



EDITORIAL

Transitional care: an omitted care unveiled by the pandemic

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Published on Mar 23, 2022

In the international literature, there is a growing interest in omitted care in clinical practice in health, particularly in nursing, where a set of care essentially related to non-pharmacological interventions are omitted or delayed and undocumented¹. Errors by omission have translations in patient safety and impact their comfort, prognosis, hospitalization experience, functionality, and quality of life.

This group of lapses includes many of the autonomous interventions provided by nurses, such as lifting, therapeutic positioning, personal and oral hygiene care, health education¹, among others. In the articles on this phenomenon, it is not clear that transitional care is also omitted care. However, difficulties in communication and articulation between levels of care are a reality and prevent an integrated response to the population's needs with complex health-disease problems^{2-3,6}.

Some research observes that people with dependence and/or complex transitions of health-disease, situational, organizational, and development must integrate the guidelines and develop specific competencies to maintain the care started in the hospital²⁻⁴. Family members need support in the transition to the new role of caregiver, which implies training both the patient and caregiver to regain,

whenever possible, personal autonomy and independence in self-care³⁻⁶.

Transitional care is complex and implies a set of interventions that guarantee the transition of care from the hospital to the home, which should happen in three moments: 1) as early as possible, during the hospital stay; 2) at the time of discharge; and 3) lastly, within 48 hours and up to 30 days thereafter^{4,6}. The high number of interventions that needs to be initiated, continued, and maintained, combined with the time required for adequate planning of the return home, communication difficulties, failure to evaluate the effectiveness of the intervention, lack of registration, and lack of systematization of the protocols used^{3,6} can contribute to the omission of transitional care.

Compounding this whole situation was the SARS-CoV-2 pandemic, which increased the burden on health systems and care organization and imposed changes to the continuity process between the hospital and the community. Restricting visits to promote and maintain social distancing has limited the involvement of family caregivers in preparing for the safe transition of dependent people. The defragmentation of communication circuits between health institutions also jeopardized the continuity of care between the hospital and the community. Simultaneously, the work overload

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<https://doi.org/10.21876/rcshci.v12i1.1271>

How to cite this article: Ferreira OMR, Baixinho CL. Transitional care: an omitted care unveiled by the pandemic. Rev Cienc Saude. 2022;12(1):1-2. <https://doi.org/10.21876/rcshci.v12i1.1271>

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of health professionals meant that transitional care was not considered a priority, making it even more omitted.

Despite this less positive aspect, the pandemic raised new and challenging questions regarding the preparation of the safe transition of hospitalized dependents to the community and in parallel with the assumption of measures to prevent the undesirable spread of COVID-19. If the pandemic, on the one hand, demonstrated that the omission of transitional care impacts serious situations of individual and collective health, on the other hand, brought to the public the discussion about the defragmentation in communication between the institutions of the health system and raised questions related to equity in accessibility, in the transition from care, quality, socio-economic and political impact. If these questions, in the hospital-community transition process, were already a concern before the pandemic⁶, they are even more relevant in the current context. The increase in disparities and exclusion of patients and their families has dramatically contributed to this, especially those most in need of access to safe and quality health care.

Undoubtedly, the health-disease transitions that generate dependence, not allowing functional recovery to pre-hospitalization levels, imply an entire adaptation of the person and family to their new health condition to guarantee self-care after returning home⁵⁻⁶. Therefore, the debate must mobilize the nursing teams for action in anticipation of the return home, which should be a central concern in planning care during the hospitalization period⁶. This is the only way to guarantee safety and avoid breaks in the continuity of care. Such mobilization for anticipatory action in preparation for returning home is in itself an effective measure to avoid readmissions in the immediate post-discharge period.

Some care cannot be delayed or provided. Among these, we highlight the identification of the needs of the informal caregiver or the family caregiver and the dependent person, symptom management, the care/education of the informal caregiver, and the timely and compliant response to detected problems. This will only be achieved with policies to support health teams, promoting the intra-institutional and inter-institutional collaboration of the care teams involved in these processes, and optimizing the coordination between social and healthcare services. In this way, it will be possible to improve the continuity and quality of transitional care from the hospital to the community and, thus, lessen the impact of the pandemic. This has been felt inexorably in this context, omitting care that is extremely important for the quality of life of dependent citizens, their families, and the economy of health institutions and, therefore, the country.

It is also essential that nurses and their teams that, in this period of the pandemic, have continued to be involved and to invest in transitional care, register, report, and publish their experiences, not only to serve as a stimulus for professionals from other institutions, both hospitals as well as the community, but so that other teams can use their good practices and the strategies used in their implementation and continuity, adopting them where they work and replicate them in favor of the quality of care and the satisfaction of dependent patients and family members caregivers.

Simultaneously, and in this sense, it is still necessary to investigate what good was done, what obstacles they faced, and how they were overcome so that, in future pandemic situations, transitional care is no longer forgotten but rather implemented based on scientific evidence.

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No conflicts of interest declared concerning the publication of this article.