The implementation of care transition for elderly individuals living with Alzheimer's: an integrative literature review

A implementação da transição do cuidado ao idoso convivendo com Alzheimer: revisão integrativa da literatura

La implementación de la transición del cuidado al adulto mayor con Alzheimer: revisión integradora de la literatura

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How to cite: Pereira GDC, Barreto RS, Farias MTD, Soares SSS, Souza SS. The implementation of care transition for elderly individuals living with Alzheimer's: an integrative literature review. REVISA. 2025; 14(3): 1742-56. Doi: https://doi.org/10.36239/revisa.v14.n3.p1742a1756

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Received: 27/04/2025
Accepted: 27/06/2025

RESUMO

Objetivo: Identificar as evidências na literatura sobre a assistência da enfermagem na implementação da transição do cuidado ao idoso diagnosticado com Alzheimer. Metodologia: Revisão Integrativa de Literatura fundamentada pelo PRISMA-ScR. A análise dos dados usou a estatística descritiva e análise qualitativa, através do software Iramuteq e a Análise de Conteúdo de Bardin. Resultados: Encontrou-se 12 artigos. A árvore de similitude do Iramuteq indicou que o termo "transição" foi central nos resultados, associando-se a três troncos de similitude relacionados às palavras-chaves: "cuidado", "medicamento", "papel", "demência", "paciente", "receber", "comunicação", "cuidador" e "estratégias". Em relação a Análise de Conteúdo de Bardin, após a leitura dos artigos na íntegra, surgiram três categorias: Benefícios da implementação da transição do cuidado nos pacientes com Alzheimer, Estratégias para a implementação da transição do cuidado e estimular o envolvimento do indivíduo, do cuidador e da equipe interprofissional no estabelecimento das metas de cuidado e Principais entraves na implementação da transição do cuidado aos idosos com Alzheimer. Conclusão: As produções selecionadas reconhecem que a Transição do Cuidado é indispensável para a continuidade de cuidados aos idosos com Alzheimer e que os principais responsáveis pela sua aplicabilidade prática é o profissional de enfermagem, trazendo alguns benefícios como a promoção da saúde e a redução da reinternação.
Descritores: Doença de Alzheimer; Cuidado Transicional; Enfermagem; Idoso.

ABSTRACT

Objective: To identify evidence in the literature on nursing care in the implementation of care transitions for elderly patients diagnosed with Alzheimer's disease. Methodology: An integrative literature review based on the PRISMA-ScR guidelines. Data analysis used descriptive statistics and qualitative analysis through the IRaMuTeQ software and Bardin's Content Analysis. Results: Twelve articles were found. The IRaMuTeQ similarity tree indicated that the term "transition" was central in the results, associating with three similarity branches related to the keywords: "care," "medication," "role," "dementia," "patient," "receive," "communication," "caregiver," and "strategies." According to Bardin's Content Analysis, after full reading of the articles, three categories emerged: Benefits of implementing care transitions for patients with Alzheimer's, Strategies for implementing care transitions and encouraging the involvement of the individual, caregiver, and interprofessional team in establishing care goals, and Main barriers to implementing care transitions for elderly people with Alzheimer's. Conclusion: The selected publications recognize that care transition is essential for continuity of care in elderly patients with Alzheimer's and that nurses are primarily responsible for its practical implementation, bringing benefits such as health promotion and reduced hospital readmissions.
Descriptors: Alzheimer Disease; Transitional Care; Nursing; Elderly.

RESUMEN

Objetivo: Identificar las evidencias en la literatura sobre la atención de enfermería en la implementación de la transición del cuidado al adulto mayor diagnosticado con Alzheimer. Metodología: Revisión integrativa de la literatura basada en la guía PRISMA-ScR. El análisis de los datos utilizó estadística descriptiva y análisis cualitativo, mediante el software IRaMuTeQ y el Análisis de Contenido de Bardin. Resultados: Se encontraron doce artículos. El árbol de similitud del IRaMuTeQ indicó que el término "transición" fue central en los resultados, asociándose con tres ramas de similitud relacionadas con las palabras clave: "cuidado", "medicamento", "papel", "demencia", "paciente", "recibir", "comunicación", "cuidador" y "estrategias". Según el Análisis de Contenido de Bardin, tras la lectura completa de los artículos surgieron tres categorías: Beneficios de la implementación de la transición del cuidado en pacientes con Alzheimer, Estrategias para implementar la transición del cuidado y fomentar la participación del individuo, del cuidador y del equipo interprofesional en el establecimiento de objetivos de cuidado, y Principales obstáculos en la implementación de la transición del cuidado a adultos mayores con Alzheimer. Conclusión: Las producciones seleccionadas reconocen que la transición del cuidado es indispensable para la continuidad de la atención a los adultos mayores con Alzheimer, y que el profesional de enfermería es el principal responsable de su aplicación práctica, aportando beneficios como la promoción de la salud y la reducción de las rehospitalizaciones.
Descriptores: Enfermedad de Alzheimer; Cuidado Transicional; Enfermería; Anciano.

Introduction

Brazil presents a concerning outlook regarding the increasing number of people with dementia, currently estimated at 2 million patients, with projections indicating a threefold increase by 2050[1]. Furthermore, the First National Report on Dementia in Brazil, published by the Ministry of Health (MoH), highlights a previous estimate that approximately 70% of people with dementia are not being diagnosed in the country, emphasizing the need to prioritize this emerging issue in public health. Early diagnosis and appropriate care become fundamental in the face of this challenging scenario[1].

Alzheimer's, or Alzheimer's Disease (AD), is characterized as a neurocognitive disorder with gradual progression. The brain region initially affected is the hippocampus, responsible for memory, which results in the impairment of other brain areas. It is a multifactorial pathology of spontaneous origin, whose progression is linked to various factors: age, presence of comorbidities such as diabetes mellitus, obesity, and depression[2]. In older adults, Alzheimer's is the most prevalent type of dementia, impairing autonomy in activities of daily living (ADLs) and consequently affecting quality of life[2,3].

Multidisciplinary follow-up is essential to preserve the quality of life of individuals living with Alzheimer's, considering the influence of lifestyle habits on the progression of the disease[2]. The aging process already brings bodily imbalances and, when associated with this pathology, there is a potential for physical debilitation and cognitive decline, requiring special care to prevent accidents, worsening of comorbidities, and to ensure the safety of these older adults[4,5]. Chronic events such as complications from diabetes mellitus and arterial hypertension, as well as accidents, may lead to recurrent and continuous hospitalizations in older adults diagnosed with dementia, triggering the progression of this pathology[2].

The progression of AD evolves with physical and cognitive deterioration and the loss of the older person's autonomy. This demands a more careful level of attention, especially for older adults undergoing hospitalization, as they are more exposed to risk factors that increase the fragility and vulnerability of these patients. In this context, the nurse is one of the professionals responsible for Care Transition (CT), which consists of actions that ensure the continuity of care across the various levels of healthcare to which the patient may be transferred. CT aims to improve the quality of care, reduce unnecessary readmission rates, enhance coping strategies and the adjustment of the patient, family, and caregiver to the disease and its treatment, and reduce hospital costs[6].

Given this, the following question arises: What has been scientifically written about the nursing team's care during the transition of care for elderly patients with Alzheimer's? In this context, the objective of this study is to identify evidence in the literature regarding nursing care in the implementation of care transition for older adults diagnosed with Alzheimer's.

Methodology

For the development of this research, an integrative literature review was chosen, which is a method that facilitates the integration and practical application of the results from selected guiding studies, allowing the inclusion of both experimental and non-experimental studies to provide a comprehensive understanding of the phenomenon under analysis[7]. The study was based on the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR), with the intention of grouping and synthesizing results from other studies on the topic of promoting care transition for older adults diagnosed with Alzheimer's, thereby enabling a deeper understanding of the theme explored.

To formulate the research question, the PICo strategy was applied, based on the acronym (P = Population; I = Interest; Co = Context), which led to the following data: P=older adults diagnosed with Alzheimer's; =nursing team care; Co= care transition. Given this, the guiding question of this study is: What has been scientifically written about the nursing team's care during the transition of care for elderly patients with Alzheimer's?

The literature search was conducted during March and April of 2024 in the following databases: Latin American and Caribbean Health Sciences Literature (LILACS) and Medical Literature Analysis and Retrieval System Online (MEDLINE), both via the Virtual Health Library (VHL); Nursing Database (BDENF) via the Latin American and Caribbean Center on Health Sciences Information (BIREME); Brazil Scientific Electronic Library Online (SciELO), Scopus, Embase, and PubMed. Controlled terms from Health Sciences Descriptors (DeCS) and Medical Subject Headings (MeSH), as well as uncontrolled terms, were used in the search strategy, which is presented in Table 1. The combination of search terms was performed using the Boolean operators "AND" and "OR".

Table 1 – Complete search strategy. Ilhéus-BA, Brazil, 2024.

Database	Search Strategy
BDENF, MEDLINE E LILACS VIA BVS	("Doença de Alzheimer" OR "Alzheimer de Início Tardio" OR "Alzheimer Precoce" OR "Alzheimer Tardio" OR "Demência de Alzheimer" OR "Demência Pré-Senil" OR "Demência Pré-Senil Tipo Alzheimer" OR "Demência Senil" OR "Demência Senil com Estado Confusional Agudo" OR "Demência Senil Tipo Alzheimer" OR "Demência Tipo Alzheimer" OR "Doença de Alzheimer de Início Focal" OR "Doença de Alzheimer de Início Precoce" OR "Doença de Alzheimer de Início Tardio" OR "Doença de Alzheimer Familiar" OR "Doenças de Alzheimer" OR "Mal de Alzheimer" OR "Alzheimer Disease" OR "Acute Confusional Senile Dementia" OR "Alzheimer Dementia" OR

	"Alzheimer Dementias" OR "Alzheimer Diseases" OR "Alzheimer Sclerosis" OR "Alzheimer Syndrome" OR "Alzheimer Type Dementia" OR "Alzheimer Type Dementia" OR "Alzheimer Type Senile Dementia" OR "Alzheimer's Disease" OR "Alzheimer's Diseases" OR "Alzheimer-Type Dementia" OR "Alzheimers Diseases" OR "Early Onset Alzheimer Disease" OR "Familial Alzheimer Disease" OR "Familial Alzheimer Diseases" OR "Focal Onset Alzheimer's Disease" OR "Late Onset Alzheimer Disease" OR "Presenile Alzheimer Dementia" OR "Presenile Dementia" OR "Primary Senile Degenerative Dementia" OR "Enfermedad de Alzheimer" OR "Demencia de Alzheimer" OR "Demencia Presenil de Alzheimer" OR "Demencia Senil" OR "Demencia Senil Aguda Confusa" OR "Demencia Senil Tipo Alzheimer" OR "Demencia Tipo Alzheimer" OR "Enfermedades de Alzheimer" OR "Mal de Alzheimer") AND ('cuidado transicional' OR 'tratamento de transição' OR 'tratamento transicional' OR 'cuidados de transição' OR 'cuidado de transição' OR 'transição para casa') AND (db:("MEDLINE" OR "LILACS" OR "BDENF") AND la:("en" OR "es" OR "pt"))
PUBMED	("aged"[MeSH Terms] OR "aged"[All Fields] OR "aging"[MeSH Terms] OR "aging"[All Fields] OR "ageing"[All Fields]) AND ("transitional care"[MeSH Terms] OR "transitional"[All Fields] AND "care"[All Fields] OR "transitional care"[All Fields]) AND ("patient discharge"[All Fields] OR "hospital care"[All Fields] OR "continuity of patient care"[All Fields] OR "discharge planning"[All Fields]) and ("alzheimer disease"[MeSH Terms] OR alzheimer[Text Word])
SCOPUS	(TITLE-ABS-KEY (alzheimer OR "alzheimer disease") AND TITLE-ABS-KEY ("transitional care") AND TITLE-ABS-KEY ("patient discharge" OR "continuity **off** patient care" OR "discharge planning"));
EMBASE	(alzheimer OR 'alzheimer disease'/exp OR 'alzheimer disease') AND ('transitional care'/exp OR 'transitional care' OR 'hospital discharge'/exp OR 'hospital discharge')
SCIELO	(((ab:(alzheimer)) OR (ab:(doença de alzheimer)) OR (ab:(Alzheimer Disease))) AND (cuidado transicional) OR (Transitional Care) OR (transição do cuidado) OR (Transferência de Pacientes) OR (Transferência da Responsabilidade pelo Paciente) OR (Patient Transfer) OR (Patient Handoff)) AND (enfermagem) OR (nursing) OR (Cuidados de Enfermagem) OR (Nursing Care)

The inclusion criteria encompassed full-text studies available in the selected databases, in Portuguese, English, and Spanish, that addressed the research question. There was no time frame restriction. On the other hand, the exclusion criteria applied were: publications that did not meet the purpose of the study, abstracts, incomplete papers, and publications from national and international conference proceedings. Original articles and reviews that did not portray the work of nursing professionals and studies in other languages were also excluded, in order to avoid translation and interpretation errors.

After the initial selection of studies from the databases, the list of references was saved in CSV and RIS formats and exported to the reference manager EndNote for duplicate identification. Subsequently, the references were extracted to the Rayyan QCRI[16] online software, in which the inclusion and exclusion of studies was carried out in a double-blind manner after reading the titles and abstracts of the articles. The studies that met the inclusion and exclusion criteria and were consensually selected by the authors were read in full.

After the final selection of articles, the next step was data extraction to characterize the studies according to publication year, database, study location, method, and main results. The extracted information was categorized into a spreadsheet using Microsoft® 365 Excel (version 2307), and the results were analyzed both quantitatively and qualitatively.

Quantitative data were analyzed using descriptive statistics and presented as absolute and relative frequencies. For the qualitative data, the Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRaMuTeQ) software, version 0.7 alpha 2, was used to analyze the results found in the selected articles. The statistical analyses performed by IRaMuTeQ algorithms allow the recovery of the context in which the words appear, organizing, classifying, and executing a series of analyses that contribute to the researcher's work. IRaMuTeQ enables a quali-quantitative approach, as it analyzes textual corpora through word counting, grouping, and association.

The IRaMuTeQ software relies on graph theory to identify the co-occurrence and connection of words within the source articles. It identifies structures and central nodes and provides time optimization for researchers who would otherwise manually identify patterns[8]. For this study, similarity analysis was chosen, based on graph theory, with the construction of a Maximum Spanning Tree, to facilitate the interpretation of results. This tree records the co-occurrence of graphs and generates an image composed of a central node connected to branches (trunks), which represent the relationships or connections between the active forms within the textual corpus—i.e., the connections between the results found.

To complement the analysis, Bardin's Thematic Content Analysis was also carried out. This is a set of techniques used to analyze communication by systematizing the description of content through data analysis. It is divided into three phases: 1)Pre-analysis (document selection and reformulation of objectives); 2)Exploration, categorization, and coding of material (category creation); 3)Treatment of results, interpretation, and inferences (result interpretation)[9].

This study complies with ethical and legal standards, as it properly credits all authors by citing their respective publications, in accordance with copyright regulations[10].

Results

A total of 2,227 studies were found in the databases; 474 articles were removed due to duplication, leaving 1,753 for title and abstract screening. After the initial screening, 29 articles were selected for full-text reading, and following critical analysis, twelve articles were included in the review. The nineteen excluded publications did not meet the study's concept, interest, or population criteria. Some studies addressed the dementia population in general but did not specifically focus on Alzheimer's disease or the elderly population. Others did not address care transition, but rather reasons for patients not being discharged. Some emphasized only financial aspects or workforce-related issues (such as training and caregiver investment). Others focused solely on the impact of care transition from the caregiver's perspective (e.g., health impact, occupational overload).

The entire selection process was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)[11], as illustrated in the figure below (Figure 1).

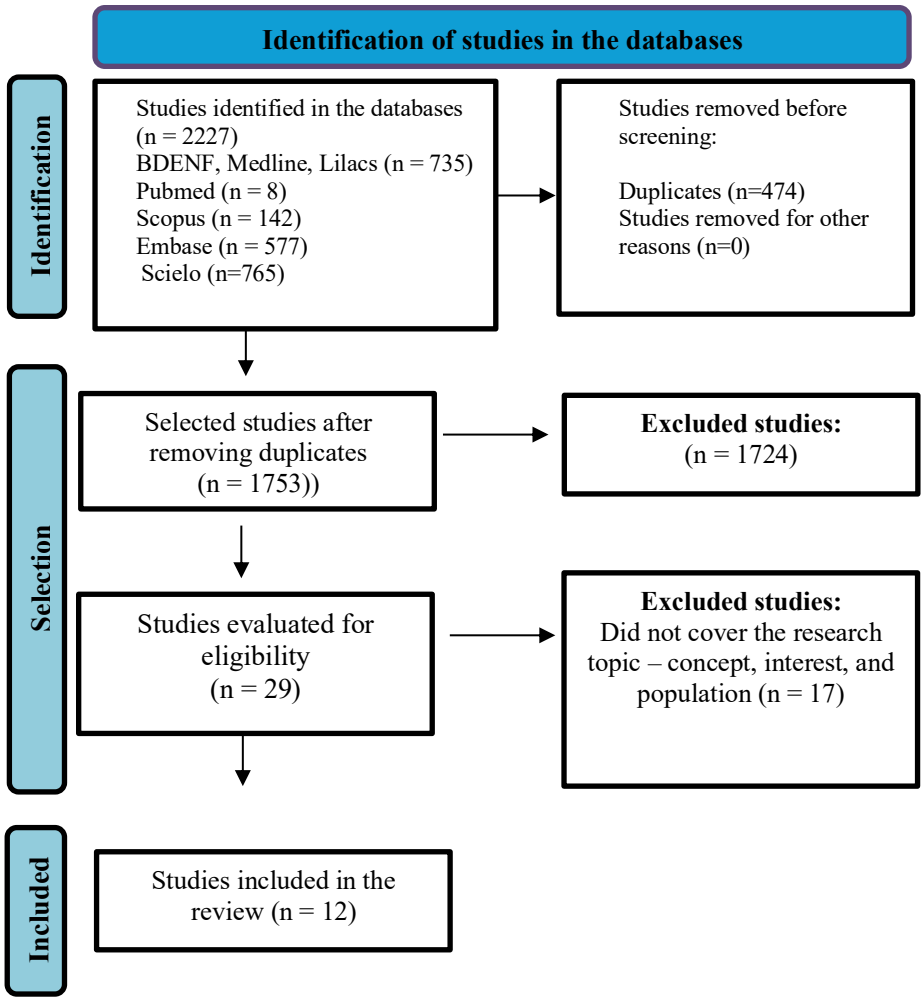

Figure 1- Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) Protocol.

According to the information described in Table 3, the studies included in the review (n=12) were mostly publications from the United States (n=9, 75%), Australia (n=2, 16.67%), and Israel and Canada (n=1, 8.33%), conducted by nurses. These articles were published between the years 2012 and 2023, with an average of approximately 1 article per year. The most commonly used research method was qualitative (n=7). The databases that published the most on the topic were: PUBMED (n=3) and EMBASE (n=9).

Table 2 - Characterization of the articles according to the year of publication, available database, country of publication, and method used.

N°	Reference/ Year	Database	Country	Method
1	Moore; Sullivan, 2017[12]	PUBMED	United States (USA)	Qualitative
2	Hirschman; Hodgson, 2018[13]	PUBMED	USA	Integrative review
3	Glober et al., 2023[14]	PUBMED	USA	Qualitative
4	Guo et al., 2023[15]	EMBASE	USA	Multicenter clinical trial
5	Shah, et al.; 2022[16]	EMBASE	USA	Randomized clinical trial
6	Cai et al., 2021[17]	EMBASE	USA	Qualitative
7	Sharma et al. 2021[18]	EMBASE	USA	Qualitative
8	Cohen-Mansfield, et al.; 2017[19]	EMBASE	Israel and Canada	Quantitative - medical record review
9	Kind, A. J. et al., 2016[20]	EMBASE	USA	Medical record
10	Deeks, L. S. et al., 2016[21]	EMBASE/ MEDLINE	Australia	Qualitative
11	Cooper; Deeks, 2012[22]	EMBASE	Australia	Qualitative
12	Rose; López, 2012[23]	EMBASE	USA	Narrative review

Legend: N° - article number; Reference – reference from the list; Year of publication; Database – where the article was found; Country where it was produced.

The data processing by the Iramuteq software was generated from a textual corpus consisting of 12 texts, separated by the program into 21 text segments, which included 1001 occurrences and hapax frequency of 334 (with 73.57% of the forms and 33.37% of the occurrences). As an analysis parameter, a cutoff point was used, with 33 forms having frequencies between 25 and 4, generating the similarity analysis graph, represented by the maximum tree shown in figure 2. This software is based on calculations executed based on the co-occurrence of words in text segments, aiming to group them into classes according to their similarity and dissimilarity.

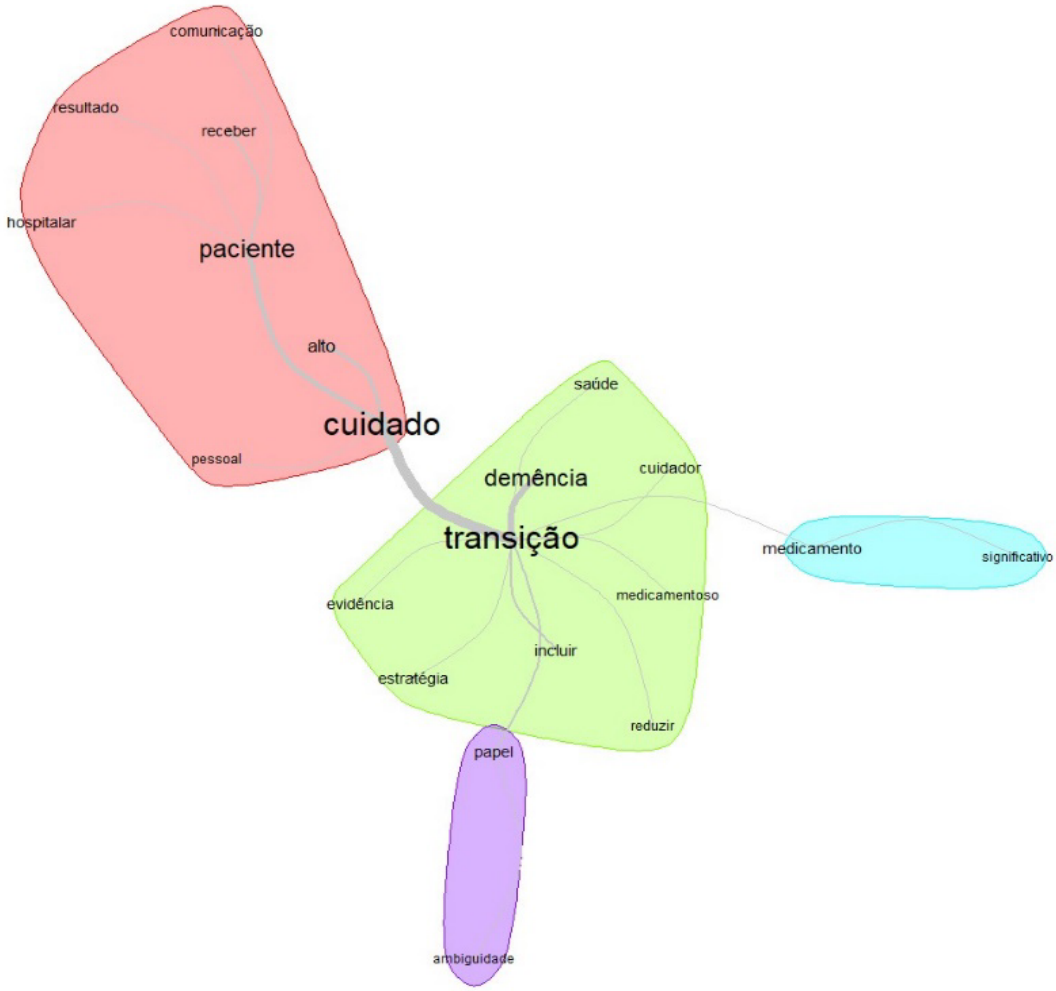

Figure 2 - Similarity Analysis: the implementation of the Transition of Care for elderly patients with Alzheimer's Disease.
Source: developed by the authors, using the IRAMUTEQ software (2024).

This tree was obtained based on 33 words and indicated that the term "transition", the subject of the research, was central in the accounts of the authors of the articles, being associated with three branches of similarity related to the keywords: "care", "medication", "role", "dementia", "patient", "receive", "communication", "caregiver", "include", and "strategies".

For completion, regarding Bardin's content analysis, after reading the articles in full, three categories emerged titled: Benefits of implementing the TC in patients with Alzheimer's (n=5; 41.7%), Strategies for implementing the TC and encouraging the involvement of the individual, caregiver, and interprofessional team in establishing care goals (n=7; 58.3%) and Main obstacles in the implementation of the TC for elderly people with Alzheimer's (n=3, 25%).

Discussion

The selected productions recognize that TC (Transitional Care) is essential for the continuity of care for elderly people with Alzheimer's and that the main responsible party for its practical applicability is the nursing professional, bringing some benefits such as health promotion and the reduction of readmission. However, they discuss the barriers present in this process, such as clarifying the ambiguity between the roles of the caregiver and the professional and avoiding errors related to communication failures and medication reconciliation.

Benefits of implementing TC in patients with Alzheimer's

In relation to this category, the similarity analysis identified the central branch formed by the term "transition," which appeared 20 times, and was surrounded by the terms "health," "reduce," "strategy," "evidence," "dementia," "caregiver," and "medications." The authors of the studies emphasized the benefits of providing care transition (CT) to older adults with Alzheimer's disease (AD), as it ensures continuity of care, mitigates errors such as drug interactions and polypharmacy, reduces hospital readmission rates, and promotes the health of older adults.

Alzheimer's disease is a condition that impairs cognition and functionality, also affecting the individual's independence, communication, and decision-making, while altering behaviors and increasing the need for external support from family, friends, or caregivers[24]. Given the lack of a curative treatment for Alzheimer's, health systems and support networks must develop strategic actions to optimize care and provide quality of life for the elderly, always aiming to protect their civil, political, economic, social, and cultural rights, and to prevent adverse events stemming from multiple interventions and unnecessary hospitalizations.

In this context, the concept of transition arises as the continuity of processes in human life. It involves changes that may relate to critical or destabilizing events, which disrupt routines, relationships, ideas, perceptions, or identity, encompassing both the individual and their environment[24,25].

The purpose of care transition is to foster continuity of assistance through coordination and effective communication among people (health professionals, family, and/or members of the individual's support circle), as they will manage care across the different levels of health services where the elderly person will be treated[26]. Thus, safe transitional care is established through continuous communication among the family, healthcare professionals, and health services.

Accordingly, implementing care transition enables effective communication and care coordination, creating a shared understanding of the caregiver's importance in following the planned actions, thereby ensuring continuity of care for individuals with Alzheimer's disease. Transition of care also improves quality of life by reducing the risk of adverse events such as falls, malnutrition, and polypharmacy. Together, these measures help decrease emergency room visits and hospital readmissions[27].

Incorrect guidance to the Alzheimer's care network can lead to high readmission rates and recurrent use of emergency services, highlighting failures in primary healthcare[28]. This underscores the need for improvements in how health systems manage patients with Alzheimer's during care transitions.

In this regard, it is important to highlight that the nurse is the main professional responsible for planning and implementing care transition, as nursing focuses on the experiences of individuals undergoing transition processes, with health and well-being as the outcomes[25,26].

The nursing professional must therefore take responsibility for ensuring a safe transition at any level of care, as it is recognized that individuals with Alzheimer's disease are especially vulnerable to poor care transitions due to their cognitive and physical frailty[14,25]. It is essential to promote quality of life through therapeutic strategies that reduce harmful transitions and support positive process indicators, such as decreased hospital readmissions and institutionalizations[24,25], considering that Alzheimer's is a condition marked by challenges, unfamiliarity, and confusion for both the affected individual and those in their support network.

In this context, the caregiver becomes the person in closest contact with the individual and the one responsible for care continuity. Therefore, effective implementation of CT must involve the training of caregivers to empower them and build confidence in handling daily care challenges. Furthermore, this training helps facilitate feedback to healthcare professionals regarding the needs of the individual with dementia after hospital discharge.

Strategies for the implementation of TC: encouraging the involvement of the individual, the caregiver, and the interprofessional team in establishing care goals

The central branch marked by the word "transition" is connected to the branch with the term "care," mentioned 25 times, and shows links with the nodes "patient," "receive," "communication," "outcome," "hospital," and "staff." The studies emphasize strategies for implementing care transition focused on the patient, highlighting that for effective outcomes, the intervention must prioritize communication among healthcare staff.

Thus, initiating care transition strategies first involves effective and standardized communication centered on patient safety. Next, it is essential to assess the patient's condition, begin planning the assisted discharge from the start of hospitalization, provide the available material resources, and stay updated on the use of support technologies[28].

Effective communication ensures patient safety by delivering information in a comprehensible, consistent, complete, accurate, and unambiguous manner. It acts as a mediator between the individual, their support network, and professionals, enabling understanding of the context in which the elderly person with AD is inserted and recognizing care demands to plan more individualized and comprehensive assistance. These strategies aim to promote quality of life and feasible interventions according to the family, social group, or institution's reality[29].

Nurses play a crucial role in assisting clients, families, and communities during transitions by anticipating responses, providing proactive guidance, managing symptoms, promoting health and well-being, and supporting the

adoption of self-care measures[24]. However, it is important to note that these professionals often work under conditions marked by excessive workload and numerous administrative duties, which may hinder the implementation of care transition in their practice.

In view of this reality, some studies have proposed tools designed to facilitate the CT process, such as the ADMIT tool (Alzheimer, Dementia, Memory Impaired Transitions), which was developed specifically for people with dementia[12]. This tool emphasizes the importance of effective communication and participatory collaboration among professionals, with care centered on the behaviors and needs of these individuals.

The authors also highlight that nursing professionals can employ effective approaches such as psychosocial and psychoeducational interventions, aimed at delaying or avoiding care transitions, such as institutionalization of elderly people with Alzheimer's. These interventions include ongoing caregiver education, support in setting care goals, and collaborative work with the interprofessional team, involving the support network, with a focus on reducing caregiver burden and implementing practices that improve care for individuals with dementia[12].

The Care Transitions Intervention (CTI) program was also presented as a useful strategy for professionals[16]. This tool includes a motivational interview that helps the individual understand the importance of self-management in care. Then, a personal health record is created, managed by the individual or their caregiver. These interventions place the older adult in an active role in promoting their own self-care, and such empowerment is essential for mitigating the effects of cognitive decline caused by AD. Finally, follow-up phone calls by healthcare professionals are used to reinforce prior content and behaviors and to outline new intervention strategies when necessary.

It is crucial that these strategies are carefully developed and followed, clearly defining each professional's responsibilities in order to reduce role ambiguity during care transitions, especially when managing older adults at home[18]. This barrier was discussed in the articles and reflected in the similarity analysis through a branch where the central word "role", cited 7 times, was connected to the term "ambiguity."

Accordingly, these strategies may include actions such as: beginning care transition planning at the time of hospitalization; establishing a routine and a space for sharing information and experiences during transitions; clearly defining the responsibilities of each professional involved in care; reassessing current medications to avoid polypharmacy and drug interactions during CT; and monitoring for potential side effects when new medications are introduced[17].

In individuals with Alzheimer's, transitions are frequent, and nurses play a crucial role as facilitators in advanced care planning. Nursing also provides structured support to families, assisting in managing changes in behavioral symptoms and raising awareness about end-of-life care for patients with the disease.

Main obstacles in the implementation of TC for the elderly with Alzheimer's

As main barriers, the articles reported: ineffective communication, deficient information systems, lack of professional knowledge about Alzheimer's disease (AD), and high work demand.

The difficulties faced within health networks are related to inefficient communication, which compromises the development of comprehensive and continuous care[31]. This discontinuity of care also stems from the fragmentation of services or the lack of integration between different levels of care, resulting in gaps in care continuity[32].

Information systems face problems such as outdated equipment incapable of supporting programs, obsolete software, and lack of training for professionals handling these systems[33]. These factors hinder access to vital information such as patient history, treatments, and care plans, leaving health professionals without access to critical data needed to support continuity of care.

Gaps in the transition process are also notable in relation to medication management, compromising patient safety. This issue is often due to the lack of a systematic approach by professionals and/or health systems to people with AD, stemming from communication failures and weak clinical governance. Another branch formed in the Maximum Spanning Tree through similarity analysis was generated by the keyword "medication," mentioned six times, which was connected to the term "meaning." This reflects one of the negative outcomes of not providing care transition, as there is no verification of the medications used during hospitalization and what will be continued after discharge, whether at home or in long-term care institutions. This can lead to errors such as drug interactions and hospital readmissions.

Another identified barrier is the lack of knowledge about AD. Healthcare professionals find themselves unprepared to deal with the demands of older adults with Alzheimer's and to provide the necessary care. This precariousness is triggered by limited knowledge about AD, thus restricting the effectiveness and safety of care[34].

Professional overload—such as multiple job contracts, low wages, and poor working conditions—can also reduce performance and weaken care coordination[7].

As a limitation of the study, the absence of Brazilian scientific publications can be noted, highlighting the lack of promotion of public policies and health education actions that foster knowledge about care transition in elderly individuals living with Alzheimer's. This reflects the difficulty in identifying AD and Care Transition as relevant fields of study, especially among nursing professionals. Furthermore, four articles could not be retrieved in full for complete reading, as they lacked abstracts, author information, and DOI numbers, despite all attempts to recover them.

Conclusion

This literature review identified 12 articles that addressed the importance of care transition (CT) for elderly patients diagnosed with Alzheimer's disease, including some strategies employed by healthcare services and the barriers to

its implementation. The studies emphasize that CT improves quality of life after hospital discharge by reducing the risk of adverse events and decreasing the need for emergency services and hospital readmissions among individuals affected by Alzheimer's disease. However, it is worth noting that none of these publications were authored by Brazilian researchers.

The topic of Alzheimer's disease requires greater public investment due to the difficulty of diagnosis and its significant repercussions on the health of the individual, the family, and society. The lack of public policies aimed at older adults with Alzheimer's disease leads healthcare systems and professionals to focus more on treatment rather than on preventive and educational measures that could delay the chronic progression of the disease and promote early diagnosis.

Another issue identified is the scarcity of publications addressing care transition as a nursing practice tool. As long as nurses do not recognize the importance of ensuring continuity of care during their professional practice, this topic will not become the object of research and academic production within the profession, thereby weakening post-discharge care.

Thus, it is also important for educational institutions to promote research lines that further explore these topics and reinforce their relevance for public knowledge and especially for future healthcare professionals. As previously discussed, these professionals are fundamental to ensuring high-quality implementation of care transition for individuals with Alzheimer's disease.

In this regard, the nurse's role is essential, as they serve as the coordinator of care actions through their knowledge and expertise, ensuring safety, comfort, and quality of life, not only for the person with Alzheimer's but also for their support and caregiving network. The nurse will help prevent complications such as falls, polypharmacy, and malnutrition, and will also serve as a support and information resource for these individuals through health education and a strategic, integrative, and continuous care approach.

Acknowledgment

This study was funded by the authors themselves.

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