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EDITORIAL

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The central question of transitional care: Integrating the person into care or care into the person?

A questão central do cuidado transicional: Integrar a pessoa no cuidado ou o cuidado na pessoa?

Cuestión central del cuidado de transición: ¿Integrar la persona al cuidado o el cuidado a la persona?

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The increase in average life expectancy has brought about a different and complicated epidemiological reality, with the underlying challenge of (re)organizing health services to adapt to the complexity of health-illness processes and transitions experienced by dependent elderly people. Prolonged hospital stays, frequent readmissions into hospital emergency services, loss of functionality, and increased frailty often makes these patients leave hospitals more dependent than they were at admission.[1-3] This highlights the need for caregivers to ensure care once they return home.[2,3]

Regarding this issue, in 2018, the World Health Organization highlighted the development of transitional care supported by advanced practice nursing as a priority practice, in order to reduce hospital costs and manage at-home care.[4] This care is initiated during hospitalization and includes preparation for hospital discharge and planning for the hospital-home transition and the first 30 days after returning home.[3] Some authors reinforce the importance of community nurses conducting assessments of these patients within 48 to 72 hours after hospital discharge.[3]

Although, in Portugal and other countries, these patients are offered care by hospital and primary care teams, what we observe is that both they and their caregivers are integrated into different clinical practice settings. This sometimes leads to fragmentation of care, without guaranteeing continuity of interventions started during hospitalization, and without the appropriate focused care that the complexity of these transitions and the need for individualization of therapeutic measures require. These aspects explain many of the difficulties faced by patients in adhering to therapeutic regimens, including nursing therapies. This increases their vulnerability, delays rehabilitation and functional recovery, and increases the risk of complications inherent to the worsening of their clinical and social situation.

These considerations confirm that health professionals focus their attention on patients and their caregivers in two static contexts: hospitals or communities.[1] This leads us, in this editorial, to present a challenge to healthcare teams to integrate care into patients rather than patients into care, developing transitional care interventions that empower both patients and caregivers for post-discharge, ensuring the continuity of planned care and safe transitions from hospitals back to communities.[1-4] To achieve this goal, it is important that nurses discuss the role and attributions of advanced practice nurses, including the ability to lead patient-centered transitional care processes and promote autonomy and functionality, while intervening with caregivers so they feel prepared to care, not only for dependent elderly individuals, but also for themselves.[2]

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