ORIGINAL ARTICLE

REVISTA ENFERMAGEM ATUAL IN DERME

EASE AND CHALLENGES OF THE CARE TRANSITION PROCESS AT HOSPITAL DISCHARGE

FACILIDADES Y RETOS DEL PROCESO DE TRANSICIÓN ASISTENCIAL AL ALTA HOSPITALARIA

FACILIDADES E DESAFIOS DO PROCESSO DE TRANSIÇÃO DO CUIDADO NA ALTA HOSPITALAR

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ABSTRACT
Objective: to know the ease and challenges of the process of transition of care at hospital discharge by professionals of a multi-professional team. Methods: a qualitative and descriptive study, whose sample was intentional, by convenience. Eight professionals from a multi-professional team of a tertiary level federal hospital in Porto Alegre participated in the study. For data collection, carried out in january, february, august and september 2021, a semi-structured interview script was used for data collection. Data was analyzed using thematic content analysis. Results: the data revealed that the participants have satisfactory knowledge about the concept of transition of care, associated as facilitators of the process the discharge management office, the multidisciplinary rounds and the monitoring of patients by the Home Care Services. However, they cited as challenges gaps in communication, socioeconomic conditions of patients and families, problems with post-discharge follow-up, exhaustive demands from professionals and the pandemic. Final considerations: the joint work of the multi-professional team is fundamental in the patient discharge process. The results point to the importance of creating discharge management teams in hospitals and conducting multidisciplinary rounds as strategies to improve transitional care.
Keywords: Transitional Care; Patient Care Team; Patient Discharge; Nursing.

RESUMEN
Objetivo: conocer las facilidades y desafíos del proceso de transición asistencial al alta hospitalaria por profesionales de un equipo multidisciplinario. Métodos: estudio cualitativo y descriptivo, cuya muestra fue de tipo intencional, por conveniencia. Participaron del estudio ocho profesionales de un equipo multidisciplinario de un hospital federal de tercer nivel de Porto Alegre. Para la recolección de datos, realizada en los meses de enero, febrero, agosto y septiembre de 2021, se utilizó un guión de entrevista semiestructurada. Los datos fueron analizados mediante análisis de contenido temático. Resultados: los datos revelaron que los participantes tienen un conocimiento satisfactorio sobre el concepto de transición asistencial, asociando como facilitadores del proceso la oficina de gestión de altas, las rondas multidisciplinares y el seguimiento de los pacientes por los Servicios de Atención Domiciliaria. Sin embargo, citaron como desafíos las brechas en la comunicación, las condiciones socioeconómicas de los pacientes y familiares, los problemas con los seguimientos posteriores al alta, la demanda exhaustiva de los profesionales y la pandemia. Consideraciones finales: el trabajo conjunto del equipo multiprofesional es fundamental en el proceso de alta del paciente. Los resultados apuntan para la importancia de la creación de equipos de gestión de altas hospitalarias y la realización de rondas multidisciplinarias, como estrategias para mejorar la atención transicional.
Palabras-clave: Cuidado de Transición; Grupo de Atención al Paciente; Alta del Paciente; Enfermería.

RESUMO
Objetivo: conhecer as facilidades e os desafios do processo de transição do cuidado na alta hospitalar por profissionais de uma equipe multiprofissional. Métodos: estudo qualitativo e descritivo, cuja amostra foi intencional, por conveniência. Participaram do estudo oito profissionais de uma equipe multiprofissional de um hospital federal de nível terciário de Porto Alegre. Para coleta de dados, realizada nos meses de janeiro, fevereiro, agosto e setembro de 2021, utilizou-se um roteiro de entrevista semiestruturado. Os dados foram analisados por meio da análise de conteúdo temática. Resultados: os dados revelaram que os participantes possuem um conhecimento satisfatório sobre o conceito de transição de cuidado, associaram como facilitadores do processo o escritório de gestão de altas, os *rounds* multidisciplinares e o acompanhamento dos pacientes pelos Serviços de Atendimento Domiciliar. No entanto, citaram como desafios lacunas na comunicação, condições socioeconômicas dos pacientes e familiares, problemas com seguimentos pós-alta, demanda exaustiva dos profissionais e a pandemia. Considerações finais: o trabalho conjunto da equipe multiprofissional é fundamental no processo de alta do paciente. Os resultados apontam para a importância da criação de equipes de gestão de altas nos hospitais e da realização de *rounds* multidisciplinares, como estratégias de melhoria do cuidado transicional.
Palavras-chave: Cuidado de Transição; Equipe de Assistência ao Paciente; Alta do Paciente; Enfermagem.

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INTRODUCTION

Care transition refers to a set of health actions to ensure the coordination and continuity of health care in the transfer of users between different units within the same health service or between different health services[1]. It is a complex process that requires coordination and communication skills, as it involves the patient, family members, caregivers and health professionals[1,2]. Studies claim that carrying out the care transition results in quality health care, contributing to the reduction of readmissions, deaths, hospital costs and post-discharge adverse events[2,3].

In Brazil, readmission rates are 14 and 18.1% within 30 days after discharge[4,5], while for Medicare beneficiaries the rates range from 11.9 to 14.9%[6]. The cost of unplanned readmissions in the United States reached 26 billion dollars per year[7]. Therefore, the implementation of strategies for the management of hospital beds aimed at care during hospitalization and discharge are important to reduce readmissions[6].

In this sense, care transition programs and activities that coordinate the transfer of patients between different health environments[2,8] are necessary. In some countries, such as Spain and Canada, transition activities are being widely implemented and nurses are the main articulators between the teams, the patient and the care network[2,9]. In Portugal, as of Decree-Law No. 101/2006 that created the National Network of Integrated Continuous Care[10], hospitals have been implementing specific programs and teams for the management of discharges. They are multidisciplinary teams that aim to organize hospital discharges and promote the follow-up of patients' social and health problems, either at home or with other points of the health network[9,10].

In Brazil, care transition activities and the proposal for discharge management teams are still recent, but have been gaining more space. At the end of 2017, a tertiary hospital in Porto Alegre / RS created a discharge management team with the objectives of reducing the length of hospital stay of patients, monitoring non-elective readmissions within 30 days and improving the quality of care. This work is carried out by a multidisciplinary team, whose main activities are carrying out the transition of care at patient discharge[11].

Care transition interventions include self-management education, patient discharge planning together with the family, structured follow-up, care coordination[2], communication with primary care services through a computerized system with clinical history or telephone contact , publishing discharge reports on a computerized platform and monitoring the patient's transition after hospital discharge[12]. The management of actions for the continuity of care requires articulation and integration between the teams' knowledge[2,8], therefore, the collaborative work of the multidisciplinary team is essential. In this sense, the transition of care

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collaborates with the development of these strategies, helping the user to access the care network[13].

It should be noted that it is important to know the activities carried out by the multidisciplinary teams for the elaboration of measures that help in the obstacles and difficulties of their work. Bearing in mind the importance of multidisciplinary teams working together in the discharge process, the need to avoid readmissions and the benefits of the care transition, it is essential to highlight the facilities and challenges of this process from the perspective of professionals who work directly in patient care.

Given the above, the objective of the present study was to understand the facilities and challenges of the transition process of care at hospital discharge from the perspective of professionals in a multidisciplinary team.

METHODS

This is a qualitative and descriptive study, using the transition of care[1] as a theoretical framework.

The study was carried out through semi-structured interviews with professionals from the multidisciplinary team of Internal Medicine (MEI) of a federal tertiary hospital in the city of Porto Alegre, RS, Brazil. The MEI team is made up of 17 medical teams, 11 teams are part of the medical residency in Internal Medicine and six teams are contracted doctors who are not accompanied by residents. Patients hospitalized for the MEI are distributed among six hospitalization units and are monitored by professionals who make up the multidisciplinary team (nurses, physiotherapists, nutritionists, social workers, speech therapists and pharmacists). This team was chosen due to the profile of its hospitalized patients, who are adults and elderly, with several comorbidities and who are rehospitalized or at high risk of rehospitalization. In addition, MEI is the team that has the largest number of beds for hospitalization.

The sample was intentional, for convenience; At least one professional from each category including physicians, nurses, physiotherapists, social workers, pharmacists, nutritionists and speech therapists was invited.

Professionals from the hospital's MEI team were included, who participated in multidisciplinary rounds, who had worked for at least six months in the institution and prepared the patient for hospital discharge. Undergraduate interns from multidisciplinary teams were excluded from the study. After selecting the participants, the Free and Informed Consent Form (TCLE) was sent via e-mail, which was forwarded to the researchers duly signed. Thus, the final sample consisted of eight health professionals. Respondents were identified by number in the order of interviews, with codes “E1, E2...”.

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For data collection, individual interviews were scheduled via Google Meet®, which took place in two periods: January and February 2021 and in August and September of the same year. A script of questions about difficulties and facilities for the discharge process and transition of care was used. The interviews were recorded and later transcribed in full. They were performed until data saturation occurred[14].

Data analysis was performed using thematic content analysis, consisting of the steps: pre-analysis; exploration of the material; treatment of results and interpretation[15].

The research followed the recommendations of Resolution No. 466/12 of the National Health Council (CNS)(16) and was approved by the Ethics and Research Committees (CEP) of the Federal University of Health Sciences of Porto Alegre (UFCSPA) with the number 37228320.0.0000.5345 and Hospital Conceição Group (GHC), with number 37228320.0.3001.5530.

RESULTS

Eight professionals participated in the research, two of which were social workers, two nurses, a speech therapist, a doctor, a nutritionist and a physiotherapist. Regarding gender, seven participants were female (87.5% of the sample). The predominant age was between 30 and 35 years old (37.5%), followed by 36 to 40 years old (25%), 41 to 45 years old (25%), finally more than 45 years old (12.5%). In addition, six interviewees had between 10 and 20 years of training and five reported between one and five years of experience with care transition activities. All participants worked exclusively in the hospital area, in inpatient units.

After analyzing the interview material, three thematic categories emerged, namely: understanding of the care transition process; facilitating strategies of the discharge process and challenges in the discharge process.

In the first category, understanding the care transition process, it was observed that there is understanding of the concept, the participants were able to see their roles in the process, in addition to listing aspects that, for them, are fundamental in the continuity of care. When questioned about the concept of care transition, the participants reported that the definition is associated with discharge planning, articulation with the care network, discussion of the patient's needs by the professionals of the multidisciplinary team and the transfer of information between healthcare professionals. different services.

> [...] it is the organization that is done with the multidisciplinary team that is in the hospital [...] some form of communication where the professionals are informed when this patient will be discharged, so that I can finish my care (E6).

> [...] the transition of care, it will permeate hospital care along with primary care. [...] it is not simply just the discharge of the patient, but a good nutritional assessment, a good interpretation of what the doctor is trying to tell you, a good transition with the speech therapy team, physiotherapy,

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> a multi-team that goes assist this patient (E3).

About their respective roles in the transition of care, the professionals mention functions focused not only on the post-discharge moment, such as the elaboration of a food plan, articulation with intersectoral services and elaboration of the discharge note, but also during the hospitalization in actions of Health education.

> [...] we evaluate according to each situation to make the referrals that are necessary then... guidance on benefits through the CRAS, [...] access to other network services too, which the person sometimes does not know that can use (E2).

> [...] What do we look for? […] scheduling transport, understanding an injury, how she will take care of it, understanding that medical prescription… So my service ends up being an education service for this patient, caregiver or family member (E3).

In this perspective, in addition to the patient's link to health care networks, patient and family guidance on access to social resources was an essential point in the care transition process.

> So, scheduling a consultation at the health center is the least thing [...] to guarantee that this person will actually arrive at the health center [...] the information will also arrive, both at the health center and the other services that make up the care networks [...] It's no use we make a simple referral, and not have the opportunity to discuss it [...] the family also has to be in this process, because otherwise it won't work, the patient will be readmitted [...] there will be failures along the way (E2).

The category facilitating strategies for the care transition process revealed how important it is to have a specific team that organizes the discharge process for transitional care.

All participants recognized the Discharge Management Office as a service that facilitates dehospitalization, since it structures the hospital discharge process, pointing out the needs of each patient and also directs their respective demands so that the teams can provide their assistance in an adequate manner.

> I think the Discharge Management Office centralizes information and manages to signal to the various members of the multidisciplinary team when this discharge will be, what the needs of this patient are, so that we can run after and make everything possible in a timely manner (E6).

> He can be an intermediary and facilitator of this process, at least that is my view. And who knows how to structure the process too (E4).

> And the office, when it gets involved with the discharged patient, it gets involved with that patient's problems, so it raises those problems and makes us reflect on what solution we can give, before that patient leaves (E1).

Some interviewees emphasized communication as one of the main functions of the Discharge Management Office, demonstrating the relevance of this service in structuring and organizing the hospital discharge process, enabling more effective communication among the multidisciplinary team.

> [...] it is a transition service and it facilitates this communication and these

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> nodes that are in this process, so, in addition to working in a multidisciplinary way, they also have this look of network articulation. They think about this issue of comprehensiveness [...] (E5).

> [...] I think the role of the discharge management office is precisely to be informed, to be aware of the date of patient discharge and to be a facilitator in communication between members of the multidisciplinary team [...] (E6).

The multidisciplinary round was described as the moment when the team discusses the care priorities for certain patients, helping in the conduct of each professional. In addition, this moment enables the bond between the entire team and also facilitates the exchange of information.

> [...] in the multidisciplinary round, what can we do to speed up discharge, what is my role to speed up discharge, like, get in touch with the family more quickly, speed up the calculation of a diet, provide guidance [...] understand that my care ends here, but that there will be another professional who has to follow up (E6).

> [...] you leave the round, you go straight there, sometimes to the bed, you know, talking to the family member and this proximity to the team, it makes a lot of difference (E2).

> [...] especially the rounds, where a whole multi-team can discuss and debate what is best for that patient. [...] I think that before, we really didn't have that bond with the whole team and today we do. So much so that we have feedback from nurture, feedback from the physiotherapy team, we have feedback from the social worker, so this project, [...] I see it as a great facilitator for nursing people (E3).

The proper referral made by the discharge management team to primary health care services and the monitoring of patients by home care services (SADs) were recognized as contributing to transitional care, due to the optimization of access to health services outside of the hospital environment.

> So make sure that this person actually arrives at the post. How will it arrive, if the information will also reach, both to the post and to the other services [...] that make up the [...] care networks [...] to the CRAS, right, the Council Tutelage [...] all the services that make up the network need [...] to participate in this transition process as well (E2).

> So, I know that there is the issue of the PAD, of the Best at Home that reassures [...] when I know that there are these professionals out of the hospital, because I know that family will be better assisted like this[...] So I think it's very important. [...] this transition process, it becomes more peaceful for the patient and for us as professionals as well (E8).

The third category, challenges in the care transition process, showed that, despite the facilitating agents, there were obstacles that hindered the care transition, such as the coronavirus pandemic. Visits by family members and companions were restricted in the pandemic context, moving them away from the institution, thus interfering with the preparation of the family and/or caregiver for hospital discharge.

> So I think that many times, especially now, with the pandemic, with restrictions on visits, most people were used to going there to receive information, they went to the visit and received the information from the doctor, they already went to other services, already I would look for social service, [...] with the pandemic I think it

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> ended up harming a lot, but on the other hand I think we also saw what is possible to do in a different way (E2).

Communication gaps both between the professionals of the multidisciplinary team and between the teams and the patients/relatives also represented an obstacle for the participants, as it ended up overloading the professionals who follow the patient directly, making it not possible to provide quality information before the moment from discharge.

> I find out, many times, on the day [...] that the patient leaves that he has to take this insulin, that I have to instruct him that he has to take this insulin [...] How is he going to do it, how is he going to save, places he will do [...] All the guidance and [...] actually I can't do this with quality, because this should have been done during the week (E1).

> [...] I think there is still a lot of failure in communication with the team, with the other professionals who care for the patient [...] we end up seeing a problem at the time of discharge many times and if there was more communication effective [...] would be seen before and it would not end up just bursting like that, there on the day that the person will be discharged [...] (E2).

> The doctor simply speaks loudly and hands the patient a paper. This is the pattern, [...] without any major follow-up information many times, nor return [...] several key pieces of a missing qualified discharge (E4).

Problems in the follow-up of care after discharge were also mentioned by the interviewees. According to them, this is often related to the difficulty in accessing the health network due to the lack of structure of the network itself to absorb the demands of the population. In addition, the lack of public policies contributes to weaknesses in the continuity of care.

> [...] is the patient not being followed up. So this transition to the health center is made, but the rehabilitation part is fine, it is, it is very deficient (E1).
> So I think that when we depend on other services, on other public policies [...] we end up seeing the difficulties [...] the management of the city hall changes, we already know that it has changed, suddenly the coordination will change from that health center [...] so I think that when it depends on external services, whether from the center or from other policies, from the assistance policy, for example, we have a lot of difficulty [...] (E2) .

> Well, I think this is a little flawed because, we there as inpatient unit nurses, we [...] cannot associate this network, of making [...] a good speech with primary care. [...] This dressing we are using such a thing, but if primary care does not have it, you can use such a product that the vast majority of primary care has. [...] I think [...] there's something missing [...] I don't know if it could be via phone or some whatsApp, that we could have this contact with primary care [...] (E3).

The unfavorable socioeconomic context of the public served by the institution was evidenced as a hindrance in the care transition process. In general, participants recognized that the family plays an important role in post-discharge patient care. However, the socioeconomic and cultural condition can prevent these people from assuming the role of caregiver, due to the lack of interest of the family members themselves. Some professionals reflected on the difficulties that patients face due to the non-guarantee of basic citizenship rights.

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> [...] a large part of the public does not have a document, they do not have very basic things. It is not literate [...] So these are things that we sometimes think [...] are obvious to those people too, you know, I think this is also an important thing, because sometimes [...] the family [...] is not involved in the care and [...] it seems [...] that it is obvious that the person will leave there needing that there, it seems that it is obvious that he will have to continue receiving that care for a long time , but it is not. So, things have to be said clearly and in a way that that person can also understand (E2).

> [...] many times the family is going to carry out part of the process [...] many times it has some difficulties in understanding it for socio-cultural, socio-economic-cultural reasons, from all spheres, but I think it is little involved, sometimes because we demand little, sometimes because they are not very interested. There are both, the two spectrums (E4).

The routine demand of professionals in the hospitalization units and, consequently, the difficulty in providing quality care transition if there is no intermediary/facilitator was reported as a difficulty in the process.

> The transition of care to be carried out effectively and [...] in the best possible way for the patient has to have someone organizing it, because the professional himself is involved with many other things, we cannot be up to date on every aspect of each patient [...] I think that having a service or a person organizing and getting in touch, communicating with the various members of the multi team, this favors a more organized discharge [...] (E6).

> [...] I could do a lot more treatment transition, but due to the conditions we have [...] take on 27 patients, often you have two sepsis, an acute edema in one morning [...] the morning you have is difficult there is no intercurrence, you cannot make this transition properly, right?! (E1).

DISCUSSION

This qualitative study shows the understanding and perceptions of a multidisciplinary team regarding facilitating agents and challenges in the care transition process. In view of this, by knowing what professionals understand about transition care, it is possible to identify gaps in how they see themselves within the process and also how they identify the role of the other in these activities, opening space to resolve deficiencies in transition care.

The findings indicate that professionals know the concept of continuity of care, but some still need to broaden their understanding of the subject. In view of the participants' speech, attributes such as discharge planning, articulation with the health care network, discussion of the patient's needs by the professionals of the multidisciplinary team, communication between professionals from different services and health education were identified. In fact, the attributes listed by the research participants and those found in the literature, such as integrated care, professional collaboration, coordination, discharge planning, communication, professional integration and case management[13,17], are synonymous or complementary.

With regard to facilitating strategies, the discharge management office contributes to the improvement of the care process, as it promotes discussions between teams through the implementation of multidisciplinary rounds.

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Among the strategies for managing cases in transitional care in emergency services, the performance of multidisciplinary teams in the care coordination stage stands out, acting collaboratively, meeting periodically to discuss cases, in order to support the management. of cases[18].

The joint work of the multidisciplinary team is essential for the dehospitalization process to be qualified, therefore, all respondents recognize the multidisciplinary rounds as a space for planning care and discussion about what is best for the patient. In addition to organizing and streamlining patient issues, the rounds are able to clarify the role of each professional in the care transition. Multiprofessional teams are present in hospital institutions carrying out patient education activities and promoting self-management, providing instructions related to the use of a central venous catheter, adverse effects of medications, medication use, adequate diet, individual needs and educational materials[19].

On the other hand, the existence of multidisciplinary teams is not experienced in some territories, resulting in transitional care carried out in an uncoordinated way, as there is no teamwork approach involving professionals from different areas; at the same time, care becomes fragmented, which is done in an incomplete and routine way, as a result of poor communication between professionals, leading to ineffective care[20].

The hospital discharge management team, where the research was carried out, works as a link between the multidisciplinary teams and the health care network. She is responsible for articulating the discharge demands of patients among the teams. In addition, it makes contact with the health unit, passing on information about the hospitalization and the post-discharge care plan. This link was listed by professionals as a strategy that contributes to safe transitions, as it inserts the patient into the care network, thus avoiding the loss of information and consequently improves their recovery. Continuity of care in the informational dimension can be enhanced when counter-references are shared by computerized systems, making it possible to insert information about their hospitalization in the patient's electronic medical record, which helps in the follow-up of care in primary care[21].

From this perspective, it is the function of the discharge management office to agree with the reference health team on the type of follow-up that the patient will receive after discharge: home visit (HV), face-to-face assistance at the health unit for consultation, assistance with dressings, participation in groups, among others.

After 30 days of hospital discharge, the discharge management team contacts the patient and/or family through telephone calls to confirm whether the demand agreed upon at discharge with the care network was carried out. In that same contact, it is verified if any other outcome

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occurred with the patient, such as other links with the network, readmission or death.

Another facilitating agent pointed out was the performance of SADs, which promote the continuity of care in a safer way for the newly discharged patient. However, there are gaps in the literature about this follow-up[20], emphasizing that one of the reasons for care disruption is the lack of assistance to patients and family members and/or caregivers through home follow-up services and post-hospitalization phone calls. These interventions are seen as essential for the success of the continuity of care, since, through these teams, it is possible to provide more information and clarifications about a specific aspect of care, in addition to identifying the patient's needs and including the family and/or caregiver. in post-discharge care.

In this regard, the preparation of the family and/or caregiver for hospital discharge was impaired due to the coronavirus pandemic, being attributed as a challenge in the care transition process by the research participants. The insertion of caregivers and family members in patient care during hospitalization is a strategy that promotes pre- and post-discharge patient self-management[19]. Thus, including caregivers during guidance and instructions at the time of hospitalization increases the possibility that what is being taught is understood. In addition, caregivers and family members become capable of caring for the post-discharge patient, as they will be equipped with the knowledge and skills they acquired during hospitalization.

Another challenge pointed out in the research is the communication between the professionals of the multidisciplinary team and between the teams and the patients/relatives. Poor communication directly interferes with the quality of care, as an orderly multidisciplinary team is able to identify the patient's needs and work together in educating and guiding the patient and his support network regarding self-management of care, the use of health services and social issues, counseling on risky behavior and helping patients find solutions to their problems[18].

Still in relation to communication, the interaction with the post-discharge segments was also evidenced as a barrier, since there is no guarantee that the information passed on will be accepted and understood by the other professionals of the health network services.

Although the discharge management office contacts primary care, the professional who is meeting that demand often does not guarantee the continuity of care due to a variety of factors, such as adversities in the referral and counter-referral system, workers' lack of knowledge about the functioning of the RAS, little articulation and difficulties in coordinating network care[22].

With regard to the difficulty associated with the profile of family members assisted by the institution, most of them are low-income and have limitations in understanding the information provided by professionals, which ends up making the process of self-management

guidance and health education difficult. In view of this, the patients' learning abilities are not assessed before discharge, impairing not only the absorption of information by the patient and family/caregivers, but also the understanding of the importance of assuming their role as caregivers[20].

In addition, the professionals' difficulty in reconciling the demands and intercurrences of the inpatient unit with transitional care was identified as an important factor that hinders the care transition process, because professionals are overloaded and become involved with many activities that the attention that should be given to the guidelines for discharge end up being in the background. In addition, lack of time, insufficient staff and workload also contribute to ineffective care[20].

FINAL CONSIDERATIONS

The experiences of the multidisciplinary team of the MEI service in situations involving the patient discharge process are complex and require planning. In this sense, the joint work of the multidisciplinary team is responsible for preparing the patient and the caregiver, even during hospitalization, providing guidance and carrying out training necessary for discharge.

The results showed the role of discharge management teams in hospital institutions and the implementation of multidisciplinary rounds as fundamental for the care transition process to be successful.

The findings of this study bring as implications for professional practice the direction for improvement strategies in transitional care by providing reflection on the importance of communication, integrated care planning and expansion of the hospital's articulation with the other points of the care network .

As a limitation of the study, it is noteworthy that the interviews were conducted only with professionals working in the hospital environment, not involving the view of users, family members and professionals from other services in the network.

It is suggested that further research be carried out with the different points of the RAS that are involved with the care transition process, in order to know the planning of these professionals who receive the patient after hospital discharge and also to understand how the network organizes and carries out this process.

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