

Active Life: a project for a safe transition hospital-community after arthroplasty

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The elderly person undergoing arthroplasty acquires a mobility limitation that will, temporarily or permanently, condition their self-care. At the time of discharge, the person may be in worse functional condition than at the time of admission to the service, which will interfere with the evolution of their functional capacity when they're back home, conditioning independence, autonomy and quality of life, promoting physical and psychological deterioration and social isolation. Discharge from the hospital is a time of change in the daily lives of patients, because it is usually accompanied by an increase in home care and therapeutics (Meyers et al., 2014). It is conceded that nurses have a fundamental role in choosing appropriate interventions that ensure continuity of care between the hospital and the community (Mendes et al., 2017). Nurses have the responsibility to ensure that clients and their families leave the hospital sufficiently prepared and supported, which is achieved through better articulation and communication among professionals, clients, caregivers and health services (Weber et al., 2017).

The aim of this investigation is to define the criteria for the continuity of care to the elderly subjected to arthroplasty, to ensure the safe transition from the hospital to the community.

The methodological option fell on reserach-action, because of the flexibility of this method, with the involvement of different praxis professionals, with the researchers. The interaction between the different actors of different organizations (academy, hospital and primary health care) allowed promoting the sharing between formal and informal knowledge, between theory and practice (Silva, Morais, Figueiredo, & Tyrrell, 2011) empowering the individual qualities and capacities of the participants. The participants were the health professionals of an orthopedic service and of the community care teams in the area of the hospital.

The analysis of records, participant observation and meetings made it possible, at the first stage, to diagnose the situation. The first findings show the impact that defragmentation of continuity of care has on the person's support on the return home and on the person's functionality after arthroplasty.

The codification of the content analysis of the participants' discourse allowed us to identify the two categories that justify the need for continuity of care: 1) Criteria for continuity of care associated with the risk of ineffective management of the therapeutic regimen; 2) Criteria for continuity of care associated with informal caregiver knowledge and level of competence.

It is also important to improve communication networks, to empower the person and his family with knowledge and adaptive strategies to meet the needs and risks of returning home.



Despite the limitations, the study contributes to the discussion about continuity of care, and patient safety in this process and raises questions about the role of nurses as clinical case managers and leaders in the management of transitions that people experience throughout the cycle of life and in different contexts.

Keywords: Elderly; Arthroplasty; Continuity to Patient Care; Self-care; Caregivers.

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