334591.
11. Hesselink G, Zegers M, Vernooij-Dassen M, Barach P, Kalkman C, Flink M et al. Improving patient discharge and reducing hospital readmissions by using intervention mapping. *BMC Health Serv Res.* 2014;14(1):389. <http://dx.doi.org/10.1186/1472-6963-14-389>. PMID:25218406.
 12. Fitzpatrick SJ, Perkins D, Handley T, Brown D, Luland T, Corvan E. Coordinating mental and physical health care in rural australia: an integrated model for primary care settings. *Int J Integr Care.* 2018;18(2):19. <http://dx.doi.org/10.5334/ijic.3943>. PMID:30127703.
 13. Wodchis WP, Dixon A, Anderson GM, Goodwin N. Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *Int J Integr Care.* 2015;15(6):e021. <https://doi.org/10.5334/ijic.2249>.
 14. Low LL, Vasawala FF, Ng LB, Chen C, Lee KH, Tan SY. Effectiveness of a transitional home care program in reducing acute hospital utilization: a quasi-experimental study. *BMC Health Serv Res.* 2015;15:100. <https://doi.org/10.1186/s12913-015-0750-2>.
 15. Diplock G, Ward J, Stewart S, Scuffham P, Stewart P, Reeve C et al. The Alice Springs Hospital Readmission Prevention Project (ASHRAPP): a randomised control trial. *BMC Health Serv Res.* 2017;17(1):153. <http://dx.doi.org/10.1186/s12913-017-2077-7>. PMID:28219383.
 16. Soto GE, Huenefeldt EA, Hengst MN, Reimer AJ, Samuel SK, Samuel SK et al. Implementation and impact analysis of a transitional care pathway for patients presenting to the emergency department with cardiac-related complaints. *BMC Health Serv Res.* 2018;18:672. <https://doi.org/10.1186/s12913-018-3482-2>.
 17. Lemetti T, Voutilainen P, Stolt M, Eloranta S, Suhonen R. An enquiry into nurse-to-nurse collaboration within the older people care chain as part of the integrated care: a qualitative study. *Int J Integr Care.* 2017;17(1):5. <http://dx.doi.org/10.5334/ijic.2418>. PMID:29042847.
 18. Gholizadeh M, Janati A, Delgoshahi B, Gorji HA, Tourani S. Implementation requirements for Patient Discharge Planning in Health System: a qualitative study in Iran. *Ethiop J Health Sci.* 2018;28(2):157-68. <http://dx.doi.org/10.4314/ejhs.v28i2.7>. PMID:29983513.
 19. Ferreira ABH. *Dicionário Aurélio da Língua Portuguesa*. 5. ed. Curitiba: Positivo; 2010.
 20. Nuño-Solinis R. Revisiting organisational learning in integrated care. *Int J Integr Care.* 2017;17(4):4. <http://dx.doi.org/10.5334/ijic.3047>. PMID:28970762.
 21. Reid RJ, Haggerty J, Mckendry R. Defusing the confusion: concepts and measures of continuity of health care. [Internet]. Canadian Health Services Research Foundation; 2002 [citado 2020 out 15]. Disponível em: https://www.researchgate.net/publication/245856177_Defusing_the_Confusion_Concepts_and_Measures_of_Continuity_of_Health_Care
 22. Coleman EA, Boulton CE, American Geriatrics Society Health Care Systems Committee. Improving the quality of transitional care for persons with complex care needs. *J Am Geriatr Soc.* 2003;51(4):556-7. <http://dx.doi.org/10.1046/j.1532-5415.2003.51186.x>. PMID:12657079.
 23. Vat M, Common C, Laizner AM, Borduas C, Maheu C. Reasons for returning to the emergency department following discharge from an internal medicine unit: perspectives of patients and the liaison nurse clinician. *J Clin Nurs.* 2015;24(23-24):3605-14. <http://dx.doi.org/10.1111/jocn.13011>. PMID:26467172.
 24. Arts SE, Francke AL, Hutten JB. Liaison nursing for stroke patients: results of a Dutch evaluation study. *J Adv Nurs.* 2000;32(2):292-300. <http://dx.doi.org/10.1046/j.1365-2648.2000.01476.x>. PMID:10964175.
 25. Glimmerveen L, Nies H, Ybema S. Citizens as active participants in integrated care: challenging the Field's dominant paradigms. *Int J Integr Care.* 2019;19(1):6. <http://dx.doi.org/10.5334/ijic.4202>. PMID:30881264.
 26. Cloonan P, Wood J, Riley JB. Reducing 30-day readmissions: health literacy strategies. *J Nurs Adm.* 2013;43(7-8):382-7. <http://dx.doi.org/10.1097/NNA.0b013e31829d6082>. PMID:23892303.
 27. Kind AJH, Jensen L, Barcsi S, Bridges A, Kordahl R, Smith MA et al. Low-cost transitional care with nurse managers making mostly phone contact with patients cut rehospitalization at a VA hospital. *Health Aff (Millwood).* 2012;31(12):2659-68. <http://dx.doi.org/10.1377/hlthaff.2012.0366>. PMID:23213150.
 28. Burke M. Transitional care. *J Gerontol Nurs.* 2009;35(12):3-4. <http://dx.doi.org/10.3928/00989134-20091103-05>. PMID:20000268.