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SHORT COMMUNICATION

Rehabilitation Nursing interventions that facilitate continuity of care between hospital and community settings

Intervenciones de enfermería de rehabilitación que facilitan la continuidad de los cuidados entre el hospital y la comunidad

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ABSTRACT

The transition from hospital to community care should begin during hospitalization and requires structured and collaborative planning. In this context, the Rehabilitation Nurse Specialist plays a key role in outlining a transdisciplinary plan that ensures continuity and effectiveness of care, promoting the client's autonomy and responding to their needs and those of the caregiver. This critical-reflective study analyzed relevant studies on the subject, with the aim of identifying interventions that can be implemented by the Rehabilitation Nurse Specialist to ensure a safe transition between different care settings. The results show that formal coordination between professionals, through the use of structured and confirmed communication tools, is essential for the effective transfer of clinical information. The early assessment of the client's social needs, as well as the implementation of educational strategies aimed at the client and the caregiver, are decisive for their safe reintegration into the community, contributing to the reduction of complications and hospital readmissions. In conclusion, Rehabilitation Nurse Specialists face challenges in maintaining continuity of care at the time of transition, and it is crucial to optimize communication between contexts in order to ensure the quality of the rehabilitation care provided.

Keywords: Continuity of Patient Care; Transitional Care; Rehabilitation Nursing; Interdisciplinary Communication

RESUMEN

La transición de la atención del hospital al contexto comunitario debe comenzar durante la hospitalización, lo que requiere una planificación estructurada y colaborativa. En este contexto, la Enfermera Especialista en Enfermería de Rehabilitación desempeña un papel fundamental en la definición de un plan transdisciplinario que garantice la continuidad y la eficacia de la atención, promoviendo la autonomía del paciente y respondiendo a sus necesidades y a las del cuidador. Este trabajo, de carácter crítico-reflexivo, analizó estudios relevantes sobre el tema, con el objetivo de identificar intervenciones que la Enfermera Especialista en Enfermería de Rehabilitación puede implementar para garantizar una transición segura entre los diferentes contextos

de atención. Los resultados muestran que la articulación formal entre profesionales, mediante el uso de herramientas de comunicación estructuradas y confirmadas, es esencial para una transferencia eficaz de la información clínica. La evaluación temprana de las necesidades sociales del paciente, así como la implementación de estrategias educativas dirigidas al paciente y al cuidador, son decisivas para su reintegración segura a la comunidad, contribuyendo a la reducción de complicaciones y reingresos hospitalarios. Se concluye que las enfermeras especialistas en enfermería de rehabilitación enfrentan desafíos para mantener la continuidad de la atención durante la transición, y es crucial optimizar la comunicación entre contextos para garantizar la calidad de la atención rehabilitadora brindada.

Palabras clave: Continuidad de la Atención al Paciente; Cuidado de Transición; Enfermería en Rehabilitación; Comunicación Interdisciplinaria

INTRODUCTION

A change in the level of care is, in the vast majority of cases, a preponderant factor in increasing the client's vulnerability.[1] Transition of care occurs when a client changes context, such as from hospital to the community, and it is essential to guarantee continuity of care. This process depends on effective organization and communication between different services and health units. Continuity between hospital and community care is fundamental to ensuring that the care provided to the client is appropriate to their needs, including clear communication between health professionals.[2]

The transition of care is characterized as an intentional, clearly defined process to which expectations and responsibilities are assigned and which should focus on the needs of the client and the caregiver. A study published in 2014 concluded that hospital readmissions in the first 30 days after discharge can be interpreted as a failure on the part of the transdisciplinary team to plan a safe and effective discharge. The following are identified as causes of hospital readmission: medication errors, inability to access necessary care, lack of self-care, illiteracy in health and low financial resources.[1]

It is desirable for the client's discharge planning to begin on the first day of hospitalization, with a view to linking care between the hospital environment and the community as a means of reducing the occurrence of hospital recurrences and readmissions, taking into account all the implications - social, economic or emotional - that these readmissions entail for the client, family and society.

In this way, continuity of care is a challenge and a growing need in the area of health, particularly in Rehabilitation Nursing, which is a specialty that aims to optimize the recovery of people with special needs, maximizing their functional capacities in the different dimensions of care.[3] In this way, the Rehabilitation Nurse Specialist (RNS) must be a precursor in the process of articulation between the two aforementioned contexts.

Objective

The reflection presented here aims to analyze the rehabilitation nursing interventions that facilitate continuity of care between hospital and community settings, with an emphasis on the link between the RNSs of both contexts. The main objective is to identify the interventions to be adopted by the RNS to ensure an effective transition of care between the hospital and community settings, improving the quality of the client's recovery.

METHOD

A search was conducted in the CINAHL, Medline, and Google Scholar databases for articles published in Portuguese and English between 2014 and 2025. The articles were analyzed to identify Registered Nurse Specialist (RNS) interventions aligned with the previously defined objective. Given the limited availability of studies explicitly focusing on RNS interventions, the analysis also included the practices of generalist nurses.

DEVELOPMENT

Throughout the process of transition from hospital care to the community, it is essential to guarantee continuity of care, which requires organization and coordinated communication between the different health services or units.[2,5] The link between hospital and community nurses is raised as a key intervention for a successful transition of care. Communication should be based on the official transmission of the discharge letter in computerized form, complemented in parallel by direct communication (e.g. via a telephone call) to ensure confirmation of receipt of the information and clarification of doubts.[4,6,7,8,9]

Since rehabilitation nursing care aims to empower clients and their caregivers to deal with the difficulties of everyday life, the Order of Nurses points out that rehabilitation nursing care includes "promoting early

diagnosis and preventive rehabilitation nursing actions, in order to ensure the maintenance of functional capacities", "preventing complications and avoiding disabilities" by developing interventions that include "improving residual functions, maintaining or recovering independence in life activities and minimizing the impact of installed disabilities".[2,3] In this way, the empowerment of the client, caregiver and their family involves promoting the education of those being cared for, achieving gains in decision-making and autonomy.[9] In order to ensure this, continuity of care between the hospital and community settings is essential, establishing a discharge plan as early as possible.[6]

Some authors consider it crucial to empower the client to self-manage their health-disease condition in this care transition process.[6,7,12] The main objectives of this empowerment are the acquisition of skills to understand their health-disease condition, recognizing signs of decompensation, adaptive needs or management of drug therapy - essential in the change of level of care that occurs in the transition process.[5]

In order to guarantee quality and safety, prevent loss of functionality and hospital readmissions after discharge, the RNS must apply specialized techniques and educate the client, caregiver and family. The RNS must plan discharge together with the transdisciplinary team and thus ensure continuity of care, the client's reintegration into the family and the community, guaranteeing their right to dignity and quality of life.[3]

Another intervention considered relevant by different authors is the survey of social needs - which includes support materials, housing structure, home support of different types - so that transdisciplinary teams, both in hospital and in the community, can optimize resources and intervene in time for the client's discharge and reintegration into their daily lives. The home visit is considered to be an essential element in the transition of care.[6,7,9,11]

Providing health education to clients and their caregivers during hospitalization is also an intervention highlighted by several authors, and is inherent in clarifying doubts and preparing for discharge. The teaching of personalized exercises according to the client's needs by the RNS in a hospital setting is essential. These exercises must be adapted to the client's context, so that continuity can be provided by the rehabilitation nurse who provides care in the community - something that is ensured, for example, through a home visit prior to discharge. This doesn't mean that the knowledge acquired doesn't need to be validated, and that new needs in the area of health education need to be identified.[6,7,12] The interventions identified above have been summarized in the table below, and we can highlight the major reference made by different authors to interventions such as: drawing up a discharge letter in order to optimize communication within the transdisciplinary team[4,6,7,8,9], assessing and evaluating the needs of the client/family [7,8,10,12] or teaching in different areas of intervention,[6,7,12] thus giving them significance in terms of the implementation of these interventions when nurses transition from hospital to community care.

Interventions / Articles	Setting medium/long-term personal/family goals and objectives	Perform teaching	Multidisciplinary teamwork	Case management methodology	Survey and assessment of the person's/family's needs	Identification of reference professionals / links	Protocols and follow-up appointments after hospital discharge	Discharge letter, optimizing communication in a transdisciplinary team	Computerization of systems and networking of health institutions.
#3								X	
#6		X	X		X			X	
#7		X			X			X	X
#8								X	
#9			X	X	X	X	X	X	
#11					X				
#12	X	X							

Figure 1. Summary of nursing interventions applied in the transition of care from the hospital setting to the community setting, by article analyzed

A qualitative study carried out in 2014 surveys issues that clients and caregivers consider to be threats to safety in a transition after hospital discharge, as well as facilitating factors. In general, it was concluded that the population interviewed identified the possibility of playing a more active role in planning the transition of care and managing self-care as a factor that promotes healthy and safe transitions.[13]

In this way, it is considered that including the client and their caregiver in the transition process from the very first moment of discharge planning, as protagonists and active elements in the continuity of care, will be essential for promoting a quality transition. In order for this to happen, the RNS must understand the needs, expectations and goals of the client and caregiver, always starting from these aspects when planning the transition between the hospital and community context - bearing in mind the main focus as being the promotion of autonomy. As a way of ensuring that the RNS plans and acquires this information effectively, the RNAO has drawn up and proposes a checklist entitled "My Transition Care Plan", which summarizes essential

information to ensure a healthy and personalized transition.[2]

The presence of little scientific support regarding the interventions that the RNS can develop to facilitate continuity of care between hospital and community settings was a significant limitation in this reflection.

CONCLUSION

The articles found describe a generalized difficulty, particularly on the part of the RNS, in maintaining the transversality of a care plan when a client moves between different contexts, which can weaken its effectiveness.

It is possible to think of adopting a dynamic clinical process that is transversal to the entire care context. It is therefore crucial to optimize communication between the different care settings so that clinical information is available for planning, prescribing, implementing and evaluating the care provided, particularly rehabilitation care. These measures will result in a feeling of security for the client, caregiver and family.

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