Cogitare Enfermagem

ORIGINAL ARTICLE

Perceptions of professionals and patients with COVID-19 regarding the transition from hospital to home care: a qualitative study*

HIGHLIGHTS

1. Weaknesses in communication and counter-referral marked the transition.
2. Patient, care, discharge, and information were central themes.
3. Lack of protocols and training increased the risk of readmission.
4. Personalized discharge plans and integration ensure a safe transition.

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ABSTRACT

Objective: To understand the perceptions of healthcare professionals and patients with COVID-19 regarding the transition from hospital to home care. **Method:** A descriptive and qualitative study was conducted between March 2022 and February 2024 using semi-structured interviews at two time points (hospital and primary care), totaling 43 participants. The results were analyzed using Thematic Content Analysis with the support of IRAMUTEQ® software, adopting the criterion of theoretical saturation. **Results:** The majority (83.7%) of participants were women aged 26 to 76 years; 79% were healthcare professionals (average 10 years of experience), and 21% were patients. The analyses revealed failures in communication and counter-referral, the absence of individualized discharge plans, care fragmentation, and insecurity in home-based care management. **Final considerations:** The transition of care revealed weaknesses in care and a risk of readmissions, highlighting the importance of effective communication, integration between levels of care, and continuous training to ensure safe and comprehensive care.

DESCRIPTORS: COVID-19; Patient Discharge; Transitional Care; Continuity of Patient Care; Patient-Centered Care.

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INTRODUCTION

The continuity and safety of care[1-3] during the COVID-19 pandemic brought unprecedented challenges to the transition of patient care from the hospital to the home[1]. This process was often fragmented, in a context marked by clinical uncertainties, overburdened health services, and the absence of consolidated care protocols, compromising the continuity and coordination of care actions.

The lack of effective communication between levels of care and clear guidelines for home management contributes to insecurity after discharge, highlighting the need for structured planning and coordination between health services to ensure the coordination of care actions[3-4].

When properly structured, the care transition can reduce adverse events, increase treatment adherence, and improve clinical outcomes. However, in the pandemic context, difficulties in coordinating post-discharge care often left patients and families helpless, revealing weaknesses in preparedness for home care and in continuity of care[3-4].

The transition from hospital to home care involves coordinated actions that ensure continuity and care safety, including discharge planning, interprofessional communication, coordination between levels of care, and preparation of patients and caregivers, being fundamental to reducing discontinuity of care and avoidable readmissions after discharge[5].

In this scenario, the need arose to improve care transition strategies, such as implementing standardized protocols, developing detailed discharge plans, promoting patient and caregiver education, and using technologies for post-discharge monitoring, capable of favoring continuity of care[3,6].

Many patients reported feeling helpless after discharge, without the necessary support to deal with complications or sequelae, while family members, who frequently assumed the role of primary caregivers, felt unprepared to provide adequate care[7].

The COVID-19 pandemic highlighted weaknesses in the transition of care from hospital to home, impacting continuity of care, interprofessional communication, and patient safety. This process proved especially vulnerable in the face of service overload, clinical uncertainties, and the absence of consolidated protocols, favoring discontinuity of care and avoidable readmissions.

Despite the progress in evidence, studies that analyze, in an integrated way, the perceptions of health professionals and patients in the Brazilian context of COVID-19 are still limited, which reinforces the relevance of investigations that support the improvement of Nursing practices, the organization of the Health Care Network, and the quality of post-discharge care.

Considering the above, this study's objective was to understand the perceptions of health professionals and patients with COVID-19 regarding the transition from hospital to home care.

METHOD

This is a descriptive study with a qualitative approach, guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines and anchored in the framework of Thematic Content Analysis, as proposed[8], which allows for the systematic

interpretation of narratives and the identification of core meanings present in the participants' discourses. This framework guided the stages of pre-analysis, material exploration, and results analysis, supporting the development of analytical categories.

Forty-three narratives were collected from professionals and patients with COVID-19, identified by alphanumeric codes to preserve anonymity (*p_1 doctor, *p_2 nurse, *p_3 technician, *p_4 psychologist, *p_5 physiotherapist, *p_6 nutritionist, *p_7 patient). The study was conducted at a high-complexity public hospital, a regional referral center for attending patients with COVID-19, and at two Primary Health Care centers in Florianópolis, SC.

Participants included adult patients who had been discharged from the hospital for COVID-19 up to 30 days prior, and professionals who had been working at the institutions for at least six months, with a minimum workload of 20 hours per week. Patients with a negative COVID-19 test, those unable to provide information, interns, and professionals without a continuous care link to the institution were excluded. The sample was defined by the criterion of theoretical saturation, the point at which no new relevant analytical elements emerged.

A sociodemographic questionnaire was used, which included variables such as sex, age, professional category, length of service, education, and institutional affiliation, as well as an interview guide, developed by the researchers, consisting of five open-ended questions related to discharge planning, communication between levels of care, preparation for home care, and experiences lived during the care transition. The interviews lasted an average of 15 minutes. Data collection took place between March 2022 and February 2024, in two phases (hospital and primary care). Participant characterization was performed using descriptive statistics in Microsoft Excel® software.

The interviews were audio-recorded, with the participants' permission, and subsequently transcribed in full by the researchers, ensuring the fidelity of the empirical material, and later processed in the Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRAMUTEQ) software (version 0.7-alpha2®).

The textual *corpus* was subjected to lexical analysis with the support of IRAMUTEQ® software, as a complementary strategy to Content Analysis, which supported the organization and deepening of thematic categories, semantic relations, and meaning structures. Similarity techniques and lexicographical analyses were applied, allowing the identification of patterns, categories, and core meanings.

The study was approved by the Research Ethics Committee (REC) of the State of Santa Catarina under Opinion No. 4,361,273, in accordance with Resolution No. 466/2012.

RESULTS

Most participants, 36 (83.7%), were female, aged 26 to 76 years; 34 (79%) were healthcare professionals, and nine (21%) were patients. Among the professionals, 30 (88.24%) had been working in the healthcare field for more than 10 years.

Textual analyses revealed 43 texts, with a total of 11,887 word occurrences, with 1,203 distinct forms present in the *corpus*, with 1,006 hapax, defined as the number of words that appear only once in the entire *corpus*, and a mean of 465 words (number of occurrences divided by the number of texts) per text, according to Figure 1.

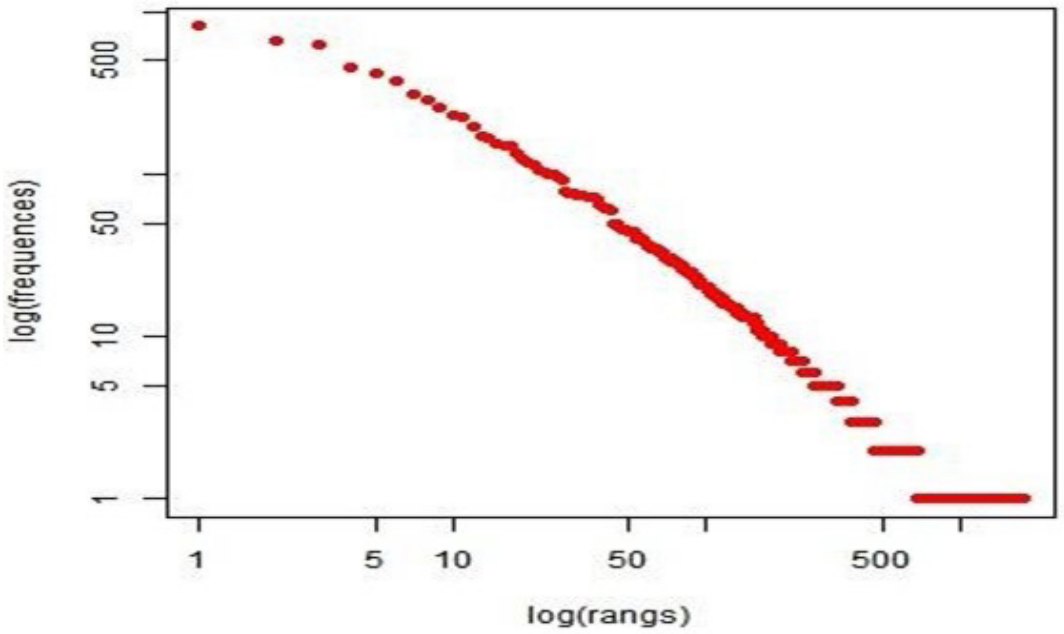

Figure 1. Zipf diagram of classical textual analysis of the CORPUS (N=43). Florianópolis, SC, Brazil, 2024

Source: The authors (2024).

The findings identified six central themes, a result consistent with the frequencies of these words throughout the text, evidenced both in the classical statistical analysis and in the similarity analysis of the narratives. The central themes identified were: patient, care, no, discharge, information, and health, according to Figure 2.

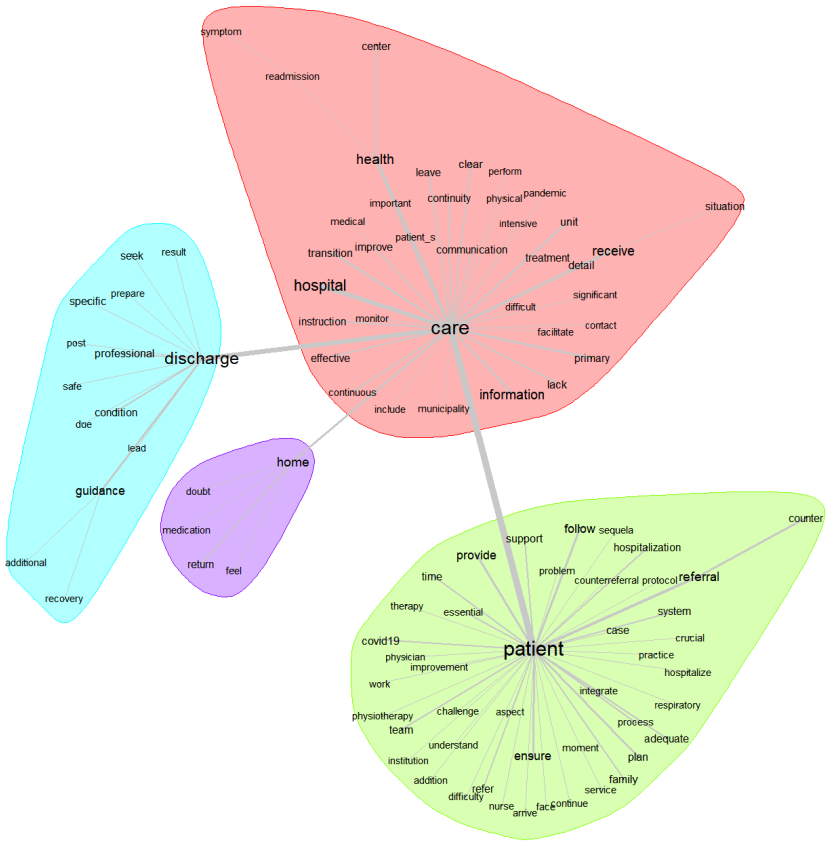

Figure 2. Similarity tree of narratives about the transition from hospital to home care. Florianópolis, SC, Brazil, 2024

Source: The authors (2024).

Regarding the central themes, the findings identified topics that describe challenges and strategies for managing the transition of care, as shown in Chart 1. Some themes were mentioned by both professionals and patients.

Chart 1. Description of the challenges in care transition and strategies. Florianópolis, SC, Brazil, 2024

Challenges in Care Transitions	Management strategies in care transitions
1- Weaknesses in counter-referral and difficulty in communication between multidisciplinary teams and patients.	1- Personalized Discharge Plans and Integrated Care System: training and professional preparation strategies for continuity of care.
2- Fragmentation in the transition and continuity of care, and lack of preparation for its effective implementation.	
3- Lack of preparation among professionals for coordinated care during the pandemic.	
4- Hospital discharge and continuity of care: impacts of the absence of structured plans and barriers within the health center.	
5- Lack of knowledge about COVID-19 and its management.	

Source: The authors (2024).

Challenges related to the management of COVID-19 patients in the transition from hospital to home care

The results revealed six central axes that describe challenges related to the management of patients in the discharge process to home, from the perspectives of professionals and patients.

1. Weaknesses in counter-referral and difficulty in communication between multidisciplinary teams and patients

Sending information about care for patients with COVID-19 showed weaknesses in the hospital-to-home transition, hindering the continuity of care. In the «Patient» axis (Figure 1), terms such as "Failure", "Gap", and "Difficulty" emerge, expressing problems in counter-referral, communication between units, and the discharge process, as reported by professionals and patients.

*[...] there was a lack of contact with primary care. The patient would leave with the discharge plan, and upon arriving at the health center, it seemed like they had just shown up out of nowhere. There was no prior communication informing the team about the patient's discharge and their needs [...]. (*p_5 physiotherapist)*

*[...] often, the patient themselves doesn't fully understand the instructions received, and we don't have access to a copy of the medical record to evaluate. Counter-referral is very rare. In COVID-19 cases, I haven't seen any examples of counter-referral [...]. (*p_2 nurse)*

[...] often, we don't receive complete and accurate information about the patient's condition or the treatment performed in the hospital. This creates significant gaps in

*care and can lead to medication errors, lack of treatment adherence, and eventually, hospital readmission [...]. (*p_1 doctor)*

*[...] the persistent fever required immediate attention, which led me to seek help in a hospital setting other than the SUS. Due to the difficulties faced previously, there was no professional support available after discharge, which made the transition home even more challenging [...]. (*p_7 patient)*

2. Fragmentation of the care transition

Professionals reported that care fragmentation hinders guidance on the continuity of care after hospitalization. In the "Care" axis (Figure 1), words such as "Transition", "Continuity", "Fragmentary", "Non-existent", "Limited", and "Integrality" stand out, evidencing failures in the transition and integrality of care.

*[...] the transition to home was done without continuous support, leaving doubts about the continuity of necessary care after hospital discharge [...]. (*p_7 patient)*

*[...] from what I perceived here, we received patients, but there was no clear transition for those who presented more serious sequelae, such as pressure ulcers. Some cases were followed up by the team, especially those who needed physiotherapy or other treatments, often carried out in affiliated clinics [...]. (*p_1 doctor)*

*[...] the transition is fragmented, resulting in continuity loss and care integrality; The discharge summary is inadequate, and intersectoral collaboration is absent, with counter-referral frequently non-existent or extremely poorly performed (*p_2 nurse) [perception corroborated by *p_5 physiotherapy and *p_6 nutritionist].*

3. Professional preparedness in coordinated care during the pandemic

Most COVID-19 patients depended on family support, while professionals faced resource limitations, especially in the management of dyspnea. Patients desired clear guidance in the post-discharge period. In the "No" axis (Figure 1), terms such as "Pandemic", "Prepare", and "Training" stand out, highlighting professionals' unpreparedness and discontinuity of care in primary care.

*[...] although we followed a rigorous COVID-19 care protocol, based on scientific evidence, I realize that this approach was not always consistent across different healthcare units (*p_1 doctor) [...] [consistent thought by *p_4 psychologist and *p_2 nurse, who also pointed out uncertainties and unpreparedness in the initial response to the pandemic].*

*[...] the lack of adequate instructions on medication and post-discharge care left us in a difficult situation. This generated a lot of anxiety and uncertainty, as we were not prepared to deal with the progression of the condition at home [...]. (*p_7 patient)*

4. Hospital Discharge and Continuity of Care: Impacts Lack of Plans and Barriers at the Health Center

Reports from professionals and patients indicate that the absence or inadequacy of discharge plans during the COVID-19 pandemic generated insecurity, doubts, and avoidable readmissions. In the "Discharge" axis (Figure 1), terms such as «Plan», "Home", "Inadequate", "Deficiency", and "Doubt" stand out, highlighting weaknesses in the preparation for returning home.

[...] the care plan and preparation for the discharge of the hospitalized patient are frequently deficient; often, the plans are generic and insufficiently detailed to address

*the individual needs of patients (*p_1 doctor) [...] [perception corroborated by *p_2 nurse who also pointed out weaknesses in the appreciation of the moment of discharge and in the guidance provided to the patient and family].*

*[...] they were not enough for me to feel prepared to return home. Upon arriving home, I didn't know the instructions or how to take some medications properly. Sometimes, I realized I was mixing them up [...] after hospital discharge, I didn't receive any professional support. This includes the lack of follow-up by healthcare professionals to monitor my recovery or provide additional guidance on home care [...]. (*p_7patient)*

In the "Health" axis, the challenges of primary care include the absence of protocols and the lack of coordination between levels of care. Terms such as "Protocol", "Lost", and "Rehospitalization" highlight the subcategory "Challenges at the Health Center". Professionals reported difficulties in managing referrals and counter-referrals, highlighting the need to strengthen communication within the network, especially for highly complex patients during health crises.

*[...] a major limitation was the initial lack of knowledge about post-COVID-19 syndrome and its clinical manifestations; The absence of clear protocols and adequate technical materials hindered the identification and management of these cases [...], a fact reiterated by *p_2 nurse [...], who also observed patients who were disoriented and insecure regarding the necessary care after hospital discharge. (*p_1 doctor)*

*[...] in our view, the readmission occurred because we believe he may not have stayed long enough during his first hospitalization. He was discharged after about eight to nine days, but he was still having oxygenation problems and was debilitated [...]. (*p_7 patient)*

5. Lack of knowledge about the COVID-19 pandemic and its management

The testimonies indicate that a lack of knowledge about the COVID-19 pandemic and its management generated anxiety and uncertainty among professionals and patients. In the "Information" axis (Figure 1), terms such as "Anxiety" and "Uncertainty" stand out, highlighting the subcategory "Lack of knowledge about the COVID-19 pandemic and its management", which reinforces the lack of clear and accurate information during the crisis.

*[...] at the peak of the pandemic, dialogue between services was difficult and information fragmented, partly due to uncertainties surrounding the complications of COVID-19 [...] (*p_2 nurse) [aligns with the perceptions of *p_1 doctor, *p_4 psychologist and *p_5 physiotherapist [...] who also reported informational gaps, technical-assistance limitations and patients and families insecurity in the health system].*

*[...] the COVID-19 pandemic left patients and their families apprehensive about what to do, generating significant anxiety. When we took over care, we provided guidance on warning signs and the need for immediate return in severe cases of respiratory distress, avoiding unnecessary visits to the unit [...]. Unfortunately, patients were often left helpless within the healthcare system, although we occasionally referred severe patients to emergency care units, utilizing the limited resources available [...]. (*p_4psychologist)*

Management strategies for improving the transition from hospital to home care for COVID-19 patients

Participants revealed professionals' perceptions of strategies considered useful for improving management during the transition of COVID-19 patients from the hospital to home care. Some themes described how these strategies were identified.

1. Personalized Discharge Plans and Integrated Care System: Training and Professional Preparation Strategies for Continuity of Care

It was emphasized that communication between teams and patients is essential for continuity of care. The lack of coordination between high-complexity care and primary care compromised post-discharge care, leaving teams without clinical information or defined therapeutic plans, as evidenced in the narratives below.

*[...] it would be ideal to have a single system where all healthcare professionals involved could access up-to-date information about the patient, regardless of the place of care, which would facilitate post-discharge follow-up and reduce the loss of information between different points in the network [...] (*p_6 nutritionist) [perception corroborated by *p_3 technician and *p_5 physiotherapist [...] who also highlighted the need to integrate information technologies to strengthen communication and continuity of care].*

*[...] which can lead to avoidable complications. It is necessary to implement rigorous follow-up programs. The limited use of technology and the adoption of information technologies could improve the coordination and continuity of care, but their use is still limited [...]. (*p_5physiotherapy)*

The importance of using communication technologies, such as health applications, to monitor and update the patient's clinical status was highlighted.

The need for structured and personalized discharge plans, developed in an interdisciplinary manner, with integration between health services, to ensure the sharing of information was emphasized.

*[...] the integration of a single medical record system would be fundamental to ensure effective counter-referral and avoid the fragmentation of information between different health units [...] (*p_4psychologist) [proposal supported by *p_2nurse [...] who also highlighted the need to establish protocols and train professionals to improve the organization of care].*

*[...] developing individualized discharge plans that are personalized for each patient, taking into account their specific needs and health conditions, is also fundamental [...]. Establishing post-discharge follow-up programs to monitor patient progress and adjust treatment as needed also contributes significantly to continuity of care. The use of technology and information, such as electronic medical records and applications [...]. (*p_1médico)*

Participants highlighted that continuous training of healthcare teams is a fundamental strategy to ensure the quality of post-discharge care. Continuing education improves the technical preparation of professionals in the development of care plans and in home-based clinical follow-up, especially in complex scenarios, such as those imposed by the pandemic.

[...] there is a significant lack of continuing education, retraining, and improvement of practices. The way care is provided often changes, requiring a different dynamic, and this shows that we need to invest more in training and improvement within hospital

*units, not only in pandemic situations, but continuously [...]. (*p_1 doctor)*

*[...] providing adequate education to patients and their families about their health condition, the care plan, and the importance of treatment adherence is crucial [...] (*p_1 doctor) [understanding corroborated by *p_2 nurse and *p_3 technician [...] who also emphasized the need for trained teams and efficient communication channels to ensure safe guidance and continuity of care after discharge].*

DISCUSSION

The study showed that the transition from hospital to home care, in the context of COVID-19, was marked by weaknesses in communication, counter-referral, and discharge planning, compromising continuity of care. These findings reinforce the need for integrated institutional strategies, professional training, and the use of technologies to improve care.

Despite the experienced profile of the multidisciplinary team, with a long history of care and postgraduate training, the findings indicated that professional experience did not guarantee adequate preparation for care transition in the context of COVID-19.

The results highlighted gaps in communication between health professionals and counter-referral services, compromising the continuity of post-discharge care. Studies[9-10] associate the absence of effective and clear channels with the fragmentation of care in the SUS and the increase in readmissions.

This fragmentation, aggravated by the pandemic, expresses difficulties in integration between levels of care[11-12]. The absence of structured discharge plans and effective counter-referral increased the risk of readmissions[13-14] and highlighted the need for systems that ensure the adequate exchange of information[15].

Including family members in the communication process proved essential, as difficulties in understanding the guidelines affect the continuity of care; the active participation of caregivers favored post-discharge follow-up[16].

Evidence indicated that the use of digital tools and the standardization[17] of protocols contribute to the qualification of care, while the absence of specialized support, such as psychologists and physiotherapists, compromises the quality of care, especially among more debilitated patients[18].

The lack of preparation among professionals proved to be recurrent. An international study[19] and a national study[20] indicated that gaps in training hindered the application of protocols, harming the quality of care. Patients reported difficulties in self-care and the absence of standardized processes, associated with higher risks of complications and readmissions[21].

The inadequacy of discharge summaries and the absence of individualized plans compromised care. Evidence has shown that personalized plans reduce readmissions[22]; however, professional insecurity, a lack of clear protocols, and a scarcity of guidance on symptoms, such as dyspnea, intensified the insecurity of patients and families[23-27].

Uncertainty in clinical management increased anxiety and stress among professionals[28], while insufficient training in areas such as respiratory physiotherapy highlighted the need for continuous training and educational materials[29]. The findings

reinforced the importance of adapted protocols and efficient discharge planning, with patients' and families' participation[30].

The results indicated relevant implications for clinical practice and health systems organization, highlighting the need to strengthen institutional policies aimed at the transition of care. Structured protocols, continuing education, and integration between levels of care can reduce readmissions and improve the quality of care provided to the population.

This study's limitation refers to the information bias resulting from the pandemic peak, which restricted communication, care planning, and the interpretation of findings.

Despite this, the research contributes to Nursing and society by highlighting concrete challenges in care practice during health crises, supporting the improvement of protocols, professional qualification, the organization of services, and health decision-making.

Furthermore, the insufficient use of information technologies and the lack of coordination between levels of care were bottlenecks amplified by the pandemic. Although recommended, the rapid implementation of these technologies requires investment and training.

Finally, the diversity of practices among regions and institutions limits the generalization of the findings. While some locations already had structured protocols, others, with fewer resources, faced greater difficulties, negatively influencing post-discharge care. It is recommended that future research explore these impacts in different socioeconomic contexts.

FINAL CONSIDERATIONS

This study highlighted that the transition from hospital to home care, in the context of COVID-19, remains marked by structural weaknesses that compromise continuity of care. The need for progress in implementing institutional protocols, strengthening counter-referral, and training teams for discharge planning is imperative.

In this sense, the findings indicated the need to strengthen communication between levels of care and the preparation of patients and caregivers, to contribute to the care organization flows and the development of integrated care strategies capable of promoting greater patient safety and sustainability for health systems in the face of complex clinical conditions.

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