

Hospital-to-home transitional care as support for older adult's caregivers: a scoping review



Cuidados de transição do hospital para domicílio como suporte para cuidadores de pessoas idosas: uma revisão de escopo

Cuidados de transición del hospital al domicilio como apoyo a los cuidadores de adultos mayores: una revisión de alcance

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ABSTRACT

Objective: To explore, in the literature, how transitional care from hospital to home supports the caregivers of older adults with functional dependence.

Method: Scoping review according to Joanna Briggs, with articles indexed in six databases and gray literature, from March to October 2022. Covidence Systematic Review was used to select the studies. The data obtained is described according to the modified PRISMA-ScR. The analysis and discussion were based on the Afaf Meleis Theory.

Results: 1.220 studies were identified and, after selection, nine publications were used for analysis. The studies found indicated that transitional care supported the caregiver of older people with functional dependence through health education, involvement in decision-making, emotional support, telemonitoring and home visits after discharge. These interventions improved care for older people, reduced anxiety and promoted a sense of security.

Conclusion: Transitional care helps the caregiver adapt to providing care at home and should be adjusted according to the caregiver's context and available support network.

Descriptors: Caregivers. Aged. Transitional care.

RESUMO

Objetivo: Explorar, na literatura, como o cuidado de transição do hospital para o domicílio apoia os cuidadores domiciliares de pessoas idosas com dependência funcional.

Método: Revisão de escopo segundo o Joanna Briggs, com artigos indexados em seis bases de dados e literatura cinzenta, no período de março a outubro de 2022. Covidence Systematic Review foi utilizado para seleção dos estudos. Os dados obtidos são descritos de acordo com o PRISMA-ScR modificado. A análise e discussão foram baseadas na Teoria de Afaf Meleis.

Resultados: Foram identificados 1.220 estudos e, após a seleção, nove publicações foram usadas para análise. Os estudos encontrados apontaram que o cuidado transicional apoiou o cuidador de pessoas idosas com dependência funcional por meio de educação em saúde, envolvimento na tomada de decisões, apoio emocional, telemonitoramento e visitas domiciliares após a alta. Essas intervenções melhoraram o cuidado com as pessoas idosas, reduziram a ansiedade e promoveram uma sensação de segurança.

Conclusão: O cuidado de transição favorece a adaptação do cuidador na prestação do cuidado em domicílio e deve ser ajustado conforme o contexto que o cuidador se encontra e rede de apoio disponível.

Descritores: Cuidadores. Idoso. Cuidado transicional.

RESUMEN

Objetivo: Explorar, en la literatura, cómo la cuidados de transición del hospital al domicilio apoya a los cuidadores de adultos mayores con dependencia funcional.

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Método: Revisión por alcance según Joanna Briggs, con artículos indexados en seis bases de datos y literatura gris, de marzo a octubre de 2022. Para la selección de los estudios se utilizó la Revisión Sistemática Covidence. Los datos obtenidos se describen según el PRISMA-ScR modificado. El análisis y la discusión se basaron en la Teoría de Afaf Meleis.

Resultados: Se identificaron 1.220 estudios y, tras la selección, se utilizaron nueve publicaciones para el análisis. Los estudios hallaron que la atención transitoria apoyaba al cuidador de personas mayores con dependencia funcional mediante educación sanitaria, participación en la toma de decisiones, apoyo emocional, telemonitorización y visitas domiciliarias después del alta. Estas intervenciones mejoraron la atención a las personas mayores, redujeron la ansiedad y fomentaron la sensación de seguridad.

Conclusión: Los cuidados transitorios favorecen la adaptación del cuidador a la prestación de cuidados en el domicilio y deben ajustarse en función del contexto en el que se encuentre el cuidador y de la red de apoyo disponible.

Descriptores: Cuidadores. Anciano. Cuidado de transición.

■ INTRODUCTION

During hospitalization, older adults may reduce or lose their independence and autonomy due to the morbidity that motivated the hospitalization, the use of devices, or even the negative impacts of prolonged hospitalization, requiring continuity of care at home assisted by caregivers⁽¹⁾. Regarding functional capacity, a survey using data from the National Health Survey showed that, in a population of 23,815 older adults who were at home, 15.8% had incapacity for basic activities of daily living and 29.1% incapacity for instrumental activities. It was necessary to prioritize, through preventive actions, autonomy, and independence, for the benefit of family members, caregivers, and the health system⁽²⁾. Faced with older adults who become functionally dependent, demanding care many times for years, caregivers develop overload, emotional exhaustion, and reduced quality of life, requiring attention, support, and training⁽³⁾.

The profile of the caregiver of older adults with functional dependence, often alone, is characterized by female family members, with an average age of 57.4 years, who dedicate, on average, 60 hours per week to care, abdicating their work, social and leisure activities, still facing financial problems, lack of social and formal support^(2,4-6). Often abruptly, they assume this role without preparation, endangering their health and continuity of care, being exposed to physical and mental illness^(5,7). Returning home, they become a link between the health team and the person with dependence, protagonists in the receipt of information, in the

execution of orientations, in the care and management of this, in addition to other necessary follow-up⁽⁸⁾.

In the context of hospitalization, the transitional care (TC) is important when preparing for the return home. TC is defined as the set of actions planned to ensure safety and continuity of care when health care passes from the hospital team to the affected person and/or their caregivers⁽⁹⁻¹¹⁾. According to Afaf Meleis "living with chronic illness and maintaining well-being initiates a series of transitions that requires nursing interventions at different stages and critical points." So, in this case, it consists of passage or movement from one condition or place to another, and it also involves caregivers in their change of role⁽⁹⁻¹²⁾.

The TC can support caregivers by relieving their burden, especially concerning the tension caused by the need for continuity of care at home, and consequently reduce adverse events for the person with dependence. In addition, identifying and providing aspects that favor hospital discharge planning effectively reduces avoidable readmissions and improves health care quality⁽¹³⁾. The actions and training focused on the basic care performed by caregivers, given the affected person's demands, collaborate for the continuity of care at home in a safe way, both for the person who receives it and the one who offers it⁽¹⁴⁾.

The groundwork for maintaining uninterrupted care at home must commence upon admission, persist throughout the hospital stay, extend until discharge, and occasionally even after discharge, facilitated by telemonitoring or home visits. As a result, individuals requiring assistance, along with their family members

and/or caregivers, must be equipped with more than just caregiving knowledge. They should also receive guidance on handling situations and self-care. This is particularly important for family members and caregivers, as neglecting their health, self-medication, and experiencing physical and mental strain can lead to musculoskeletal discomfort⁽¹⁵⁾.

It is urgent that health professionals think and articulate actions to support responsible caregivers during hospitalization until the discharge of older adults and, if necessary, minimize harm to their health and the risk of destabilization of the people under the care^(4,15,16).

Scientific productions on caregivers of elderly people with functional dependence address relevant aspects such as overload or care to be performed, leaving a gap regarding the support offered by transitional care and how this occurs⁽¹⁷⁾.

Aiming at greater visibility and implementation of measures related to the theme, this scoping review aimed to explore in the literature how transitional hospital-home care supports the home caregiver of older adults with functional dependence.

■ METHOD

The study followed the methodology of the Joanna Briggs Institute – JBI for scope review⁽¹⁸⁾. The protocol of this review is registered in the International Platform for Registered Systematic Review and Meta-Analysis Protocols (INPLASY n.202230143).

The guiding question “How transitional care from hospital to home supports the caregivers of older adults with functional dependence?” followed the Population, Concept and Context (PCC) conceptual model.

This review considered studies conducted with home caregivers of functionally dependent older adults. The concept of interest was the hospital-home TC performed to support caregivers. In this study, TC was understood as the preparation of caregivers for hospital discharge, health education of patients and families, support in the continuity of home care, and follow-up after hospital discharge⁽¹⁹⁾. The hospital and home care environments were considered contexts of the study, and any research conducted in longterm care

institutions (LTCI), or non-hospital health clinics was disregarded. No geographical boundaries were applied.

The review considered different sources of evidence with the most varied designs: qualitative studies, phenomenological studies, grounded theory, ethnography, qualitative description, action research, and descriptive observational studies, in addition to integrating case series, individual case reports and cross-sectional studies, analytical observational studies, including prospective and retrospective cohort studies, case-control studies, systematic reviews, and literature reviews. Experimental and quasi-experimental studies involving randomized and non-randomized controlled studies were also welcomed.

Methodological research and other relevant documents such as these, dissertations, laws, manuals, and guidelines were also considered.

The databases searched were: Online System for Search and Analysis of Medical Literature MEDLINE® (access via PubMed), Scopus, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Science (WoS), Latin American Information Bibliography (LILACS) and Embase. For gray literature, we used the Digital Network Library of Theses and Dissertations of the Coordination for the Improvement of Higher Education Personnel (CAPES), the OpenGrey platform, and information from organizations, websites, manuals, and guidelines considered relevant by the research group, from official institutions linked to the Brazilian Ministry of Health. The mapped descriptors are described in Chart 1.

The search strategy followed three phases. In the first, it was limited to PubMed and CINAHL, followed by the observation of words of the text included in the title and abstract and the descriptors used to present the studies. From there, search strategies were developed for each source of information, followed by the second phase, when keywords and descriptors found in the first phase were used in the other sources (Chart 2).

In the third phase, the reference relationship of each material and articles included was investigated for complementary studies, provided that they answered the research question.

Chart 1 – Mapping of DeCS, MeSH, and Emtree Terms. Salvador, Bahia, Brazil, 2023

TERM MAPPING		
SYSTEMATIZATION	VOCABULARIES	MAPPINGS
PARTICIPANT	DECS	Elderly* OR "Person of Age" OR "Elderly Person" OR "People of Age" OR "Elderly People" OR "Elderly Population" OR Aged OR Elderly OR Ancian* OR "Adulto Mayor" OR "Persona de Edad" OR "Persona Mayor" OR "Personas de Edad" OR "Personas Mayores" OR "Sujet âgé" OR "Adulte âgé" OR "Adulte de 65 à 79 ans" OR "Personne âgée" OR "Personne du troisième âge" OR "Home Patients" OR "Home Care Patients" OR "Patients Sheltered at Home" OR "Patients Retained in Home" OR "Persons with Temporary Disabilities" OR "Persons Confined at Home" OR "People Confined at Home" OR "Persons in Home Treatment" OR "Homebound Persons" OR "Home Bound Persons" OR "Home-Bound Person" OR "Home-Bound Persons" OR "Homebound Person" OR "House Bound Persons" OR "House-Bound Person" OR "House-Bound Persons" OR "Shut Ins" OR "Shut-In" OR "Shut-Ins" OR "Personas Imposibilitadas" OR "Personas Confinadas a su Hogar" OR "Personas que no Pueden Salir de Casa" OR "Personnes dépendantes à domicile" OR "Elderly of 80 Years or more" OR Centen* OR "Elderly of 80 years or more" OR "Elderly of 80 years or more" OR "Elderly of 80 years or more" OR Nonagen* OR Octogen* OR "Velhíssimos" OR "Aged, 80 and over" OR "Oldest Old" OR "Anciano de 80 o más Años" OR "Anciano de 80 Años o más" OR "Ancianos de 80 Años o más" OR "Ancianos de 80 Años y más" OR "Ancianos de 80 o más Años" OR "Viejísimos" OR "Sujet âgé de 80 ans ou plus" OR "Adulte de 80 ans ou plus" OR "Adulte très âgé" OR "Personne du quatrième âge" OR "Personne très âgée" OR "Personnes du grand âge" OR "Sujet très âgé" OR "Caregiver Spouses" OR Caregiver* OR "Family Caregiver" OR "Family Caregiver" OR "Spouse Caregivers" OR "Family Caregivers" OR "Family Caregivers" OR "Family Caregivers" OR "Family Caregivers" OR "Other Supporter" OR Caregivers OR "Care Givers" OR "Caregiver" OR Carer* OR "Family Caregiver" OR "Family Caregivers" OR "Spouse Caregiver" OR "Spouse Caregivers" OR "Caregivers" OR "Family Caregiver" OR "Family Caregiver" OR "Family Caregivers" OR "Family Caregivers" OR Aidants OR "Aidants de la famille" OR "Aidants naturels" OR "Aidants-conjoints" OR "Conjoints soignants" OR "Épouses soignantes" OR "Époux soignant" OR "Époux soignants" OR "Soignants" OR "Soignants conjoints" OR "Soignants de la famille" OR FamI* OR "Family Life Cycles" OR "Adoptive Family" OR "Extended Family" OR "Extended Family" OR "Reconstituted Family" OR "Surrogate Family" OR Filiation OR "Family Members" OR Parent* OR "Family Research" OR "Family Searches" OR "Kinship Network" OR "Family Network" OR "Kinship Networks" OR "Family Networks" OR "Extended Families" OR "Extended Family" OR "Families" OR "Family Life Cycle" OR "Family Life Cycles" OR "Family Member" OR "Family Members" OR "Family Research" OR "Filiation" OR "Kinship Network" OR "Kinship Networks" OR "Reconstituted Families" OR "Reconstituted Family" OR "Relatives" OR "Stepfamilies" OR "Stepfamily" OR "Familia" OR "Ciclos en la Vida Familiar" OR "Familia Adoptiva" OR "Familia Amplida" OR "Familia Extendida" OR "Familia Reconstituida" OR "Familia Sustituta" OR "Familiars" OR "Filiación" OR "Investigación de Familia" OR "Investigación Familiar" OR "Miembros de la Familia" OR Parient* OR "Red de Parentesco" OR "Red Familiar" OR "Redes de Parentesco" OR "Redes Familiares" OR "Segunda Familia" OR "Belle-famille" OR "Cercle familial" OR "Cercles familiaux" OR "Étude de la famille" OR "Famille élargie" OR "Famille recomposée" OR "Famille reconstituée" OR "Filiation" OR "Membres de la famille" OR "Personnes apparentées" OR "Personnes parentes" OR "Recherche sur la famille" OR "Réseau parental" OR "Réseaux de parents" OR "Réseaux parentaux"
	EMTREE	aged OR 'very elderly' OR 'homebound patient' OR caregiver OR family.
	MESH	Aged OR Elderly OR "Homebound Persons" OR "Home-Bound Persons" OR "House-Bound Persons" OR "Shut-Ins" OR "Aged, 80 and over" OR "Oldest Old" OR Caregivers OR "Care Givers" OR Carers OR "Family Caregivers" OR "Informal Caregivers" OR "Spouse Caregivers" OR Family OR "Extended Family" OR "Family Life Cycle" OR "Family Life Cycles" OR "Family Members" OR "Family Research" OR Filiation OR "Kinship Networks" OR Relatives OR Stepfamily

Chart 1 – Cont.

TERM MAPPING		
SYSTEMATIZATION	VOCABULARIES	MAPPINGS
CONTEXT	DECS	"Hospital Discharge Summaries" OR "Patient Discharge Summaries" OR "Hospital Discharge Summaries" OR "Patient Discharge Summaries" OR "Patient Discharge Summary" OR "Resumen del Alta del Paciente" OR "Comptes-rendus de sortie des patients" OR "Bulletins de sortie des patients" OR "Comptes rendus de sortie des patients" OR "Feuilles médico-administratives des patients" OR "Résumés à la sortie des patients" OR "Résumés au congé des patients" OR "Résumés de sortie des patients" OR "Sommaires d'hospitalisation des patients" OR "Sommaires de congé des patients" OR "Home Care" OR "Home Care for the Elderly" OR "Home Care by Non-Health Professionals" OR "Home Care" OR "Home Health Care" OR "Home Nursing" OR "Non-Professional Home Care" OR "Nonprofessional Home Care" OR "Atención Domiciliaria de Salud" OR "Asistencia Domiciliaria de Salud" OR "Atención no Profesional en Domicilio" OR "Cuidados Domiciliarios de Salud" OR "Soins à domicile" OR "Soins à domicile par des personnes non diplômées" OR Hospital* OR "Hospital Admission Communication" OR "Hospital Admission" OR "Voluntary Hospitalization" OR "Hospital Admission"
	EMTREE	'medical record' OR 'home care' OR hospitalization
	MESH	"Patient Discharge Summaries" OR "Home Nursing" OR "Non-Professional Home Care" OR "Nonprofessional Home Care" OR Hospitalization.
AND NOT	Child* OR Adolec* OR Newborn*	
Resources for Designing Search Strategies	() establishes the set and order of the search Boolean operators – relate the terms (AND – intersection of terms, OR – sum of terms, NOT – exclusion of terms *expand from the root of the word or term" "Indicate compound terms and establish order Search field tags in Pubmed - [AU] Author [TI] Title [TIAB] Title and Abstract Mesh [MH]	

Source: Research data, 2023.

Chart 2 – Databases and respective search strategies. Salvador, Bahia, Brazil, 2023

Database	Search strategy	Total articles obtained
MEDLINE® (PubMed)	(Aged[Title/Abstract] OR Elderly[Title/Abstract] OR "Homebound Persons"[Title/Abstract] OR "Home-Bound Persons"[Title/Abstract] OR "Shut-Ins"[Title/Abstract] OR "Aged, 80 and over"[Title/Abstract] OR "Oldest Old"[Title/Abstract] OR Caregivers[Title/Abstract] OR "Care Givers"[Title/Abstract] OR Carers[Title/Abstract] OR "Family Caregivers"[Title/Abstract] OR "Informal Caregivers"[Title/Abstract] OR "Spouse Caregivers"[Title/Abstract] OR Family[Title/Abstract] OR "Extended Family"[Title/Abstract] OR "Family Life Cycle"[Title/Abstract] OR "Family Life Cycles"[Title/Abstract] OR "Family Members"[Title/Abstract] OR "Family Research"[Title/Abstract] OR Filiation[Title/Abstract] OR "Kinship Networks"[Title/Abstract] OR Relatives[Title/Abstract] OR Stepfamily[Title/Abstract] OR (Aged OR "Homebound Persons" OR "Aged, 80 and over" OR Caregivers OR Family[MeSH Terms]) AND ("Nurses Improving Care for Health System Elders"[Title/Abstract] OR "Nurses Improving Care for Healthsystem Elders"[Title/Abstract] OR "Transitional Care"[Title/Abstract] OR "Home Transition"[Title/Abstract] OR "Transition Care"[Title/Abstract]) OR ("Nurses Improving Care for Health System Elders" OR "Transitional Care"[MeSH Terms]) AND ("Patient Discharge Summaries"[Title/Abstract] OR "Home Nursing"[Title/Abstract] OR "Non-Professional Home Care"[Title/Abstract] OR "Nonprofessional Home Care"[Title/Abstract] OR Hospitalization[Title/Abstract]) OR ("Patient Discharge Summaries"[MeSH Terms] OR "Home Nursing"[MeSH Terms] OR Hospitalization[MeSH Terms]) AND NOT Child*[Title/Abstract] OR Adolec*[Title/Abstract] OR Newborn*[Title/Abstract])	305
CINAHL	Aged OR Elderly OR "Homebound Persons" OR "Home-Bound Persons" OR "House-Bound Persons" OR "Shut-Ins" OR "Aged, 80 and over" OR "Oldest Old" OR Caregivers OR "Care Givers" OR Carers OR "Family Caregivers" OR "Informal Caregivers" OR "Spouse Caregivers" OR Family OR "Extended Family" OR "Family Life Cycle" OR "Family Life Cycles" OR "Family Members" OR "Family Research" OR Filiation OR "Kinship Networks" OR Relatives OR Stepfamily AND "Nurses Improving Care for Health System Elders" OR "NICHE Hospital Programs" OR "Nurses Improving Care for Healthsystem Elders" OR "Transitional Care" OR "Home Transition" OR "Transition Care" AND "Patient Discharge Summaries" OR "Home Nursing" OR "Non-Professional Home Care" OR "Nonprofessional Home Care" OR Hospitalization AND NOT Child* OR Adolec* OR Newborn*	142
WOS	Aged OR Elderly OR "Homebound Persons" OR "Home-Bound Persons" OR "House-Bound Persons" OR "Shut-Ins" OR "Aged, 80 and over" OR "Oldest Old" OR Caregivers OR "Care Givers" OR Carers OR "Family Caregivers" OR "Informal Caregivers" OR "Spouse Caregivers" OR Family OR "Extended Family" OR "Family Life Cycle" OR "Family Life Cycles" OR "Family Members" OR "Family Research" OR Filiation OR "Kinship Networks" OR Relatives OR Stepfamily (Topic) and "Nurses Improving Care for Health System Elders" OR "NICHE Hospital Programs" OR "Nurses Improving Care for Healthsystem Elders" OR "Transitional Care" OR "Home Transition" OR "Transition Care" (Topic) and "Patient Discharge Summaries" OR "Home Nursing" OR "Non-Professional Home Care" OR "Nonprofessional Home Care" OR Hospitalization (All fields) not Child* OR Adolec* OR Newborn* (All fields) and Open Access	133
SCOPUS	(TITLE-ABS-KEY (aged OR elderly OR "Homebound Persons" OR "Home-Bound Persons" OR "House-Bound Persons" OR "Shut-Ins" OR "Aged, 80 and over" OR "Oldest Old" OR caregivers OR "Care Givers" OR carers OR "Family Caregivers" OR "Informal Caregivers" OR "Spouse Caregivers" OR family OR "Extended Family" OR "Family Life Cycle" OR "Family Life Cycles" OR "Family Members" OR "Family Research" OR filiation OR "Kinship Networks" OR relatives OR stepfamily) AND TITLE-ABS-KEY ("Nurses Improving Care for Health System Elders" OR "NICHE Hospital Programs" OR "Nurses Improving Care for Healthsystem Elders" OR "Transitional Care" OR "Home Transition" OR "Transition Care") AND TITLE-ABS-KEY ("Patient Discharge Summaries" OR "Home Nursing" OR "Non-Professional Home Care" OR "Nonprofessional Home Care" OR hospitalization) AND NOT TITLE-ABS-KEY (child* OR adolec* OR newborn*)) AND PUBYEAR > 1998 AND PUBYEAR < 2023 AND (LIMIT-TO (OA , "all")) AND (LIMIT-TO (LANGUAGE , "English") OR LIMIT-TO (LANGUAGE , "SPANISH") OR LIMIT-TO (LANGUAGE , "PORTUGUESE"))	278
EMBASE	('aged'/exp OR 'very elderly'/exp OR 'homebound patient'/exp OR 'caregiver'/exp OR 'family'/exp) AND ('nurses improving care for healthsystem elders'/exp OR 'transitional care'/exp) AND ('medical record'/exp OR 'home care'/exp OR 'hospitalization'/exp) NOT ('child'/exp OR 'adolescent'/exp OR 'newborn'/exp) AND [1999-2022]/py AND [embase]/lim	304

Chart 2 – Cont.

Database	Search strategy	Total articles obtained
LILACS	(elderly* OR "Person of Age" OR "Elderly Person" OR "Persons of Age" OR "Elderly People" OR "Elderly Population" OR aged OR elderly OR ancian* OR "Adulto Mayor" OR "Persona de Edad" OR "Persona Mayor" OR "Personas de Edad" OR "Personas Mayores" OR "Sujet âgé" OR "Adulte âgé" OR "Adulte de 65 à 79 ans" OR "Personne âgée" OR "Personne du troisième âge" OR "Home Patients" OR "Patients of Shelter at Home" OR "Patients Retained in Home" OR "Persons with Temporary Disabilities" OR "Persons Confined at Home" OR "People Confined at Home" OR "Persons in Home Treatment" OR "Homebound Persons" OR "Home Bound Persons" OR "Home-Bound Person" OR "Home-Bound Persons" OR "Homebound Person" OR "House Bound Persons" OR "House-Bound Person" OR "House-Bound Persons" OR "Shut Ins" OR "Shut-In" OR "Shut-Ins" OR "Personas Imposibilitadas" OR "Personas Confinadas a su Hogar" OR "Personas que no Pueden Salir de Casa" OR "Personnes dépendantes à domicile" OR "Elderly of 80 Years or more" OR centen* OR "Elderly of 80 years or more" OR "Elderly of 80 years or more" OR "Elderly of 80 years or more" OR nonagen* OR octogen* OR "Velhíssimos" OR "Aged, 80 and over" OR "Oldest Old" OR "Anciano de 80 o más Años" OR "Anciano de 80 Años o más" OR "Ancianos de 80 Años o más" OR "Ancianos de 80 Años y más" OR "Ancianos de 80 o más Años" OR "Viejísimos" OR "Sujet âgé de 80 ans ou plus" OR "Adulte de 80 ans ou plus" OR "Adulte très âgé" OR "Personne du quatrième âge" OR "Personne très âgée" OR "Personnes du grand âge" OR "Sujet très âgé" OR "Caregiver Spouses" OR "Caregiver*" OR "Family Caregiver" OR "Family Caregiver" OR "Spouse Caregivers" OR "Family Caregivers" OR "Family Caregivers" OR "Family Caregivers" OR "Family Members" OR "Family Members" OR "Caregivers" OR "Other Supporter" OR caregivers OR "Care Givers" OR "Caregiver" OR carer* OR "Family Caregiver" OR "Family Caregivers" OR "Spouse Caregiver" OR "Spouse Caregivers" OR "Caregivers" OR "Family Caregiver" OR "Family Caregivers" OR "Family Caregivers" OR "Family Caregivers" OR "Family Caregivers" OR "Aidants de la famille" OR "Aidants naturels" OR "Aidants-conjoints" OR "Conjoints soignants" OR "Épouses soignantes" OR "Époux soignant" OR "Époux soignants" OR "Soignants" OR "Soignants conjoints" OR "Soignants de la famille" OR famli* OR "Family Life Cycles" OR "Adoptive Family" OR "Extended Family" OR "Extended Family" OR "Reconstituted Family" OR "Surrogate Family" OR "Filiation" OR "Family Members" OR parent* OR "Family Research" OR "Family Research" OR "Kinship Network" OR "Family Network" OR "Kinship Networks" OR "Family Networks" OR "Extended Families" OR "Extended Family" OR "Families" OR "Family Life Cycle" OR "Family Life Cycles" OR "Family Member" OR "Family Member" OR "Family Research" OR "Filiation" OR "Kinship Network" OR "Kinship Networks" OR "Reconstituted Families" OR "Reconstituted Family" OR "Relatives" OR "Stepfamilies" OR "Family" OR "Cycles in Family Life" OR "Familia Adoptiva" OR "Familia Ampliada" OR "Familia Extendida" OR "Familia Reconstituida" OR "Familia Sustituta" OR "Familiars" OR "Filiación" OR "Investigacion de Familia" OR "Investigación Familiar" OR "Miembros de la Familia" OR parient* OR "Red de Parentesco" OR "Red Familiar" OR "Redes de Parentesco" OR "Redes Familiar" OR "Redes Familiar" OR "Redes Familiar" OR "Réseau familial" OR "Cercles familiaux" OR "Étude de la famille" OR "Famille élargie" OR "Famille recomposée" OR "Famille reconstituée" OR "Filiation" OR "Membres de la famille" OR "Personnes apparentées" OR "Personnes parentes" OR "Recherche sur la famille" OR "Réseau parental" OR "Réseaux de parents" OR "Réseaux parentaux") AND ("Nursing Care for the Hospitalized Elderly" OR "Nurses Improving Care for Health System Elders" OR "Nurses Improving Care for Healthsystem Elders" OR "Hospital Programs NICHE" OR "Nurses Improving Care for Health System Elders" OR "NICHE Hospital Program" OR "NICHE Hospital Programs" OR "Nurses Improving Care for Healthsystem Elders" OR "Nurses Improving Care for Health System Elders" OR "Enfermeras que Mejoran la Atención de los Ancianos en el Sistema de Salud" OR "Nurses Improving Care for Healthsystem Elders" OR "Profesionales de Enfermería para la Mejora de la Atención Sanitaria Geriátrica" OR "Programa Hospitalarios NICHE" OR "Nurses Improving Care for Healthsystem Elders (USA)" OR "NICHE (USA)" OR "Transitional Care" OR "Transitional Care" OR "Transitional Care" OR "Transitional Care" OR "Treatment Transitional" OR "Transitional Care" OR "Transition Care" OR "Transition Cares" OR "Transitional Cares" OR "Cuidado de Transición" OR "Soins de transition" OR "Soins transitionnels") AND ("Hospital Discharge Summaries" OR "Patient Discharge Summaries" OR "Patient Discharge Summaries" OR "Patient Discharge Summary" OR "Resumen del Alta del Paciente" OR "Comptes-rendus de sortie des patients" OR "Bulletins de sortie des patients" OR "Comptes rendus de sortie des patients" OR "Feuilles médico-administratives des patients" OR "Résumés à la sortie des patients" OR "Résumés au congé des patients" OR "Résumés de sortie des patients" OR "Sommaires d'hospitalisation des patients" OR "Sommaires de congé des patients" OR "Home Care" OR "Home Care for the Elderly" OR "Home Care by Non-Health Professionals" OR "Home Care" OR "Home Care" OR "Home Nursing" OR "Non-Professional Home Care" OR "Nonprofessional Home Care" OR "Atención Domiciliaria de Salud" OR "Asistencia Domiciliaria de Salud" OR "Atención no Profesional en Domicilio" OR "Cuidados Domiciliarios de Salud" OR "Soins à domicile" OR "Soins à domicile par des personnes non diplômées" OR hospital* OR "Comunicação de Internação Hospitalar" OR "Internação Hospitalar" OR "Internação Voluntário" OR "Internación Hospitalaria") AND NOT (child* OR adolec* OR newborn*) AND (fulltext:("1" OR "1" OR "1" OR "1") AND db: ("LILACS") AND la:("en" OR "pt" OR "es")) AND (year_cluster:[1999 TO 2022])	53

Source: Research data, 2023.

To select the studies, we considered publications in English, Portuguese, or Spanish, with open access, elaborated after 1999, when the National Health Policy for the Older Adults was promulgated⁽²⁰⁾ when the definition of caregiver was established. Interministerial Ordinance No. 5.153/99⁽²¹⁾ was published, which established the Program of Caregivers of the Older Adults. Studies that did not explicitly address the concept of hospital-home TC were excluded.

After the search in the database, the other steps, peer reading of the material, inclusion/exclusion, extraction of the information of interest, and organization of these were carried out through the Covidence Systematic Review, a platform for managing review studies. The initial selection occurred by reading the title and abstract following inclusion and exclusion criteria. Once the eligible studies were identified, the full text was read, focusing on the answer to the research question. The complete reading of the documents and the identification of the main aspects of the hospital-home TC and its support to the caregiver was carried out independently by two reviewers to verify similarities, discrepancies, and complementarities in the materials, minimizing possible inconsistencies. Any contradictions were discussed and resolved by a third reviewer.

The data of interest were collected using an instrument previously elaborated for information on title, authors and year of publication, country of the study, methodological design, profile of the participants, and results relevant to the review's objective. An expository abstract comprises the tabulation of the results, correlating them with the review's objective and the research question. The survey took place between March and October 2022.

The data obtained in the study are described according to the PRISMA-ScR checklist, modified to direct scope review studies⁽²²⁾. The analysis and discussion of the results were based on the Theory of Transitions by Dr. Afaf Meleis, considering the transition that the caregiver goes through after the illness of his or her loved one⁽¹²⁾.

■ RESULTS

We identified 1.220 articles that, after reading and peer analysis, resulted in nine studies to compose the review. In the gray literature, five studies were identified, three dissertations and two theses, excluded because they did not meet the question of interest. On the OpenGrey platform, there was no identification of eligible work. The entire selection and eligibility process is shown in Figure 1.

Studies were predominately conducted in the American continent (44.4%). There was interest and growth in research on the subject before 2015, reinforcing its contemporaneity.

The main results, answering the research question, are organized in Chart 3. In 55% of the studies, the authors emphasized the gains obtained by caregivers after the support offered. In 33%, the authors reported the difficulties faced.

Four studies were conducted in the United States of America, two in Canada, two in Portugal, and one in Australia. Regarding the methodology, two studies had a qualitative approach, a methodological study with a mixed approach, two literature reviews, a scientific statement, an opinion text, an informative text, and a realistic synthesis. This refers to the deficit of scientific production on the subject. A review found a lack of research focused on the needs of caregivers during the transition of care and warns that the health professional observes the demands of these people during the care of dependent older adults throughout the hospitalization, still focusing on caregivers' self-care⁽¹¹⁾.

Regarding the profile of caregivers, five productions addressed family caregivers^(16,23,25-27), three^(11,15,24) informal caregivers, without distinguishing between family members or not, and one did not address the particularities of the participants. Of the studies, three disclosed the age range of the caregivers. Of these, one indicated the majority participation of older adults and women, alerting them to the need for support.

A study⁽²³⁾ was included despite not presenting with clarity the tools to support the caregiver, but after evaluation of the reviewers, for approaching in an improved way the actions of the TC and its positive reverberations

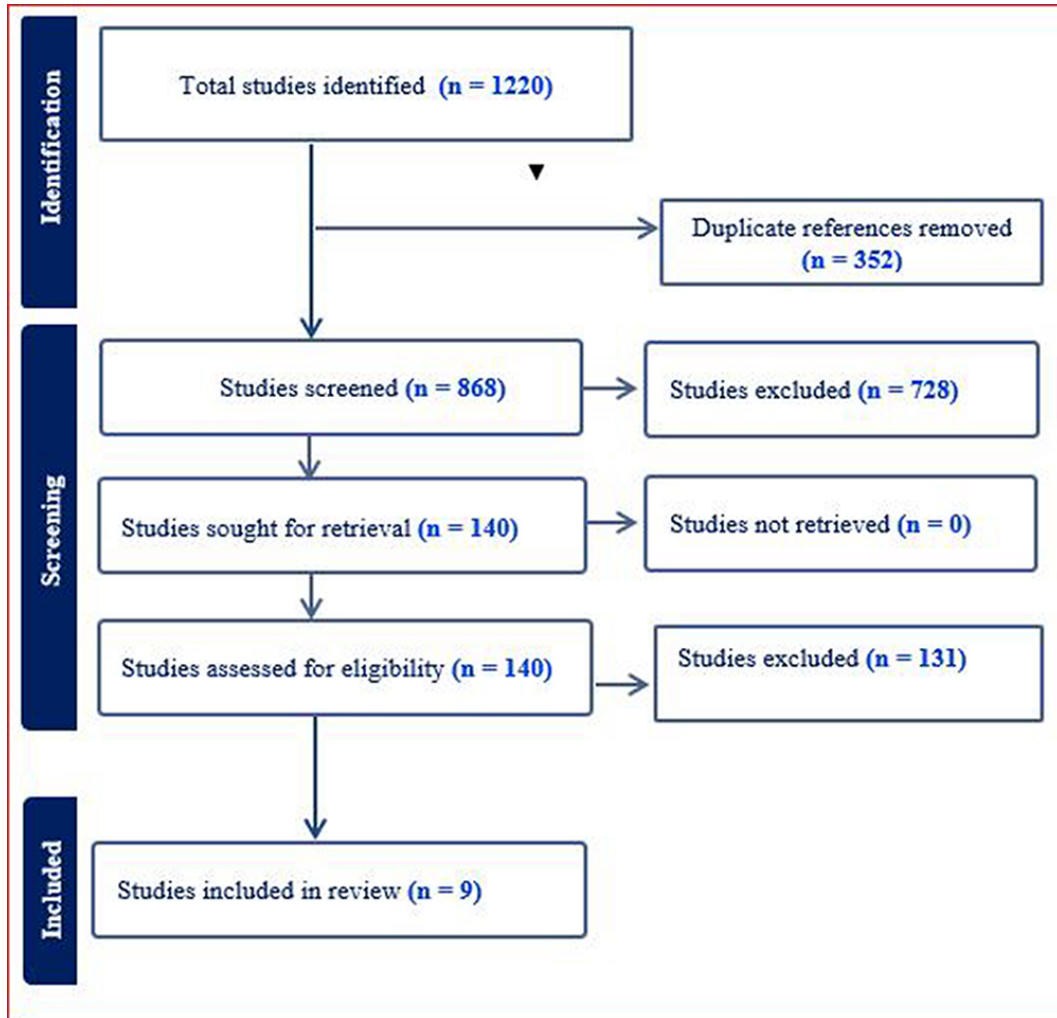


Figure 1 - Flowchart of the process of selection and eligibility of studies, according to Prisma (2020) and Prisma ScR. Salvador, Bahia, Brazil, 2023
Source: Adaptation of PRISMA-ScR, 2023.

Chart 3 – Description of the selected studies according to author, location, year, study design, and caregiver profile. Salvador, Bahia, Brazil, 2023

Author(s)	Country/ year	Method and main objective	Caregiver Profile	How Transitional Care Supported Caregivers	Gains obtained by caregivers	Difficulties reported during support
A1. Ferreira et al. ⁽¹¹⁾	Portugal/ 2020	Integrative literature review. Objective – To identify the needs of caregivers of dependent older adults for self-care in the transition from hospital to home.	Informal caregiver of both sexes aged 65 years or older	- Provision of information for the acquisition of skills related to care and its management, based on the condition of the assisted older adults. - Guidelines on financial support. - Emotional support to prevent overload. - Strengthening coping strategies and informal support network. - Guidelines for self-care. - Support in the manifestation of spirituality.	Not informed.	Not informed.
A2. Gomes et al ⁽¹⁵⁾	Portugal/ 2021	Methodological study of mixed approach. Objective - To build and validate an algorithm for the transitional care of caregivers of dependent older adults.	Informal caregiver. No additional information	- Health education in the hospital with information and training for health, economic, social and community demands. - Caregiver training for care management and self-care - Telephone contact within 72 hours by the primary health care nurse, when necessary, reinforcement for the acquisition of skills at home. - Home visit 24 hours after discharge, for information/ education, articulation with community resources and training of caregivers for basic care, when there is no acquisition of the skill during hospitalization. - Monthly follow-up to verify acquisition of mastery for care, self-care and support. - Continuity of home visits 72 hours when there is no acquisition of mastery, to promote acceptance of the role of caregiver and emotional support, inform about resources and empower self-care.	Not informed.	Not informed.

Chart 3 – Cont.

Author(s)	Country/ year	Method and main objective	Caregiver Profile	How Transitional Care Supported Caregivers	Gains obtained by caregivers	Difficulties reported during support
A3. Dale et al. ⁽¹⁶⁾	Canada/ 2020	Qualitative research Objective-To explore potentially modifiable support needs and care processes of importance for family caregivers of patients requiring prolonged mechanical ventilation and transition from the intensive care unit to a specialized weaning center.	Family caregiver, of both sexes, over 18 years old, able to read and speak English. Identified mainly women (61%) and spouses (50%).	- Survey of support needs for information, emotional support and training. - Evaluation of the acquisition of skills, the attendance to doubts and acceptance of the role of caregivers.	- Information needs met more often when professionals recognized their presence. - Improved skills with proactive updates - Reduction in fear and anxiety regarding the survival of the older adults person under care. - Empathetic interactions with professionals during transitional care.	- Deficits in informational, emotional, training and evaluation support of family caregivers. - Increased uncertainty about the prognosis of the person under care and the feeling of isolation for family caregivers.
A4. Hirschman et al. ⁽²³⁾	USA/ 2015	Opinion text Objective – To provide a detailed summary of the evidence base for transitional care and the nine core components of this model; discuss the measurement of the core components of the Care Transition Model and the overall impact of this evidence-based care management approach.	Family caregiver. No additional information.	- Identification and strengthening of sources of emotional support, including community organizations, peer groups, and the inclusion of family and friends. - Conducting interviews to establish and maintain relationships of trust mirrored in face-to-face visits and telephone calls after hospital discharge - Elaboration of care plans aligned with preferences, values and goals. - Preparation and follow-up of the caregiver until the first visit 72 hours after hospital discharge. - Inclusion of caregivers in team meetings. - Documentation and periodic updates of care plans, delivery of plans for the occurrence of urgent and emerging situations that includes contact information of the appropriate physician or provider, as well as adequate guidance as to the need and appropriate administration of medications.	Not informed.	Not informed.

Chart 3 – Cont.

Author(s)	Country/ year	Method and main objective	Caregiver Profile	How Transitional Care Supported Caregivers	Gains obtained by caregivers	Difficulties reported during support
A5. Allen et al. ⁽²⁴⁾	Australia/ 2017	Qualitative research Objective-To report the experience of older adults and caregivers about care for older adults in transition from hospital to home.	Informal caregiver, over 18 years old.	Not informed.	- The caregivers were able to negotiate the best time, the date of hospital discharge of the older adults and the best place for care after discharge, favoring greater security in the transition process.	Not informed.
A6. Hirschman; Hodgson ⁽²⁵⁾	USA/ 2018	Systematic literature review Objective – To provide an overview of the evidence-based interventions available to improve transitions in the care of people living with dementia and their caregivers	Family caregiver. No additional information.	- Immediate communication with the reference professional of the findings of the evaluation of the older adults. - Caregiver health education with a focus on reducing suffering (social worker/occupational therapist). - Medical evaluation with planning of care goals, combating isolation and reducing guilt (psychiatrist) - Support for new ways of thinking and coping skills (psychologist/occupational therapist). - Physical conditioning (Physiotherapist / Nutritionist). - Review of community services (welfare agent). - Management and control of behavioral symptoms (whole team).	Not informed.	Not informed.
A7. Kitko et al. ⁽²⁶⁾	USA/ 2020	Scientific Statement of the American Heart Association Objective – To synthesize the evidence regarding the care of adult individuals with Heart Failure.	Family caregiver. No additional information.	- Involvement of caregivers in making decisions related to treatment, place of care and end-of-life preferences. - Intervention with standardized written information about care through booklets and folders. - Face-to-face education with supplementary follow-up by phone or in person (4 to 6 contacts). - Conducting online forums, telemonitoring, psycho-educational support groups, skills training. - Use of technology such as applications to track symptoms early, control diet and medications, assisting in the management of care.	- Improved quality of life, symptoms of depression and anxiety of caregivers. - Reduction of re-hospitalizations of the older adults in care - The technology employed has increased the efficiency and effectiveness of the delivery of the care offered.	- The implementation in the private sector showed a greater barrier to the development of care interventions - The lack of payment and reimbursement mechanisms for professionals in private services was an identified barrier to the implementation of TC and support for caregivers, especially fee-for-service payment models.

Chart 3 – Cont.

Author(s)	Country/ year	Method and main objective	Caregiver Profile	How Transitional Care Supported Caregivers	Gains obtained by caregivers	Difficulties reported during support
A8. Provencher et al. ⁽²⁷⁾	Canada/ 2021	Realistic synthesis Objective – To identify the main components of discharge planning interventions for the older adults after a fall and to develop preliminary theories that improve understanding of how these intervention components lead to different mechanisms and in what contexts (when, where and for whom) these components are executed.	Family caregiver. No additional information.	- Video training - Offer of written material, personal and individual discussions about care before discharge. - Telemonitoring two weeks after discharge to reinforce the education previously provided at the hospital.	- Feeling of greater security for the provision of care with less negative psychological impact. - Reduction of stress and frustration in the face of communication interventions. - Increased self-confidence and self-efficacy, sense of control, self-care and better symptom management of the older adults under care after hospitalization. - Knowledge of the disease/ injury helped caregivers to care with more resilience, flexibility and proficiency.	- Lack of communication between health professionals and caregivers
A9. Carbonell et al. ⁽²⁸⁾	USA/ 2022	Informative text Objective – To present considerations for the implementation of the 4Ms ¹ structure (which matters, prevention, mentalization and mobility) for the incorporation of hospital care to families.	No additional information.	- Inclusion of caregivers in the home care plan, evaluating the feasibility of implementation and adherence. - Identification of what matters to the caregiver through the 4Ms of an age-friendly health system (what matters, medication, mentalization and mobility). - Monitoring the degree of caregiver burden with the application of a scale.	- Increased caregiver satisfaction. - Acquisition of the necessary skills for the continuity of care.	Not informed.

Source: Research data, 2023

in the care offered by the caregiver and in his quality of life. Six articles^(11,15,16,23,26,27) report on the provision of information and training for the acquisition of caregivers' skills in the scope of care and management, including financial, through videos, training, educational material written as booklets and folders, as well as face-to-face education in the hospital with subsequent reinforcement through home visits when necessary⁽¹⁵⁾.

The constitution of support groups for emotional and psychoeducational support was mentioned in six articles^(11,15,16,23,25,26), showing its importance for caregivers and highlighting the need for community involvement⁽²⁵⁾. Three studies^(23,25,26) showed improvement in the care offered from the engagement of caregivers in the therapeutic goals when they participate in the decisions with the care team, also evaluating the care plan to adapt it to their life context⁽²⁶⁾. Telemonitoring was another support reported in four studies^(15,23,26,27), as a strategy for monitoring and evaluating caregivers regarding providing and managing care.

Home visits were identified as an important support resource in three studies, complementing telemonitoring, mainly when the expected discharge skill was not acquired^(15,23,26), and the people involved did not achieve mastery.

Regarding strengthening the domestic and family support network, three studies^(11,24,25) brought the need to establish bonds that favor the care process and reduce the emotional burden imposed on caregivers. Other interventions such as overload prevention⁽¹¹⁾, promotion of self-care^(11,15), stimulation of the manifestation of spirituality⁽¹¹⁾, and use of new technologies⁽²⁶⁾, although listed in a smaller proportion, also represented important support tools for safe return. In the studies of this review, no support was found related to adjustment or guidance in the home care environment.

As a reflection of the support to the caregiver, mainly through effective communication and health education, a reduction in fear and anxiety was reported^(16,26,27) in the face of the new role played, increased efficiency and effectiveness in the provision of care^(26–28) and a greater sense of security for the execution of these^(24,27). Improvement of self-care⁽²⁷⁾ and the feeling

of the information needs met⁽¹⁶⁾ were also reported as a consequence of the support.

The mismatch in the communication between professionals and caregivers, with a lack of clear and elucidative language about the health status of older adults and the use of professional jargon^(16,27), hindered the implementation of actions for support during the transition of care. Moreover, the lack of financial incentives for the professionals who develop this activity, especially in the private initiative⁽²⁶⁾, given the new attributions, hindered the adherence of this care model in supplementary care.

■ DISCUSSION

The transition is a critical moment that can impact the health and quality of life of caregivers of elderly people with functional dependence. These people need to be aware of their new role to get involved, maintaining physical and mental health^(12,17). It is observed that the main interventions found in the studies permeate communication, planning and preparation for discharge, emotional and educational support, access to resources and continuity of care^(23,25–27,15).

All the studies identified were foreign. This points to the embryonic face of Brazil in the discussions on the subject and actions with the caregiver in the hospital-home transition.

Few studies in this review identified the profile of caregivers in relation to gender and age. However, the literature highlights the prevalence of middle-aged and older women with low income and educational levels isolated in their activity^(29,30). These characteristics can interfere with the caregiver's health and the quality of continuity of care⁽³¹⁾, alerting them to the relevance of support. Most studies highlighted health education as an important support strategy that enhances and improves the experience, continuity, and quality of care^(32,33).

The health education reported in the studies emphasized skills training, evaluation related to their acquisition, training regarding sources of financial support and care management, and guidance for self-care⁽¹¹⁾. Such actions are relevant since, for a satisfactory continuity

of care, the orientations must go beyond support practices for activities of daily living, also considering the management of care and self-care, especially with ergonomics, when performing tasks in environments that are not always healthy.

Regarding ergonomics, for example, studies show that caregivers often complain of pain, especially in the cervical and lumbar regions, due to care⁽⁸⁾. However, in clinical practice, it is observed that, in the hospital environment, health education practices and skills training with caregivers are timid and undervalued by the care team, leading to lost opportunities for support. One of the studies of the review⁽²⁵⁾ reported the action of physiotherapists and nutritionists to support the physical health of caregivers who lived with older adults with dementia within the same household. In this aspect, it is important to point out the preparation and knowledge as factors facilitating the transition process⁽¹²⁾.

Knowledge acquisition is important for the caregiver, improving their adaptation and mastery of safe care and self-care. However, it is necessary to pay attention to the delimitation of activities between what is the responsibility of the health team and what can be attributed to the caregiver at the time of the transfer of care. It is also worth mentioning the necessary evaluation of the skills of the responsible caregivers and working on them during hospitalization, following up with telemonitoring after discharge and home visits when necessary^(12,15).

In the studies, emotional support was placed as support. It should be performed throughout the hospitalization, ensuring acceptance of the main emotional demands and assisting these people in raising awareness of the role of caregivers, minimizing suffering, and enabling better engagement⁽¹²⁾. A study with 66 family caregivers of older adults observed reduced overload, anxiety, and depression after emotional support, which favored mental health and positively impacted the care offered⁽³⁴⁾.

A review study⁽²⁵⁾ brought actions that strengthened emotional support, such as medical evaluation with a psychiatrist to reduce the guilt of caregivers with the execution of care, strengthening of coping skills with psychologist and occupational therapist, and the

so-called "welfare agents" who are part of community services for this support in the community, demonstrating special attention to demands usually forgotten. In addition, caregiver support groups function as spaces for exchanging experiences, listening, and welcoming, helping to control and reduce anguish and uncertainty during care. This movement, carried out in person or remotely, such as in groups by messaging applications, can be stimulated.

For Meleis, transitions develop by pointing out process indicators and response patterns that are evidenced by changes in functional state, connection and interaction with the interpersonal network, being located/situated and developing confidence and a coping strategy, setting indicators towards health vulnerabilities and risks⁽¹²⁾.

A study shows that creating a virtual support group favors communication and enables sharing orientations and experiences. In addition, it minimizes the feeling of loneliness and improves the emotional state of caregivers when experiences are shared⁽³⁵⁾. The support of this informal network is essential for the success of continuity of care. Community support was scored by the authors of this review⁽²⁵⁾, corroborating what the Theory of Transitions⁽¹²⁾ recommends when it highlights the relevant role of the community and society for a healthy transition with the acquisition of mastery.

A study highlighted that the involvement of caregivers in decision-making throughout the hospitalization, together with the health team, promotes a sense of security and confidence for the continuity of care and reduces the risk of adverse events and readmissions⁽³⁶⁾. It is necessary to consider the context of older adults and their caregivers for discharge planning, aligning the care plan for this transition. Therefore, the involvement of caregivers is important being reported in the literature⁽³⁷⁾. In this review, this consideration was made in three studies^(16,25,26), which pointed out the survey of the needs to adapt to the care plan, the preparation of plans considering the family's values and objectives and the involvement of caregivers, including in team meetings for the therapeutic plan.

In addition, these studies have identified that training and involving caregivers in drawing up the care plan,

as well as knowing the context in which the care will be developed, allows for the observation of the meanings, beliefs and attitudes of these people⁽¹²⁾, facilitating the transition. For this, communication is an important tool. Authors^(11,15,16,26–28) point out that when effective, it favors acquiring new skills and understanding the role played, having relevance in the requests for other forms of support that are useful and appropriate for care.

Effective communication between health professionals and caregivers is essential to equip them in relation to the continuity of care⁽³⁸⁾, and the lack of this, with the absence of clarification and/or accurate information, for example, contributes to overload and emotional exhaustion⁽¹⁴⁾. Therefore, ineffective communication was a barrier to safe TC since it is fundamental to identify early complications, prevent them, and enable a greater quality of life for those involved⁽³⁹⁾. Informal caregivers attach great importance to the adequate provision of information, which promotes greater involvement in decision-making, planning, and preparation for the transition to the home⁽³⁷⁾. In this sense, the patterns of positive responses to the transition care offered also collaborate, allowing the caregiver to feel more connected and situated, developing confidence and adaptation⁽¹²⁾.

The use of telemonitoring for clarification and guidance was a support resource brought by the authors. When returning to the home and finding oneself alone with the responsibility of care in an uncontrolled environment and often with a deficient structure, residual doubts, and insecurities may arise despite the orientations throughout the hospitalization. The authors understand telemonitoring as an allied technology that favors bonding, transmits security and support, and encourages self-care actions⁽⁴⁰⁾. This resource can support families with impaired access to primary care, such as those living in rural areas or places with low coverage.

A study⁽⁸⁾ reported the use of home visits as support, especially in the difficulties of acquiring skills during hospitalization, also considering that, when returning home, residual doubts may occur. These visits were reported mainly in situations where there was not the

desired security and adaptation to the process, as well as the skills required, for acquiring mastery and fluid integration of identity⁽¹²⁾. In this context, it is necessary to prepare health professionals to monitor the needs at home.

Although mentioned only in one study of this review, spirituality is an important emotional support for the caregiver, highlighted in other studies as an aid in coping with discomfort and development of resilience in the face of care activities^(41,42). In addition to ineffective communication as a barrier to supporting caregivers, the difficulty of establishing bonds on the part of some professionals involved was also highlighted, especially in the private sector⁽²⁷⁾. The fragility of the bond in the service is a risk factor and limits the continuity of care at hospital discharge, as well as inadequate remuneration with overlapping activities^(27,43).

In clinical practice, it is observed that health professionals have difficulty perceiving the caregiver in their context, to offer orientations that adapt to the individual reality, which can cause more insecurity and care difficulties, resulting in unhealthy transitions. In this sense, transitional care should include practices aimed at helping caregivers acquire new knowledge and skills related to self-care and the provision of care at home, in order to respond to activities of daily living⁽¹¹⁾. At this point, the work on the screen showed support for caregivers in addition to training skills for care, as it also focused on physical and emotional preparation actions, and support in the community.

As limitations of this review, we highlight the scarcity of primary studies addressing the theme. It is necessary to address the caregiver's issues involving the acquisition and empowerment of skills, determining a sense of security in caring at home. This points out the vast field to be explored.

Another limitation is the inclusive criteria used in the study method, when the search was restricted only to hospital and home spaces, subtracting experiences in other environments of care for the elderly. This context limited the possibility of identifying other forms of support for the caregiver.

■ CONCLUSION

Transitional hospital-home care is an important support to the home caregiver of older adults with functional dependence through health education, training, telemonitoring, home visits, and emotional support, placing the caregiver in the focus of attention, observing the context of care and involving physical and mental aspects.

Seeking to meet the needs of caregivers and to minimize disorders in return to home, transitional care should be adapted according to the educational, economic, and social condition of the people involved, offering information, answering questions, and including the caregiver in care decisions throughout the hospitalization, considering their context and support network.

This study highlights how effective discharge planning, carried out by nurses, promotes continuity of care and improves the safety and well-being of caregivers, reducing avoidable complications.

The results presented can encourage the development of other forms of intervention with caregivers of the elderly during transition care, with a view to qualifying the actions implemented and promoting a more assertive communication. Thus, it can contribute significantly to guiding the management of transitional care, whether in the improvement of care techniques or in the identification of health education strategies for the caregiver, ensuring that all relevant aspects of care are addressed in a systematic way.

■ REFERENCES

1. Luzardo AR, Paula Júnior NF, Medeiros M, Wolkers PCB, Santos SMA. Repercussions of hospitalization due to fall of the elderly: health care and prevention. *Rev Bras Enferm.* 2018;71(supple2):763–9. <https://doi.org/10.1590/0034-7167-2017-0069>
2. Schmidt TP, Wagner KJP, Schneider IJC, Danielewicz AL. Padrões de multimorbidade e incapacidade funcional em idosos brasileiros: estudo transversal com dados da Pesquisa Nacional de Saúde. *Cad Saúde Pública.* 2020;36(11):e00241619. <https://doi.org/10.1590/0102-311X00241619>
3. Couto AM, Caldas AP, Castro EAB. Home care for dependent elderly patients by caregivers with overload and stress. *Cad Pesqui: Cuid Fundam.* 2019;11(4):922–50. <https://doi.org/10.9789/2175-5361.2019.v11i4.944-950>
4. Gomes NP, Pedreira LC, Gomes NP, Fonseca EOS, Reis LA, Santos AA. Health-related consequences of caring for dependent relatives in older adult caregivers. *Rev Esc Enferm USP.* 2019;53:e03446. <https://doi.org/10.1590/S1980-220X2018002303446>
5. Wang Y, Tyagi S, Hoenig H, Lee KE, Venketasubramanian N, Menon E. Burden of informal care in stroke survivors and its determinants: a prospective observational study in an Asian setting. *BMC Public Health.* 2021;21:1945. <https://doi.org/10.1186/s12889-021-11991-3>
6. Figueiredo LC, Barbosa GC, Monteiro DQ, Martins G, Silva AFO, Ruy LFT. Factors associated with symptoms of physical and emotional burden in informal caregivers of the elderly. *Rev Bras Enferm.* 2022;75(Supple 4):e20210927. <https://doi.org/10.1590/0034-7167-2021-0927>
7. Onwumere J, Creswell C, Livingston G, Schiers D, Tchanturia K, Charman T, et al. Carers of Young People with Mental Health Problems 3 COVID-19 and UK family carers: policy implications. *Lancet Psychiatr.* 2021; 8:929–36. [https://doi.org/10.1016/S2215-0366\(21\)00206-6](https://doi.org/10.1016/S2215-0366(21)00206-6)
8. Silva NRG, Gurgel Junior GD, Sá DA, Silva VL, Moreira RS. Satisfaction of caregivers and older adults who use the Better at Home Program. *Rev Saude Publica.* 2022;56(34). <https://doi.org/10.11606/s1518-8787.2022056003759>
9. Lima MADS, Magalhães AMM, Oelke ND, Marques GQ, Lorenzini E, Weber LAF, et al.. Care transition strategies in Latin American countries: an integrative review. *Rev Gaúcha Enferm [Internet].* 2018;39:e20180119. <https://doi.org/10.1590/1983-1447.2018.20180119>
10. Oliveira SG, Caldas CP. Processo de transição do familiar para o papel de cuidador familiar de um idoso dependente. *Enferm Foco.* 2021;12(3):608–14. <https://doi.org/10.21675/2357-707X.2021.v12.n3.3364>
11. Ferreira BAS, Gomes TJB, Baixinho CRSL, Ferreira ÔMR. Transitional care to caregivers of dependent older people: an integrative literature review. *Rev Bras Enferm.* 73(Suppl 3):e20200394. <https://doi.org/10.1590/0034-7167-2020-0394>
12. Meleis AI. Theoretical nursing: development and progress. 5. ed. Philadelphia, Pennsylvania: Wolters Kluwer Health/ Lippincott Williams & Wilkins; 2012. 690p
13. Bernadino E, Sousa SM, Nascimento JD, Lacerda MR, Torres DG. Transitional care: analysis of the concept in hospital discharge management. *Esc Anna Nery* 2022;26:e20200435. <https://doi.org/10.1590/2177-9465-EAN-2020-0435>
14. Lileheie I, Debesay J, Bye A, Bergland A. Informal caregivers' views on the quality of healthcare services provided to older patients aged 80 or more in the hospital and 30 days after discharge. *BMC Geriatrics.* 2020;97. <https://doi.org/10.1186/s12877-020-1488-1>

15. Gomes TJB, Ferreira BAS, Baixinho CL, Ferreira ÓMR. Algorithm for transitional care for caregivers of dependent older adults: a validation study. *Rev Bras Enferm.* 2021;74(Suppl 2):e20200625. <https://doi.org/10.1590/0034-7167-2020-0625>
16. Dale CM, Carbone S, Instanboulian L, Fraser I, Cameron JI, Herridge MS. Support needs and health-related quality of life of family caregivers of patients requiring prolonged mechanical ventilation and admission to a specialised weaning centre: a qualitative longitudinal interview study. *Intensive Crit Care Nurs.* 2020;58: 102808. <https://doi.org/10.1016/j.iccn.2020.102808>
17. Sousa LS, Pontes MLF, Pereira RR, Leite MAP, Nova FALV, Monteiro EA. Older adult transition from hospital to home from caregivers' / older adults' perspective: a scoping review. *Acta Paul Enferm.* 2023;36:eAPE03631. <https://doi.org/10.37689/acta-ape/2023AR03631>
18. Peters MDJ, Godfrey C, Mclnerness P, Munn Z, Tricco AC, Khalil, H. Chapter 11: Scoping Reviews (2020 version). Aromataris E, Munn Z, editors. *JBI Manual for Evidence Synthesis*. JBI; 2020. <https://doi.org/10.46658/jbimes-20-12>
19. Acosta AM, Lima MADS, Marques GQ, Levandovski PF, Weber LAF. Brazilian version of the Care Transitions Measure: translation and validation. *Int Nurs Rev.* 2017;64(3):379-387. <https://doi.org/10.1111/inr.12326>
20. Ministério da Saúde (BR). Portaria nº. 2.528 de outubro de 2019, 2006. Aprova a Política Nacional de Saúde da Pessoa Idosa [Internet]. Brasília, DF: Ministério da Saúde; 2006 [cited 2023 Jun 15]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2006/prt2528_19_10_2006.html
21. Ministério da Saúde (BR). Portaria Interministerial MPAS/MS no. 5.153, de 7 de abril de 1999. Institui o Programa Nacional de Cuidados de Idosos [Internet]. Brasília; 1999 [cited 2023 Jun 16]. Available from: https://www.normasbrasil.com.br/norma/portaria-interministerial-5153-1999_181344.html
22. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): checklist and explanation. *Ann Internal Med.* 2018;169(7):467-73. <https://doi.org/10.7326/M18-0850>
23. Hirschman KB, Shaid E, McCauley K, Pauly MV, Naylor MD. Continuity of care: the Transitional Care Model. *Online J Issues Nurs.* 2015;20(3):1. <https://doi.org/10.3912/OJIN.Vol20No03Man01>
24. Allen J, Hutchinson AM, Brown R, Livingston PM. User experience and care for older people transitioning from hospital to home: patients' and carers' perspectives. *Health Expect.* 2018;21:518-527. <https://doi.org/10.1111/hex.12646>
25. Hirschman KB, Hodgson NA. Evidence-based interventions for transitions in care for individuals living with dementia. *Gerontologist.* 2018;58(Supple 1):129-40. <https://doi.org/10.1093/geront/gnx152>
26. Kitko L, McIlvennan CK, Bidwell JT, Dionne-Odom JN, Dunlay SM, Lewis LM, et al. Family caregiving for individuals with heart failure: a scientific statement from the American Heart Association. *Circulation.* 2020;141(22):864-878. <https://doi.org/10.1161/CIR.0000000000000768>
27. Provencher V, D'Amours M, Menear M, Obradovic N, Veillette N, Sirois MJ, et al. Understanding the positive outcomes of discharge planning interventions for older adults hospitalized following a fall: a realist synthesis. *BMC Geriatr.* 2021;21(1):84. <https://doi.org/10.1186/s12877-020-01980-3>
28. Carbonell E, Zonsius MC, Rodriguez-Morales G, Newman M, Emery-Tiburcio EE. Addressing What Matters. *Am J Nurs.* 2022;122(1):54-58. 19544.ed. <https://doi.org/10.1097/01.NAJ.0000815440.19544.ed>
29. Allen J, Lobchuk M, Livingston PM, Layton N, Hutchinson AM. Informal carers' support needs, facilitators and barriers in the transitional care of older adults: a qualitative study. *Health Expect.* 2022;25:2876-92. <https://doi.org/10.1111/hex.13596>
30. Santos-Orlandi AAS, Brito TRB, Ottaviani AC, Rossetti ES, Zazzetta MS, Gratão ACM, et al. Profile of older adults caring for other older adults in contexts of high social vulnerability. *Esc Anna Nery* 2017;21(1):e20170013. <https://doi.org/10.5935/1414-8145.20170013>
31. Rangel RL, Santos LB, Santana ES, Marinho MS, Chaves RN, Reis LA. Avaliação da sobrecarga do cuidador familiar de idosos com dependência funcional. *Rev Atenc Saúde.* 2019;17(60):11-18. <https://doi.org/10.13037/ras.vol17n60.5564>
32. Burgdorf JG, Arbaje AI, Wolff JL. Training needs among family caregivers assisting during home health, as identified by home health clinicians. *J Am Med Directors Assoc.* 2020;21(12):1914-19. <https://doi.org/10.1016/j.jamda.2020.05.032>
33. Houtven CHV, Smith VA, Lindquist JH, Chapman JG, Hendrix C, Hastings SN, et al. Family caregiver skills training to improve experiences of care: a randomized clinical trial. *J Gen Int Med.* 2019;34:2114-22. <https://doi.org/10.1007/s11606-019-05209-x>
34. Manzini CSS, Vale FAC. Emotional disorders evidenced by family caregivers of older people with Alzheimer's disease. *Dement Neuropsychol.* 2020;14(1):56-61. <https://doi.org/10.1590/1980-57642020dn14-010009>
35. Mattos EBT, Francisco IC, Pereira GC, Novelli MMPC. Virtual support group for family caregivers of elderly people with dementia in the COVID19 scenery. *Cad Bras Ter Ocup.* 2021;29: e2882. <https://doi.org/10.1590/2526-8910.ctoRE2201>
36. Chen L, Xiao LD, Chamberlain D, Newman P. Enablers and barriers in hospital-to-home transitional care for stroke survivors and caregivers: a systematic review. *J Clin Nurs.* 2021;30(19-20):2786-807. <https://doi.org/10.1111/jocn.15807>
37. Kraun L, Vliegheer K, Vandamme M, Holtzheimer E, Ellen M, Achterberg TV. Older peoples' and informal caregivers' experiences, views, and needs in transitional care decision-making: a systematic review. *Int J Nurs Stud.* 2022;134:e104303. <https://doi.org/10.1016/j.ijnurstu.2022.104303>

38. Mitchell SE, Laurens V, Weingel GM, Hirschman KB, Scott AM, Nguyen HQ. Care transitions from patient and caregiver perspectives. *Ann Fam Med*. 2018;16(3):225-31. <https://doi.org/10.1370/afm.2222>
39. Lemos DMP, Barcellos RA, Borba DSM, Caballero LG, Goldraich LA, Echer IC. Effective communication for the safe care of patients with ventricular assist device implantation. *Rev Gaúcha Enferm*. 2019;40(esp):e20180344. <https://doi.org/10.1590/1983-1447.2019.20180344>
40. Slatyer S, Aoun SM, Hill HD, Walsh D, Whitty D, Toye C. Caregivers' experiences of a home support program after the hospital discharge of an older family member: a qualitative analysis. *BMC Health Services Research*. 2019;19:e220. <https://doi.org/10.1186/s12913-019-4042-0>
41. Oliveira AC, Pilon JK, Santos QS, Pereira DA, Rocha AC, Luz GA, et al. Qualidade de vida e espiritualidade dos cuidadores informais de pacientes oncológicos: uma revisão narrativa. *Rev Eletrôn Acervo Saúde*. 2022;15(2). <https://doi.org/10.25248/reas.e9835.2022>
42. Ferreira TS, Costa JF, Bartholomeu D, Montiel JM. Implicações e contingências da espiritualidade e religiosidade na velhice bem sucedida. *Estud Relig*. 2023;37(3):101-25. <https://doi.org/10.15603/2176-1078/er.v36n2p101-125>
43. Gallo VCL, Hammerschmidt KSA, Khalaf DK, Lourenço RG, Bernardino E. Transição e continuidade do cuidado na percepção dos enfermeiros da atenção primária à saúde. *Rev Recien*. 2022;12(38):173-82. <https://doi.org/10.24276/rrecien2022.12.38.173-182>

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