



EDITORIAL

Strategies to implement the safe hospital-community transition and mitigate hospital readmissions

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Transition is defined as a journey made by a person between two relatively stable moments. This experience is lived over a certain period and is characterized by the appearance of changes that cause imbalances, doubts, disorganization, and interpersonal conflicts¹.

Therefore, hospital discharge is a multiple transition (from health-illness, but also situational) from the hospital to the community, through which all individuals who have serious health problems have required hospitalization go through. If such a transition is made early and without proper planning, there is a serious risk that the discharged person will be readmitted in the short or medium-term. Recently, readmission rates have been increasing, particularly among the elderly population²⁻³. This increase does not seem to be due to the severity of the diagnosis, but the comorbidities of which sick people are carriers³.

However, how, as nurses, can we contribute to alleviating this problem?

The answer seems to be in planning and making a safe transition from the hospital to the community. This process often seems to be neglected. At the hospital, the guidelines for discharge are scarce, performed routinely and not individually, in a hurry, without considering the specific conditions and needs of each

client and their family. Also, much of the information is provided only when leaving the hospital^{4,5}, not constituting a systematically integrated activity into the individualized care plan to be provided to the client and his family.

Simultaneously, the care fragmentation and disruption between hospital and community can also cause this problem, contributing to the client and family insecurity due to confusing treatment continuity guidelines and, eventually, a considerable possibility of mistakes, repetitions, and gaps^{3,5}. This is related to the need for time to adequately prepare for homecoming, the difficulty and even the lack of communication between hospital and community health teams, the failure to assess the intervention's effectiveness, the lack of records, and the lack of systematization of the protocols used⁶.

So how to proceed? First, as soon as possible, during the hospitalization period, it is vital to ensure safety, avoid fractures in the continuity of care, minimize readmissions, start planning, and develop actions to prepare for discharge⁷, involving the client and family caregiver.

Then, bet heavily on the articulation between the hospital and primary health care, creating a good communication network and involving the institutions'

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responsible managers, without forgetting in this context the necessary training dimension of all involved nurses. For this, it is urgent to create partnerships involving higher nursing schools, which can agglutinate and stimulate the training of all professionals, both hospital and community. They may support and provide project consultancy and programs created within the hospital's scope for the community, stimulating and conducting in parallel research that reveals acceptable practices in favor of the quality of care and consequent satisfaction of customers, families, and professionals^{6,8}.

To promote a safe transition, it is still essential to use the most recent scientific evidence, and, in this sense, the partners should increase the translation of knowledge to the clinic⁸.

Despite all difficulties that transition from the hospital to the community safely entails, there will undoubtedly be projects on this subject that we are concerned about. The importance of a safe transition for the quality of care and satisfaction of all involved requires those responsible for disclosing them in magazines, scientific events, and discussion forums. This can be done as case reports or reflections so that such practices and experiences can be appropriated by others, replicated, and improved in their services and institutions. The debate of ideas and identifying obstacles will undoubtedly help find the best way to overcome them. Moreover, this can be done in the teams themselves intra and interinstitutional, and the higher nursing institutions that are dedicated to teaching and

research can function in this area as catalysts of the entire process.

Nursing professors and clinical advisors should also encourage students with whom they work and guide, in their teaching-learning process, to start as early as possible the planning of discharge with patients and families receiving health care. Also, to involve students in safe transition projects and programs from the hospital to the community, to lead them to translate knowledge about the safe transition to the clinic and to mobilize the most recent scientific evidence for the sake of better care, and to collaborate in investigations conducted in related institutions. Thus, we also judge whether it will be possible to prepare for the future, training nurses skilled in promoting the safe transition from the hospital to the community and managing projects/programs in this area of nursing and health care.

As a conclusion and challenge, we can only affirm that it is necessary to bet on a safe transition when the patient returns to his home to promote the continuity of the care provided. For this purpose, it is essential not only to build bridges between all health, education, and research institutions involved in the process but also to keep them cohesive and functioning. This is obliged by the importance of making a safe transition from the hospital to the community, the quality of professional health care, and all providers' and customers' satisfaction.

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