

ORIGINAL ARTICLE

Perceptions of the Nursing Team Regarding Hospital Discharge Planning for People After Strokes

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Highlights:

Nursing coordinates the hospital discharge process for individuals affected by Stroke. They coordinate the multidisciplinary team and guide family members so they can communicate with primary health care services. They conduct educational activities to enhance the knowledge of users and their families about post-discharge care. They highlight challenges such as family members' adherence to care, as well as turnover during the hospitalization period.

ABSTRACT

This study has the objective of describing the perception of the nursing team regarding discharge planning for individuals affected by strokes. It is a descriptive study, with a qualitative approach, conducted with 13 nursing professionals from a general hospital in the northwest region of Rio Grande do Sul, Brazil. Data collection was performed through semi-structured interviews, which were audio-recorded, fully transcribed, and subjected to content analysis. Two categories were identified: Perception of the nursing team regarding hospital discharge planning for people with strokes; and Perception of the nursing team regarding preparing relatives/caregivers for the discharge of people with strokes. In the first category, nursing professionals emphasize the importance of discharge planning, taking the lead in this process, coordinating the multidisciplinary team, and guiding relatives to effectively communicate with primary health care services. In the second category, nursing professionals conduct educational actions to enhance the insertion and knowledge of users and their relatives about post-discharge care. They also identify challenges related to the adherence of family members to take part in these actions, as well as the high turnover of this group. In conclusion, nursing professionals understand the process of preparation for hospital discharge, emphasizing the central role of the nurse and recognizing the crucial participation of other members of the multidisciplinary team, providing guidance, and promoting health education for caregivers. In addition, they highlight the need to consider other critical health-related points to reduce risks and prevent possible readmissions.

Keywords: Stroke. Nursing care. Patient-centered care. Patient discharge.

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INTRODUCTION

Currently, considering the demographic and epidemiological transition of the Brazilian population, the discussion on hospital discharge planning has been gaining relevance for the scientific community and health services, in order to meet this new profile of people, who need qualified care¹. According to Ordinance nº 3.390/2013, hospital discharge must be conducted through guidance to users and their relatives regarding the continuity of treatment and home care, which can reinforce the individual's autonomy and provide self-management, linking the care process to the other points of care in the Health Care Networks², making individualized planning necessary, focused on the person's uniqueness³. Hospital discharge planning is considered a complex activity⁴, as it demands shared decision-making between users and health professionals. It requires knowledge of the individuality of the subject and empowerment of the family to develop actions already carried out and initiated in the hospital environment, demanding knowledge and training⁵. In this setting, hospital discharge planning is recognized worldwide as a potential transition of care, given the benefits to users². In the context of an ageing population, marked by an increase in chronic non-communicable diseases (NCDs)⁶, stroke stands out as a highly prevalent condition, ranking second in the global ranking of NCDs with high mortality². Thus, stroke is characterized as a condition capable of causing permanent consequences to the physical, emotional, and social health of the individual, which can leave him/her incapacitated or even lead to his/her death⁷. In addition, it is characterized by two major groups: hemorrhagic (caused by a hemorrhage, resulting in extravasation of blood into or around the structures of the central nervous system); and ischemic (resulting in failure of the vessel to adequately oxygenate and perfuse the brain)⁸.

According to the World Stroke Organization⁹, approximately 14 million people are affected by hemorrhagic stroke each year on a global scale, while more than 80 million people experience the lasting impacts of the disease, which highlights the importance of actions aimed at health surveillance, with a view to preventing, promoting, and rehabilitating the health of these users. In this setting, people in the post-stroke period need greater support from their families, given the complexity of the care demands arising from the degree of dependence, which varies according to the severity of the clinical picture. The transition from hospital to the community environment becomes a process that requires supervision, involving psychological, physiological, and functional support provided by both the health team and the caregivers⁷.

The nursing professional plays a crucial role in preparing for hospital discharge and must work with the family on issues related to food, hygiene, the environment, medication and possible events resulting from the clinical conditions of the person with a stroke. Accordingly, hospital discharge planning and preparation needs to start from admission, with the help of institutional protocols planned in a unique way by the multidisciplinary team, favoring the systematic sharing of behaviors between the multidisciplinary team and the family¹⁰.

In light of the foregoing and considering the benefits of preparing for hospital discharge from the moment the user is admitted, with a view to continuity of care, as well as the challenges in the praxis of professionals who work in the face of the complexity of caring for people with strokes, recognizing the perception of nursing professionals makes it possible to provide subsidies for managers and professionals who are committed to qualifying care in hospital services. Moreover, the implementation of hospital discharge planning by nursing is identified as an action to qualify the provided care, as well as a contributing factor to the therapeutic success of the team, capable of recognizing the implications caused by failures in the transfer of care for people after a stroke. In addition, there is a lack of studies on discharge planning in the literature for people with strokes, strengthening the study's proposal.

Accordingly, the research question of this study is: What are the perceptions of the nursing team regarding hospital discharge planning for people with strokes? Based on the above, the objective is to describe the perception of nursing team regarding hospital discharge planning for people affected by stroke.

METHODOLOGY

This is a descriptive study, with a qualitative approach, which followed the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ)¹¹. The study was carried out in a medical clinic unit of a general hospital, level 3 – Accredited with Excellence by the National Accreditation Organization (ONA) in Brazil, from July 2022.

As for the participants, nurses or nursing technicians working in the medical clinic were included, regardless of their work shift, as long as they had been employed at the institution for at least six months. Nonetheless, nursing professionals who were on sick leave or vacation at the time of data production were excluded. The number of participants in the study was defined by data saturation. In order to organize data production, the institution initially provided a list of the nursing professionals working in the unit. Based on this, the participants were drawn sequentially, followed by contact with the unit manager to arrange the interviews.

In order to gather data, semi-structured interviews were conducted, guided by a script consisting of questions about the characterization of the subjects and open-ended questions about hospital discharge planning from the perspective of people with strokes: What do you understand by discharge planning? Who is responsible for discharge planning? When should preparation for hospital discharge start? What strategies are used to prepare for hospital discharge?

The interviews were conducted in a private room, audio-recorded using digital equipment and transcribed in full twice independently. In order to maintain the participants' anonymity, they were coded as Nurses (Nurs) and Nursing technicians (Tech), followed by Arabic numerals. The data underwent Minayo's content analysis, which is divided into three stages: pre-analysis (floating reading, choice of statements, synthesis of ideas, reformulation of objectives); exploration of the material and treatment (creation of categories); and inference and interpretation of the obtained results (interpretation of the results). This study follows the ethical precepts set out in Resolution nº 466/2012, and the research was approved by the Research Ethics Committee of the Regional University of the Northwest of the State of Rio Grande do Sul, under Opinion nº 5.362.581/2022.

RESULTS

Thirteen nursing professionals took part in the study, five of them nurses and eight nursing technicians. Most were female (90%), with an average age of 35. In terms of educational level, 61.5% of the professionals had completed high school, 15.4% had completed higher education and 23.1% had a *lato sensu* postgraduate degree.

In terms of work characteristics, the length of time they had worked at the institution varied from one to three years (61.5%); four to five years (15.4%); and more than five years (23.1%). With regard to work shifts, 53.8% worked during the day and 46.2% during the night. In addition, most participants reported working thirty-six hours a week (69.2%) or forty to forty-four hours a week (23.1%). In the meantime, one participant chose not to answer the question about weekly working hours.

From the data analysis, it was possible to recognize how the nursing team perceives hospital discharge planning for people affected by strokes. Consequently, two thematic categories were established: Perception of the nursing team regarding hospital discharge planning for people with strokes; and Perception of the nursing team regarding preparing relatives/caregivers for the discharge of people with strokes.

Perception of the nursing team regarding hospital discharge planning for people with strokes

In order to better organize hospital discharge planning, the professionals understand the need, as well as alluding that continuity of care is necessary, preparing family members so that they feel able to guarantee the user the care and equipment required at home after discharge from hospital. In addition, nursing professionals perceive the need to identify who the caregivers will be, and who this person will live with after discharge from hospital, in order to avoid a progressive worsening of the condition and, consequently, possible further hospitalizations. They also point out the need for the family to get in touch with the health service in their area, with a view to providing continuity of care.

Discharge planning is the best possible way for us to make sure that this patient, at the time of discharge, feels comfortable going home and that relatives feel safe dealing with this patient at home (Tech 7).

It's important to know where they live, with whom, if the family will have a caregiver. Therefore, the team plans this part with the relative, if the family is able, notifies the health center so that the area is aware that this patient has been affected by an illness and is now returning home with other care (Tech 1).

The way you will organize for these patients to leave the hospital and be able to continue, check what their needs will be outside the hospital, from medications, oxygen, physiotherapy, and even nutritional care. Therefore, the planning is to see what these patients will need post-discharge so that they don't relapse and have to return to the institution with a re-hospitalization (Nurs 2).

In addition, it is possible to highlight the role of the professional nurse, who provides direct care during the hospitalization process and, in collaboration with the multidisciplinary team, prepares for hospital discharge once the patient's clinical condition has improved. Furthermore, nurses have the role of informing primary health care of the patient's clinical picture and discharge from hospital, in order to promote continuity of treatment at another level of complexity.

The entire multidisciplinary team has contact with the patient and his/her relatives and plans his/her discharge from hospital. In addition to the nursing team, we have a daily nutritionist, physiotherapist, psychologist and, if necessary, a social worker who also provides support (Nurs 2).

When the patient's condition improves, a multidisciplinary assessment is carried out and he/she is prepared for hospital discharge, and primary health care is notified so that they can prepare to receive the patient (Nurs 4).

The physician is going to talk about the patient's clinical condition, the nurse is going to hold all the communication process with the nutritionist, the social worker, so that they can come to the patient and provide guidance, and also the nursing guidance, which is carried out by us as technicians [...] (Tech 1).

I think it's more up to the sector nurse to organize the hospital discharge, depending on the shift. But I think it's a multidisciplinary job, which also involves the nursing technician, the nurse, physiotherapy, medical issues, nutritional issues; therefore, it's a multidisciplinary team (Nurs 5).

They receive a lot of [hospital discharge] advice from nurses, nutritionists and, sometimes, physicians, but it's the nurses who give the most [discharge advice] to relatives and patients (Tech 2).

The professionals understand that the family is crucial in this context. Therefore, nursing professionals apply all the necessary institutional protocols, besides trying to help them to manage hospital discharge and answer any questions they may have about this process.

I think that the family is an important point for the patient to get out of the situation he/she's in, because, at the institution, we've done everything that's instructed, we follow all the protocols; when a new protocol comes in, we start applying it [...] so it's a team. I think the family is directly involved, because the patient is fine and, out of the blue, he/she's here in hospital, it's all new for that family (Tech 1).

I think it depends a lot on the understanding of each relative, how the patient goes home [...]. But, in general, we try to answer questions as best we can. Let's say that 90% of them leave well prepared, with some we have a lot of difficulty [...] (Nurs 1).

Finally, the nursing professionals highlight the importance of discharge planning for people with strokes, emphasizing the need for continuity of care and preparation of relatives. The essential role of nurses is highlighted in multidisciplinary coordination, communication with primary care and the application of protocols to ensure an effective and safe transition to the home environment.

Perception of the nursing team regarding preparing relatives/caregivers for the discharge of people with strokes

Concerning the strategies used to improve the preparation of patients for hospital discharge, health education with relatives and caregivers stands out as an important enhancer of this process. In addition, nursing professionals offer guidance during daily care, addressing aspects like changes of position, skin care, medication administration, bronchoaspiration risk and dressing procedures. Communication between the participants reveals a consistent harmony in the explanations given to patients and their relatives.

I think it's the care, when we're giving the bath, we're talking about skin care, care with maintaining the tube, care with diluting the medication, we're preparing for discharge (Tech 3).

When it's time for the bed bath, we invite the relative, he/she takes part in this care together [...] he/she takes part in the care, in the change of decubitus [...]. When I visit, I always reinforce this issue of the risk of injury, or the risk of bronchoaspiration when the patient is on a diet, or even when he/she's on an oral diet, giving him/her advice on positioning and feeding. You always need to be planning this discharge with the family; of course, it depends a lot on each professional who is working and whether we are including that caregiver in the planning (Nurs 2).

I think that, when it comes to care, all the technicians are guided in the same way, in other words, we speak the same language with the relatives (Tech 1).

In addition to the spoken instructions, we also have written discharge instructions. Therefore, it's going to depend a lot on each physician, how they're going to describe it [...] because the patients we have, for example surgical patients, leave with a detailed dressing, how it has to be done (Nurs 1).

Nonetheless, it can be perceived that nursing professionals have difficulties when it comes to preparing for hospital discharge, as they point out that family relationships often end up directly interfering in the preparation of patients for discharge, given that there is a high turnover of caregivers and a lack of interest in care, which becomes a weakness when it comes to preparing these patients, limiting the provided guidance. Discharge instructions are an important ally for continuity of care, guaranteeing qualified care at home.

If it's the same relative who's with the patient every day, that's fine, but, in the event of a change of caregivers, you have to start all over again, but generally they don't come prepared (Tech 3)

It depends on the involvement between family and patient. Sometimes, we have family members who aren't very interested in that care, we've seen a lot of patients who don't have a bond [...]. Therefore, sometimes, it's just that gentleman who's there, that elderly patient with the relative who's going to stay at home, also elderly [...] it's a problem (Nurs 2).

No, they don't leave prepared. They have no idea what the aftermath is. They are dependent on nursing and few relatives are collaborative and want to participate and understand the process that the patient will demand afterwards (Nurs 4).

Nursing professionals use educational strategies to prepare relatives and caregivers for the discharge of patients with strokes. The guidelines cover various aspects, such as daily care, changes of position, medication administration and associated risks. Nonetheless, challenges arise due to caregiver turnover and lack of interest, impacting discharge preparation and continuity of home care.

DISCUSSION

Nursing professionals have shown that they understand the importance of discharge planning for people affected by strokes, given that its proper management provides the patient with continuity of qualified care. In addition, it is possible to observe the nursing team's commitment to providing guidance on basic care to relatives and including them in the care while still in the hospital environment. Furthermore, the professionals always seek integration with primary health care with a view to providing continuity of care.

The important role played by the multidisciplinary team was identified, as well as the nurse's leadership role in preparing patients for hospital discharge. Furthermore, the correct preparation and management of the patient for discharge influences the quality of the provided services. The interviewees pointed to the use of health education actions as a strategy for increasing the knowledge of users and their relatives. However, there is vulnerability in terms of caregiver turnover and, sometimes, apathy towards the provided guidance.

The high prevalence of strokes in Brazil is reflected during the rehabilitation process, when there is a search to resume self-care and activities that influence social life¹³. In this sense, the acquisition of independence becomes significant after stroke, guaranteeing quality of life and a considerable improvement in self-esteem¹⁴.

In certain situations, patients face several phases, varying from acceptance of the new condition to the adaptation process, requiring the acquisition of new knowledge and skills. Building self-management skills requires the implementation of health education actions. Nevertheless, in order to guarantee the success of the interventions carried out by nursing professionals, it is essential to establish a relationship of trust with users and their relatives, promoting greater adherence to the proposed actions and ensuring continuity of care¹⁵.

Therefore, it is underlined that a qualified transition of care requires the implementation of effective strategies, where preparation for hospital discharge is considered a crucial element in ensuring effective continuity of care. However, weaknesses have been identified in this context, which emphasizes the need to look for practices that act positively¹⁶.

Accordingly, interventions involving communication between health services and hospital discharge plans ensure an effective transition of care, and it is necessary to think about assistance for care at home, providing inputs that will be indispensable for the patient's therapy¹⁷. The process requires decision-making that must involve a multidisciplinary team, as well as the Health Care Networks, clients, and their relatives, considering their main difficulties and then looking for coping strategies¹⁸.

In light of the foregoing, it is understood that preparing users for discharge from hospital should start from the first moments of hospitalization, through actions designed by the multidisciplinary team, discussed with family members, based on the individual's reality, acting as a facilitator for successful discharge from hospital at home¹⁹, which can be qualified based on care transition protocols, as well as the transfer of other technologies¹⁵.

Thus, among the issues that facilitate successful hospital discharge, one can highlight multidisciplinary communication, knowledge of the family context and interaction among the team members. In view of this, it is emphasized that, among the professionals included in the hospital discharge process, the nurse and the nursing team end up being responsible for patient care, as well as helping to insert the other members of the multidisciplinary team, based on the diagnosis, hospital care and the current clinical situation of the person affected by the stroke¹⁷.

Consequently, nurses have an important role to play as providers of actions that guarantee continuity of care. However, there is still a weakness in discharge planning in order to follow-up on care at the different points of health care²⁰. The importance of nursing professionals in the management of users should also be emphasized, with a view to passing on knowledge about their post-discharge care²¹.

Access to information for elderly users, provided by professional nurses, must consider the singularities of each individual, using methods that contribute to the safety of the actions carried out at home, ensuring that all demands are met satisfactorily, leading to the search for the formation of a facilitating bond among professional-patient-caregiver relationships¹⁴. Furthermore, it should be noted that the advances in preparing users for hospital discharge favor a quality service, and that follow-up after hospital discharge is of great value, making it possible to reduce new readmissions⁴ and prepare patients to self-manage their post-discharge care while they are still hospitalized, which generally ends up reducing new admissions within 30 days of hospital discharge²².

This highlights the need for strategies that contribute to the success of hospital discharge, minimizing the risk of failures in the continuity of care that result in readmissions. Although there are weaknesses, it is possible to identify that the use of strategies for transition of care contributes positively, favoring care between the different points of health care²³.

In addition, the study identifies weaknesses regarding family relationships, besides highlighting the degree of importance of the guidance provided by the team, identifying it as a relevant method for preparing the patient²¹. However, despite understanding patient preparation as recognized by health institutions, it is possible to perceive that preparation for hospital discharge is held in a piecemeal fashion, weakening the process by not identifying the precepts that govern the issue²⁴.

To that end, it is important to highlight the role of liaison nurses, who are responsible for preparing the patient in different spheres, in an individualized way, seeking to promote comprehensive care, thus spreading discussions on the topic, leading to an increase in practice in the country²⁵. Accordingly, the different strategies used to manage patients after hospital discharge should be emphasized, where the advantages they present are identified, highlighting the role of nurses as essential for continuity of care in an organized way, as well as the need for professionals in the area to act in a specific way with regard to the topic²⁶.

The work carried out by navigation nurses should also be highlighted. Preparing for hospital discharge is based on practices developed by the team and they point to behaviors that should be centered on the patient and his/her family, since effective communication is maintained among professionals on the team during information processing, continuously identifying the patient's clinical and psychological needs, acting as educators and coordinators between services, since it is difficult to promote continuity of care without coordination actions²⁵.

In view of its complexity, preparing patients for hospital discharge is perceived as a collective responsibility. Therefore, as it suggests comprehensive care, discharge planning must be carried out continuously, from the moment they are admitted to hospital until they return to the community, seeking to ensure that they are cared for at the different points of health care. Therefore, discussions on the topic are necessary, with a view to qualifying health services in the face of hospital discharge planning, seeking continuity of care at home, in view of the benefits for the patient, his/her relatives, as well as the institution.

With respect to the study's limitations, as this is still an incipient topic in the country, there is a lack of studies on hospital discharge planning for patients with strokes, which implies that new studies should be carried out to encourage discussions on the topic.

FINAL CONSIDERATIONS

Nursing professionals recognize and understand how important it is to plan the discharge of patients with strokes from the hospital setting. They highlight the role of the nurse as essential to the functionality of the processes, but also reinforce the importance of the involvement of the entire multi-disciplinary team, with a view to guaranteeing qualified care in a systematized and comprehensive way.

Furthermore, it can be perceived that the provided health education guidelines are considered to be potential for preparing patients for hospital discharge, but weaknesses were also observed that could intervene in the quality of care. Therefore, it is necessary to involve the other points of health care, with a view to reducing the risks and possible readmissions.

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