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SCOPING REVIEW OPEN ACCESS

The Documentation Used by the Nurses During the Transition From the Hospital to the Community Setting: A Scoping Review

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ABSTRACT

Aim: This study aimed to identify the content of documentation used between hospital and community care and describe the communication mechanisms that allow the continuity of care.

Design: We conducted a scoping review following the JBI recommendations.

Methods: The sources of the information used were obtained from the MEDLINE and CINAHL databases (via EBSCO), Web of Science, SCOPUS, Joanna Briggs Institute and Cochrane Database of Systematic Reviews. Additionally, grey literature was included. The databases searched from 2018 to 2023 for articles written in English and Portuguese. Two researchers independently screened articles based on inclusion and exclusion criteria, and a third researcher adjudicated disagreements.

Results: We retrieved 3217 articles, of which 5 were included. Six themes were summarised from these articles: Communication and information between clinical practice environments; Discharge letter content; The use of technologies in healthcare communication; Client empowerment in information communication; Factors hindering the safe transition of information between hospital and community; and Benefits of secure information transition between hospital and community.

Implications for the Profession and/or Patient Care: The results allow systematisation of the information that should accompany the person at the time of discharge to ensure the continuity of transitional care, including the patient/family's own perception of their difficulties and needs.

Reporting Method: PRISMA 2020.

1 | Introduction

Continuity of care can be defined as the transmission of care to another professional in a different health care setting. This concept is one of the cornerstones of a safe transition between health care settings, and it is underdeveloped at a theoretical level and has several frailties in clinical practice, mainly regarding the documentation used during it. In this process, everyone involved in care, including the client, should communicate and work together in order to coordinate care and establish goals (Tasew, Mariye, and Teklay 2019; Wasserman et al. 2023).

The transition between different contexts of care is known as a moment of major vulnerability for the client, mainly for those who are more dependent. This happens due to the possibility of experiencing a break in the continuity of care (Baixinho and

Ferreira 2019). At the present time in Portugal, the communication process in transitional care is unidirectional from hospital to community: it happens through the discharge nursing letter (Baixinho and Ferreira 2019; Mendes et al. 2017). This letter, being the only communicational tool, conditions care delivery heavily. It contains the information considered important by the nurse in charge regarding the hospital stay and some recommendations about the delivery of care afterwards. The letter is later given to the client, who should deliver it at the community setting.

2 | Background

Nowadays, the healthcare system has its focus on preventive care; in other words, on the prevention of disease (WHO 2022). This happens due to the fact that preventive care enables better health outcomes with fewer expenses overall.

The primary care setting has, as one of its roles, answering existing problems in the community, enabling its citizens to optimise and protect their health (WHO 2022). This role becomes even more relevant considering the Portuguese population is aging and those older people tend to live at home. Primary health care contributes to the mitigation of the health risk factors, improving the efficiency of care delivery in the hospital by decreasing the number of hospitalisations (WHO 2022). Therefore, it can be said that these health units complement the function of hospitals in non-urgent care delivery, for instance, in care delivery post-hospitalisation due to the articulation between health care services that exists.

According to the Canadian Institute of Health Information, a follow-up appointment should be scheduled in the maximum period of time of 2 weeks after discharge (McPherson, 2015). Despite that, Lam et al. (2018) claim that only 52% of clients complied with that guideline. Hereupon, there's a significant portion of the population that doesn't have the adequate clinical follow-up. This is a phenomenon that culminates in a discontinuity of care, with possible prejudice for the client.

A safe transition is defined as a group of measures that help to prevent risks in the delivery of care and adverse events. The articulation between care levels requires, among others, that continuity of information is guaranteed to ensure quality and safety, preventing the decline of functionality in the post-discharge and unnecessary readmissions by the appearance of risks and predictable complications, such as dehydration, falls, respiratory and urinary infections, and immobility syndrome (Baixinho, Bernardes, and Henriques 2020; Goodwin et al. 2021).

Security flaws are common, and it is claimed that 1 in 10 clients are affected by adverse events that could have been prevented (WHO 2018) and these are: adverse reactions to medication, infections acquired in consequence of the delivery of care, and even complications regarding medical procedures that might lead to long-term morbidity (Agency for Healthcare Research Quality 2019).

At the core of this problem, thereis care fragmentation between health care contexts (Baixinho and Ferreira 2019). This could lead to wrong treatment guidelines with a high probability of errors and duplications, inadequate follow-up, and a lack of preparation/information on the part of the user and informal caregivers (Mendes et al. 2017).

The care fragmentation is caused by a lack of efficient communication between nursing teams, due to the different perspectives regarding health needs. Furthermore, there is also the high-volume workload at the hospital, with limited time to prepare for the discharge. This also leads to a weakened communication with the client, with a negative outcome in transitional care and a decrease in client satisfaction (Facchinetti et al. 2019; Hellesø and Gautun 2018).

Embracing a perspective of continuous improvement of professional practice, the client's satisfaction is one of the relevant aspects to provide a safe transition, which is referred to as an element of the role of the nurse to minimise the negative impact on the client caused by the change of context in care delivery (Baixinho and Ferreira 2019). Additionally, the nursing team should guarantee the security of written and oral information during the discharge process through the use of adequate material resources (Mendes et al. 2017; WHO 2018).

In order to accomplish a safe and effective transition of care, it is important to implement several nursing interventions, targeting either the client or the nursing team at the primary care facility. The empowerment of the client is a possible strategy to be used, where the team enables the client to participate in the delivery of care (Baixinho and Ferreira 2019; Hellesø and Gautun 2018). Regarding the nursing interventions, it is fundamental to register all the interventions implemented in order to deliver care safely and effectively (Baixinho and Ferreira 2019; Facchinetti et al. 2019).

This study aims to identify the content of documentation used between hospital and community care and describe the communication mechanisms that allow the continuity of care.

3 | Methods

3.1 | Study Design

A scoping review was the method chosen to answer the research question. The protocol followed the six steps recommended for this type of systematic review: (1) Identification of the review question; (2) Designation of inclusion and exclusion criteria for studies and identification of relevant studies; (3) Selection of studies to be included; (4) Assessment of the level of evidence of the collected literature according to the JBI guidelines; (5) Discussion of the results; and (6) Synthesis and presentation of the obtained results (Peters et al. 2020).

The study protocol was registered on the Open Science Framework (OSF) platform under the registration: https://doi.org/10.17605/OSF.IO/6H8MD.

3.2 | Eligibility Criteria

The research was conducted in April 2023 with the research question, based on the PCC mnemonic—Population, Concept

and Context: "What documentation are made by nurses that guarantee transitional care between the hospital and the community?". In order to guarantee the relevance of the literature included, several inclusion and exclusion criteria were settled on (Table 1).

Concerning the inclusion criteria were accepted studies related to the documentation produced specifically by the nursing team at the discharge of the elderly from hospital to primary health, such as discharge or transfer letters, computerised or paper-based records that allow continuity of care between these two levels of care. Concerning languages, our inclusion criteria were English and Portuguese, and the literature had to be available online for free, published between 2018 and 2023. Since this research is a scoping review, all literature reviews will be included.

Regarding the exclusion criteria, the articles could not be about transitional care into rehabilitation services or nursing homes, articles about documentation and continuity of care for children, adults, and those with mental health diseases.

3.3 | Data Collection

The search strategy was developed using descriptors and free terms, and Boolean operators 'AND' and 'OR' were used to combine search terms. The detailed search strategy in Medline, via Pubmed, is presented in Table 2.

Our research started in MEDLINE (via EBSCO) with the search strategy present in Table 2. This action was then replicated in CINAHL (via EBSCO), Web of Science, SCOPUS, Joanna Briggs Institute and Cochrane Database of Systematic Reviews. First, we analysed the titles of each result and their indexing terms, following their abstracts if considered necessary in order to choose which articles were suitable for our scoping review. We then searched for new literature through the bibliographic references of our research and finally looked for grey literature. Additionally, grey literature from governmental information media was included. Two researchers independently screened articles based on inclusion and exclusion criteria, and a third researcher adjudicated disagreements.

In order to gather all the articles found through the research strategy, we use the Rayyan application, a free online platform that facilitates the selection of the literature. This selection process was made by two reviewers who screened the titles and abstracts thoroughly. The entire process of finding and selecting the studies is explained in the results section, according to the PRISMA 2020 flow diagram for new systematic reviews, which included searches of databases, registers and other sources (Page et al. 2021).

3.4 | Data Extraction and Analysis

A Microsoft Excel table was created to extract the content from the final bibliographic sample It contained the following information: article title, author name(s), publication year, article type, objectives, methods, and main results/conclusions.

The articles that answered the research question and respected the inclusion criteria were subjects of analysis and a narrative synthesis of the results was carried out.

4 | Results

Initially, we retrieved 3360 articles that were reduced to 40 after eliminating duplicates and reading all abstracts. These were read, and 10 were left, from which five were included in this scoping review. Furthermore, grey literature was added, specifically three articles. In total, eight articles were included in this scoping review. The detailed process is presented in Figure 1.

The included articles have different methodologies and are from the United Kingdom ($n=1$), Italy ($n=1$), Norway ($n=2$) and Australia ($n=1$). The grey literature is from Portugal ($n=2$) and New South Wales ($n=1$). Table 3 shows the studies that comprise the final bibliographic sample and synthesise the main results that answered the research question.

All the information collected was categorised into six themes, each one being an element of communication in transitional care.

4.1 | Communication and Information Between Clinical Practice Environments

Different communication methods are used between professionals and with clients. According to the Dispatch n° 9390/2021 from the Plano Nacional para a Segurança dos Doentes 2021/2026 (2021), the improvement of security in transitional care is fundamental and should be done through the implementation of communication tools between healthcare professionals in different levels of care.

TABLE 1 | Eligibility criteria, Lisbon, 2023.

	Inclusion criterion	Exclusion criterion
P	Elderly with discharge from hospital.	Newborns, children, adolescents, and young adults hospitalised. Elderly discharged to nursing homes or rehabilitation services/institutions.
C	Documentation produced by the nursing team.	Documentation produced by the multidisciplinary team.
C	Transitional care from hospital to primary health care setting.	Transitional care to nursing homes; Elderly with no expectation of discharge; Transitional care from primary health care setting to hospital; mental health and psychiatric nursing.

TABLE 2 | Search Strategy in detail. Lisbon, 2023.

Search strategy
((((((“discharge”[Title/Abstract] OR “clinical discharge”[Title/Abstract] OR “patient discharge”[Title/Abstract] OR “clearance”[Title/Abstract] OR ((“patient discharge”[MeSH Terms] OR (“patient”[All Fields] AND “discharge”[All Fields]) OR “patient discharge”[All Fields] OR “release”[All Fields] OR “released”[All Fields] OR “releases”[All Fields] OR “releasing”[All Fields]) AND “from hospital”[Title/Abstract]) OR “discharg*”[Title/Abstract] OR “dismissal”[Title/Abstract] OR “dismiss*”[Title/Abstract] OR “patient discharge”[MeSH Terms] OR “patient discharge”[MeSH Terms] OR “patient discharge”[MeSH Terms] OR “patient discharge”[MeSH Terms] OR “patient discharge summaries”[Title/Abstract] OR “patient discharge summaries”[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter])) AND ((y_5[Filter]) AND (ffrft[Filter]))) OR (patient handoff[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter])) AND ((y_5[Filter]) AND (ffrft[Filter]))) AND (((“Aged”[Title/Abstract] OR “age”[Title/Abstract] OR “elderl*”[Title/Abstract] OR “old”[Title/Abstract] OR “older person*”[Title/Abstract] OR “older people”[Title/Abstract] OR “geriatric*”[Title/Abstract] OR “Senior”[Title/Abstract] OR “Aged”[MeSH Terms] OR “frail elderly”[MeSH Terms] OR “frail elderly”[MeSH Terms] OR “frail elderly”[MeSH Terms]) NOT “animals”[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter])) AND ((y_5[Filter]) AND (ffrft[Filter]))) AND ((y_5[Filter]) AND (ffrft[Filter]))) AND (((((((((“transitional care”[Title/Abstract] OR “transition”[Title/Abstract] OR “articulation”[Title/Abstract] OR “health care network”[Title/Abstract] OR “health care”[Title/Abstract] OR “care transition”[Title/Abstract] OR “healthcare”[Title/Abstract] OR “articulat*”[Title/Abstract] OR “transition*”[Title/Abstract] OR “integrated care”[Title/Abstract] OR “care coordination”[Title/Abstract] OR (“car”[All Fields] AND “coordination”[Title/Abstract]) OR “transfer”[Title/Abstract] OR “transfer*”[Title/Abstract] OR “patient pathway”[Title/Abstract] OR “transition of care”[Title/Abstract] OR “care transitions”[Title/Abstract] OR “transitional care”[MeSH Terms] OR “patient transfer”[MeSH Terms] OR “patient transfer”[MeSH Terms] OR “delivery of health care, integrated”[MeSH Terms] OR “delivery of health care”[MeSH Terms] OR “health services accessibility”[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter]))) OR (continuity of patient care[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter]))) OR (continuity of care[MeSH Terms])) OR (care continuity[MeSH Terms])) OR (care continuity, patient[MeSH Terms])) OR (patient care continuity[MeSH Terms])) OR (care continuum[MeSH Terms])) OR (continuum of care[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter]))) AND ((y_5[Filter]) AND (ffrft[Filter]))) AND ((((((((((primary care[Title/Abstract]) OR (home care[Title/Abstract])) OR (hospital-community[Title/Abstract])) OR (community[Title/Abstract])) OR (hospital[Title/Abstract])) OR (primary healthcare[Title/Abstract])) OR (community care[Title/Abstract])) OR (primary healthcare[MeSH Terms])) OR (primary health care[MeSH Terms])) OR (community health centers[MeSH Terms])) OR (community health center[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter]))) OR (community health nursing[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter]))) AND ((y_5[Filter]) AND (ffrft[Filter]))) AND ((“documentation”[Title/Abstract] OR “doc”[Title/Abstract] OR “register”[Title/Abstract] OR “reg”[Title/Abstract] OR “report”[Title/Abstract] OR “rep”[Title/Abstract] OR “clinical process”[Title/Abstract] OR “nursing process”[Title/Abstract] OR (“nurs*”[All Fields] AND “doc”[Title/Abstract]) OR (“nurs*”[All Fields] AND “reg”[Title/Abstract]) OR “document*”[Title/Abstract] OR “documentation”[Title/Abstract] OR “register”[Title/Abstract] OR “doc”[Title/Abstract] OR “rep”[Title/Abstract] OR “reg”[Title/Abstract] OR “nursing diagnoses”[Title/Abstract] OR “education, nursing, continuing”[MeSH Terms] OR “documentation”[MeSH Terms] OR “documentation”[MeSH Terms] OR “clinical audit”[MeSH Terms] OR “clinical audit”[MeSH Terms] OR ((“nephron clin pract”[Journal] OR “clin pract lond”[Journal] OR (“clinical”[All Fields] AND “practice”[All Fields]) OR “clinical practice”[All Fields]) AND “guidelines as topic”[MeSH Terms]) OR “clinical nursing research”[MeSH Terms] OR “medical staff, hospital”[MeSH Terms] OR “medical staff, hospital”[MeSH Terms] OR “nursing staff”[MeSH Terms] OR “nursing staff, hospital”[MeSH Terms] OR “nursing staff, hospital”[MeSH Terms] OR “education, nursing, continuing”[MeSH Terms] OR “health planning guidelines”[MeSH Terms] OR “practice guidelines as topic”[MeSH Terms] OR “guidelines as topic”[MeSH Terms] OR “guidelines as topic”[MeSH Terms]) AND ((y_5[Filter]) AND (ffrft[Filter])) AND ((y_5[Filter]) AND (ffrft[Filter]))) AND ((y_5[Filter]) AND (ffrft[Filter]))

Regarding communication methods between nurses, phone calls and electronic messages should be used due to the ease of information transmission, making it more precise and effective (Fjellså, Husebø, and Storm 2022; Hellesø and Gautun 2018). The use of electronic messages also allows for a discussion and clarification of different perspectives of health care needs in an extended time period (Hellesø and Gautun 2018).

At the time of discharge, an automatic notification system is used in order to notify the nurse in a primary healthcare setting (Fjellså, Husebø, and Storm 2022).

Shannon et al. (2022) and Allen et al. (2020) advocate for the precocious communication with the client regarding discharge, specifically from the moment of admission in the ward. From that moment on, nurses should start preparing for the discharge, facilitating this process and optimising communication with their clients. The tools implemented to achieve this are:

1. An information booklet for patients, encouraging them to be more involved in their care by retaining independence, signposting and offering suggested questions;
2. A stand-up ‘question card’ for patients to write and display their questions to staff, and promote communication between staff, patients, and families;
3. A ‘hospital record sheet’ for patients to record events or conversations regarding their health;
4. A ward induction leaflet to orientate patients to ward routines (...) on hospital admission;
5. A patient-friendly discharge letter (...) for staff to complete and provide to patients at discharge (Shannon et al. 2022).

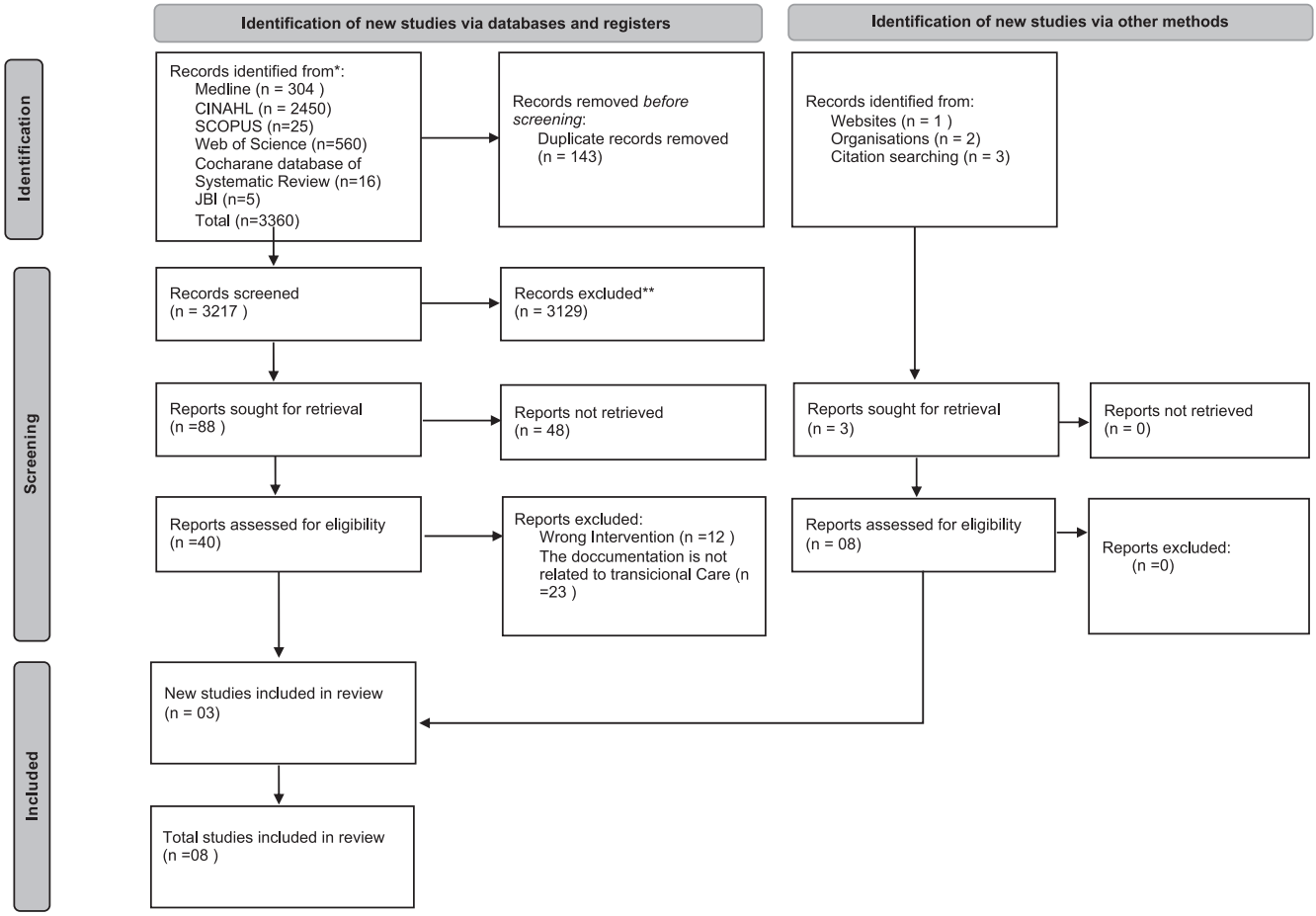

FIGURE 1 | PRISMA 2020 flowchart. Lisbon, 2023.

Although these tools were found useful, some frailties are identified by the authors, specifically that the question card and the hospital record sheet were not used by a portion of clients for the following reasons: lack of mental or physical capacity, lack of will and a big quantity of items to fill in. It is concluded that the clients who were already active in the health project were the ones who resorted to these tools. Thus, they are only complementing the communication that is already efficient. On the question card, it is suggested that there should be standard questions already printed, as the blank space was perceived as too intimidating. With regard to the user-friendly letter, it was found to be a great success, despite being rarely carried out by the team due to duplication of work, lack of knowledge about the computer system and subjectivity in the level of complexity of the information to be written.

On the other hand, Allen et al. (2020) advocate the use of the TRANSITION Tool as a tool to be applied from admission in ward, as it allows a holistic understanding of the client. The name of this tool is an acronym for a set of tasks and knowledge that the nurse must take into account in order to better prepare the user for discharge. These consist of: time to question and listen; to know the user and care provider; carry out welcoming activity to the service; to determine the existence of cognitive deficits in terms of memory; understand the existing support at home; to verify the risk of events causing harm in the household; how the therapeutic regime is managed; what is the level of knowledge about the current health situation and what are the current health education needs; what stage of discharge planning we are at and, finally, the existence of concerns underlying the hospitalisation and return home. This tool can work as a guide for planning the discharge and discussing different aspects of it with the user and their caregiver. On the other hand, it can also operate as a checklist at discharge, in order to confirm the health needs of the user at home.

After discharge, the nursing team from primary health care also resorts to phone calls to establish contact with clients, mainly to schedule the follow-up consultation (Fjellså, Husebø, and Storm 2022).

4.2 | Discharge Letter Content

According to Facchinetti et al. (2019), the content of the nursing discharge note consists of information on the instituted therapeutic regime, pain control, functional dependence, caregiver education needs, provision of care to the user with a wound (especially dressings used), management of the bladder catheter, critical problems until the time of discharge, condition of the client at the time of discharge, date and time of discharge, and means of transportation used. Even so, the author considers that nursing documentation should be improved through a predefined discharge plan that guides nurses' activities throughout the process.

TABLE 3 | Final bibliographic sample. Lisbon, 2023.

Title, authors (year)	Country	Aim	Methods	Main results
eHealth in Care Coordination for Older Adults Living at Home: Scoping Review Fjellså, Husebø, and Storm (2022)	Norway	Mapping the literature about eHealth used in the continuity of care of the elderly living at home (activities, results and factors that influence its use according to the older patients and healthcare professionals).	Scoping review (articles from 2009 to 2021).	The healthcare professionals communicate with each other through electronic messaging and phone calls. The primary healthcare professionals receive automatic notifications when the client is clinically discharged from the hospital (information about the discharge, medication changes and booking of *follow-up* appointments). Continuity of care activities: ease the transitions, support self-management goals, monitor, follow and respond to the change. The lack of a universal communication system causes the fragmentation of information.
A qualitative formative evaluation of a patient facing intervention to improve care transitions for older people moving from hospital to home. Shannon et al. (2022)	United Kingdom	To explore the acceptation and usefulness of the flyer, question card, record note and the patient-friendly discharge note for the patients, caregivers and professionals.	An experimental study where several semi-structured interviews and observations of the healthcare professionals and the elderly were done.	Patients and professionals recognise how important it is to use this tool (some don't think it is useful). However, there is the need to clarify the information present on the flyer and simplify the discharge note in order to decrease the workload.
Digitalized Discharge Planning Between Hospitals and Municipal Health Care. Hellesø and Gautun (2018)	Norway	To investigate how secure and efficient it is to message discharge notes electronically.	Observational study in which an online questionnaire was sent to nurses across the country.	Nurses use electronic messages during the discharge process as their main communication tool. Nurses who participated in the questionnaire claim to use telephone calls as a way to complement electronic messages, maintaining the accuracy and detail of the information.
Discharge of older patients with chronic diseases: What nursesvdo and what they record. An observational study. Facchinetti et al. (2019)	Italy	Describe the nursing interventions observed during the discharge process and the consistency between the interventions performed and those documented.	Observational study on interventions performed during discharge process and retrospective audit of nursing records.	What they record: self-administration of medication, pain control, functional dependence, caregiver education, dressings used, urinary catheter management, critical discharge problems, patient healthcare status, time of discharge and means of transport, technical interventions. Nursing documentation needs to be improved with a predefined discharge plan that guides the nurses' activities during the process.

(Continues)

TABLE 3 | (Continued)

Title, authors (year)	Country	Aim	Methods	Main results
Evaluation of the TRANSITION tool to improve communication during older patients' care transitions: Healthcare practitioners' perspectives. Allen et al. (2020)	Australia	To evaluate the healthcare professionals' perceptions about the viability and acceptability of a communication tool named TRANSITION, for communication with the elder patient during their transition.	Experimental study where the researchers did an interview in order to study the acceptability and viability of the instrument after being used by the healthcare staff.	The TRANSITION tool can facilitate the screening and evaluation which will be continued during the planning of the transitional care. It might be used as an additional verification element on the care plan, that was initiated, and developed while the patient was hospitalised or during his entrance to the emergency room in order to sustain a multidisciplinary approach.
Cabinet of the Assistant Secretary of State for Health Despacho n.° 9390/2021. Cabinet of the Assistant Secretary of State for Health (2021)	Portugal	—	—	Communication is one of the pillars for patient's safety. There are interventions that should be executed in order to enhance the communication and safety of the transition process: develop and implement communication tools to ensure a safe discharge and promote specific training programs about the information exchange during the discharge process
Patient Discharge Documentation New South Wales Government (2022)	Australia	—	—	The discharge documentation has two components: the hospitalisation summary and a discharge note for the patient. It's crucial to directly communicate with the healthcare staff, the patients and their caregivers
Technical norm for the availability of the structured discharge notes on the integrated informatic systems of the hospital. Serviços Partilhados do Ministério da Saúde (2019)	Portugal	—	—	The discharge note should contain information about the patient and the professionals involved, entrance and discharge dates, destination, description of the hospitalisation, medication, diagnoses and interventions with a continued care planning.

At the time of clinical discharge, the automatic notification sent presents information about discharge, change in therapeutic regime and scheduling of a follow-up appointment (Fjellså, Husebø, and Storm 2022).

According to the Government of New South Wales (2022), discharge documentation consists of two components: the hospitalisation summary and a discharge letter addressed to the user. However, these do not exclude the need to communicate directly with all those involved in the process, namely the clinical team, users and caregivers. They also state that the discharge letter must be sent electronically to the primary healthcare setting and that the verbal transmission of information regarding the delivery of care must be carried out when clinically indicated. In turn, the discharge letter addressed to the user and caregiver should take into account their health literacyand their level of culture and cognition. Abbreviations should not be used, using simple and clear language. Finally, they gather information that must be present in the discharge letter. Firstly, information related to the user must be present (name, process number, gender, age, date of birth, address, telephone number), and information related to the period of hospitalisation (date of admission and discharge, duration of hospitalisation, institution of discharge and destination after discharge). Current problems and diagnoses must be explained (reason for seeking healthcare, diagnoses, complications, relevant health history, food and drug allergies), as well as the procedures performed during hospitalisation, in chronological order. The therapeutic regime at the time of discharge and cessation of therapy should be identified, including dose, frequency, duration of treatment, and specific indications (such as the need for fast). The new therapeutic regime instituted must be in alphabetical order and placed first, followed by the therapy whose posology has been changed and, finally, the one that remains unchanged, with the name of the brand through which the user knows the medication. The risk of infection and other specific recommendations should be highlighted, as well as warning symptoms and, finally, consultations and complementary diagnostic tests scheduled, though there should still be a place for placing free text.

Also, the use of recommendations for the standardisation of the discharge letter from hospital clinical record systems suggests starting with the identification of the user, adding the nationality, country of residence and number of the National Health Service. Next, the date of admission, as well as the date of medical discharge, and the date of administrative discharge must be indicated. The name of the doctor and nurse responsible for the discharge, professional email address and professional card number must be present, as well as the general and family medicine doctor. Next, the user's discharge destination, existing medical diagnoses and a brief description of the period of hospitalisation (including reason for seeking health care, therapy and invasive procedures performed) must be included. There must be a continuity of the care plan, with mention of therapeutic regime, its dosage and also the existence of infection associated with health care delivery (with identification of the etiological agent when known). Even if allergies are not known, this situation should be mentioned. Subsequently, active nursing diagnoses and interventions must be included. It is also necessary to include a list of diagnoses and procedures according to the user's health literacy and mention the existence of an implantable device in the patient if applicable, regardless of whether it was placed in that hospitalisation episode or not. Finally, the prescription of assistive products and the risk of transfer to the intensive care unit (Serviços Partilhados do Ministério da Saúde 2019) should be mentioned.

4.3 | The Use of Technologies in Healthcare Communication

As mentioned previously, several technological means are proposed in the evidence, such as electronic messages, telephone contacts and video calls (Fjellså, Husebø, and Storm 2022; Hellesø and Gautun 2018). The Serviços Partilhados do Ministério da Saúde (2019) also advocates carrying out discharge notes electronically on the existing registration systems in the wards.

This technological method is the main form of communication used to contact the primary healthcare system. This is evidenced by the fact that a large number of nurses consider this technological method effective and appropriate to use during discharge. It appears that most nurses (65%) state that the isolated use of electronic messages ensures a safe discharge for older users (Hellesø and Gautun 2018). However, the authors state that this alone is considered insufficient and should be complemented with phone calls, maintaining the accuracy and detail of the information given.

The referred method is used in two ways, which are isolated telephone contact and supplemented with electronic messages. The application of this technological medium has shown positive results, as it works effectively in conjunction with electronic messages (Fjellså, Husebø, and Storm 2022).

According to Fjellså, Husebø, and Storm (2022), the use of video calls facilitated the continuity and coordination of care provided between the client and health professionals. Consequently, there was an improvement in the circulation of information with the primary healthcare sector, which reduced the number of runs to emergency services and relieved the workload felt by hospitals.

4.4 | Client Empowerment in Information Communication

Several activities are identified for which the client and caregiver are responsible during the hospital discharge process, putting into practice the responsibility for the health project through empowerment. By involving clients and care providers in the health project during hospitalisation, better self-management after discharge is encouraged. This is due to the fact that the activities that clients will be able to carry out at home are directly related to the functional readaptation carried out by health professionals during the hospitalisation period (Facchinetti et al. 2019; Shannon et al. 2022). Nursing interventions, aimed at health education, should be started as early as possible (Facchinetti et al. 2019).

According to Shannon et al. (2022), the activities related to client empowerment at the time of discharge are understanding the current health situation, managing the therapeutic regime, carrying out activities of daily living according to the health situation, and understanding which symptoms indicate the need to seek help.

Hume and Tomsik (2014), as cited by Facchinetti et al. (2019) state that it is the role of the nurse to talk to the user and/or caregiver about their readiness for discharge, knowledge about the diagnosis and prognosis, follow-up appointments, management of the therapeutic regime, ability to detect warning symptoms, and provide recommendations regarding physical activity and nutrition.

For Fjellså, Husebø, and Storm (2022), empowerment involves a set of activities such as negotiating and establishing responsibilities, defining objectives and participating in the construction of a proactive care plan. In this way, the client actively contributes to his health project.

4.5 | Factors Hindering the Safe Transition of Information Between Hospital and Community

In the literature found by us, we learned of several barriers to a safe transition from the nurses and the clients who are the carerecipients.

Specifically from the clients' standpoint, several barriers are described such as the individual's characteristics, lack of experience, knowledge and trust while using technological gadgets (Fjellså, Husebø, and Storm 2022) and the unavailability for participating in the interventions proposed by the professionals (Shannon et al. 2022).

When it comes to the individual's characteristics, the ones classified as barriers include being older than 80 years old, since it's the age group that has the least usage of technological gadgets, and having other health problems like hearing loss and amnesia. These harden the manipulation of technological devices (Fjellså, Husebø, and Storm 2022).

Relative to the unavailability for participating in the interventions proposed by the professionals, some clients regard those as onerous and not relevant to their health condition (Shannon et al. 2022).

When we focus on the professionals, the main struggles are the high workload, limited access to the clients' electronic records (Fjellså, Husebø, and Storm 2022), time constraints (Facchinetti et al. 2019) and lack of availability and ability from the nurse to involve the client in the planned interventions (Shannon et al. 2022). This last one adds to the fact that the exchange of data is frequently interrupted by the change of professionals responsible for the care delivery to a certain client.

As stated by Fjellså, Husebø, and Storm (2022), the nurses' participation in activities related to the discharge increased their workload. Besides that, the limited access to the electronic records due to the registration platforms' fragmentation of the several healthcare institutions is also described as a major barrier to a safe exchange of data

According to Kalisch (2006), as cited by Facchinetti et al. (2019), it's possible to verify the existence of information omitted during the discharge process, being only registered the minimal needed interventions. This occurs due to the low nurse to patient ratio, high influx of patients and arduous manipulation of the electronic systems since most nurses don't consider the registration of those important to their practice (TOMS, 1992 as cited by Facchinetti et al. 2019).

Lastly, according to Facchinetti et al. (2019), the lack of nursing staff to do the interventions and their respective registrations necessary for a safe discharge process is a relevant issue.

4.6 | Benefits of Secure Information Transition Between Hospital and Community

The nursing research has revealed many benefits of a safe data transition from the hospital to the community settings, which are the improvement of care quality in primary care (Fjellså, Husebø, and Storm 2022), the decrease in the number of hospitalisations and in the recurrence to the emergency room, and higher continuity of the relation between the professional and the client (Facchinetti et al. 2019; Fjellså, Husebø, and Storm 2022), higher compromise between both parties with the planned interventions and a better preparation for the patient's discharge (Allen et al. 2020; Facchinetti et al. 2019; Fjellså, Husebø, and Storm 2022; Shannon et al. 2022).

As mentioned before, better discharge planning reduces the number of hospitalisations, something thatis not only a priority to our healthcare systems but also important when we talk about older patients. Those types of patients need to receive more care from the hospital and that, consequently, has exacerbated the problems related to the hospital discharge and increased the pressure in the hospitals when it comes to the number of beds available (Facchinetti et al. 2019).

If the information were more accessible to health professionals and patients on a shared registration platform by both healthcare institutions, better quality nursing care could be given since the interventions would be targeted to the client's health condition (Fjellså, Husebø, and Storm 2022).

Finally, efficient communication is a necessary tool so that the nurses can work in partnership with the older patients and their respective caregivers. This favours the prevention and a better management of the most common diseases in old age at the moment of discharge and during the most critical moments of the care process (Facchinetti et al. 2019).

5 | Discussion

It's relevant to address the existing conflict between the outcomes obtained from the research and other types of literature about the different ways to exchange information and its

respective content during the transition process. With regard to information content, the need for a set of interventions promoting integrated transitional care is evident, with the need for frequent communication with primary health care during the hospitalisation period, the existence of a care plan continuity of individualised and systematised care that must be sent to the community team before discharge, as well as scheduling a follow-up appointment in the community within a maximum of 48 h after discharge. A multidimensional assessment of social and health needs must be carried out, which must be discussed in the multidisciplinary team to formulate a plan to meet them (Brown and Menec 2021).

One systematic review which aimed to analyse the health quality of life in older persons' received transicional care concludes that transitional care significantly improved mental health, physical functioning and vitality at both short and long term after discharge (Zou et al. 2022), but to achieve it's goal it's need that the discharge plan and the continuity of care be known by the healthcare community teams.

The most used communication tool is the mnemonic ISBAR that summarises the information that has to be transmitted orally. This starts with the letter "I" for identification, "S" for situation, "B" for background, "A" for assessment and "R" for recommendations. Although a considerable improvement in the information transmitted was noticeable, ISBAR is a very general approach to the crucial data that has to be shared (Despacho n° 9390/2021 2021). Despite the fact that this tool clarifies what type of information should be included in every item, additional data may be necessary, which is not present in the mnemonic. In order to solve this, the Government of New South Wales (2022) proposes the inclusion of a table where additional information could be written.

The British National Healthcare System presents several directives related to the continuity of care, especially an auxiliary tool to the needs' assessment of the hospitalised patient. This tool can be used to guarantee the continuity of care on primary care by the nursing staff. It is essential to emphasise that the patient should be included in the process so he can share his own perspective and, consequently, to get a better understanding of his needs. Therefore, a small summary of the identified needs written by the patient himself and his caregiver should be included. Also, this should be complemented with the professional's assessment, where the nature, intensity and complexity of the identified needs should be detailed. There are 12 care areas that should be incorporated, such as breathing, nutrition, continence, skin integrity, mobility, communication, emotional and psychological needs, cognition, behaviour, therapeutics and treatments, consciousness, and finally, other significant needs (Department of Health and Social Care 2022).

Facchinetti et al. (2019) mention the existence of data omission in the nursing records in their article. This finding is in accordance with other authors who observe that more than half of nurses did not document their nursing care (Ayele et al. 2021; Pernes et al. 2023; Tasew, Mariye, and Teklay 2019).

When it comes to the small percentage of attendance at the follow-up appointments in the first 2 weeks after the hospital discharge, several factors related to this problem were studied. The existence of a scheduled appointment before the discharge greatly increases this proportion; likewise, the mention of the appointment in the discharge note. Also, the low availability to schedule an appointment and the indifference from the patients and caregivers complicate attendance at follow-up appointments (Lam et al. 2018). Considering the factors studied, it's crucial to educate the patient while being discharged, warning of the importance of the follow-up appointments after the discharge. It's only in this way that itis possible to give responsibility to the patient for not going to the primary healthcare centre.

The results point to the need to increase nurses' knowledge about documentation and for the existence of management strategies that promote professionals' adherence to the registry, for example, through auditing (Ayele et al. 2021; Pernes et al. 2023).

This review has limitations associated with the restriction to articles in Portuguese, English and Spanish, as well as the failure to assess the methodological quality of the articles included.

6 | Conclusion

Transitional care is an essential part of nursing, as an incorrect execution in this area will compromise the stability of the patient's health–illness transition process.

As shown by the results, this is an area of study that still lacks research because, even though an answer was reached to the issues that arose during clinical practice, the use of grey literature was necessary. This proves that this field of research demands more production of scientific knowledge.

The problem that was identified relates to the contents of the hospital discharge letter. However, it was recognised as merely a part of the problems faced by the staff. This is part of the theme of communication in nursing practice, a topic which does not get enough recognition.

Through this article, we managed to explain the pillars of communication in transitional care and its consequences, whether they were positive or negative (cases where it lacks effectiveness). Afterwards, it was shown which communication channels can be used in a scenario of transition between institutions and their benefits, mainly the use of phone calls and electronic messages. Additionally, when it comes to communicating with patients, the studies presented innovative proposals through an instrument that allows a holistic evaluation of the patient, thus helping the healthcare professional do their work effectively. As for the discharge letter, evidence was gathered to make a guideline for its elaboration in hospital inpatient treatment units if they so desire.

The participation and accountability of the patient in their health treatment plan is an emergent topic, being present more often in the ideology of excellent health care giving. For this reason, it was relevant to associate empowerment mechanisms to transitional care by presenting a set of methods that are required to be

used, complementing the patient and their respective caregiver. Despite what was presented, itis clear that it needs adjustments in order to be applicable to real-life scenarios.

It is recommended that future studies explore the experience of people and their families with continuity of care and the quality of the information that is passed on to primary carers.

6.1 | Relevance to Clinical Practice

After the research and discussion of the data, it's important to develop the implications of this.

First, the joint use of electronic messages and telephonic contact on the transitional care of the patient is proposed so they can assure a safe transition from the hospital to the primary care setting. Additionally, we suggest sending the discharge note electronically to the final destination.

Second, the application of live video calls during the patient's discharge is necessary. However, some services are unable to do this because of a lack of technological resources; that is, the absence of video cameras. This would require an extra expenditure which the inpatient unit might not be able to afford.

Third, the implementation of some communication and empowerment optimisation strategies is defended in this article.

Finally, hiring a nurse who would be assigned to ease the transitions between the hospital and other healthcare institutions is recommended to alleviate the other nurses' workload. However, the service where we did our internship can't retain nurses to work there, which makes it extremely difficult to hire a nurse to just facilitate the transition between contexts.

Author Contributions

Each author of this study has substantially contributed to conducting the underlying research and writing the article itself. It is also important to highlight that the aims, methods and registered protocol were defined among all authors.

Ethics Statement

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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