Revista ARACÊ
ISSN: 2358-2472

RESPONSIBLE HOSPITAL DISCHARGE FROM THE PERSPECTIVE OF PRIMARY HEALTH CARE NURSES: AN INTEGRATIVE LITERATURE REVIEW

https://doi.org/10.56238/arev6n4-111

Submitted on: 11/09/2024 **Publication date:** 12/09/2024

Querem-Hapuque Soares[1], Magali Aparecida Alves de Moraes[2] and Elza de Fátima Ribeiro Higa[3].

ABSTRACT

This research, an Integrative Literature Review (RIL), examines the view of Primary Health Care (PHC) nurses on Responsible Hospital Discharge, a fundamental process to ensure the safe transition of patients from the hospital to other levels of care, promoting continuity and self-care at home. This practice is crucial to reduce readmissions, adverse events, and healthcare costs, as well as to involve patients and families in treatment management. The RIL followed six steps: formulation of the survey question based on the acronym PICo; search in databases (MEDLINE, Web of Science, LILACS, BDENF, SciELO), identifying 2,823 articles; and screening and critical analysis of the selected studies. Eight articles were included and their results organized into three categories: 1) Continuity of Care, which highlights the importance of effective planning and communication between health teams, patients, and families; 2) Challenges of Post-Discharge Care, evidencing difficulties such as limited resources and lack of structure for the continuity of care; and 3) Patient- and Family-Centered Care, which underlines the relevance of education and family involvement in recovery. The categories reinforce the need for efficient communication between the levels of care and for a well-structured counter-referral, pointing out barriers such as the fragmentation of health services. Strategies for continuity of care include educational actions for patients and caregivers, as well as clear communication between teams. The research suggests the implementation of more effective public policies and the strengthening of intersectoral articulation to improve health outcomes and patient satisfaction.

Keywords: Nurses. Primary Care. Patient Discharge.

[1] Nurse – Master's student in Health Education
Faculty of Medicine of Marília - FAMEMA
E-mail: hapuquesoares@gmail.com
ORCID: https://orcid.org/0009-0007-3335-4269
LATTES: http://lattes.cnpq.br/4573057156521452
[2] Psychologist – Dr. in Education
Faculty of Medicine of Marília - FAMEMA
Email: dmagalimoraes@gmail.com
ORCID: https://orcid.org/0000-0001-5888-1638
LATTES: http://lattes.cnpq.br/0447887914920603
[3] Nurse – Dr. in Fundamental Nursing
Faculty of Medicine of Marília - FAMEMA
E-mail: hirifael@gmail.com
ORCID: https://orcid.org/0000-0001-5772-9597
LATTES: http://lattes.cnpq.br/7363324618190102

Revista ARACÊ
ISSN: 2358-2472

INTRODUCTION

The Responsible Hospital Discharge, established by Brazilian legislation, aims to organize the transition of care between the different levels of health care, ensuring guidance on the continuity of care and promoting dehospitalization in a safe manner. This policy proposes alternatives for hospital discharge in conjunction with the Health Care Network (RAS), aiming to stimulate self-care and autonomy of patients, their families and caregivers, through training, qualification and network connections (Brasil, 2013).

The RAS encompass both integrated actions and services, with the purpose of promoting equity, expanding access and ensuring integrality and quality of care. In Brazil, the process of regionalization of the RAS, driven by the Management Pact of the Unified Health System (SUS), provides for the integration of the various levels of care: from Primary Health Care (PHC), through specialized care (outpatient and hospital), to health surveillance, in addition to work management and health education. PHC plays the central role in coordinating the patient's therapeutic pathway, ensuring continuity of care throughout the process (Nakata, et al., 2020).

Continuity of care is a widely discussed topic internationally, being recognized as a responsibility of all levels of health care, with special emphasis on PHC. It is associated with a closer relationship between patient and professional, greater satisfaction and adherence to treatment, in addition to contributing to the reduction of hospitalizations, adverse events, deaths, and costs (Brasil, 2013; Fagundes and Scandol, 2018).

This concept refers to people's experience of health care, taking into account their needs and preferences over time, through interconnected events. Continuity combines informational, relational and managerial aspects. The informational part concerns the use of data to plan current and future care, and depends on the interaction between professionals, services, and the active participation of patients and their families (Fagundes and Scandol, 2018).

To deal with the complex demands of health, which involve multiple service providers, continuity of care requires effective coordination. The actions that ensure this coordination for people who move between different services or health units include the Transition of Care (TC) process. CT is an important strategy to overcome the fragmentation of the health system and ensure continuity of care, involving patients, family members, caregivers, and health professionals at different levels of care (Fagundes and Scandol, 2018).

Revista ARACÊ
ISSN: 2358-2472

The effectiveness of CT depends on efficient communication between professionals and services. However, there is still a significant gap in the transition between Hospital Care (HA) and PHC, and the problems related to hospital discharge are complex and require specific strategies to improve this process (Uchimura, et al., 2023).

The literature highlights the role of nurses as managers in the planning of Responsible Hospital Discharge. This professional has skills, values and knowledge about the HCN that, when applied in an integrated way, reinforce their responsibility in care. Nurses who work in the continuity of care need to have clinical judgment, a holistic view of the human being, be an advocate for the rights of the patient and the family, in addition to having organizational skills, leadership, clear communication, and dissemination of information in a respectful manner (Aued, et al., 2021).

METHODOLOGY

This is an Integrative Literature Review (RIL), which should follow a systematic and rigorous approach, being directed to the critical analysis of scientific production with the objective of synthesizing the available information, which in this research was about the understanding of Responsible Hospital Discharge from the perspective of Primary Health Care nurses. This review modality should ensure that decisions are based on robust evidence and the quality of studies. It involves the formulation of the research question, identification of the necessary information, conducting a systematic search in the databases, critical evaluation of the studies found, analysis of the applicability of the results and the determination of how these data can be used in care practice (Souza, Silva and Carvalho, 2010).

RIL follows six interrelated steps. The first consists of the formulation of the guiding question, considered the most crucial phase, as it directs the keywords to be used in bibliographic searches and establishes the criteria for inclusion and exclusion of articles (Santos, Pimenta and Nobre, 2007). In this research, the question was structured according to the acronym PICo that represents Population, Interest and Context, structured as follows: P: nurses; I: Responsible hospital discharge; Co: Primary Health Care. The research question was: "What is the understanding of responsible hospital discharge from the point of view of Primary Health Care nurses described in the literature?".

The second stage refers to the search for articles in the databases. Controlled and uncontrolled descriptors combined by Boolean operators (AND; OR). The databases

Revista ARACÊ
ISSN: 2358-2472

selected for the search were Medical Literature Analysis and Retrievel System Online (MEDLINE), Web of Science (WOS), Latin American and Caribbean Literature on Health Sciences (LILACS), Nursing Database (BDENF) and Scientific Electronic Library Online (SciELO), and the descriptors used included terms such as "Nurses", "Hospital Discharge" and "Primary Health Care", in addition to its translations in English and Spanish. The search was conducted without time limitations and included articles published in Portuguese, English and Spanish, as shown in Chart 1.

Table 1. Search strategy in databases. Marília 2024 in São Paulo, Brazil - Dates

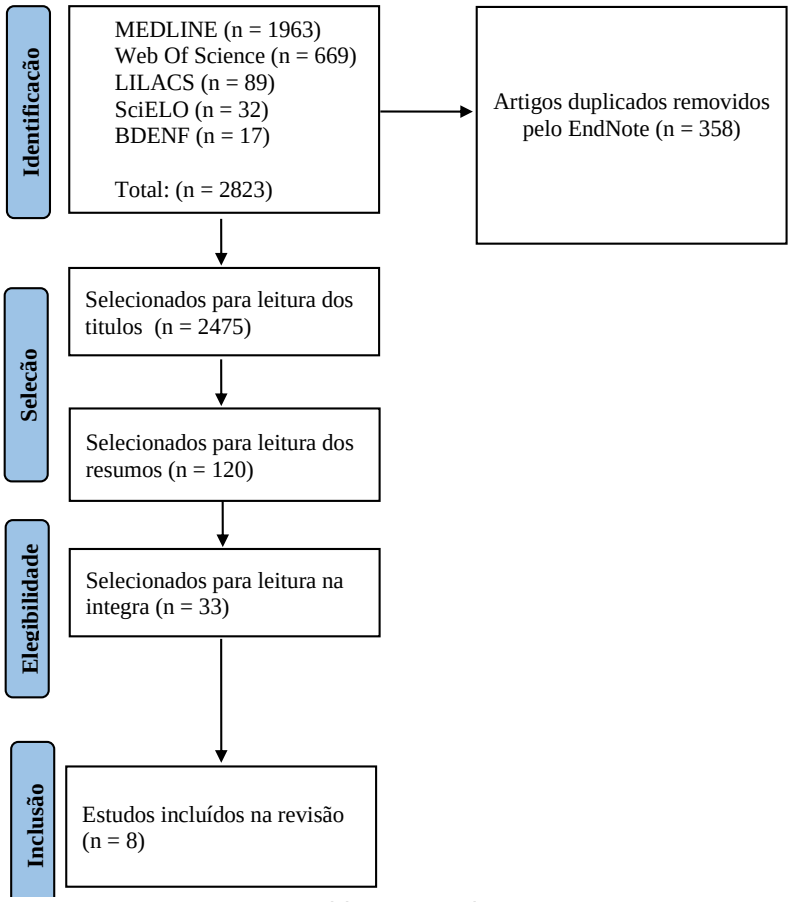
DATABASE	SEARCH STRATEGY	QUANTITY
LILACS	((mh:("Nurses" OR "Nurses" OR "Nursing")) OR (NURSING* OR NURSING)) AND ((mh:("Primary Health Care")) OR ((ATTENTION OR CARE* OR ASSISTANCE) AND (PRIMAR* OR BASIC) AND ((mh:("Patient Discharge")) OR (DISCHARGE))	89
BDENF	(((mh:("Nurses" OR "Nurses" OR "Nursing")) OR (NURSING* OR NURSING)) AND ((mh:("Primary Health Care")) OR ((ATTENTION OR CARE* OR ASSISTANCE) AND (PRIMAR* OR BASIC) AND HEALTH)) AND ((mh:("Patient Discharge")) OR (DISCHARGE)))	70
SciELO	(ENFERMEIR* OR ENFERMAGEM) AND ((ATENÇÃO OR CUIDADO* OR ASSISTENCIA) AND (PRIMAR* OR BASICA) AND SAUDE) AND (ALTA)	32
MEDLINE	(((Primary Health Care[MeSH Terms]) OR (Primary Health Care)) AND (((Patient Discharge[MeSH Terms])) OR (DISCHARGE))) AND ((Nurses OR Nurses, Male OR Nursing[MeSH Terms]) OR (NURSE OR NURSES OR NURSING))	1963
WEB OF SCIENCE	Primary Health Care (All Fields) and Patient Discharge (All Fields) and NURSE OR NURSES OR NURSING (All Fields)	669

Source: prepared by the authors (2024)

The search resulted in a total of 2823 articles. After the removal of 358 duplicates, 2475 articles remained for initial analysis. In the third stage, the titles and abstracts were screened, excluding studies that did not meet the inclusion criteria. From this initial screening, 120 abstracts were selected for more detailed reading, and 61 articles were read in full. As shown in figure 1.

Revista ARACÊ
ISSN: 2358-2472

Figure 1 - Flowchart for the search of articles included in the RIL



Source: Haddaway, et al., 2022

The fourth stage involved a complete analysis of the selected articles, which were evaluated for their relevance and adequacy to the research question. At this stage, the studies are critically examined, considering the methodological quality and relevance of the information presented. The analysis includes a detailed synthesis of key aspects, such as objectives, methods, results, and conclusions, to identify patterns, knowledge gaps, or areas of consensus (Santos, Pimenta, and Nobre, 2007).

In the fifth stage, the data from the included studies were extracted using a standardized instrument, which enabled the collection of relevant information, such as the year of publication, type of study, sample size, and main results. This information was organized and critically analyzed to identify the most significant points for the theme (Santos, Pimenta and Nobre, 2007).

Finally, the sixth stage consisted of presenting the results in a descriptive way, organizing them into analytical categories. The article selection process was documented using the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA)

Revista ARACÊ
ISSN: 2358-2472

flowchart, ensuring transparency in the process of selecting and including studies (Page, et al., 2022).

The results were interpreted and discussed in the light of the literature and legislation on Responsible Hospital Discharge, with emphasis on the articulation with Primary Health Care. In addition, the articles were evaluated for the level of evidence, according to the classification of the Joanna Briggs Institute. The levels of evidence system classifies studies as follows: Level 1 includes experimental studies, while Level 2 covers quasi-experimental studies. Level 3 involves observational analytical studies, and Level 4 refers to observational descriptive studies. Level 5 corresponds to expert opinion and bench research. Each level has sub-levels that specify the type of study, such as systematic reviews, controlled clinical trials, cohort studies, case-control, cross-sectional studies, and case series (JBI, 2020).

In sublevel 1.a, there are systematic reviews of randomized clinical trials; 1.b includes systematic reviews that combine randomized controlled trials with other types of studies. Sublevel 1.c covers individual randomized controlled trials, while sublevel 1.d includes pseudo-controlled clinical trials, with partial randomization. In sublevel 2.a, we have systematic reviews of quasi-experimental studies; Sublevel 2.b contains systematic reviews that mix these studies with other less rigorous designs. Sublevel 2.c encompasses prospective quasi-experimental controlled studies, and sublevel 2.d encompasses pre-test and post-test studies or with a historical/retrospective control group. Sublevel 3.a includes systematic reviews of comparable cohort studies; In 3.b, there are revisions that include cohorts and other less robust designs. Sublevel 3.c covers cohort studies with a control group, and sublevel 3.d includes case-control studies. Sublevel 3.e covers observational studies without a control group. Sublevel 4.a includes systematic reviews of descriptive studies, while sublevel 4.b includes cross-sectional studies. Sublevel 4.c covers case series, which analyze small groups over time, and sublevel 4.d is composed of isolated case studies. Finally, at sublevel 5.a are systematic reviews of expert opinions; in 5.b, expert consensus; and, in 5.c, bench polls or individual opinions, based on practical knowledge or direct experience (JBI, 2020).

RESULTS AND DISCUSSION

The data obtained in the eight articles analyzed are presented in chart 2, organized according to their authors, year of publication, authors, title of the article, name of the

Revista ARACÊ
ISSN: 2358-2472

journal, database, country of origin, method, level of evidence and the understanding of responsible hospital discharge from the point of view of PHC nurses. The most frequent level of evidence was 3.c, followed by 4.b.

Table 2. Studies included in RIL.

Authors Article Title Name of the Journal Year of publication Database Country of origin	Method Level of Evidence (NE)	Understanding responsible hospital discharge from the perspective of PHC nurses
Authors: Mauro, Cucolo, Perroca. Titulo do artigo: Nursing actions for continuity of care in primary health care: a validation study. Journal name: Text & Context – Nursing Year of publication: 2023 Database: LILACS Country of Origin: Brazil	Method: Qualiquantitative NE: 3.c	Post-discharge follow-up Multiprofessional team Continuity of care Clear and effective communication Team, patient and family
Authors: Lima, Bernardino, Silva, Peres and Trigueiro Journal name: Electronic Journal of Nursing Title of the article: Counter-reference: strategy for continuity of care in the health of women and newborns. Year of publication: 2023 Database: LILACS Country of origin: Brazil	Method: Qualitative NE: 3.c	Post-discharge follow-up Counter-reference Continuity of care
Authors: Duarte, Zugno, Rodrigues, Birolo, I. Soratto, Ceretta, Tomasi Journal name: Revista O Mundo da Saúde Title of the article: Nurses' perception of the transition of care at hospital discharge. Year of publication: 2023 Socket Base: LILACS Country of origin: Brazil	Method: Quantitative NE: 4.b	Weaknesses in the agreements between health services Post-discharge home follow-up Need for proper planning Effective support
Authors: Mauro, Cucolo, Perroca Journal name: Journal of the School of Nursing of the University of São Paulo Title of the article: Articulation between the hospital and primary care in the transition of care: the two sides of the process. Year of publication: 2021 Socket Base: MEDLINE Country of origin: Brazil	Method: Qualitative NE: 4.b	Health care network Multiprofessional team Educational actions Continuity of care at home

Revista ARACÊ
ISSN: 2358-2472

Authors: Reig-Garcia, Bonmatí-Tomàs, Suñer-Soler Nome do periódico: BMC Health Services Research Título do artigo: Evaluation and perceptions of a nursing discharge plan among nurses from different healthcare settings in spain. Year of publication: 2022 Socket Base: MEDLINE Country of origin: Spain	Method: Mixed NE: 4.d	Inadequate guidance in the tertiary service Belief about primary service not fulfilling its role
Authors: Kang, Mondesir, Young Journal Name: Home Healthcare Now Título do artigo: Home healthcare nursing visits for nonhomebound patients with heart failure after hospital discharge: a quality-improvement pilot project Year of publication: 2021 Socket Base: MEDLINE Country of origin: United States	Method: Qualiquantitative NE: 3.d	Caregivers and family members Care process Encouragement and support Educational actions Continuity of care at home
Authors: Batista, Pinheiro, Madeira, Gomes, Ferreira, Baixinho Nome do periódico: HealthCare: The Journal of Delivery Science and Innovation Título: Transitional Care Management from Emergency Services to Communities: An Action Research Study. Year of publication: 2021 Socket: Web Of Science Country of origin: Portugal	Method: Qualiquantitative NE: 4.d	High in complex situations Poor information sharing Difficulty in home preparation Lack of material and human resources
Autores: Misra-Hebert, Rothberg, Fox, Ji, Hu, Milinovich, Zafirau, Onuzuruike, Stange Nome do periódico: International Journal of Environmental Research and Public Health. Título do artigo: Healthcare utilization and patient and provider experience with a home visit program for patients discharged from the hospital at high risk for readmission Year of publication: 2021 Socket: Web Of Science Country of origin: United States	Method: Mixed NE: 3.d	Community organizations and social services Family support Social support and community resources

Source: prepared by the authors (2024)

Revista ARACÊ
ISSN: 2358-2472

In the articles included in the RIL, presented in Chart 2, it was observed that Brazil was the country with the largest representation, followed by the United States and Spain. Most of the publications focused on the years 2021 and 2023, with six articles published. Among the journals, the Revista Texto & Contexto Enfermagem and the Revista Eletrônica de Enfermagem were the most recurrent. Regarding the methodologies, the qualitative and qualitative and quantitative approaches were highlighted, present in four articles. The main strategies mentioned for continuity of care include hospital discharge planning and counter-referral, which are widely discussed in studies.

From the analysis of the eight selected articles, three analytical categories emerged: 1. Continuity of care; 2. Challenges of post-discharge care and 3. Patient- and family-centered care. The discussion integrates findings from recent studies, highlighting both good practices and the main challenges faced by health professionals in monitoring patients after discharge. The need for a better articulation between the levels of care and the strengthening of the nurses' performance in the coordination and execution of responsible hospital discharge is revealed.

CONTINUITY OF CARE

The continuity of care after hospital discharge is a priority widely recognized in the literature. Studies point to the need for careful planning to ensure that patients receive adequate follow-up after leaving the hospital. Mauro, Cucolo and Perroca (2023) highlight the importance of clear and coordinated communication between the health team, patients and their families to ensure that home care is effective. Similarly, Lima *et al.* (2023), address counter-referral as a fundamental component for the continuity of care, noting that the articulation between hospital services and PHC is crucial to adjust and reorient interventions carried out at other levels of care.

While the authors Mauro, Cucolo and Perroca (2021) focus on educational actions and strengthening communication between teams and families, Duarte *et al.* (2023), reveal structural weaknesses, such as the lack of adequate agreements between health services, which compromises the continuity of post-discharge follow-up. This highlights a difference in the barriers faced by nurses: on the one hand, the importance of communication as a bridge to the continuity of care, and, on the other hand, the institutional challenges that limit the ability of professionals to perform this follow-up effectively.

Revista ARACÊ
ISSN: 2358-2472

Reig-Garcia, Bonmatí-Tomàs and Suñer-Soler (2022), when studying the perception of nurses in Spain, introduce an additional dimension by discussing the perception that the care offered by PHC is often insufficient, due to the lack of adequate information passed on by tertiary services. This finding complements the view of Duarte *et al.* (2023), which suggest that the problem of continuity of care is not only a matter of planning, but also of transparency and flow of information between levels of care.

CHALLENGES OF POST-DISCHARGE CARE

Post-discharge care faces a number of challenges, ranging from limited resources to the lack of formalization of transition processes. The authors Batista *et al.* (2021) report that patients are often discharged in complex conditions, without PHC having the necessary support to manage these cases properly. This lack of resources and formal communication between the levels of care creates barriers to the continuity of care, which is reinforced by Kang *et al.* (2021), which highlight the importance of educational actions that can empower caregivers and family members, in order to minimize the impact of these structural limitations.

A significant challenge discussed by Misra-Hebert *et al.* (2021) involves patients at high risk for readmission, who are frequently released without the social and community support needed to manage their conditions at home. In this context, the study suggests the integration of social support and community resources as a solution to overcome the limitation of resources available in PHC. This point is complemented by Batista *et al.* (2021) who also suggest that the lack of resources compromises the adequate preparation of homes to receive patients who require continuous care.

Although both studies discuss resource limitations, they offer different solutions: while Batista, et al, (2021) suggest the need for more robust public policies, Misra-Hebert *et al.* (2021) indicate the exploration of partnerships with community organizations to compensate for this lack of resources. Thus, the challenges of post-discharge care seem to require both an institutional response, through public policies, and a community response, which considers the involvement of local organizations.

PATIENT- AND FAMILY-CENTERED CARE

Patient- and family-centered care emerges as a critical theme in the literature, and several studies have pointed out as essential to ensure the continuity and quality of care

Revista ARACÊ
ISSN: 2358-2472

after hospital discharge. Kang *et al.* (2021) highlight that involving caregivers and family members in the recovery process is essential to ensure treatment adherence and promote changes in patients' lifestyles. This educational care is seen as a way to empower both the patient and the family, making them active partners in the health process.

The authors Mauro, Cucolo, and Perroca (2021) complement this view by emphasizing that continuous education for the family and patients about home care should be a regular practice in the transition from hospital to PHC. This entails not only providing detailed guidance, but also ensuring that these guidelines are understood and followed correctly, with strong support from educational and communicational actions. Thus, family involvement is not only seen as a complement to care, but as a central pillar for the success of interventions.

The study by Reig-Garcia, Bonmatí-Tomàs, and Suñer-Soler (2022) presents a scenario in which patients and their families often have misaligned expectations regarding what PHC can offer. Often, the perception that the primary health system is not fulfilling its role is due to the lack of clarity in the guidelines and the absence of effective communication between the levels of care. This misalignment between patient expectations and the reality of PHC raises important questions about the need to better manage patient expectations, which could be addressed with more consistent education and transparent communication from the moment of discharge.

Finally, the authors Misra-Hebert *et al.* (2021) suggest that, in order to improve health outcomes, it is necessary to integrate community resources and family support, creating a more robust network of care. This approach not only improves treatment adherence but also contributes to building a holistic support system, which includes both the medical and social needs of patients.

CONCLUSION

The compilation of these articles made it possible to discuss the findings, revealing that responsible hospital discharge depends on interconnected factors, which involve both institutional resources and family and community support. Continuity of care depends on good intersectoral communication, which includes the appropriate exchange of information between the hospital and primary levels. However, challenges such as limited resources and fragmentation of the healthcare system make it difficult for patients to transition to home care.

Revista ARACÊ
ISSN: 2358-2472

In addition, patient- and family-centered care emerges as an indispensable practice to ensure that patients have effective support after discharge. Educational actions, the empowerment of caregivers and the integration of community resources are essential strategies to address the identified gaps. However, it is necessary to recognize that there are misalignments in patient expectations and PHC capacities, which requires a more effective management of expectations and a strengthening of communication between health services and the population served.

ACKNOWLEDGMENT

The present work was carried out with the support of the Coordination for the Improvement of Higher Education Personnel – Brazil (CAPES) – Financing Code 001.

Revista ARACÊ
ISSN: 2358-2472

REFERENCES

1. Aued, G., et al. (2021). Liaison nurse competences at hospital discharge. Revista Gaúcha de Enfermagem, 42(spe). https://doi.org/10.1590/1983-1447.2021.20200211. Accessed on: Nov 24, 2024.

2. Brasil, Ministério da Saúde. (2013). Política Nacional de Atenção Hospitalar. Diário Oficial da União, Brasília. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt3390_30_12_2013.html. Accessed on: Nov 24, 2024.

3. Duarte, B., et al. (2020). Percepção dos enfermeiros sobre a transição do cuidado na alta hospitalar. Revista Mundo da Saúde, 44(3), 402-416. https://revistamundodasaude.emnuvens.com.br/mundodasaude/article/view/1294/1368. Accessed on: Nov 24, 2024.

4. Fagundes, P., & Scandol, E. (2018). Alta hospitalar responsável sob a ótica do cuidado em rede. Serviço Social e Saúde, 17(1), 181-204. https://doi.org/10.20396/sss.v17i1.8655207. Accessed on: Nov 24, 2024.

5. Haddaway, N., et al. (2022). PRISMA2020: An R package and Shiny app to produce PRISMA 2020 flow diagrams, with interactivity for optimized digital transparency and Open Synthesis. Campbell Systematic Reviews, 18, e1230. https://doi.org/10.1002/cl2.1230.

6. Kang, Y., et al. (2021). Home Healthcare Nursing Visits for Nonhomebound Patients With Heart Failure After Hospital Discharge: A Quality-Improvement Pilot Project. Home Healthcare Now. https://doi.org/10.1097/NHH.0000000000000925.

7. Lima, L., et al. (2023). Contrarreferência: estratégia para continuidade do cuidado na saúde da mulher e recém-nato. Revista Eletrônica de Enfermagem. https://doi.org/10.5216/ree.v25.73154.

8. Mauro, A., et al. (2021). Hospital – primary care articulation in care transition: both sides of the process. Revista da Escola de Enfermagem da USP. https://doi.org/10.1590/1980-220X-REEUSP-2021-0145.

9. Mauro, A., et al. (2023). Nursing actions for continuity of care in primary health care: A validation study. Texto & Contexto - Enfermagem. https://doi.org/10.1590/1980-265X-TCE-2023-0058en.

10. Misra-Hebert, A., et al. (2021). Healthcare utilization and patient and provider experience with a home visit program for patients discharged from the hospital at high risk for readmission. Healthcare (Amsterdam). https://doi.org/10.1016/j.hjdsi.2020.100518.

11. Nakata, L., et al. (2020). Conceito de rede de atenção à saúde e suas características-chave: uma revisão de escopo. Escola Anna Nery, 24(2), e20190154. https://doi.org/10.1590/2177-9465-EAN-2019-0154.

Revista ARACÊ
ISSN: 2358-2472

12. Batista, J., et al. (2021). Gestão de cuidados transicionais de serviços de emergência para comunidades: um estudo de pesquisa-ação. International Journal of Environmental Research and Public Health. https://doi.org/10.3390/ijerph182212052.

13. Page, M., et al. (2022). A declaração PRISMA 2020: diretriz atualizada para relatar revisões sistemáticas. Epidemiologia e Serviços de Saúde. https://doi.org/10.1136/bmj.n71.

14. Reig-Garcia, G., et al. (2022). Avaliação e percepções de um plano de alta de enfermagem entre enfermeiros de diferentes ambientes de saúde na Espanha. BMC Health Services Research. https://doi.org/10.1186/s12913-022-08109-9.

15. Santos, C., Pimenta, C., & Nobre, M. (2007). A estratégia PICO para a construção da pergunta de pesquisa e busca de evidências. Revista Latino-Americana de Enfermagem, 15(3), 508-511. https://www.revistas.usp.br/rlae/article/view/2463. Accessed on: Nov 24, 2024.

16. Souza, M., Silva, M., & Carvalho, R. (2010). Integrative review: What is it? How to do it? São Paulo Medical Journal, 8(1), 102-106. https://doi.org/10.1590/S1679-45082010RW1134.

17. The Joanna Briggs Institute. (2020). JBI levels of evidence. https://jbi.global/sites/default/files/2019-05/JBI-Levels-of-evidence_2014_0.pdf. Accessed on: Nov 24, 2024.

18. Uchimura, L., et al. (2023). Evidências de efetividade dos cuidados de transição em idosos após internação hospitalar: uma revisão sistemática rápida. Revista Panamericana de Salud Pública. https://doi.org/10.26633/RPSP.2023.143.

19. Zanetoni, T., Cucolo, D., & Perroca, M. (2022). Responsible hospital discharge: content validation of nurse's activities. Revista Gaúcha de Enfermagem. https://doi.org/10.1590/1983-1447.2022.20210044.pt.