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Patient experience in hospital care transition: analysis in light of clinical management

Experiência do paciente na transição de cuidados hospitalares: análise à luz da gestão da clínica

Experiencia del paciente en la transición de la atención hospitalaria: análisis desde la perspectiva de la gestión clínica

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ABSTRACT

Objective: To analyze the patient experience during the transition of care, at hospital discharge, in light of clinical management.

Method: This is a qualitative study conducted with 31 patients at a public university hospital in the Central-West region of Brazil. Data were collected through interviews, mediated by the

critical incident technique. The information was processed using IRaMuTeQ® software and subjected to content analysis.
Results: The main categories were: challenges in transition and in the logistics of care within the Health Care Network; interpersonal relationships and clinical follow-up in care; and perception of care and satisfaction in the recovery process. Experiences related to the presence of consistent therapeutic bonds, clear communication, a welcoming environment, and coordinated action by multidisciplinary teams were associated with greater satisfaction and trust in care, while communication failures and lack of follow-up were frustrating.
Conclusion: The findings highlight the need to improve coordination between healthcare services, especially in logistical and communication aspects. In this context, clinic management emerges as an opportune strategy to promote the integration of care practices, contributing to more effective, continuous, and patient-centered care throughout their journey at different levels of care.
Descriptors: Patient-centered care; Hospital-to-home transition; Clinical management; Quality of patient care; Patient satisfaction.

RESUMO
Objetivo: Analisar a experiência do paciente na transição do cuidado, na alta hospitalar, à luz da gestão da clínica.
Método: Pesquisa qualitativa realizada com 31 pacientes de um hospital público universitário da região Centro-Oeste do Brasil. Os dados foram coletados por meio de entrevistas, mediadas pela técnica do incidente crítico. As informações foram processadas no *software* IRaMuTeQ® e submetidas à análise de conteúdo.
Resultados: As categorias principais foram: desafios na transição e na logística do atendimento na Rede de Atenção à Saúde; relações interpessoais e acompanhamento clínico no cuidado; e percepção de atendimento e satisfação no processo de recuperação. Experiências relacionadas à presença de vínculos terapêuticos consistentes, comunicação clara, ambiente acolhedor e atuação coordenada das equipes multiprofissionais foram relacionadas à maior satisfação e à confiança no cuidado, enquanto falhas comunicacionais e ausência de acompanhamento foram frustrantes.
Conclusão: Os achados apontam a necessidade de aprimorar a coordenação entre os serviços de saúde, especialmente em aspectos logísticos e comunicacionais. Nesse contexto, a gestão da clínica se apresenta como uma estratégia oportuna para promover a integração das práticas assistenciais, contribuindo para uma atenção mais resolutiva, contínua e centrada no paciente ao longo de sua jornada nos diferentes níveis de atenção.
Descritores: Assistência centrada no paciente; Transição do hospital para o domicílio; Gestão clínica; Qualidade da assistência ao paciente; Satisfação do paciente.

RESUMEN
Objetivo: Analizar la experiencia del paciente durante la transición de atención, al alta hospitalaria, a la luz del manejo clínico.
Método: Estudio cualitativo realizado con 31 pacientes en un hospital universitario público de la región Centro-Oeste de Brasil. Los datos se recopilaron mediante entrevistas, mediadas por la técnica de incidentes críticos. La información se procesó mediante el software IRaMuTeQ® y se sometió a análisis de contenido.
Resultados: Las categorías principales fueron: desafíos en la transición y la logística de la atención dentro de la Red de Atención Médica; relaciones interpersonales y seguimiento clínico durante la atención; y percepción de la atención y satisfacción en el proceso de recuperación. Las experiencias relacionadas con la presencia de vínculos terapéuticos consistentes, una comunicación clara, un ambiente acogedor y la acción coordinada de

equipos multidisciplinarios se asociaron con una mayor satisfacción y confianza en la atención, mientras que las fallas en la comunicación y la falta de seguimiento resultaron frustrantes.
Conclusión: Los hallazgos resaltan la necesidad de mejorar la coordinación entre los servicios de atención, especialmente en los aspectos logísticos y de comunicación. En este contexto, la gestión clínica se presenta como una estrategia oportuna para promover la integración de las prácticas de atención, contribuyendo a una atención más efectiva, continua y centrada en el paciente a lo largo de su trayectoria en los diferentes niveles de atención.
Descriptores: Atención centrada en el paciente; Transición del hospital al domicilio; Gestión clínica; Calidad de la atención al paciente; Satisfacción del paciente.

INTRODUCTION

During hospital admission, patients experience successive transfers of responsibility between professionals and care settings[1]. These moments constitute critical points of vulnerability for patients and families, permeated by uncertainties, risk of discontinuity of care, and weakening of support network and insufficient integration between levels of care. International evidence, including studies with Chinese older adults[2], for example, shows that poor communication, fragmented care, and lack of discharge planning are significant barriers that compromise continuity of care, contributing to adverse events, readmissions, mortality, and increased burden on health services[3,4].

These findings indicate that the transition of care constitutes a cross-cutting challenge for health systems, observed in different international contexts[2-4], especially at the moments of articulation between points and levels of care, such as in hospital care, Primary Health Care (PHC), specialized secondary care services, home care, as well as in internal transfers between hospital units[1-4].

The transition of care comprises interventions aimed at ensuring the coordination and continuity of care throughout the patient's therapeutic journey. Each transfer between teams, sectors, or institutions constitutes a transition, which can occur within the same hospital, between hospitals, or between the hospital and any other healthcare service, including the home. It is not limited to movement between different institutions, but also includes internal changes of team, sector, or unit within the hospital, as well as transfers between hospitals and referrals to primary care services, specialized secondary care services, and home care. National and international evidence highlights that well-structured transitions are associated with greater safety, improved quality of care, reduced readmissions, improved quality of life,

and increased satisfaction of patients and families, in addition to reduced costs for health services[4-6].

For a transition to be successful, it must involve a set of integrated actions, such as: detailed discharge planning, adequate education and guidance for the patient and their family, with an emphasis on supported self-care[2-3], and post-discharge follow-up. These actions directly influence the patient experience and support better clinical outcomes[7,8]. In this context, the essential role of nursing stands out, which assumes the coordination of the discharge process from hospitalization, articulating actions of comprehensive and safe care[5,9].

Care transition is therefore a fundamental component of the Health Care Network (HCN), especially in the dehospitalization process, playing a strategic role in articulating the different points of care. When adequately coordinated, it contributes to the reduction of care fragmentation, the strengthening of patient safety and improving the care experience[10], while organizing essential activities that begin at hospital admission and extend to transitions between teams, services and levels of care[11].

Considering that the transition of care involves multiple actors, interdependent care processes and clinical decisions distributed throughout the patient's journey, its effectiveness depends on organizational models capable of integrating care, management and educational practices. In this sense, the clinical management model proposed by Eugênio Vilaça Mendes[12], reveals as a relevant analytical framework for understanding and qualifying the patient's experience in the care transition process. It is a model that seeks to coordinate care, management and education practices, guiding them by the principles of continuity, comprehensiveness and safety of care.

Clinical management incorporates principles of managed care and clinical governance, developed in the North American and European health care systems, valuing continuing education, risk management, a culture of quality, the use of scientific evidence, and the organization of care processes, with a view to ensuring person-centered care[12,13]. It consists of a set of micromanagement technologies – case management, clinical audit, health condition management, and waiting list – that aims to ensure that care is effective, safe, timely, equitable, efficient, and humanized[12].

The model proposes the articulation of critical elements of the care transition, such as effective communication among health teams, integration between points of the HCN, shared responsibility among the teams, definition of clinical flows and guidelines, and active participation of the patient and family, aiming at greater quality and safety of patient care

during transitions between different levels of care[12,13]. This approach justifies the relevance of this framework for the analysis of the patient experience. Thus, by examining the patient's experience based on these components, it becomes possible to identify operational weaknesses, organizational barriers, and opportunities to strengthen coordination and continuity of care.

The literature about care transition is extensive and has prioritized analyses focused on the effectiveness of interventions, clinical outcomes, and organizational indicators[5-6,9,11]. Although there are studies that include users as participants[2-4,8], at the time this study was conducted, the authors did not identify research that adopted the user experience as the central axis of analysis, particularly with regard to expectations related to the moment of hospital discharge. The lack of alignment between users' perspectives and the services offered can negatively impact the organization of care, leaving teams without a common purpose and favoring the implementation of solutions that are poorly aligned with real needs, often focused on technologies and immediate results, to the detriment of valuing the patient's experience and adopting sustainable long-term strategies[14]. In this sense, the present investigation seeks to contribute to the deepening of this still underexplored dimension.

The care transition investigated in this study refers to hospital discharge, recognized as a critical moment in the transition of hospital care, which begins immediately after the patient's admission and ends when they are received by the next service[8]. It is assumed that the patient's experience at this moment is influenced by experiences accumulated throughout the care process, such as access to hospitalization, internal transfers, and expectations regarding post-discharge follow-up.

Thus, it is stated that analyzing the patient's experience in the care transition, in light of clinical management, provides a detailed and systemic view of how care encounters are experienced, allowing the identification of opportunities to improve care coordination and enhance management processes. Given the above, this study aimed to analyze the patient's experience in care transition at the time of hospital discharge, in light of clinical management.

METHOD

This is a descriptive, qualitative research, guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ)[15], with a view to ensuring methodological rigor in the preparation of the scientific report. The adoption of COREQ was operationalized from the systematic consideration of its items, distributed in three dimensions: research domain (profile

and role of researchers), study design (theory, sampling, context and collection), analysis and findings.

The research team consisted of professors and/or researchers with training in the health field and previous experience in qualitative research, linked to public teaching and research institutions. None of the researchers had an employment relationship with the hospital where the investigation took place, nor any prior relationships with the participants, a condition that did not imply neutrality, but contributed to making explicit the researchers' position in the field. In light of the assumptions of qualitative research, a reflective and critical stance was adopted throughout the entire investigative process, recognizing that interpretations are constructed from the interaction between researchers, participants and context. The possible influences and assumptions involved in data collection and analysis were systematically discussed in validation meetings and joint analysis of the findings.

The study was conducted at a federal university hospital in the Central-West region of Brazil, affiliated with the Brazilian Hospital Services Company (*Empresa Brasileira de Serviços Hospitalares* - EBSERH). The hospital is classified as medium-sized institution, with 124 beds distributed among the medical, surgical, pediatric, obstetric and gynecological clinics, in addition to having intensive care units (adult and neonatal) and a surgical center. Its care organization adopts clinical management as a management model[16].

Data collection was conducted in adult inpatient units, specifically in the medical, surgical, obstetric and gynecological clinic sectors. The choice of these different care settings aimed to capture distinct experiences during the transition of care, the guiding axis of this investigation, with emphasis on the hospital discharge process. The specificities of each unit were considered in the design of the data collection and analysis process, recognizing that each clinical context presents its own challenges related to communication, coordination, and continuity of care. The diversity of the settings investigated broadened the analytical scope of the research, enabling the identification of recurring patterns and relevant differences in the patients' experience during hospital discharge. It is believed that this strategy enriches the understanding of care transitions and provides support for the development of care models that are more sensitive to the specific needs of different clinical profiles within the HCN.

In this context, it was considered that the experience of hospitalized patients comprises different phases of the care process: previous transition experiences, such as entry into hospital care; the moment of hospitalization; and the perceptions, expectations, and projections regarding care after hospital discharge. These dimensions were fundamental to understanding the meanings attributed by participants to the experiences of care transition in

the context of the HCN, especially in its interface with PHC and specialized outpatient services.

The sampling was non-probabilistic, using a convenience sampling approach, including patients and/or caregivers/family members who met the eligibility criteria. Transition events were those that involved shifts in hospital care, based on the understanding that discharge is not an episodic and static event, but a process that begins with preparation of the individual immediately after admission and extends until reception at the next service[8]. Inclusion criteria were being ≥18 years old and exclusion criteria were having remained hospitalized for a period of less than 48 hours, so as to allow the experience of transition events, as well as presenting clinical conditions that prevented their participation in the interview, as assessed by the healthcare team, such as: drowsiness, delirium, mental confusion, tracheostomy or inability to communicate verbally adequately. For caregivers and/or family members, the inclusion criterion was having accompanied the patient during hospitalization or at the time of hospital discharge.

The data collection process was preceded by dialogue with the multidisciplinary teams of the hospital units, in which the objectives, justifications, and inclusion criteria of the research were presented, with the aim of obtaining institutional acceptance and ensuring that the interviews did not interfere with the care dynamics. Participants were approached in person during on-site visits by the researchers to the inpatient units.

Explanations regarding the study, the patients, or the caregivers/family members were provided individually, detailing the objectives, risks, benefits, and guarantees of confidentiality and voluntariness, as expressed in the Informed Consent Form (ICF). From the 30 patients invited, six refused to participate in the study. As for caregivers and/or family members, 10 individuals were invited, of whom three refused to participate.

Data collection took place between January and February 2024, conducted by two previously trained researchers. The interviews were carried out in person, preferably at the bedside, with an average duration of 15 minutes, and were based on the Critical Incident Technique (CIT). This technique, of a retrospective and phenomenological nature, aims to identify events experienced by participants in real situations, allowing the elucidation of behaviors, feelings, and judgments attributed to concrete experiences within the investigated context. The reported incidents are considered “critical” insofar as they reveal central and decisive aspects of the lived experience[17].

The semi-structured script included evocative questions, which encouraged participants to recall significant situations during their care trajectory, especially regarding

care transitions, as per the initial question: "*Think about your hospitalization process. What moments marked your experience*?" Based on this, other questions were formulated asked to the perceptions of those involved, the feelings evoked, the ways things were resolved (or not) the reported episodes, and suggestions for improvement.

The end of data collection was determined based on the criterion of theoretical saturation, reached when the reports began to present a pattern of repetition, with no emergence of new relevant data[18]. The interviews were audio-recorded and fully transcribed. Due to patient turnover in the units, no formal feedback of the transcripts was provided to participants.

The interviews were transcribed and organized into a single textual corpus, structured according to the recommendations of the IRaMuTeQ® software (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*). The corpus was prepared through text standardization, spelling review, and automatic segmentation into Elementary Context Units (ECU), and was subsequently submitted to the software, with 92.32% of the textual material being used[19].

Initially, Descending Hierarchical Classification (DHC) was performed, based on Reinert's method, which allows the grouping of text segments based on the occurrence and frequency of words. This processing generated thematic lexical classes, representative of core meanings, presented in the form of a dendrogram, allowing for a preliminary understanding of the empirical material. The generated classes were not used as final analytical categories, but as an exploratory and complementary resource to the subsequent interpretive process.

Next, thematic content analysis[20], was performed, conducted systematically by researchers with previous experience in qualitative analysis, involving three articulated analytical movements. The pre-analysis consisted of a floating reading, aimed at immersion in the corpus and the identification of initial meanings related to care transition experiences. In the material exploration phase, the registration units (textual fragments with meaning) were identified and thematically coded, with support from the exploratory results of the DHC. Finally, the treatment of results involved the organization of categories, the analysis of their internal relations and the consolidation of the thematic cores, ensuring internal coherence and interpretive consistency.

The interpretation of the findings was carried out in a subsequent analytical moment, through systematic articulation between the constructed categories and the theoretical framework of clinical management, which grounds the investigation, namely: orientation to health needs and comprehensiveness of care; pursuit of quality and safety of care; articulation

between different knowledge and practices, promoting interdisciplinary work; sharing of power and shared responsibility among managers, healthcare professionals and citizens, establishing participatory and collaborative decision-making processes in the HCN; education of people and organizations, conceived as a continuous and transformative process; orientation towards results that add value to health and life, which reinforces the commitment of clinical management to the production of positive outcomes and the efficient use of available resources; and, finally, transparency and accountability to collective interests, which support the democratic principle of public health management – used as interpretative axes to understand the meanings attributed by the participants to their care transition experiences[12,13].

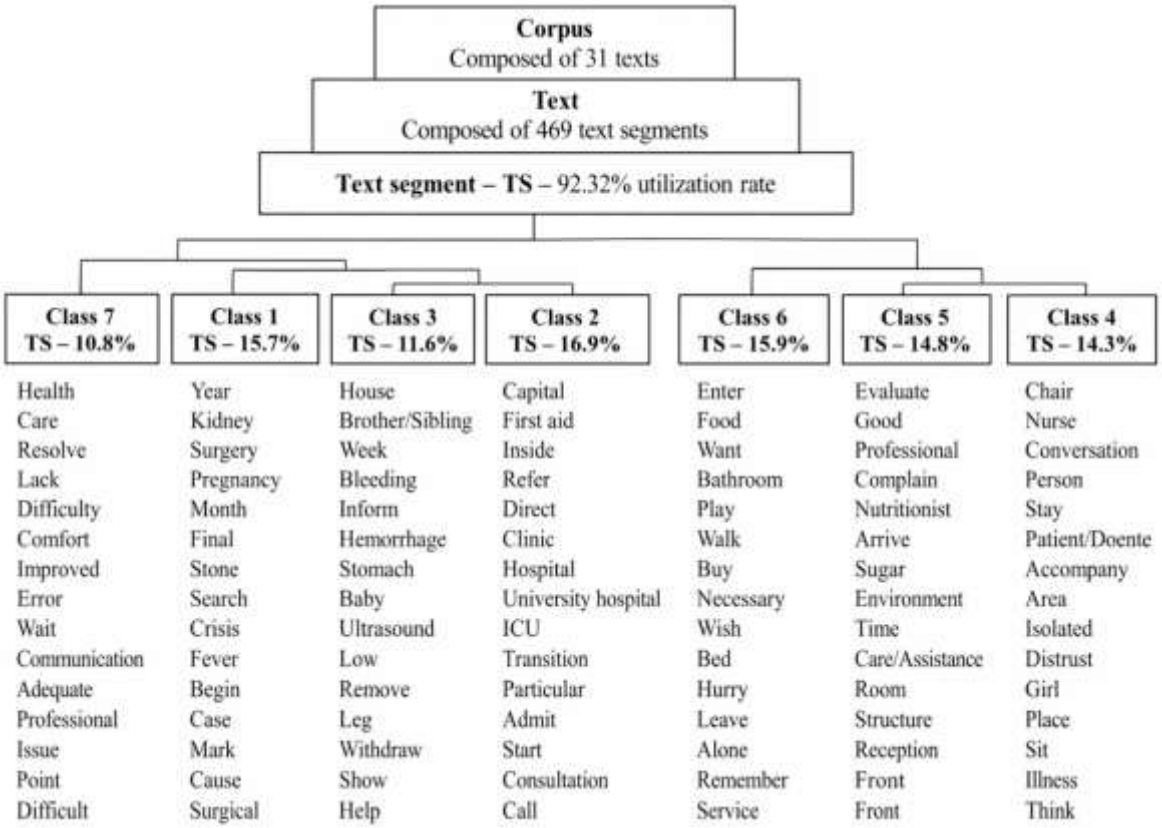
This study is part of the project entitled "Experimentations in design in the production of artifacts for clinical management in hospital care", reviewed by the local Research Ethics Committee (REC) under CAAE: 68867823.4.0000.5541, approved under opinion no. 6.080.123, in compliance with Resolution 466/2012 of the National Health Council. All participants were informed about the risks and benefits of their participation and assured of their right to withdraw at any time, without prejudice to their therapeutic care. Participation was voluntary and formalized by signing the ICF. To ensure anonymity, the participants' statements were coded (I – interviewee, followed by the interview number).

RESULTS

The sample of this study consisted of 31 participants, of whom 77.4% (n = 24) were hospitalized patients and 22.6% (n = 7) were caregivers/family members. Most participants identified as female (80.6%, n = 25), while 19.3% (n = 6) identified as male. Participants' ages ranged from 18 to 73 years, and length of hospital stay varied between 2 and 23 days, providing a diversity of experiences related to care transition in the hospital setting.

The textual corpus processed in the IRaMuTeQ® software resulted in the generation of a dendrogram with two major thematic subdivisions, which present hierarchical relationships with each other (Figure 1).

Figure 1 – Dendrogram of the textual corpus of the interviews. Cuiabá, Mato Grosso, 2024.



Source: Research data, 2024.

In the first subdivision, a predominance of Class 7 (ST = 10.8%) is observed, overlapping with Class 1 (ST = 15.7%). This, in turn, unfolds into Classes 3 (ST = 11.6%) and 2 (ST = 16.9%), establishing direct thematic connections between them. In the second subdivision, Class 6 (ST = 15.9%) appears as the category with the greatest hierarchical weight, branching into Classes 5 (ST = 14.8%) and 4 (ST = 14.3%), which are also interrelated.

The classes generated by IRaMuTeQ® were correlated with the subcategories of the thematic content analysis, resulting in the organization of the empirical findings into three central categories, formulated by the researchers based on the articulation between the emerging meaning units and the objectives of the investigation.

The first category, “Challenges in transition and in the logistics of care within the HCN,” encompasses the barriers identified in the regulation and access process to health services (Class 7), as well as logistical and bureaucratic obstacles that hinder care flow, care transition, and well-being during hospitalization (Class 2). The reports that compose this grouping highlight long waiting periods for obtaining specialized services, difficulties navigating care pathways, and the perception of inequalities in resource distribution and in the

organization of the HCN. In addition, bureaucracy and inter-hospital transfers are described as “very difficult” processes, something that “disappoints” and “greatly hinders.”

The second category, “Interpersonal relationships and clinical follow-up in care,” includes aspects related to the clarity and quality of clinical, diagnostic, and therapeutic information provided to patients (Class 1), as well as communication established with the healthcare team (Class 3). The testimonies emphasize the importance of early detection of severe conditions, qualified listening, and effective communication as essential elements for strengthening bonds and ensuring care safety.

Finally, the third category, “Perception of care and satisfaction in the recovery process,” highlights subjective elements of the care experience, such as the presence of a welcoming environment (Class 6), the humanized and proactive performance of the health teams (Class 4), and the perception of efficient and integrated coordination among the professionals of the multidisciplinary team (Class 5). These aspects were associated with the feeling of continuous and effective care and the appreciation of listening and technical support during the recovery process.

The structured synthesis of these findings is presented in Chart 1 below.

Chart 1 – Categories and subcategories – Cuiabá, Mato Grosso, 2024.

THEME: Patient experiences during care transition in hospital care			
CATEGORY	**SUBCATEGORY**	**ILLUSTRATIVE EXCERPTS**	**ARTICULATION WITH CLINICAL MANAGEMENT**
Challenges in transition and in the logistics of care within the Health Care Network (HCN)	Barriers in regulation and access to care (Class 7)	*She stayed in the UPA for days until she was referred to this hospital. This delay worsened her condition; she now has a corneal injury because she was not receiving medication. Given the urgency, the sequelae could have been severe*. (I5)	- Deficiencies in coordination between levels of care and network points; - Weaknesses in regulation processes and interinstitutional agreements; - Lack of shared accountability for timely access to care.
	Logistical and bureaucratic challenges in hospital care (Class 2)	*One experience that marked me was how very difficult the transfer to [hospital] was; there is a lot of bureaucracy, too much for someone who is unwell.* (I6) *Because of the bureaucracy, we had to leave the [municipal hospital], go to the UPA to arrange the transfer to the [study hospital]; the ambulance that brought us, we went to the UPA just because of the transfer. (I9)*	- Lack of clinical continuity and absence of a longitudinal care plan; - Inequality in resource distribution and institutional support; - Care and administrative processes disconnected from actual health needs.
Interpersonal relationships and clinical follow-up in care	Gaps in clinical, diagnostic, and treatment information (Class 1)	*Healthcare professionals say every day that discharge will be granted, but no one ever comes here. Since Wednesday, they have been saying we would be discharged, but he had to go to phototherapy. (I6)* *She [the nurse] said she could only give you a diagnosis when the tests are ready, in 10 days. The feeling I had at that moment was a loss of control; I was already anxious, and it got worse. All this delay in finding out why I had that symptom. (I20)*	- Inadequate clinical communication, compromising care safety; - Gaps in therapeutic continuity, revealing failures in integrated treatment management; - Lack of a clinical approach centered on the patient's chronic condition.
	Clarity in instructions received and in	*She requested an urgent ultrasound; I returned to the blood center to confirm the pregnancy, and they referred me to high-risk prenatal care.* (I24) *They performed the ultrasound, and the doctor said it was*	- Effective communication as a strategy for therapeutic adherence and care safety; - User participation as an active subject in care decisions;

	communication with the healthcare team (Class 3)	*necessary to remove the baby urgently, as it was in distress and could die.* (I12) *I was anemic, and they gave me medication for possible blood loss. They said I would receive a transfusion and explained each procedure.* (I23)	- Clear and timely information, strengthening the clinical bond and patient autonomy.
Perception of care and satisfaction in the recovery process	Welcoming environment and team readiness (Class 6)	*[...]it was very calm; everything was tidy and organized. They are very attentive.* (I13) *They treat us very well. Whenever we ask, they assist us; they are available at any time.* (I15) *The nurse comes and explains what she is doing all the time*. (I30)	- Welcoming environment and valuing well-being as a dimension of comprehensive care; - Promptness in service, reflecting commitment to the value of life; - Empathetic attitude and continuous communication, reinforcing recognition of the patient as the subject of care.
	Continuous attention, humanized care, and proactive team action (Class 4)	*Professionals are attentive to the patient's needs; in cases of pain, the doctor has already prescribed medication, so they no longer feel it. (I14)* *Professionals perform examinations, try to do [everything] correctly, and do not make a diagnosis without certainty. (I17)* *The [resident] helped me walk to undergo the exam, held my hand, it was very important to me, the affection and attention given. (I10)*	- Clinical action sensitive to the unique needs of patients; - Social recognition of the institution as a reflection of care quality; - Humanization as a practice integrating management, clinical practice, and relational ethics.
	Efficient coordination and integrated communication of the multidisciplinary team (Class 5)	*The nutritionist asked questions and explained how they would proceed. The team is good, with a doctor, psychologist, and nutritionist involved in the process*. (I8) *The service is excellent, from doctors and nurses to the cleaning staff. In the surgical center, everything was great*. (I17).	- Integration between professionals, promoting interdisciplinary and effective care; - Joint planning of actions, enhancing clinical effectiveness; - Valuing diverse knowledge and practices in the provision of comprehensive care.

Source: Research data, 2024.

DISCUSSION

The experience of hospitalized patients during care transitions revealed structural vulnerabilities that compromise the effectiveness of care. The findings of this study show that obstacles such as logistical difficulties, bureaucratic barriers, and fragmentation of care operate in an interconnected manner, affecting the subjective experiences of users of the Unified Health System (*Sistema Único de Saúde* - SUS) and imposing disproportionate burdens on more vulnerable groups.

The narratives highlight the lack of coordination between the different points of the HCN, reflected in the difficulty of accessing specialized services and the disarticulation between levels of care. However, it is worth noting that this reality is not limited to the Brazilian context. International studies indicate that fragmentation of care continues to be a significant barrier to the effectiveness of health care in high-income countries[21]. In Denmark[22], greater fragmentation of care was associated with higher rates of potentially inappropriate medication use and higher mortality, especially among patients with multimorbidity. Frequent transitions and lack of continuity with a reference healthcare professional were associated with worse outcomes.

These gaps indicate the lack of effective inter-institutional agreements and the low occurrence of shared accountability in the care process, forcing users themselves to mediate care flows, often without adequate support. These findings are consistent with studies that identify failures in regulatory and logistical processes as critical factors in care transition, contributing to delays, inconsistent information, and emotional burden for patients[5,10-11,23]. By transferring responsibility for care coordination to users, these failures reveal silent inequalities in healthcare and weaknesses in network governance.

The specialized literature has emphasized the need to strengthen integration mechanisms within the HCN, highlighting that the lack of coordination between services compromises both systemic efficiency and patient experience[2,10,24]. This scenario was confirmed in this study through reports marked by feelings of helplessness, insecurity, and confusion regarding the therapeutic plan. A Canadian study[25], conducted with patients with hip fractures, found that transitions often result in confusion, unmet needs, and low satisfaction, especially when care was not personalized or when caregivers were excluded from planning. Similarly, a recent Brazilian study on the patient journey during hospital discharge highlights the lack of qualified listening, communication failures, and difficulty accessing information as factors that hinder continuity of care[24].

From the perspective of clinical management, these results reveal more than mere operational failures, pointing to the fragmentation of shared management processes, the absence of longitudinal care plans, and weaknesses in collaborative practices. The clinical management model specifically proposes the integration of technical, institutional, and subjective rationalities, focusing on coordinated, responsive, and humanized care, especially at critical moments such as care transition[12]. However, the observed reality points to a distancing from this proposal, evidenced by regulatory delays, scarcity of resources and limited responsiveness of the system.

The fragmentation of services, by compromising therapeutic continuity, results not only in inefficient use of resources, but also in experiences of frustration and insecurity among patients[12]. Abrupt changes between institutions, without clear guidance or a follow-up plan, highlight the impact of disarticulation on the care experience, negatively influencing clinical outcomes. In this context, clinical management, by proposing shared accountability among points of care and the co-construction of care, emerges as a strategic alternative to address these challenges and advance toward comprehensiveness[2,12].

Another relevant aspect highlighted in the findings was territorial inequality. Patients from peripheral regions reported the need for long journeys to obtain care, revealing an unequal distribution of resources and institutional support. This dynamic aggravates the risks of therapeutic discontinuity, overburdens urban centers and contradicts the principles of equity and universality of the SUS[26]. Overcoming this situation requires not only expanding the supply of services but also strengthening clinical management strategies capable of promoting more responsive approaches to the singular needs of users.

Disorganization in interinstitutional communication was also recurrent in patients' statements. The precariousness of communication processes between services, associated with the absence of effective institutional communication channels, duplication of tests, avoidable readmissions, and delays in scheduling procedures, exposes a system in which the exchange of information between professionals is insufficient to guarantee success in care transition. The literature corroborates these findings, pointing out that failures in referral and counter-referral processes generate distrust among patients and hinder treatment adherence[27]. In contrast, clinical management proposes mechanisms to enhance interprofessional dialogue, strengthen shared responsibility, and promote more integrated practices that are sensitive to the needs of users[12].

Thus, the search for alternatives in the private sector, especially for carrying out urgent examinations and procedures, reflects the structural limitations of the HCN, notably the

delays in specialized consultations and the low problem-solving capacity of primary care services[27]. These elements highlight the need for management guided by values such as comprehensiveness, accountability, equity and user protagonism in the therapeutic process, foundational principles of clinical management.

The quality of communication with the healthcare team also emerged as a determining factor in patients' experience during care transitions. The lack of clear and understandable explanations about the clinical condition and therapeutic follow-up, especially regarding the provision of medications, generated feelings of insecurity, helplessness, and distrust in services, compromising both continuity of care and the therapeutic bond. These findings are consistent with the literature, which emphasizes clear, empathetic, and accessible communication as a key factor for patient engagement in the therapeutic process[24] and for building trust with healthcare professionals[2,21]. The absence of adequate information goes beyond technical limitations, revealing failures in coordination processes and distancing care from the principles of a person-centered model.

From the perspective of clinical management, communication deficits reflect the fragility of care co-management processes. The absence of qualified listening and information sharing prevents the patient from becoming an active subject in therapeutic decisions[12,13], which is even more critical in contexts of social and clinical vulnerability[28,29]. Nevertheless, some positive experiences have illustrated the transformative potential of effective communication. Cases in which patients received detailed guidance, such as in referrals to high-risk prenatal care or in explanations about procedures, such as transfusions, favored understanding of the treatment and provided greater emotional security. These experiences reinforce evidence that respectful and structured communication practices strengthen therapeutic adherence, improve clinical outcomes, and enhance the care experience[27,30].

The coexistence of these experiences reveals the oscillation between practices centered on listening and others marked by misinformation. Situations in which patients were unaware of information related to their diagnosis or did not know how to continue treatment after discharge illustrate critical gaps in the management of clinical information, with a direct impact on the safety and continuity of care. The absence of shared plans and structured care flows weakens therapeutic continuity, especially in patients with chronic conditions, whose care itineraries require longitudinal follow-up and coordination between different levels of care. The lack of supplies and discontinuity of medication reveal failures in coordination between points in the network and in the management of pharmacological care, forcing patients to seek palliative solutions, such as resorting to other units or resorting to legal action

to access services[27,30]. These mismatches intensify the suffering of users and overload the healthcare network.

In this context, clinical management proposes communication as a light and essential technology for comprehensive care. This implies ensuring the transmission of information, in a clear and appropriate way to the moment experienced by the patient, within an environment of welcoming and respect[12,13]. Effective communication therefore becomes a clinical co-management strategy, enhancing patient autonomy and promoting their ability to make informed decisions about their own health[8,30].

Thus, properly guiding patients, especially at the time of discharge, goes beyond the domain of technical information and enters the relational and ethical dimension of care, reaffirming the centrality of communication as a structuring element of a successful care transition. As suggested in the literature, clear and appropriate guidance reduces anxiety, promotes greater understanding of the clinical condition and favors a safer return to home or to the follow-up unit[27,30]. This is a process that requires sensitivity and shared responsibility, which are fundamental aspects for ensuring a safe transition centered on the real needs of patients.

By highlighting these dimensions, clinical management points out to ways to reconfigure institutional practices and strengthen listening, bonding and shared responsibility between professionals and patients[12,13]. In this sense, the clarity of clinical information and the quality of communicative interaction, in addition to enhancing the care experience, should be understood as structuring axes of a more responsive, coordinated HCN, committed to comprehensive care.

The experience of participants during hospitalization was associated with the quality of relationships established with the multidisciplinary team. Welcoming care, an organized physical environment, clear communication, and prompt responses to needs were highlighted as key factors for generating trust and a sense of security during the recovery process. These findings are consistent with the literature, which identifies a welcoming environment, proactive team performance[29] and effective communication[28] as determining factors for patient satisfaction and therapeutic success[30].

The construction of an environment that values patient well-being and active listening, in addition to strengthening trust in professionals, acts as a therapeutic device, promoting emotional comfort and contributing to treatment adherence[30]. From the perspective of clinical management, such aspects represent more than acts of kindness, as they express a relational ethic and the valuing of bonds as structuring components of comprehensive

care[12,13]. In this model, the patient is recognized as an active subject and co-author of the therapeutic plan, whose qualified participation enhances clinical effectiveness and the humanization of the hospital experience.

The constant presence of the team, associated with sensitivity to deal with the immediate demands of patients, was pointed out as a positive differential. Interactions with physicians, nurses, nutritionists and psychologists were described as moments that generate security and bonding, reinforcing findings from studies that associate the active involvement of the team with the perception of quality of care[10,30]. Furthermore, international studies reveal the importance of interdisciplinary practices and integrated communication among professionals, elements that broaden clinical response capacity and reduce care failures[3,4]. From the perspective of clinical management, this interdisciplinary articulation translates into an ethical and technical commitment to comprehensiveness, demonstrating that quality care depends on the collective capacity to plan and implement joint actions.

In this sense, the integration of different professional knowledge and the recognition of the patient's lived experience are central to responsive care. Clinical management proposes that qualified listening be integrated into action planning, promoting cooperation among team members and patient protagonism[12,13]. This perspective broadens the decision-making process, reinforces autonomy, and enhances the care experience, especially in contexts of greater vulnerability.

The reports also show that the perception of quality is not limited to technical competence but is deeply connected to how care is experienced. The sensitive approach of the team and the clarity of the guidelines were recognized as key elements for safety and trust in the services, in line with other studies that highlight health education and communication as pillars for patient engagement and continuity of care after discharge[4-6,9,30]. In this context, the organization of the hospital environment and the team's ability to provide understandable information become strategic in ensuring safer, patient-centered transitions. Clinical management, by valuing educational processes and qualified dialogue, offers tools for transitional care to go beyond technical efficiency and become an ethical, sensitive, and co-responsible process. Therefore, the coordinated performance of professionals, combined with effective communication, emerges as a structuring axis of care quality. This approach strengthens the therapeutic bond and contributes to the implementation of more resolutive and humanized care practices, aligned with the principles of comprehensiveness and equity.

However, this study has some limitations. The main limitation relates to the participants' reliance on memory, which may have generated recall biases. In addition, data

collection during hospitalization, a moment of emotional fragility, may have influenced the clarity and depth of the statements. However, qualified listening and respect for each interviewee's time helped to mitigate these effects. The heterogeneity of the sample, while enriching the findings, may have made it difficult to identify specific patterns. Still, this aspect reflects the complexity of the HCN and the diversity of care transition experiences within the SUS.

These limitations point to the need for further studies that follow the patient journey across different stages of care and incorporate the perspectives of professionals and managers, contributing to the improvement of clinical practice and the management of care networks.

The main contribution of this study lies in broadening the understanding of patients' experiences in this process, offering concrete support to improve clinical practice and care management. By highlighting gaps and potential in the transition between services, the study invites professionals, managers, and policymakers to rethink strategies that ensure comprehensive, equitable, and effective care, aligned with the real needs of the population using the SUS. It reaffirms, therefore, the importance of strengthening policies and practices guided by clinical management within the scope of the HCN, so that the transition of care ceases to be merely a physical displacement between services and becomes a potential strategy for the continuity of care, centered on comprehensiveness, bonding, autonomy, and shared responsibility of the actors involved in the care process.

CONCLUSION

The experience of patients during hospital care transitions was permeated by discontinuities in care, failures in the articulation between services, and logistical and communicational barriers, which compromise the continuity of care and negatively impact the users' experience. The statements evidenced not only difficulties in accessing care and in transfers between healthcare units, but also subjective dimensions, such as insecurity, distress, and feelings of abandonment, expressed in a system still marked by fragmented practices and limited responsiveness to the singularities of care.

On the other hand, the data also indicated that the quality of the transition is strongly associated with the presence of consistent therapeutic bonds, clear communication, a welcoming environment, and coordinated action by multidisciplinary teams. These elements reaffirm that care goes beyond the technical dimension, requiring qualified interpersonal relationships and the construction of spaces for listening, trust, and shared responsibility among professionals, patients, and families.

In this context, the incorporation of the principles postulated by clinical management appears promising for reconfiguring care practices. By promoting the integration of HCN, guiding care based on evidence and the real needs of users, and encouraging shared responsibility among the actors involved, this model fosters a safer, more continuous, and humanized transition. User-centered care and the pursuit of effective clinical outcomes thus become strategic pillars for improving the quality of healthcare.

REFERENCES

1. Acosta AM, Lima MADS, Pinto IC, Weber LAF. Transição do cuidado de pacientes com doenças crônicas na alta da emergência para o domicílio. Rev Gaúcha Enferm. 2020;41(esp):e20190155. https://doi.org/10.1590/1983-1447.2020.20190155

2. Sun M, Qian YM, Liu L, Wang JN, Zhuansun M, Xu TY, et al. Transition of care from hospital to home for older adults with chronic diseases: a qualitative study of the perspectives of elderly patients and healthcare professionals. Front Public Health. 2023;11. https://doi.org/10.3389/fpubh.2023.1128885

3. Hurducas F, Csesznek C, Moșoiu DV. The experience of transition from hospital to community care of patients with advanced cancer: a qualitative narrative review of patients', families' and healthcare professionals' perspectives. Soc Sci. 2025;14(5):287. https://doi.org/10.3390/socsci14050287

4. Mitchell S, Laurens V, Weigel G, Hirschman K, Scott AM, Nguyen HQ, et al. Care transitions from patient and caregiver perspectives. Ann Fam Med. 2018;16:225-31. https://doi.org/10.1370/afm.2222

5. Gheno J, Ulbrich AHDP dos S, Andreatta APF, Fish P, Petry RC, Nunes T da S, et al. Impact of transition of care on clinical outcomes: historical cohort. Texto Contexto Enferm. 2024;33:e20230231. https://doi.org/10.1590/1980-265X-TCE-2023-0231en

6. Bordin-Wosk T, Klubnick J, O'Toole J, Jenkins I, Donato J. Handoffs, care transitions, and readmissions. Med Clin North Am. 2025;109(5):1047-60. https://doi.org/10.1016/j.mcna.2025.02.016

7. Mendes VA, Costa MFBNA, Martins AFSA, Mocheuti KN, Ferreira GE, Ribeiro MRR. Continuity of care for patients recovering from Covid-19 under the angle of clinical management principles. Rev Esc Enferm USP. 2023;57:e202320123. https://doi.org/10.1590/1980-220X-REEUSP-2023-0123en

8. Tomazela M, Valente SH, Lima MADS, Bulgarelli AF, Fabriz LA, Zacharias FCM, Pinto IC. Care transition of older adults from hospital to home. Acta Paul Enferm 2023;36:eAPE00291. https://doi.org/10.37689/acta-ape/2023AO00291

9. Posadas-Collado GMJ, Membrive-Jiménez JL, Romero-Béjar J, Gómez-Urquiza LAG, Suleiman-Martos GA. Continuity of nursing care in patients with coronary artery disease:

a systematic review. Int J Environ Res Public Health 2022;19(5):3000. https://doi.org/10.3390/ijerph19053000

10. Lanzoni, GMM, Costa MFBNA, Peiter CC, Lima LMN, Bernardino E. Continuidade do cuidado na rede de atenção à saúde [Internet]. Ponta Grossa-PR: Editora Atena; 2023[cited 2025 Dec 1]. Available from: https://atenaeditora.com.br/catalogo/post/continuidade-do-cuidado-na-rede-de-atencao-a-saude

11. Uchimura LYT, Figueiró MF, Silva DB, Paiva LK, Chrispim PPM, Yonekura T. Evidências de efetividade dos cuidados de transição em idosos após internação hospitalar: uma revisão sistemática rápida. Rev Panam Salud Publica. 2023;47:e143. https://doi.org/10.26633/RPSP.2023.143

12. Mendes EV. Desafios do SUS [Internet]. Brasília: Conass; 2019[cited 2025 Dec 1]. p.869. Available from: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-1104190

13. Padilha RQ, Gomes R, Lima VV, Soeiro E, Oliveira JM, Schiesari LMC, et al. Princípios para a gestão da clínica: conectando gestão, atenção à saúde e educação na saúde. Ciênc Saúde Coletiva. 2018;23(12):4249–57. https://doi.org/10.1590/1413-812320182312.32262016

14. Kalbach J. Mapeamento de Experiências: um guia completo para alinhamento de clientes por meio de jornadas, blueprints e diagramas. Rio de Janeiro: Alta Books; 2022.

15. Souza VRDS, Marziale MHP, Silva GTR, Nascimento PL. Tradução e validação para a língua portuguesa e avaliação do guia COREQ. Acta Paul Enferm. 2021;34:eAPE02631. https://doi.org/10.37689/acta-ape/2021AO02631

16. Empresa Brasileira de Serviços Hospitalares (Ebserh). Hospital Universitário Júlio Müller: nossa história [Internet]. Cuiabá (MT): Ebserh; 2020[cited 2025 Dec 1]. Available from: https://www.gov.br/ebserh/pt-br/hospitais-universitarios/regiao-centro-oeste/hujm-ufmt/acesso-a-informacao/institucional/sobre

17. Flanagan JC, A técnica do incidente crítico. Arq Bras Psicol [Internet]. 1973[cited 2025 Dec 1];25(2):141-99. Available from: https://periodicos.fgv.br/abpa/article/view/16975/15786

18. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, Burroughs H, Jinks C. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018;52(4):1893-1907. https://doi.org/10.1007/s11135-017-0574-8

19. Souza MAR, Wall ML, Thuler ACMC, Lowen IMV, Peres AM. The use of IRAMUTEQ software for data analysis in qualitative research. Rev Esc Enferm USP. 2018;52:e03353. https://doi.org/10.1590/S1980-220X2017015003353

20. Bardin L. Análise de Conteúdo. São Paulo: Edições 70; 2016.

21. Geese F, Schmitt KU. Interprofessional collaboration in complex patient care transition: a qualitative multi-perspective analysis. Healthcare. 2023;11. https://doi.org/10.3390/healthcare11030359

22. Prior A, Vestergaard C, Vedsted P, Smith SM, Virgilsen LF, Rasmussen L, et al. Healthcare fragmentation, multimorbidity, potentially inappropriate medication, and mortality: a Danish nationwide cohort study. BMC Med. 2023;21. https://doi.org/10.1186/s12916-023-03021-3

23. Powell C, Ismail H, Davis M, Taylor A, Breen L, Fylan B, et al. Experiências de pacientes com insuficiência cardíaca com medicamentos na intervenção de transição: Resultados da avaliação do processo do programa Melhorando a Segurança e a Continuidade da Gestão de Medicamentos em Transições de Cuidados (ISCOMAT). Health Expect. 2022;25:2503-2514. https://doi.org/10.1111/hex.13570

24. Saragosa M, Nizzer S, McKay S, Kuluski K. The hospital-to-home care transition experience of home care clients: an exploratory study using patient journey mapping. BMC Health Serv Res. 2023;23:934. https://doi.org/10.1186/s12913-023-09899-2

25. Brooks L, Stolee P, Elliott J, Heckman G. Transitional care experiences of patients with hip fracture across different health care settings. Int J Integr Care. 2021;21. https://doi.org/10.5334/ijic.4720

26. Medeiros TM, Valerio FR, Silva MFB, Santos PL, Tenório BA, Branco SMC, et al. Desafios da universalidade no SUS: avaliação do acesso e qualidade dos serviços de saúde no Brasil. Cad Ped. 2024;21(6):e5102. https://doi.org/10.54033/cadpedv21n6-212

27. Maciel AMM, Lettiere-Viana A, Mishima SM, Fermino TZ, Matumoto S. The longitudinality of care from the perspective of Family Health users. Rev Esc Enferm USP. 2024;58:e20240051. https://doi.org/10.1590/1980-220X-REEUSP-2024-0051en

28. Defante MLR, Monteiro SON, Silva CDOD, Santos LRD, Leonardo RS. Os impactos da comunicação inadequada na relação médico-paciente. Rev Bras Educ Med. 2024; 48(1). https://doi.org/10.1590/1981-5271v48.1-2023-0146

29. Almeida HOC, Góis RMO. Avaliação da satisfação do paciente: indicadores assistenciais de qualidade. Rev Adm Saúde. 2020;20(81). https://doi.org/10.23973/ras.81

30. Costa DGD, Moura GMSSD, Moraes MG, Santos JLGD, Magalhães AMMD. Satisfaction attributes related to safety and quality perceived in the experience of hospitalized patients. Rev Gaúcha Enferm. 2019;41(spe): e20190152. https://doi.org/10.1590/1983-1447.2020.20190152

Data and material availability

Access to the dataset is available upon request from the corresponding author.

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