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RESEARCH

SOCIAL REPRESENTATIONS OF NURSES REGARDING THE HOSPITAL DISCHARGE PLAN

REPRESENTAÇÕES SOCIAIS DE ENFERMEIRAS SOBRE O PLANO DE ALTA HOSPITALAR

REPRESENTACIONES SOCIALES DE ENFERMERAS SOBRE EL PLAN DE ALTA HOSPITALARIA

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ABSTRACT

Objective: to analyze nurses' social representations regarding hospital discharge plan. ***Methods:*** a descriptive and exploratory study with a qualitative approach, grounded in the theoretical-methodological framework of the Theory of Social Representations in its structural approach, as proposed by Abric. One hundred nurses participated by answering an online form containing a Free Word Association Test. The corpus was organized and processed using the software Open Ensemble de Programmes Permettant L´analyse des Évocations (v. 1.1), and the data were analyzed according to the structure of representations. ***Results:*** the central core of the representation was composed of the terms orientation, care, recovery, safety, self-care, and transition, highlighting the nursing identity as a protagonist in the continuity of care. Peripheral elements, such as the Nursing Process (Systematization of Nursing Care), the multiprofessional team, protocols, and return, revealed tensions between normative values and the concrete conditions of practice, marked by the absence of institutional protocols and educational gaps. ***Final considerations:*** the meanings attributed to discharge planning are anchored in the execution of care that ensures the continuity of patient assistance and safe transition after hospitalization and are objectified as educational tools guiding user care and safety. It is recommended to systematically include the topic in undergraduate and postgraduate nursing curricula, as well as to institutionalize protocols that strengthen nurses' autonomy and multiprofessional integration during discharge.

Keywords: Patient Discharge; Social Representation; Nurses; Nursing; Qualitative Research.

RESUMO

Objetivo: analisar as representações sociais de enfermeiras sobre o plano de alta hospitalar. ***Métodos:*** estudo descritivo e exploratório, com abordagem qualitativa e fundamentada no aporte teórico-metodológico da Teoria das Representações Sociais, em sua vertente estrutural e conforme proposta por Abric. Participaram 100 enfermeiras, que responderam a um formulário virtual contendo um Teste de Associação Livre de Palavras. O corpus foi organizado e processado com o auxílio do software Open Ensemble de Programmes Permettant L´analyse des Évocations (v. 1.1), e os dados foram analisados segundo a estrutura das representações. ***Resultados:*** o núcleo central da representação foi composto pelos termos orientação, cuidado, recuperação, segurança, autocuidado e transição, evidenciando a identidade da enfermagem como protagonista da continuidade do cuidado. Elementos periféricos, como a Sistematização da Assistência de Enfermagem, a equipe multiprofissional, os protocolos e o retorno, revelaram tensões entre valores normativos e condições concretas da prática, marcadas pela ausência de protocolos institucionais e por lacunas formativas. ***Considerações finais:*** os sentidos atribuídos ao plano de alta estão ancorados na execução de cuidados que garantam a continuidade da assistência ao paciente e a transição segura após a hospitalização, sendo objetivados ferramentas educacionais orientadoras do cuidado e da segurança do usuário. Recomenda-se a inclusão sistemática do tema nos currículos de graduação e pós-graduação em enfermagem, bem como a institucionalização de protocolos que fortaleçam a autonomia do enfermeiro e a integração multiprofissional durante a alta.

Palavras-chave: Alta do Paciente; Representação Social; Enfermeiras e Enfermeiros; Enfermagem; Pesquisa Qualitativa.

RESUMEN

Objetivo: *analizar las representaciones sociales de enfermeras sobre el plan de alta hospitalaria.* ***Métodos:*** *estudio descriptivo y exploratorio, con enfoque cualitativo fundamentado en el aporte teórico-metodológico de la Teoría de las Representaciones Sociales, en su vertiente estructural, propuesta por Abric. Participaron 100 enfermeras, quienes respondieron un formulario virtual que contenía un Test de Asociación Libre de Palabras. El corpus se organizó y procesó con la ayuda del software Open Ensemble de Programmes Permettant L´analyse des Évocations (v. 1.1), y los datos se analizaron de acuerdo con la estructura de las representaciones.* ***Resultados:*** *el núcleo central de la representación estuvo compuesto por los términos orientación, cuidado, recuperación, seguridad, autocuidado y transición, lo que evidencia la identidad de la enfermería como protagonista de la continuidad del cuidado. Los elementos periféricos, como la Sistematización de la Atención de Enfermería, el equipo multiprofesional, los protocolos y el retorno, revelaron tensiones entre los valores normativos y las condiciones concretas de la práctica, marcadas por la ausencia de protocolos institucionales y por lagunas formativas.* ***Consideraciones finales:*** *los sentidos atribuidos al plan de alta se basan en la ejecución de cuidados que garanticen la continuidad de la asistencia al paciente y una transición segura después de la hospitalización, objetivados en herramientas educativas orientadoras del cuidado y de la seguridad del usuario. Se recomienda la inclusión sistemática del tema en los planes de estudio de grado y posgrado en enfermería, así como la institucionalización de protocolos que fortalezcan la autonomía del enfermero y la integración multiprofesional durante el alta.*

Palabras clave: *Alta del Paciente; Representación Social; Enfermeras y Enfermeros; Enfermería; Investigación Cualitativa.*

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INTRODUTION

Hospital discharge planning constitutes a systematized methodology of care, oriented toward organizing and qualifying the process of dehospitalization. It is a structured instrument that gathers information on the patient's clinical conditions, potential complications in their health status, and the need for special and continued care after leaving the hospital[1]. In this sense, patient discharge must be understood as a responsible process of transition of care that considers their autonomy and individual needs, including the family in the caregiving process. The more adequate the plan is to the patient's lifestyle, the better their adherence to instructions will be, minimizing the risk of complications and the emergence of comorbidities[2].

A study points out that about 25% of users develop some type of preventable complication up to 30 days after hospital discharge, generally associated with a lack of guidance from professionals[3]. Planning care only after discharge contributes to readmissions, generates high costs for management, and exposes the patient to risks, such as hospital-acquired infections and falls, which can further compromise their health status[4].

Responsible discharge is a requirement of the Joint Commission on Accreditation of Healthcare Organizations and is provided for in Brazilian legislation, under Ordinance No. 3,390 of December 30, 2013, which establishes the National Hospital Care Policy within the scope of the Unified Health System (Sistema Único de Saúde) [5,6]. This ordinance establishes responsible discharge as a fundamental strategy to ensure the continuity of care and considers that the Health Care Network must be articulated among its different levels of technological density in order to favor the continuity of care and promote safe dehospitalization[5].

However, despite this normative guideline, evidence points out that, in care practice, the discharge plan is still frequently carried out in an incipient manner, often restricted to verbal instructions and without formal recording, as a result of factors such as work overload, organizational limitations, and competing care priorities[6,7]. This mismatch between what is advocated by health policies and what actually materializes in the daily routine of services highlights the need to understand how nurses perceive, interpret, and attribute meaning to the hospital discharge plan.

In this context is the nurse, a healthcare professional who plays a primordial role in direct and safe assistance to the patient and family. However, although these professionals recognize the importance of the hospital discharge plan, its applicability in daily life either does not occur or occurs verbally, without any written record[7]. Excessive workload, the high number of patients per professional, and the high demand for administrative activities are reported by nurses as impediments to carrying out this stage of care[7].

Although the hospital discharge plan is recognized as an essential strategy to ensure the continuity of care, reduce post-discharge risks, and strengthen patient safety, it is observed that the literature is still limited regarding the understanding of the subjective dimensions that guide the performance of nurses in this process. Publications concentrate mostly on the normative, procedural, and structural aspects of the discharge plan, but dedicate little attention to the perceptions, meanings, and symbolic systems that influence the way these professionals conceive, value, and operationalize its construction in the care routine.

From this perspective, it becomes crucial to investigate nurses' social representations regarding the hospital discharge plan, since such representations constitute central elements for understanding how this knowledge is appropriated, reworked, and applied in everyday practice. This understanding is fundamental and, at the same time, justifies the execution of this study, since access to the imaginary of this social group can subsidize formative interventions, improve institutional protocols, guide patient safety policies, and strengthen work processes anchored in effective, collaborative, and safe communicational practices.

Therefore, this study was guided by the following questions: What are the social representations of nurses regarding the hospital discharge plan? How do the symbolic elements of these representations guide their practice in the transition of care? In this sense, the objective was to analyze the social representations of nurses regarding the hospital discharge plan.

METHOD

The present study adopted a qualitative, exploratory, and descriptive approach, grounded in the theoretical-methodological framework of the Theory of Social Representations in its structural approach, proposed by Jean-Claude Abric[8]. Representations are socially elaborated and shared, influencing professional behaviors and

conduct. Thus, the theory underlies not only the methodological path but also the analytical process of the study[9].

The adoption of Abric's approach is justified by recognizing that the understanding of the hospital discharge plan involves symbolic, evaluative, and practical elements that guide the performance of nurses in daily care practice. Thus, it seeks to apprehend not only the manifest contents, but also the internal organization of the representations that structure ways of thinking and acting, based on the Central Core Theory and the Peripheral System. This approach makes it possible to understand how more stable and normative elements, considered central, articulate with contextual and experiential aspects, considered peripheral, structuring ways of thinking and acting[8,9]. Therefore, Abric's theory not only guides the research method but also supports the analysis.

To guide the writing, the Consolidated Criteria for Reporting Qualitative Research (COREQ) instrument was used[10]. Data were collected between March and September 2024 by the lead researcher, female, a fourth-year undergraduate nursing student at a state university in southern Bahia. The researcher was previously trained by the faculty member responsible for the development of this study, linked to a scientific initiation program.

The research was conducted in a virtual environment with nurses from various geographic regions of Bahia, which made it possible to expand the scope of the investigation and favored the participation of professionals inserted in different institutional contexts. Thus, data collection encompassed multiple spaces and work realities in the hospital environment. The lead researcher conducted the interviews via video calls, which were attended only by the interviewee and the researcher herself, ensuring privacy, confidentiality, and adequate conditions for the free expression of experiences and perceptions. Each interview lasted, on average, 15 minutes. It was not necessary to record or repeat the interviews.

The study was composed of 100 nurses, a number considered adequate for research grounded in the Theory of Social Representations, especially when associated with structural techniques, which broadens the reliability of the lexical and structural analyses of the investigated social representations. All approached professionals agreed to participate in the research, with no sample loss. Nurses with at least six months of experience in hospital inpatient units from any region of Brazil who agreed to participate were included. Subjects who answered the data collection instrument partially were excluded.

No prior relationship was established with the participants before the research. Participants were selected through snowball sampling, a non-probabilistic convenience sampling technique in which participants themselves recruit other individuals to participate in the study from among their acquaintances, in order to expand the number of participants. After acceptance, the researcher scheduled the moment of virtual collection, identified herself to the professionals, explained the objective of the research, and provided the Free and Informed Consent Term for signature, sending a copy to the participant's e-mail.

For the apprehension and interpretation of the structure of social representations, the Free Word Association Test (FWAT) and the interview were used as data collection techniques, conducted via a structured virtual form. The interview contained participant characterization information (e.g., sex, age, marital status, skin color, length of professional experience, professional training, and prior experience with the discharge plan).

The FWAT consists of presenting an inducing word to individuals (discharge plan) and asking them to freely and quickly associate five words or expressions that come to mind from it. The virtual application of the FWAT required the adoption of standardized guidelines for participants, requesting that they immediately record the first words that came to mind upon encountering the inducing term, without prior reflection, so as to preserve the spontaneity and speed characteristic of this technique, even in a digital environment. Thus, the following question was presented: "What comes to your mind when you hear the term 'discharge plan'?" Subsequently, the centrality test, that is, of attributed importance, was carried out by asking participants to order the words in order of importance and justify the one considered most important. Central elements tend to be more frequent and more important.

After collection, participant characterization data were transferred and tabulated in Excel (2021) software and presented descriptively, in the form of absolute numbers and percentages. The words resulting from the FWAT were gathered, forming a corpus for analysis, and processed by the software Open Ensemble de Programmes Permettant L´analyse des Évocations (v. 1.1), which processes evocations through factorial typification or cluster analyses, allowing the identification of significant terms for the research participants. The analysis of the findings from this stage was guided by Abric[8], through the identification of the central core (CC) and the peripheral elements of the social representation.

The evoked terms or expressions were subjected to prototypical analysis using the OpenEvoc software, which

performs calculations based on absolute frequency and mean order of evocation (MOE), organizing the terms into a four-cell matrix. The frequency and MOE indicators make it possible to estimate the cognitive saliency of the terms for the studied group. The combination of these criteria makes it possible to identify elements potentially belonging to the CC of the representation, that is, the most frequent and/or those evoked first[8]. In addition, procedures for confirming the centrality of the terms were considered, based on the joint analysis of frequency, order of evocation, and semantic coherence of the contents, strengthening the interpretive consistency of the identified representational structure.

The ethical aspects regulated by the National Health Council were observed, in accordance with Resolution No. 466/12, which guides research ethics involving human beings, and Circular Letter No. 1/2021-CONEP/SECNS/MS, which guides procedures in research with any stage carried out in a virtual environment. The work was submitted to the Research Ethics Committee for evaluation and approved under Opinion Report No. 6,339,030.

RESULTS

A total of 100 professionals fully answered the data collection form, with 89% identifying as female and 11% as male. Regarding age, most professionals were in the 41 to 49 age group (32.0%), followed by the 36 to 40 age group (23.0%). In terms of marital status, 56.84% reported being married and 28.42% single. Regarding self-reported skin color, 58.95% of nurses identified as Brown. When adding the percentages of brown and Black respondents, this figure reached 72%, making it the most expressive group in the racial composition of the respondents.

Most professionals (69.47%) had more experience working in tertiary care. Regarding professional experience in the hospital, most had worked for more than four years (42.9%). Regarding time since graduation, a significant portion of the nurses had between 11 and 15 years of graduation (43.16%). Among the interviewees, 88.42% had completed some postgraduate course, with the majority (31.58%) holding a lato sensu postgraduate degree in Intensive Care Nursing.

Regarding the discharge plan, 53.68% of the professionals reported working or having worked with this instrument. As for the question about having had any classes during undergraduate school on the topic of the discharge plan, 66.32% of the professionals reported not having had classes on the subject during undergraduate or technical training, and 76.84% reported never having had such classes in postgraduate school. These data highlight a significant gap in the continuing education of nurses regarding a crucial aspect of care.

Regarding the analysis of the structure of social representations, the product of free evocations in response to the inducing term "discharge plan" totaled 500 words, of which 22 were distinct. The cutoff points defined for this analysis corresponded to a minimum frequency of 8 and an MOE of 2.96, which corresponds to the average position of each word in the analyzed corpus, as presented in Figure 1, which demonstrates the result of the prototypical analysis of evocations, arranged in the four-cell matrix.

DISCUSSION

The characterization of the participants corroborates the female predominance in nursing, a historically constituted phenomenon reiterated by the literature, which points to the profession as an expression of the feminization of the health workforce[11]. This data contextualizes the representational field in which nurses' practices are inscribed, reinforcing that their experiences and the meanings attributed to the hospital discharge plan are immersed in a social construction of gender, professional identity, and care.

The profile identified in this study may reflect the socioprofessional composition of nursing in the Brazilian context, marked by the strong presence of Black and Brown women in care positions. Such a characteristic can influence social representations regarding the hospital discharge plan, since professional trajectories marked by work overload, structural inequalities, and specific organizational conditions tend to shape the meanings attributed to care practices. Thus, the analysis of this data dialogues with the literature that discusses the relations between race, work, and health, broadening the understanding of the representations produced within this professional category[12].

The main finding of this study consists in the identification of a representational structure in which the hospital discharge plan is centrally associated with practices of guidance and patient preparation for returning home, evidencing that nurses understand this process predominantly as an educational action linked to the continuity of care. As an innovative element, it was observed that institutional aspects, such as the formal record of the discharge plan and the performance of the multiprofessional team, appear in peripheral positions, indicating a

Figure 1 – Prototypical analysis of nurses' evocations regarding the inducing term "discharge plan". Salvador, BA, Brazil, 2024 (n = 100)

MOE >2,96			MOE < 2,96		
Evoked term	Freq.	MOE	*Evoked term*	Freq.	MOE
1st Quadrant Elements of the central core			2nd Quadrant Elements of the peripheral system (1st periphery)		
Orientation	68	2,19	SNC	40	3,71
Care	52	2,79	Multiprofessional team	14	3,57
Recovery	27	2,67	Return	23	3,36
Safety	21	2,62	Protocol	18	3,45
Self-care	19	2,89			
Transition	15	2,33			
3rd Quadrant Zone of contrast			4th Quadrant Elements of the peripheral system (2nd periphery)		
Safe discharge	12	2,58	Responsibility Know-	12	3,58
Effective communication	10	2,2	ledge	11	3,64
Individuality	8	2,5	Family	11	4
			Autonomy	9	3
			Dressing	9	3,78
			Medication	8	3,13

SNC: Systematization of Nursing Care.
Source: Research data, 2024.

possible dissociation between the normative discourse of interdisciplinarity and the practical experience of nurses. This result dialogues with international studies on the transition of care, which also point to the central role of nursing in coordinating patient orientations and preparing for hospital discharge[1,13].

The CC is composed of the terms "orientation" (f = 68), "care" (f = 52), "recovery" (f = 27), "safety" (f = 21), "self-care" (f = 19), and "transition" (f = 15), evidencing high cognitive saliency and early evocation. These elements indicate that the hospital discharge plan is represented, in a stable and shared way, as a process centered on patient orientation, the continuity of care, and the promotion of recovery with safety, articulated to the idea of care transition and encouragement of self-care. The low MOEs (2.19–2.89) reinforce that these terms are readily accessed, configuring the structuring nucleus of the representation, with a strong normative and organizing character of practices.

The elements of the CC express normative and stable values, rooted in daily practice and the collective memory of the profession. According to Abric, the CC constitutes the basis of stability of the representation, conferring permanence and resistance to change[8,14]. In this study, such elements evidence the identity construction of the nurse as a central agent in guaranteeing the continuity of care, concretized in the orientation and preparation of the patient for hospital discharge[15].

The predominance of the word "orientation" indicates that, for nurses, the hospital discharge plan configures itself as a pedagogical and communicational device. In this sense, orientation is a process that goes beyond informing, educating, instructing, or transmitting information: it represents the professional responsibility of empowering the patient and their family, promoting safety and autonomy. Therefore, it fulfills a symbolic function by legitimizing the role of the nurse as a mediator between technical-scientific knowledge and lay knowledge. This practice is fundamental for the prevention of complications and the reduction of hospital readmission rates, as it promotes better understanding and adherence to the post-discharge care plan. In addition, adequate orientation empowers patients, allowing them to assume a more active role in managing their health and increasing their confidence and capacity for self-care[16].

The term "care," equally central, broadens this understanding, as it refers to the identity essence of nursing, articulating both the technical and humanistic dimensions. For the investigated social group, "care" refers to continuous monitoring, empathy, emotional support, and personalized attention to the patient's singularities; this representation is not restricted to the execution of procedures. This breadth reaffirms the normative dimension

of the CC, as it expresses collectively shared values about "what it means to be a nurse" facing the responsible construction of the hospital discharge plan[16].

By ensuring that patients understand and feel supported in their responsibilities after discharge, nurses play a crucial role in preventing adverse events and promoting well-being[17]. Thus, the word "care" emerged as a frequently mentioned term because it encapsulates the core of their responsibilities and values in promoting health and patient safety during the hospital discharge process.

The presence of "recovery" and "safety" in the CC reinforces the functional dimension of the representation: both point to the practical objective of the hospital discharge plan, which is to ensure that the patient transitions in a protected and effective manner between levels of care. From Abric's perspective, these terms indicate the purpose of care: to make therapeutic continuity viable, reduce risks, and prevent complications[16,17].

The study indicates that nurses associate "recovery" not only with the physical improvement of the patient, but also with their emotional well-being and ability to resume daily activities safely. Furthermore, recovery is seen as an indicator of the success of the care provided, encompassing aspects of education, emotional support, and resource coordination to ensure a safe and effective transition[17].

"Patient safety," in turn, is a central concept in the nurse's practice, encompassing actions that prevent harm, errors, and complications during hospitalization and after discharge. During the construction of the hospital discharge plan, nurses play a fundamental role in identifying risks, communicating essential information, and implementing strategies that ensure patients understand all provided orientations, such as the correct administration of medications, the recognition of warning signs, and the need for adequate follow-up by other health services[18]. The concern with safety reflects nurses' commitment to minimizing risks, preventing adverse events, and promoting a safe transition of care[18].

The word "self-care," emerging in the evocations, reflects contemporary discourses of patient empowerment and responsabilization, articulating with user-centered health policies. Understood as a set of deliberate and learned practices by the individual to meet their own physical, psychological, and social health needs, self-care favors autonomy and co-responsibility[19]. Thus, in the CC, the captured representations regarding the valuation of self-care reveal a tension between the tradition of team-centered care and the gradual shift toward practices that demand patient co-responsibility, allowing them to assume an active role in the effective and sustainable management of their own health[20].

"Transition" also appears as a central concept in the social representations of these professionals. Transitional care is defined as coordinated and effective practices that ensure the continuity of care, minimizing risks and promoting patient safety during this critical process[2]. The effectiveness of this transition depends on a well-structured hospital discharge plan, which includes clear communication among health professionals, case management, and integration of the services involved. During interviews with nurses, "transition" was highlighted as one of the main concerns in patient discharge, reinforcing the need for well-coordinated actions to avoid fragmentations in care.

According to Meleis's Transition Theory[21], the nurse plays a central role as a facilitator of the transition process, acting intentionally and continuously to support the patient and their family facing the changes imposed by hospital discharge. This performance involves personalized health education based on the patient's needs, prior knowledge, and sociocultural context, as well as clear and continuous communication, which is fundamental for establishing a bond, safety, and understanding of the therapeutic plan. Thus, in the construction of the hospital discharge plan, when combined with effective transition strategies, such as systematized planning, encouragement of strengthening self-care, and family involvement, it is ensured that the patient receives adequate support at all stages of care, strengthening the continuity of assistance and improving health outcomes.

The elements composing the second and fourth quadrants, clockwise, constitute representations considered peripheral in relation to the CC. The peripheral system can be considered an indispensable complement that protects the CC, in addition to updating and contextualizing the significant units. They are more flexible elements, which can be modulated based on the experienced reality in which the nurses are inserted. In summary, these elements make the interface between the lived reality and the CC[17].

In the second quadrant, or first periphery, appear "Systematization of Nursing Care" (SNC) (f = 40), "return" (f = 23), "protocol" (f = 18), and "multiprofessional team" (f = 14). Despite the high frequency, high MOEs (3.36–3.71) indicate less immediate evocation, suggesting that these elements possess a more operational and contextual character. They express the instrumentalization of the discharge plan, linking it to the systematization of care, the organization of care through protocols, post-discharge

follow-up, and teamwork. Thus, they function as mediators between the CC and concrete practice, guaranteeing applicability without altering the essential meaning of the representation.

These peripheral elements fulfill the function of updating and protecting the CC, adapting it to concrete working conditions[15]. The evocation of "SNC" refers to the organization of care and the need for standardization of processes. By structuring care through interrelated steps, such as evaluation, diagnosis, planning, implementation, and evaluation, systematization plays an essential role in ensuring that the hospital discharge plan is carried out in a structured and efficient manner[17]. The integration of SNC in this context enables the nurse to use evidence-based interventions, adapting them to the specific needs of each patient, which enhances treatment adherence and recovery at home[22]. Thus, the construction of the hospital discharge plan combined with SNC not only optimizes care management but also strengthens the autonomy of the patient and their family, transforming the moment of discharge into an opportunity for empowerment and continuity of care.

Another relevant aspect refers to the peripheral position attributed to the systematization and recording of care in discharge planning. Although SNC is recognized as a fundamental instrument for care organization, its peripheral location in the representational structure may indicate that, in daily care practice, formal records are frequently perceived as bureaucratic activities in the face of immediate care demands. This finding dialogues with the characterization data captured in the interviews, in which nurses report work overload, a high number of patients, and an accumulation of administrative activities. In this context, the discharge plan tends to be represented primarily as a direct care practice, expressed in orientations to the patient and family, while its documentary formalization may be relegated to the background. This tension between care and bureaucracy reveals an important aspect of social representations: the CC values the assistance and relational dimension of care, while peripheral elements express the operational and organizational difficulties that permeate professional practice.

The mention of the "multiprofessional team" highlights the complexity of transitional care, reinforcing the perception that safe discharge requires collective articulation, although, in practice, this responsibility falls predominantly on the nurse[23]. Studies show that lack of communication and fragmentation of care are significant risk factors for adverse events in hospital environments[24]. In this sense, working in a multiprofessional team is seen as a strategy to minimize errors and increase patient safety. Integration among team members not only improves the quality of care, but also strengthens patient trust and satisfaction with the health service. Another relevant aspect is effective communication, which proves crucial for identifying and resolving potential problems before they affect the patient[25].

Although the theoretical framework supports that the hospital discharge plan constitutes an interdisciplinary process, the results of the FWAT evidenced that the multiprofessional team appears in a peripheral position in the representational structure. This finding suggests that, in daily care practice, discharge planning is still perceived predominantly as a responsibility attributed to the nurse. Such a configuration may reflect what can be termed "assistance solitude," in which the nurse centrally assumes the organization of the continuity of care, often facing institutional limitations for effective interprofessional work. This tension between the interdisciplinary ideal and daily practice is built from the concrete experiences of the subjects. Thus, even though normative discharge is conceived as a collective process, the practical experience of nurses may reinforce the perception that this responsibility falls mostly on their performance.

The term "return" emerges as a result of carrying out a responsible discharge. For the patient, the main benefit is the guarantee of the continuity of care. For this to be effective, efficient articulation among health professionals from the various units comprising the health network is essential. Fluidity of information among different health services contributes to minimizing the risk of hospital readmissions and preventing possible complications.

"Protocol" appears with lower frequency because, according to data obtained in the research, not all hospitals in Bahia have a protocol for the discharge plan of institutionalized patients. Therefore, this dimension is not always consolidated to the point of being part of the imagination and daily practice of these professionals. Protocols include detailed guidelines on patient evaluation, communication of discharge information, patient and family education, and coordination of post-discharge care. Thus, they are essential for safe assistance, as they help standardize the process, ensuring that all patients receive a consistent level of care, regardless of the responsible health professional[1].

Internationally, the use of protocols guiding the transition of care is a habitual practice. In the United States, Europe, and Australia, the practice of care transition mediated by protocols and hospital discharge plans has been structured based on international models of

transitional care, such as the Care Transitions Intervention, the Transitional Care Model, and Better Outcomes for Older Adults through Safe Transitions, widely used. These models include components such as anticipated discharge planning during hospitalization, patient and family education, post-discharge follow-up via home visits or phone calls, medication reconciliation, and contact with primary care or community health services before discharge, reducing readmissions and adverse events in the post-discharge period[25]. Such interventions are widely recommended by organizations such as the Agency for Healthcare Research and Quality for reducing harms and improving safety in the transition of care.

The zone of contrast, or zone of tension, is represented by the third quadrant and possesses elements with low MOEs and low frequencies. These terms reinforce the meanings present in the CC and the peripheries, expressing emerging and potentially transforming values of practice. In this study, the zone of contrast brought together terms such as "safe discharge" (f = 12), "effective communication" (f = 10), and "individuality" (f = 8). Although less frequent, low MOEs indicate that these terms are readily evocable by a subgroup, revealing possible sub-representation or an alternative nucleus. These elements emphasize more specific dimensions of care, such as safety at discharge, communication quality, and respect for individuality, pointing to a vision more centered on the patient and the singularity of care. Such a configuration may indicate tensions or nuances within the studied group.

The evocation of the term "safe discharge" is justified as it is an essential component and final objective of the hospital discharge plan, ensuring that the patient continues to receive adequate care after dehospitalization. This process involves several steps and requires the collaboration of a multidisciplinary team to minimize risks and promote the patient's continuous recovery[1]. Simultaneously, effective communication and the valuation of individuality point to a growing need for the humanization of care, indicating that nurses' social representations already incorporate social demands for more patient-centered practices[21].

In this sense, the evocation of individuality may indicate the emergence of innovative or tension-generating elements of the dominant representation regarding the hospital discharge plan. It thus signals a movement of broadening the understanding of hospital discharge beyond a strictly technical or protocol-based practice, incorporating dimensions related to the patient's singularity, their specific needs, and the sociocultural context in which they are inserted. Thus, this element suggests a possible transition from a representation predominantly centered on procedures and standardized orientations to a more humanized and person-centered conception, aligned with contemporary guidelines of integral care and safe care transition.

In the fourth quadrant of the second periphery, we find "responsibility" (f = 12), "knowledge" (f = 11), "family" (f = 11), "autonomy" (f = 9), "dressing" (f = 9), and "medication" (f = 8). These terms present lower saliency and delayed evocation (MOE: 2.2–2.58), characterizing themselves as more flexible and contextual elements, strongly influenced by practical experience. They represent specific aspects of post-discharge care, such as technical procedures, family involvement, and professional competences. Although less structuring, they contribute to the adaptation of the representation to concrete situations, without directly impacting its core.

The terms "responsibility," "knowledge," and "family" reinforce the perception that the effectiveness of the discharge plan depends not only on professional performance, but also on the co-responsibilization of the patient and their caregivers. The absence of formal contents on the hospital discharge plan in academic training, revealed in the results, articulates with this finding: the lack of institutionalized knowledge weakens the representation, transferring part of the burden of the continuity of care to practical experience and the family.

Regarding the term "knowledge," the research revealed that most professionals reported not having had classes on the subject during undergraduate school. This data highlights a significant gap in training, which reverberates into practice and demands greater investment in the continuing education of nurses on this crucial aspect of care. Converging with this finding, a study points out that many professionals present a low level of knowledge regarding discharge planning, difficulty defining this process, and limitations in applying it in care practice, evidencing the need for education and training programs to enhance this professional competence[15].

In this direction, it is recorded that nurses face several barriers in utilizing the hospital discharge plan, which can compromise care quality and patient safety. The lack of appropriation of the theme, heavy workload, and the need to attend to multiple patients frequently limit the time available for drafting and implementing detailed discharge plans. Another significant impediment is resistance to change. Some professionals may cling to traditional care methods, preferring them over new processes and protocols[4]. Furthermore, the scarcity of studies

and scientific productions on the theme still constitutes a challenge that needs to be overcome. This gap reflects, in large part, the absence of the theme during the academic training of nurses, since the discharge plan is rarely addressed in undergraduate thesis projects or scientific initiation research[1].

In turn, the evocation of the word "autonomy" presents a fundamental aspect in the hospital discharge plan, as it empowers the patient to assume an active and responsible role in their own care after leaving the hospital. Promoting patient autonomy is essential to ensure they can manage their health effectively, make informed decisions, and follow the care plan independently[24].

In light of Abric[8], it is understood that the social representations of nurses regarding the hospital discharge plan reveal a balance between normative dimensions (e.g., orientation, care, and safety), which stabilize practice, and functional dimensions (e.g., protocols, return, and communication), which adapt to the concrete conditions of work. This representational arrangement expresses the professional identity of nursing as a protagonist in the continuity of care, but also exposes tensions related to formative gaps, the absence of institutional protocols, and work overload.

Therefore, the identified representations not only describe individual perceptions, but also reflect a broader social field in which institutional values, professional experiences, and social expectations intertwine. This critical understanding, in turn, imposes relevant practical implications.

For teaching, an expressive formative gap is pointed out regarding the hospital discharge plan, making it imperative to insert the theme transversally into nursing curricula, articulating theoretical foundations, clinical simulations, case studies, and supervised practices that contemplate care transition, patient autonomy, and family involvement.

Within the scope of research, the results indicate the need to expand scientific production on the hospital discharge plan, especially studies exploring professionals' social representations, the impacts of academic training on care practice, and outcomes related to patient safety. Evaluative and interventive investigations can contribute to the development and validation of protocols, educational instruments, and permanent education strategies, strengthening the scientific basis supporting nursing practice in this field.

Regarding implications for professional practice, the CC and identified peripheral elements reinforce the central role of the nurse in coordinating the transition of care, signaling the need to institutionalize the hospital discharge plan as an essential component of assistance, with clear definition of flows, multiprofessional responsibilities, and protected time for its drafting. Furthermore, the importance of strategies promoting patient autonomy and family co-responsibilization is highlighted, with systematic orientations on medication, dressings, and self-care, contributing to the safe continuity of care after hospital discharge.

FINAL CONSIDERATIONS

Nurses' social representations regarding the hospital discharge plan evidence that this process is conceived as a structuring axis for the continuity of care and safe transition between different levels of care. The central elements, orientation, care, safety, recovery, self-care, and transition reflect normative values that sustain the nursing identity as a protagonist in care management. At the same time, peripheral elements, such as protocols, SNC, and the multiprofessional team, reveal tensions between the normative ideal and concrete working conditions, indicating institutional and formative frailties that compromise the consolidation of this practice.

The analysis considering Abric[8] made it possible to understand that the representations of nurses regarding the hospital discharge plan are not restricted to technical procedures, but translate a symbolic construction that articulates professional knowledge, social expectations, and institutional demands. This critical understanding allows us to identify both the aspects that stabilize practice and those that need to be transformed to strengthen assistance.

The results point to the need to incorporate the topic of the hospital discharge plan systematically into undergraduate and postgraduate nursing curricula, expanding the critical and instrumental training of professionals. Similarly, it is urgent that health institutions implement institutional protocols and policies that value the participation of the nurse in coordinating the transition of care, favoring integrated multiprofessional practices and the autonomy of these professionals.

As a limitation, it is highlighted that the study does not aim at the statistical generalization of the results, but rather the understanding of social representations shared by a specific group of nurses, in line with the epistemology of qualitative research. Furthermore, data collection carried out in a virtual environment may present limitations related to unequal access to digital technologies and the inability to control the respondents' environment.

However, this strategy also made it possible to expand the geographical reach of the research and include professionals from different Bahian hospital contexts, contributing to greater diversity of experiences in the analyzed corpus.

It is concluded that strengthening the hospital discharge plan as a care technology demands not only organizational changes, but also the valuation of the symbolic dimension present in nurses' social representations. This valuation is fundamental so that the discharge plan ceases to be a fragmented practice and becomes a consolidated instrument for promoting safety, self-care, and the integrality of health assistance.

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