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Continuity of care for surgical patients and the hospital-to-home transition as a safety strategy in the postoperative period.

Continuity of care in surgical patients and the hospital-to-home transition as a safety strategy in the postoperative period

Continuity of care for the surgical patient and the hospital-home transition as a safety strategy in the post-operative period

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SUMMARY

Surgical patient safety does not end with the completion of the surgical procedure or hospital discharge. The transfer of care from the hospital environment to the home constitutes a particularly vulnerable clinical stage, characterized by reduced continuous professional supervision, transfer of responsibilities to patients and caregivers, and the need for integration between different levels and care teams. This article critically analyzes the continuity of care in the postoperative period, with emphasis on the hospital-home transition, discharge planning, clinical communication, medication reconciliation, patient education, early identification of complications, and governance of care processes. This is a narrative review based on indexed scientific literature and institutional reference documents. Evidence demonstrates that structured transition interventions can reduce readmissions and unplanned use of health services, although the magnitude of the effects varies according to population, clinical complexity, and components employed. In surgical populations, discharge planning, individualized education, follow-up after higher-risk procedures, and certain modalities of home visits show favorable results, but methodological heterogeneity prevents the adoption of a universal model. It is argued that postoperative safety should be understood as a longitudinal property of the care system and not exclusively as a technical outcome of the surgical act. The integration between clinical practice, protocols, communication, risk management, and active patient participation therefore emerges as a central element for safe and continuity-oriented surgical care.

Keywords: Patient Safety. Continuity of Care. Postoperative Care. Hospital Discharge. Home Care. Healthcare Management.

ABSTRACT

Surgical patient safety does not end with the completion of the operative procedure or hospital discharge. The transfer of care from the hospital to the home constitutes a particularly vulnerable clinical stage, characterized by reduced continuous professional supervision, transfer of responsibilities to patients and caregivers, and the need for integration among different levels and teams of care. This article critically analyzes continuity of care during the postoperative period, with emphasis on hospital-to-home transition, discharge planning, clinical communication, medication reconciliation, patient education, early identification of complications, and governance of care processes. This is a narrative review based on indexed scientific literature and institutional reference documents. Evidence indicates that structured transitional care interventions may reduce readmissions and unplanned health service utilization, although effect magnitude varies according to population, clinical complexity, and intervention components. In surgical populations, discharge planning, individualized education, follow-up after higher-risk procedures, and selected home-visit strategies have demonstrated favorable outcomes, although methodological heterogeneity prevents adoption of a universal model. Postoperative safety should therefore be understood as a longitudinal

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property of the care system rather than exclusively as a technical result of the surgical act. Integration among clinical practice, protocols, communication, risk management, and active patient participation emerges as a central element of safe surgical care oriented toward continuity.
Keywords: Patient Safety. Continuity of Patient Care. Postoperative Care. Patient Discharge. Home Care Services. Health Management.

1 INTRODUCTION

The evolution of modern surgery has profoundly changed the capacity of healthcare systems to...
To treat acute and chronic diseases, trauma, neoplasms, and potentially disabling conditions.
development of less invasive techniques, safer anesthesia, perioperative protocols and
Infection control mechanisms have allowed for increased access and reduced associated risks.
numerous procedures. However, the expansion of technical capacity has not eliminated the
Inherent vulnerability in surgical care. The World Health Organization (WHO, 2023)
It reports that more than 300 million surgical procedures are performed annually worldwide.
and that approximately 10% of preventable harm related to care is observed in contexts
surgical events, with a significant portion of the events occurring before or after the operation.
The contemporary understanding of surgical safety must, for this reason, go beyond the limits.
The technical success of an operation represents only one step in the process.
Therapeutic course. After the procedure, risks related to infection remain.
bleeding, thromboembolic events, surgical wound changes, inappropriate pain
controlled, drug interactions, decompensation of pre-existing diseases and failures in
Interpretation of clinical signs. The World Health Organization's Global Patient Safety Report 2024.
Health officials reinforce this perspective by estimating that complications can affect up to 25% of patients.
patients undergoing surgery during hospitalization, and a significant portion of surgical damage is potentially
avoidable (WHO, 2024).
This transfer of responsibility makes the hospital-to-home transition a phenomenon.
simultaneously clinical and organizational. Dusek et al. (2015), when reviewing transition practices from
Carefully, they describe this period as a change that requires coordination and continuity between
Clinical conditions, care needs, professionals, and care locations. The definition is...
especially relevant to surgery, in which anesthesiologists, surgeons, nursing staff, primary care,
Home care services and caregivers can participate in the same therapeutic episode.
The fragmentation of this process creates opportunities for information loss and discontinuity.
Prescriptions can be misinterpreted, medication changes can be made during the course of treatment.
Hospitalization may not be adequately understood, and potentially relevant symptoms may be identified.

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These may be underestimated by the patient. Rennke et al. (2013), in a systematic review on Transition interventions initiated in the hospital have demonstrated that the post-discharge period should be analyzed as a matter of patient safety and not merely as an administrative or other problem. bed utilization.

The importance of this discussion also stems from the change in the profile of patients undergoing... procedures. Population aging, multimorbidity, polypharmacy and greater capacity for Interventions in people with complex diseases increase the need for post-operative plans. Individualized. The same surgery can produce very different care needs depending on... functional reserve, family support, cognitive ability, socioeconomic conditions, and presence of comorbidities.

Given this scenario, this article aims to analyze the continuity of patient care. surgical care during the transition between hospital and home, discussing the fundamentals of post-operative safety. operative care, discharge planning, clinical communication, patient education, management medication, home care, clinical governance, and the role of indicators in evaluation. of the results. The proposal is not to establish a universal protocol, but to critically examine the components capable of making this passage safer and more consistent with the needs Individuals.

2 METHODOLOGY

The study was developed as a critical-analytical narrative literature review, an appropriate approach. to the integration of evidence from different research designs and technical documents- institutional studies were prioritized. Studies indexed in PubMed/MEDLINE, systematic reviews, meta-analyses, clinical trials and documents produced by the World Health Organization, Ministry of Health and National Health Surveillance Agency related to patient safety, Safe surgery, continuity of care, discharge planning, and home care.

The conceptual search strategy considered combinations of the terms patient safety, surgical patients, continuity of care, transitional care, hospital discharge, postoperative care, hospital readmission, Home care and corresponding expressions in Portuguese. Classic works have been incorporated. when necessary for understanding the evolution of transition models, while publications Recent findings were prioritized in the analysis of contemporary evidence.

The synthesis was organized into thematic areas, avoiding the isolated interpretation of hospital readmission. as the sole indicator of quality. Results related to the use of services, adverse events, communication, patient experience, continuity and implementation of

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care processes.

To preserve interpretative rigor, results from systematic reviews were described according to the populations and interventions actually studied. Thus, evidence produced in populations General clinical practices were used to discuss transition mechanisms, while inferences Specifically surgical studies were primarily based on studies of patients undergoing procedures.

The analysis also incorporated Brazilian normative documents due to their relevance to the context. National healthcare system. The Protocol for Safe Surgery, developed by the Ministry of Health and Anvisa. Fiocruz, and the materials from the Better at Home Program were used as references. Institutional guidelines for surgical safety and home care.

Since this is a narrative review based exclusively on literature and public documents, it does not There was intervention on participants, use of medical records, or collection of information. identifiable. Consequently, the work does not constitute an original clinical study nor does it intend to. to establish causal relationships beyond those supported by the studies analyzed.

3. Surgical Safety as a Longitudinal Process

The traditional conception of surgical safety has focused much of its attention on risks. directly related to the procedure, such as incorrect patient identification, site error surgical, anesthetic failures, hemorrhage, infection, and communication problems within the team. operative. These risks remain fundamental. In Brazil, the Ministry of Health, Anvisa and the Fiocruz (2013) established the Protocol for Safe Surgery with the explicit purpose of reducing Incidents, adverse events, and surgical mortality can be mitigated through structured safety measures. However, the temporal distribution of the damages themselves demonstrates that safety cannot be... confined to the operating room. The WHO (2023) reports that more than 300 million surgeries are performed annually, and most adverse events associated with surgical harm are preventable. It occurs in the pre- and post-operative periods. In the 2024 global report, the organization also highlights Complications in hospitalized patients during surgery can occur in up to 25% of cases.

This perspective leads to the concept of longitudinal safety. The surgical outcome depends on a chain of decisions initiated before the procedure and continued throughout recovery. Preoperative assessment, therapeutic decision, technical execution, anesthesia, immediate recovery, discharge. Adherence to guidelines, monitoring, and recognition of complications all belong to the same process. continuum, even though they occur in different locations.

Organizational fragmentation can disrupt this continuum. When the professional who receives the

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The patient does not have the necessary information, or when the patient himself does not understand the
This occurs during hospitalization, creating a gap between the clinical decision and its subsequent implementation.
The literature on perioperative handoffs describes these passages as vulnerable points because
The information must remain accurate despite changes in team, environment, and responsibility.
Standardization, in this context, functions as a mechanism for reducing unwanted variability.
Checklists, structured summaries, discharge criteria, and formal transfer mechanisms can...
to prevent critical information from depending solely on individual memory. The Ministry of
Health (2026) characterizes basic safety protocols as systemic instruments and
Management practices that promote communication, teamwork, and risk management.
Standardization, however, should not be confused with clinical uniformity. Protocols define
Minimum requirements and control points exist, but patients present different risks and capabilities.
self-care. Security emerges precisely from the combination of a reliable structure and the
professional ability to individualize decisions within it.

4. Hospital Discharge as a Clinical and Organizational Intervention

Discharge is often treated as an administrative event determined by clinical stability.
and due to the absence of an immediate need for hospitalization. This interpretation is insufficient. Discharge
It modifies the environment in which the treatment will be performed and redistributes responsibilities among...
hospital, external professionals, patient and family. It should therefore be understood as a
planned clinical intervention.
The randomized trial conducted by Jack et al. (2009), which evaluated a redesigned program of
Hospital discharge, it became a reference in this field. The intervention brought together the organization of the follow-up,
medication reconciliation, individualized education, and post-discharge pharmacist contact
hospital. Among 749 hospitalized adults, the authors observed lower hospital utilization in the 30
subsequent days in the group undergoing the program compared to usual care.
Although Jack et al. (2009) did not exclusively study surgical patients, their principles
These principles are applicable to the discussion about transition. A safe discharge requires that the treatment plan be...
translated into actionable steps. This includes understanding which medications will be used, which
were suspended, how to care for the wound, what restrictions should be observed, when to return and
Given which symptoms should a patient seek medical attention before their scheduled appointment?
The specific literature on surgery reinforces this need. Jones et al. (2016), in a systematic review
which identified three randomized trials and seven observational studies in surgical populations,
They found that readmission reductions were associated with discharge planning programs and education of

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patient, follow-up in primary care after higher-risk surgeries and certain
Home visit strategies. The authors themselves highlighted, however, the limited quantity and the
heterogeneity of the studies.

Another key aspect is advance preparation. Plan for discharge only when the decision to...
Releasing the patient has already been done, reducing the time available to identify barriers. Need for
Caregiver, mobility difficulties, access to medication, ability to return to work,
Understanding the guidelines and availability of professional assistance can be predicted beforehand.
from the moment of departure.

Thus, physiological criteria for stability must coexist with functional and care-related criteria.
The question is no longer just whether the patient can leave the hospital, but begins to include under what conditions.
Treatment can continue safely outside of it. This seemingly semantic change
This translates to an important transformation in senior governance.

5. Clinical Communication and Transfer of Responsibility

Communication is a clinical component of safety. Incomplete, contradictory, or...
Transmissions made without a clear definition of responsibility can produce such significant consequences.
as well as technical failures. The post-operative transition increases this risk because it involves different
distinct teams and, often, institutions.

Dusek et al. (2015), in systematizing transition practices, highlighted the coordination between
environments and professionals as a central element of continuity. This logic is particularly
Relevant in the postoperative period, when data about the procedure, complications, devices, wound,
Medications and follow-up care need to remain accessible to those who assume responsibility for care.

Discharge notifications have at least three different recipients. The first is the patient, who
one needs to understand their own therapeutic plan. The second is the family member or caregiver, when
The third party is the professional or service that will provide continuity.
to follow-up. The same information may need to be presented in different ways.
each of them.

It is also necessary to distinguish between the transfer of information and the transfer of responsibility.
Sending a summary does not guarantee that there is a professional actually responsible for it.
Follow-up. Fragmented systems can produce situations in which different teams assume...
which other entity will assume surveillance, creating zones of uncertainty precisely during the period in which
Complications may begin to arise.

Rennke et al. (2013) observed that transition interventions initiated in the hospital are complex and

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often composed of multiple elements. This characteristic helps explain why a
A single communication solution is rarely sufficient: documentation, access, follow-up, education
Accountability and management need to work in a coordinated manner.
In this sense, quality communication must respond not only to what happened, but to...
What will happen? Diagnosis, procedure performed, and evolution are fundamental, but they must be...
accompanied by a plan, risks, pending issues, planned follow-up, and escalation criteria.
Retrospective communication without forward-looking guidance is insufficient to ensure continuity.

6. Medication Reconciliation and Prevention of Adverse Events

The transition from hospital to home often alters the medication regimen. Medications
Medications used before hospitalization may be discontinued, doses modified, and new drugs may be introduced.
Introduced. Analgesics, anticoagulants, antibiotics, and medications related to conditions.
Chronic conditions can coexist post-operatively, increasing the complexity of treatment.
The WHO (2023) estimates that half of preventable harm related to healthcare is associated with
medications and reports that drug-related harm affects approximately one in 30 patients.
in healthcare. Medication reconciliation, therefore, should not be considered an activity
bureaucratic, but a process of systematic comparison between the schemes used before, during and
after hospitalization.
Jack et al. (2009) incorporated reconciliation and pharmacological review among the components of their
High-level intervention. The overall favorable outcome of the program does not allow us to attribute the effect.
This does not relate to reconciliation in isolation, but it demonstrates that medication management integrates models of
transitions capable of reducing subsequent hospital use.
In surgical patients, the risk may be increased by the coexistence of temporary prescriptions.
with chronic treatments. Guidance that simply states to maintain usual medications, for
For example, it may be inadequate when there have been changes during hospitalization. The discharge list should
to represent the regimen actually intended for that clinical moment.
Communication also needs to consider health literacy. Technically correct terms are not...
They guarantee understanding. Schedules, duration, instructions, main precautions and differences in relation to
The information regarding previous treatment needs to be presented in an intelligible way, without loss of clinical precision.
Reconciliation thus becomes a clear example of the interaction between medical decision-making and the organization.
care. The correct medication may have been prescribed and harm may still occur if the
The transition does not ensure that the patient understands which regimen to follow.

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7. Patient Education and Early Recognition of Complications

Patient education is not an optional addition to discharge. Upon leaving the hospital, the patient undergoes...
to be one of the main observers of its evolution. Its ability to recognize changes and
Communicating symptoms can determine how quickly a complication is evaluated.
Jones et al. (2016) found reductions in readmission rates among studies of surgical populations.
associated with specific educational interventions, although not all results have
achieved statistical significance. This heterogeneity suggests that education should not be treated
as a homogeneous intervention: content, timing, communication method, reinforcement, and profile of
Patients modify their effectiveness.
The guidance needs to distinguish between expected symptoms and signs that warrant evaluation. Pain, edema,
Changes in bowel movements, functional limitations, and wound characteristics vary according to
The procedure and recovery period. Overly broad, generic lists can lead to...
Anxiety; vague guidance, on the other hand, can delay people from seeking assistance.
Furthermore, receiving information is not the same as understanding it. Pain, residual effect of anesthetics,
Anxiety and the volume of information received at the time of discharge can compromise retention.
The caregiver's involvement and the use of written or digital materials can serve as...
Mechanisms of informational redundancy.
Jack et al. (2009) incorporated individualized education into the design of their intervention, while
Jones et al. (2016) identified patient education among the components evaluated.
specifically in surgical populations. The convergence between these studies supports the importance
to transform information into practical self-care skills, without exceeding the limits of
available evidence.
These results demonstrate that active participation does not mean undue transfer of
Responsibility. The patient needs to receive the tools to participate in their own safety, but
The system remains responsible for providing appropriate channels for communication, tracking, and access.
when unforeseen events occur.

8. Home Care and Post-Operative Continuity

Home care occupies a particular position in the post-hospital continuum. For certain
For patients, home care can allow for continuity of care with less exposure to the environment.
hospitalization and greater proximity to family routine. For others, the clinical complexity may require
Institutional placement or other form of care. The decision should be based on criteria.

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clinical and support capacity.

In Brazil, the Ministry of Health differentiates home care modalities according to stability.
Clinical aspects, difficulty in mobility, frequency of care, and need for resources. The modality
AD1 covers situations requiring less intensive care, while AD2 and AD3 are intended for...
users who require more frequent care, resources, and ongoing monitoring.
(BRAZIL, 2024).

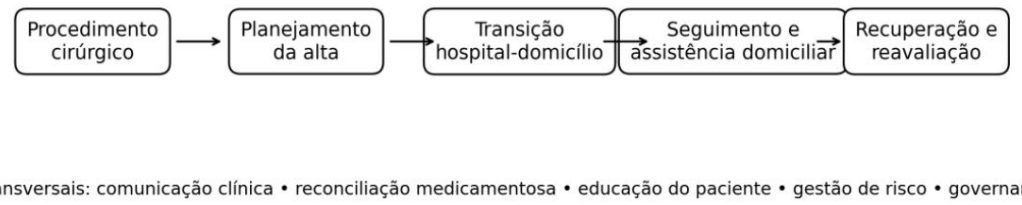
This stratification is important because home care does not represent a single intervention. It can
to mean periodic follow-up, wound care, rehabilitation, device management, administration
of therapies or more intensive multidisciplinary assistance. The indication must relate
Clinical need and operational capacity.

The Better at Home Program materials include eligibility assessment tools and
The complexity of home care requires specific criteria, reinforcing the need for transfer to the home.
and planning. This institutional structure aligns with the transition literature by recognizing that
Continuity depends on the adequacy between the patient's needs and the capacity of the environment.
assistance.

In surgical patients, home care should remain linked to the possibility of...
Gradual adjustments. Certain changes can be managed at home; others require evaluation.
In-person appointments, exams, or hospital visits. A safe model needs to establish the requirements beforehand.
operational limits and workflows for situations that exceed the capacity of that environment.

Therefore, home and hospital care should not be understood as structures
competitors, but as different points in a network. The quality of the transition depends on
The ability to preserve information, accountability, and access throughout this change.

Figure 1 – Continuity of care in the surgical pathway and transversal safety axes.



Source: own elaboration, based on WHO (2023; 2024), Jack et al. (2009), Dusek et al.

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(2015) and Jones et al. (2016).

9. Clinical Governance, Protocols, and Risk Management

Postoperative safety depends on individual clinical decisions, but also on the quality of the...
The system in which these decisions are implemented. Clinical governance can be understood, in this context, as...
context, such as the creation of structures capable of supporting accountability, evaluation of results,
Standardization of critical processes and continuous improvement.
Protocols constitute one of these structures. The Ministry of Health (2026) characterizes its
Basic security protocols as systemic and managed instruments, associated with improvement.
From communication to teamwork and risk management. The value of a protocol,
However, it is not only in its documentary existence, but in its adherence and capacity to produce.
consistent caregiving behavior.
International experience with the Surgical Safety Checklist illustrates this logic.
The Brazilian protocol for safe surgery, based on the WHO initiative, uses checks.
structured to reduce incidents and mortality. The relevance of this model lies in transforming
actions recognized as important in deliberate and reproducible steps (BRAZIL; ANVISA;
FIOCRUZ, 2013).
The same principle can be applied to high prices. Structured criteria can include stability,
medication review, understanding instructions, scheduling follow-up appointments, needs
of wound care, devices, mobility, home support, and identifying warning signs. The list does not
It replaces medical judgment, but reduces the likelihood of predictable omissions.
Governance also implies examining failures without restricting the analysis to the individual. A readmission
Potentially avoidable losses can result from insufficient guidance, difficulty of access, or delays in...
monitoring, medication problems, or inevitable progression of the disease itself. A
The investigation should seek to distinguish these mechanisms.
This approach allows for replacing a purely reactive culture with proactive management.
risks. The more predictable the points of vulnerability, the greater the possibility of building
Barriers can be put in place before an adverse event occurs.

10 Indicators, Readmission and Quality Assessment

Hospital readmission has become one of the most widely used outcomes for evaluating transitions.
The relevance is evident: an unplanned return may indicate a complication, a failure to continue, or...

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unresolved care need. However, using "readmission" in isolation as a synonym
Poor quality leads to inadequate interpretations.

Jones et al. (2016) found reductions in readmissions associated with different strategies in
Surgical populations. Discharge planning programs showed reductions of 11.5%, 12.5% and
23% in the included studies; educational interventions showed reductions of 14% and 23.5%;
Follow-up in primary care after high-risk surgeries reduced readmissions by 8.3%; and
Home visits showed reductions of 7.69% and 4%. Not all results were
statistically significant, which reinforces the need to interpret magnitude and context.
together.

Rennke et al. (2013), when analyzing hospital transition interventions as a safety strategy,
They observed variable evidence across models and components. The conclusion is methodologically
Important: the existence of benefits in certain programs does not authorize the assumption that any
A transitional intervention will produce the same result.

The essay by Jack et al. (2009) adds another relevant point. By combining multiple components,
The study demonstrated a reduction in hospital use after discharge, but it does not allow for the identification of a...
The single element responsible for the effect. In complex systems, results often follow
from the interaction between various security barriers.

Quality assessment should therefore combine indicators. Readmission, emergency room visit,
complications, drug events, infection, adherence to follow-up, unplanned contact,
Patient experience and mortality can provide complementary dimensions. Indicators of
process — such as the proportion of patients with medication reconciliation or follow-up.
programmed — they also help identify where the chain is failing.

The goal should not be to eliminate all readmissions. Some returns are clinically necessary and
They represent an appropriate response to a complication. The goal is to reduce preventable events and ensure
so that, when deterioration occurs, it is recognized and treated at the appropriate time.

11 INTEGRATION BETWEEN SURGICAL PRACTICE, MANAGEMENT AND MEDICAL TRAINING

The complexity of the transitions highlights that individual technical excellence, while indispensable,
This is not enough to produce safe systems. The contemporary physician operates within networks.
comprised of processes, teams, technologies, and different levels of assistance. Understanding this
Structure has become a relevant part of clinical practice.

In surgery, this integration is particularly evident. The surgeon makes decisions that will have
consequences after the patient leaves the surgical center and, subsequently, the hospital.

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quality of the prescription, record keeping, guidance, and communication with those who will continue the treatment.
Care influences the system's ability to properly execute these decisions.
Clinical management adds tools to transform medical knowledge into processes.
Reproducible. Auditing, event analysis, protocol development, indicators, and review of
Flowcharts allow us to identify differences between planned care and the care that is actually delivered.
Ministry of Health protocols (2026) make this relationship explicit by linking safety to
Communication, teamwork, and risk management.
Medical training also plays a crucial role. Teaching patient safety only as a tool is not enough.
Preventing technical errors is insufficient. Future doctors need to understand communication.
Continuity, transition, multi-professional work, and organizational factors as elements.
directly related to clinical outcomes.

The WHO's Global Patient Safety Report 2024 reinforces the systemic dimension of the problem by showing
that the harm related to assistance remains relevant internationally and that portion
substantial damage is potentially avoidable. In the surgical field, the report relates the magnitude of...
complications arising from the need for safety interventions at different stages of the route
healthcare (WHO, 2024).
The training of professionals capable of navigating between clinical reasoning and systemic understanding.
It therefore constitutes a security strategy. It is not about turning doctors into
administrators, but to recognize that clinical decisions are implemented by organizations and that
The quality of these organizations affects the therapeutic outcome.

FINAL CONSIDERATIONS

Analysis of the literature leads to the conclusion that the safety of the surgical patient must be understood.
as a longitudinal process. The procedure constitutes a central moment, but not
self-sufficient, with a trajectory that begins before the operation and continues during recovery, high
and follow-up. The technical quality of the surgery and the quality of the care transition belong to,
therefore, to the same security system.
The transition from hospital to home represents one of the most sensitive stages of this journey.
The patient leaves an environment characterized by continuous professional supervision and begins to perform part
The importance of treatment in a context where the recognition of changes depends, to a greater extent...
This change requires a degree of self-understanding and the involvement of family members or caregivers.
to be planned as a clinical intervention.
Available evidence suggests that structured transition strategies can reduce

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Readmissions and unscheduled use of services do not support the idea of an intervention.
isolated or universally effective. Jones et al. (2016) demonstrated benefits of different
components in surgical populations, while Rennke et al. (2013) emphasized heterogeneity
of the interventions and the need for caution in defining universal models.
This finding has significant practical implications. The pursuit of security should not be guided by...
not through the indiscriminate multiplication of protocols, but through the identification of the predominant risks in each case.
population and by building barriers proportionate to those risks. Protocols are more useful
when they define minimum safety standards and allow for clinical individualization.
Communication occupies a cross-cutting position in all these strategies. Dusek et al. (2015) demonstrate
that continuity depends on coordination between environments and professionals, while Jack et al. (2009)
They show that structured programs can integrate education, medication, and follow-up. One
A technically correct treatment plan loses effectiveness when it does not follow the patient's progress between [various stages].
different environments.

Home care, in turn, should be understood as part of a network and not as a separate service.
Automatic replacement of hospital infrastructure. Its indication depends on eligibility.
complexity, operational capacity, and the existence of escalation flows when the framework
exceeding what can be safely performed at home. The Brazilian modalities AD1,
AD2 and AD3 embody this need for stratification.
It is also necessary to qualify the use of indicators. Readmissions are relevant, but not
They represent failure or success in isolation. Proper evaluation should incorporate clinical outcomes.
emergency use, adverse events, patient experience, and own indicators.
Transition processes. Safe care is not one in which no one returns to the hospital, but
that which is capable of avoiding preventable returns and quickly recognizing when a return is necessary.
From a clinical governance perspective, the hospital-to-home transition demonstrates how care...
and management become inseparable. Individual decisions require systems that ensure
Continuity, communication, documentation, accountability, and evaluation. Security emerges from...
Interaction between professional competence and organizational reliability.
Finally, recognizing discharge as part of treatment modifies the very definition of outcome.
surgical. Success cannot be measured solely by immediate technical execution, but by the ability
to guide the patient safely throughout the recovery period. The surgery ends in
at a given moment; the responsibility for the continuity of care needs to remain.
organized until the patient reaches a condition compatible with autonomy and clinical stability.

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