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ROLE OF THE NURSE IN PATIENT CARE TRANSITION: SCOPE REVIEW

PAPEL DO ENFERMEIRO NA TRANSIÇÃO DE CUIDADOS DO PACIENTE: REVISÃO DE ESCOPO

PAPEL DE LA ENFERMERA EN LA TRANSICIÓN DE LA ATENCIÓN AL PACIENTE: REVISIÓN DEL ALCANCE

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ABSTRACT

Objective: To map the literature on the role of nurses in the transition of patient care from the hospital level to primary health care. **Method**: Scope review according to the Joanna Briggs Institute. Search in sources: PubMed, Cumulative Index to Nursing and Allied Health Literature, Science Direct, Web of Science, Scopus, Database of Nursing and Latin American and Caribbean Literature in Health Sciences. Search in gray literature: Brazilian Digital Library Theses and Dissertations and Google Scholar. **Results**: 5,435 studies were retrieved. Excluded: 1,291 duplicates, 4,105 after reading the title and abstract. 39 were selected for full reading and 26 made up the final sample. Studies in Portuguese predominated in the area of nursing, coming from Brazilian public universities, with greater production in 2021. **Conclusion**: The role of the nurse was to coordinate care, identify the needs of the patient and family, discharge instructions and carry out counter-referral.

Descriptors: Nurse's role; Transitional care; Hospitals; Primary Health Care; Nursing

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RESUMO

Objetivo: Mapear a literatura sobre o papel do enfermeiro na transição de cuidados do paciente do nível hospitalar para a atenção primária à saúde. **Método**: Revisão de escopo conforme o Instituto Joanna Briggs. Busca nas fontes: *PubMed, Cumulative Index to Nursing and Allied Health Literature, Science Direct, Web of Science, Scopus*, Base de Dados de Enfermagem e Literatura Latino-Americana e do Caribe em Ciências da Saúde. Busca na literatura cinzenta: Biblioteca Digital Brasileira de Teses e Dissertações e Google Acadêmico. **Resultados**: Recuperaram-se 5.435 estudos. Excluídos: 1.291 duplicatas, 4.105 após leitura do título e do resumo. Selecionados 39 para leitura na integra e 26 compuseram a amostra final. Predominaram estudos em português, na área de enfermagem, oriundos de universidades públicas brasileiras, com maior produção em 2021. **Conclusão**: O papel do enfermeiro foi a coordenação do cuidado, identificação das necessidades do paciente e da família, orientações de alta e a realização da contrarreferência.

Descritores: Papel do Profissional de Enfermagem; Cuidado transicional; Hospitais; Atenção Primária à Saúde; Enfermagem.

RESUMEN

Objetivo: Mapear la literatura sobre el papel de las enfermeras en la transición de la atención al paciente desde el nivel hospitalario a la atención primaria de salud. **Método**: Revisión de alcance según el Instituto Joanna Briggs. Búsqueda en fuentes: PubMed, Índice acumulativo de literatura en enfermería y afines a la salud, Science Direct, Web of Science, Scopus, Base de datos de enfermería y literatura latinoamericana y caribeña en ciencias de la salud Búsqueda en literatura gris: Tesis y Disertaciones de la Biblioteca Digital Brasileña y Google. Erudito. **Resultados**: Se recuperaron 5.435 estudios. Excluidos: 1.291 duplicados, 4.105 después de leer el título y el resumen. 39 fueron seleccionados para lectura completa y 26 constituyeron la muestra final. En el área de enfermería predominaron los estudios en portugués, provenientes de universidades públicas brasileñas, con mayor producción en 2021. **Conclusión**: El papel del enfermero era coordinar los cuidados, identificar las necesidades del paciente y de la familia, dar instrucciones de alta y realizar contra- remisión.

Descriptores: Rol de la Enfermera; Cuidado de transición; Hospitales; Atención Primaria de Salud; Enfermería.

INTRODUCTION

Transition of care is defined as a set of actions that coordinate and provide continuity of patient care outside the hospital environment.[1] It involves the use and coordination of health services, especially primary health care, seeking to reduce hospital readmission rates.[2] A poorly executed transition can generate serious adverse events, such as medication errors, lack of continuity of care, hospital readmissions and, ultimately, negatively affect the patient's prognosis.[3]

Thus, the transfer of patients with complex conditions from the hospital to the PHC service requires efficient communication and demands more detailed attention to the entire context involved in the care and discharge of each person.[4] Due to their presence in several health services in the RAS and their commitment to direct patient care, they stand out as the professional most capable of establishing

links and developing effective care plans in collaboration with the multidisciplinary team.[5]

The nurse is the key professional in the development of connected care transition strategies, demonstrating their importance in ensuring continuity of care.[6] This scoping review aims to map the scientific literature on the role of the nurse in the transition of patient care from the hospital to PHC, aiming to provide foundations for an effective and quality transition.

METHOD

This is a scoping review according to the guidelines established by the Joanna Briggs Institute, registering the protocol in the Open Science Framework (OSF) under DOI: 10.17605/OSF.IO/9T3PJ. Before its implementation, it was found that there were no scoping reviews on the role of the nurse in the transition of patient care from the hospital environment to Primary Health Care until August 2023, both in the JBI Sumari repository and in the OSF platform.

This scoping review contains the following steps: (1) Defining and aligning the objectives and questions; (2) developing and aligning the inclusion criteria with the objectives and questions; (3) describing and planning the approach to searching, selecting, extracting data, and presenting evidence; (4) searching for evidence; (5) selecting evidence; (6) extracting evidence; (7) analyzing evidence; (8) presenting results; (9) summarizing the evidence in relation to the purpose of the review, conclusions, and implications of the reviews, which are described in detail below.[7]

In the first stage, the theme was defined and the objectives and questions were aligned. The formulation of the review question was developed according to the Person, Concept and Context (PCC) approach in which: P = Nurses, C = Transition of health care and C = From the hospital level to primary health care. Thus, the following guiding question was elaborated for this scoping review: What evidence is available in the scientific literature on the role of the nurse in the transition of patient care from the hospital level to PHC?

In the second stage, the inclusion criteria were developed and aligned with the objectives and questions: the types of evidence sources included were studies that addressed the role of nurses in the transition of patient care from the hospital level to PHC, in different countries, available free of charge and in full. Primary, quantitative and qualitative studies of any design were included; in addition to case studies, experience reports, clinical practice protocols and guidelines, literature reviews, opinion articles, postgraduate monographs latu-sensu, undergraduate course completion work, dissertations and theses. The

following were excluded: responses to the editor, specialization monographs that did not present results, course completion work on the subject in the form of intervention projects that did not present results, conference abstracts. No time or idiomatic cuts were used.

In the third stage, the description and planned approach for search, selection, data extraction and presentation of evidence were sought. A preliminary search was carried out in PubMed, in which the controlled descriptors and keywords corresponding to each letter of the PCC were identified, as shown in Table 1:

Table 1- Controlled descriptors and keywords. Alfenas, Minas Gerais, 2024.

BASE	Mesh Controlled Descriptors	*Entry Terms*
PubMed	*Community Health Nursing* *Home Health Nursing* *Nursing Staff, Hospital* *Continuity of Patient Care* *Patient Discharge* *Patient Handoff* *Primary Health Care* *Hospitals* *Community Health Services* *Health Services* *Community Networks* *Medical-Surgical Nursing*	*Hospital Nursing Staff* *Hospital Nursing Staffs* *Nursing, community health* *Home Health Care Nursing* *Nursing, Home Health* *Care Continuity, Patient* *Patient Care Continuity* *Continuum of Care* *Care Continuum* *Continuity of Care* *Care Continuity* *Discharge, Patient* *Discharges, Patient* *Patient Discharges* *Discharge Planning* *Planning, Discharge* *Handoff, Patient* *Handoffs, Patient* *Patient Handoffs* *Patient Hand Off* *Hand Off, Patient* *Patient Hand Offs* *Nursing Handoff* *Handoff, Nursing* *Handoffs, Nursing* *Nursing Handoffs* *Nursing Hand Offs* *Nursing Hand Off* *Clinical Handoffs* *Clinical Handoff* *Handoff, Clinical* *Care, Primary Health* *Health Care, Primary*

		Primary Healthcare *Healthcare, Primary* *Primary Care* *Care, Primary* *Community Health Service* *Health Service, Community* *Service, Community Health* *Services, Community Health* *Health Services, Community* *Community Health Care* *Health Care, Community* *Community Healthcare* *Healthcare, Community* *Health Service* *Services, Health* *Community Network* *Community Care Networks* *Care Network, community* *Community Care Network* *Community Health Networks* *Community Health Network* *Health Networks, community* *Network, Community Health* *Networks, Community Health* *Nursing, Medical-Surgical* *Medical Surgical Nursing* *Nursing, Medical Surgical*

Source: authors, 2024.

To carry out the search strategy, the descriptors and keywords were articulated with the Boolean operators AND and OR. Next, a more comprehensive search was carried out with adaptations of the descriptors, keywords from PubMed in the sources: Cumulative Index to Nursing and Allied Health Literature (CINAHL); Science Direct from Elsevier; Web of Science (WOS); Scopus; Virtual Health Library (VHL): Nursing Database (BDENF); and Latin American and Caribbean Literature in Health Sciences (LILACS). In addition, a search was carried out in the gray literature through the Brazilian Digital Library of Theses and Dissertations, as well as Google Scholar. The search was carried out on January 31, 2024, through the Journals portal of the Coordination for the Improvement of Higher Education Personnel (CAPES), via remote access by the Federated Academic Community (CAFe), of which the Federal University of Alfenas (UNIFAL-MG) is a participant.

In the fourth stage, searching for evidence, the identified references were

exported to the EndnoteWeb® reference manager. This manager was used to detect and eliminate duplications. Then, a new file export was created and sent to the Rayyan - Intelligent Systematic Review web application, which was used to identify possible new duplications and to proceed with the selection of studies.

In the fifth stage, evidence selection, was carried out with the help of the Rayyan - Intelligent Systematic Review web application, in two blinded phases by two independent reviewers. The first phase consisted of reading titles and abstracts applying the inclusion and exclusion criteria. Then, the second phase involved reading the full texts applying the selection criteria. In both phases, in the event of a lack of consensus, the two reviewers met to discuss the discrepancies and determine the selection of studies, without the need for the intervention of a third reviewer.

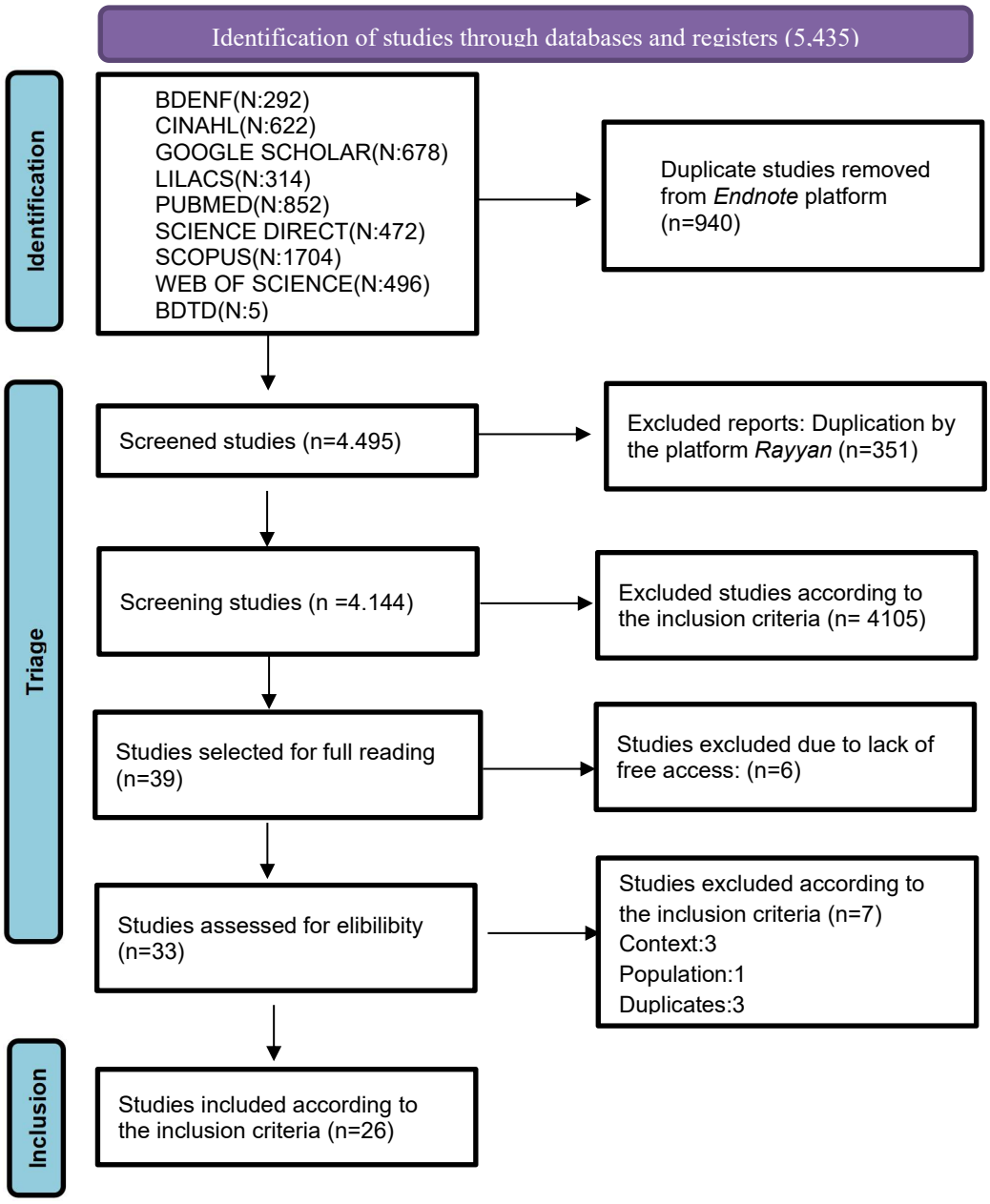
The results of the selection are presented in a flowchart that describes the information through the different phases of the sample composition of the identified, included and excluded records and the reasons for the exclusions.[8] In the sixth stage, evidence extraction, a logical and descriptive summary of the results is made, which are aligned with the objectives and the guiding question. For data extraction and presentation, the model instrument of the JBI manual was used, adapted by the reviewers in their own protocol, together with a guidance form for evidence extraction.[9]

In the seventh stage, analysis of the evidence, occurred through descriptive mapping of the results of the included sources, aiming at the transparency of this process. The content of the results related to the phenomenon was organized descriptively through categories. In the eighth stage, presentation of the results, the writing of the results of this scoping review was guided by the PRISMA Extension for Scoping Reviews (PRISMA-ScR) checklist.10 Finally, the ninth stage, the synthesis of the evidence in relation to the purpose of the review, conclusions and implications of the reviews, is presented in the results and discussion.[7]

RESULTS

The search of the sources returned 5,435 studies; after removing 1,291 duplicates, 4,144 studies remained. After a thorough reading of the titles and abstracts, 4,105 were excluded because they did not meet the inclusion criteria. A total of 39 studies were evaluated in full, excluding 6 that were not freely available, 7 because they did not meet the inclusion criteria (1 for population, 3 for context, 3 duplicates not previously detected). No additional studies were identified in the references of the included studies.

Figure 1- Study selection flowchart. Brazil, 2024



Source: Prepared by the author following the model provided.[8]

Thus, 26 studies were included in this scoping review. The results of the selected studies reveal a growing attention to the role of nurses in the transition of patient care between hospital and primary care, especially in recent years, with a significant peak in 2021 (26.92%). The predominance of publications in Portuguese (88.46%) and the Brazilian geographic origin (76.92%) reflect the relevance of the topic in the

national context, with most studies being conducted in Brazilian public universities, such as the Federal University of Paraná (30.77%).

The mapping of data from the included studies is presented in Table 1, highlighting information such as authors and year of publication, country, language and main evidence and conclusions.

Table 2– Characterization of selected articles according to identification of studies, countries, language and role of the nurse, Alfenas-MG, Brazil, 2024.

Identification of Studies	Country	Language	Role of the Nurse
Silva *et al*., 2021[11]	Brazil	Portuguese	-Coordinate hospital discharge; -Monitor and collaborate on the care provided in the hospital environment; -Transmit relevant information for the continuity of care in primary care and other points in the health care network.
Lanzoni et al., 2023[12]	Brazil	Portuguese	-Promote safe and qualified practices for the patient.
Acosta et al., 2018[13]	Brazil	Portuguese	-Clarify doubts of the patient and family during discharge instructions. -Provide guidance on the continuity of care with the reference health team. -Identify needs and discuss the care plan with the patient and family. -Follow up on the patient after discharge. -Inform the reference health team about the patient's discharge. -Develop a discharge plan with essential home care.
Goularte et al., 2021[14]	Brazil	Portuguese	-Guidance for patients and family members.
Östman et al., 2020[15]	Brazil	Portuguese	-Act as a "hub" (focus/center) in coordinating care, promoting relationships of trust and care.
Lemetti et al 2020[16]	Brazil	Portuguese	-Central role during the transfer of responsibility from the hospital to the PHC, ensuring safety and continuity of care.
McMurray;Cooper,2017[17]	Brazil	Portuguese	-Act as a hub in the interdisciplinary team, contributing to healthcare reform and working toward patient-centered care.
Duarte et al., 2023[18]	Brazil	Portuguese	-Central role in the successful transition of patients; Promote health education and clinical skills to manage these patients.

Assis, 2018[19]	Brazil	Portuguese	-Guide and support the patient during care transitions, helping family members and users to deal with challenges and adapt to the new situation.
Lima, 2021[20]	Brazil	Portuguese	-Coordinate discharge; -Promote the integration of members of the care team who are relevant to the process.
Lima et al., 2022[21]	Brazil	Portuguese	-Fundamental role in ensuring continuity and safety of care;
Gallo et al., 2021[22]	Brazil	Portuguese	-Act as coordinator of the care transition process; -Identify the patient's needs; -Share information between professionals and health services, providing support to the patient during the transition; -Develop strategies to ensure the continuity and quality of care provided;
Belga;Jorge;Silva, 2022[23]	Brazil	Portuguese	-Acts as a link between the user, the family and the health team; -Management and coordination of care; -Provide guidance on self-care involving the family and the multidisciplinary team.
Bernarndino et al., 2022[24]	Brazil	Portuguese	-Manage and counter-refer care to PHC and other points in the healthcare network.
Coelho et al., 2016[25]	Brazil	Portuguese	-Communication with APS; -Coordination of care during the transition from hospital to PHC.
Costa et al., 2019[26]	Brazil	Portuguese	-Clinical and social evaluation of patients; -Communication with APS professionals.
Costa et al., 2020[27]	Brazil	Portuguese	-Coordinate continuity of care for APS;
Ribas et al., 2018[28]	Brazil	Portuguese	-Act as a link between the hospital and APS, promoting continuity of care; -Identify the user and their care needs after hospital discharge; -Identify the reference UMS; -Make contact by telephone with the nursing assistant; -Discuss user needs and schedule appointment; -Fill out the counter-referral form in two copies, print the cover page, discharge summary of the medical record; attach it to the first copy of the

			counter-referral form and send it by email to the UMS coordination; -Guide the user and deliver the second copy of the counter-referral form.
Mauro; Cucolo; Perroca, 2021[29]	Brazil	Portuguese	-Discharge planning; -Coordinate actions and interactions between professionals, services and patients/families and post-hospitalization care.
Mauro; Cucolo; Perroca, 2023[30]	Brazil	Portuguese	-Facilitate the connection between levels of care and coordinate care for continuity of care. -Educate users, families and caregivers about home care and guide the team for monitoring. -Assess user/family needs and plan care strategies with the team. -Plan and conduct home visits to assess health needs and provide care. -Participate in interprofessional meetings to integrate care and discuss discharge and transition protocols. -Promote educational actions to develop the team in the discharge process and continuity of care.
Oliveira et al., 2021[31]	Brazil	Portuguese	-Evaluate patients for continued care after hospital discharge; -Discharge planning; -Communication and guidance with patients and family members.
Paniagua et al., 2018[32]	Brazil	Portuguese	-Manage the clinical case of people who require continuity of care; -Develop more effective solutions to adopt evidence-based decision-making in clinical practice; -Formulation of health policies.
Santos et al., 2022[33]	Brazil	Portuguese	-Clarifying doubts of patients and family members during discharge instructions; -Contact with the reference health team for continuity of care; -Identification of customer needs; -Discussion with the patient and family about the post-discharge care plan; -Perform activities such as medication reconciliation; -Guidance/teaching to patients and/or caregivers; -Monitoring post-discharge care.
Silva; Ramos, 2011[34]	Brazil	Portuguese	-Reorient the person responsible for the

			child regarding the information received during hospitalization and upon discharge, including the guidelines recommended by the doctor; -Provide medication for continued treatment, when necessary; -Provide guidance for the family's needs, both inintra-hospital and extra-hospital context, explaining how to proceed after discharge; -Recover the child's history upon discharge to check whether all needs were addressed during hospitalization; -Establishes the articulation between hospital and basic care, aiming to guarantee the continuity of care and the integrality of the process.
Silva; Ramos, 2011[35]	Brazil	Portuguese	Not described.
Martins dos Santos et al., 2022[36]	Brazil	Portuguese	Fundamental role in care management.

Source: Prepared by the authors, 2024.

DISCUSSION

The results of the selected studies reveal a growing attention to the role of nurses in the transition of patient care from hospital to primary care, especially in recent years, with a significant peak in 2021 (26.92%). The predominance of publications in Portuguese (88.46%) and the Brazilian geographical origin (76.92%) reflect the relevance of the topic in the national context, with the majority of studies being conducted in Brazilian public universities, such as the Federal University of Paraná (30.77%).

The role of nurses in the transition of care from the hospital level to PHC is essential to ensure continuity and quality of care provided to patients.[37] Effective transition depends on several functions performed by nurses, who act as care coordinators, needs identifiers, educators and counter-referral facilitators. Thus, nurses are central to coordinating patient care during the transition from hospital to PHC. This role involves acting as a "hub" (focus/center) in the coordination of care, promoting relationships of trust and ensuring safety and continuity of care.[15]

The literature highlights the importance of nurses in coordinating the transfer of responsibility from the hospital to the PHC[16]; ensuring that all important information is communicated effectively and that the care plan is followed correctly after hospital discharge. In addition, nurses play a central role in interdisciplinary teams, contributing to health reform and working towards patient-centered care.[17] Nurses' management and coordination of the

transition process are vital for continuity of care and the promotion of patient health.[22, 23]

Another essential function performed by nurses is to identify the needs of the patient and his/her family. They perform comprehensive assessments that include clinical and social aspects, identifying health needs, use of equipment and supplies, and the degree of autonomy of the patient and family to implement care at home.[26,30] Through detailed discussions with the patient and their family, nurses are able to identify specific needs and discuss the plan of care after discharge.[13] This detailed and ongoing assessment is important for developing a realistic and effective care plan, preventing complications and hospital readmissions.[26; 28; 30; 31]

Next, it is worth highlighting that providing discharge guidance is a major responsibility of nurses, involving educating the patient and family about the care required after hospital discharge. Nurses play a vital role in clarifying doubts and providing clear guidance on self-care, involving the family and the multidisciplinary team in this process.[13,23] Likewise, counter-referral is an essential process to ensure continuity of care between the hospital and PHC.

Nurses are responsible for transmitting all relevant information for continuity of care to the PHC team and other points in the health care network.[1;13] They maintain an open channel of communication with the referring health team, filling out counter-referral forms and sharing important information about the patient's discharge.[28;33] This effective communication process ensures that patient follow-up is adequate and that there are no gaps in continuity of care.

FINAL CONSIDERATIONS

The mapping identified that nurses play essential roles as care coordinators, educators, and counter-referral facilitators, which are essential to ensuring continuity and quality of care. The analysis revealed that effective communication and coordination are important for a safe transition, although challenges such as communication failures are common. Studies define transition of care by coordination and continuity during the transfer between health services, highlighting the importance of strategies such as clear communication, patient education, and accurate documentation. These practices are vital to manage all stages of care, improving its quality and safety. The scoping review highlights gaps for future research, including specific interventions to improve transition of care and evaluation of the effectiveness of different coordination models. Standardized protocols and organizational tools may be promising for future investigations. This

study emphasizes the need for new research on transition of care, highlighting the national and international scientific gap that affects scientific and practical evolution. The work provided profound learnings about the importance of coordination and continuity of nursing care, in addition to the challenges faced in daily practice. Mapping and synthesizing evidence reinforced the critical view of care transition as an area that requires more attention and investment in research, clinical practice, and management. This study contributes significantly to nursing by highlighting the central role of nurses in the transition of care from hospital to PHC, and provides a solid basis for future research and practical interventions aimed at improving the quality of care during patient transition.

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