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Practices of nurses in a university hospital for the continuity of care for primary care[a]

Práticas de enfermeiros de um hospital universitário na continuidade do cuidado para a atenção primária

Prácticas de las enfermeras en un hospital universitario en la continuidad de la atención primaria

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Abstract

Objective: to understand the practices of nurses from a university hospital in the continuity of care for primary care. **Method:** an exploratory, descriptive, and qualitative study, conducted between August and November 2019, in a university hospital in Southern Brazil, with 21 nurses and the director of Nursing, applying, respectively, an online instrument in the Survey Monkey platform and a semi-structured interview. The data collected was submitted to Content Analysis according to Minayo. **Results:** three categories emerged: nurses' practices; strengths and weaknesses, and competencies for continuity of care. On admission and discharge, nurses interview and physically examine the patient. The positive aspects were communication and knowledge of the family context by the multiprofessional hospital team, and the negative aspects were the lack of a computerized system, the integration of hospital professionals with primary care, the nurse discharge manager and the counter-reference protocol. Continuity of care requires from nurses professional experience, knowledge about the care network, communication skills, leadership, and decision making. **Conclusion and implications for practice:** nurses understand the importance of continuity of care, however, some weaknesses found in the institution make it difficult to carry out these practices.

Keywords: Continuity of Patient Care; Transitional Care; Patient Discharge; Hospitals; Primary Health Care.

Resumo

Objetivo: compreender as práticas dos enfermeiros de um hospital universitário na continuidade do cuidado para a atenção primária. **Método:** estudo exploratório, descritivo e qualitativo, realizado entre agosto e novembro de 2019, em hospital universitário no Sul do Brasil, com 21 enfermeiros e a diretora de Enfermagem, aplicando-se, respectivamente, um instrumento *on-line* na plataforma *Survey Monkey* e uma entrevista semiestruturada. Os dados coletados foram submetidos à Análise de Conteúdo segundo Minayo. **Resultados:** emergiram três categorias: práticas dos enfermeiros; fortalezas e fragilidades e competências para a continuidade do cuidado. Na admissão e alta, os enfermeiros realizam entrevista e exame físico do paciente. Os pontos positivos foram a comunicação e o conhecimento do contexto familiar da equipe multiprofissional hospitalar e os negativos, a falta de sistema informatizado, a integração dos profissionais do hospital com a atenção primária, o enfermeiro gestor de altas e o protocolo de contrarreferência. A continuidade do cuidado requer, dos enfermeiros, experiência profissional, conhecimento sobre a rede de atenção, habilidades de comunicação, liderança e tomada de decisão. **Conclusão e implicações para a prática**: os enfermeiros compreendem a importância da continuidade do cuidado, entretanto, algumas fragilidades encontradas na instituição dificultam a realização dessas práticas.

Palavras-chave: Continuidade da Assistência ao Paciente; Cuidado Transicional; Alta do Paciente; Hospitais; Atenção Primária à Saúde.

Resumen

Objetivo: conocer las prácticas de los enfermeros de un hospital universitario en la continuidad de los cuidados de la atención primaria. **Método:** estudio exploratorio, descriptivo y cualitativo, realizado entre agosto y noviembre de 2019, en un hospital universitario del sur de Brasil, con 21 enfermeros y la Directora de Enfermería, aplicando, respectivamente, instrumento online en la plataforma Survey Monkey y una entrevista semiestructurada. Los datos recogidos se sometieron a un análisis de contenido según Minayo. **Resultados:** emergiron tres categorías: prácticas de los enfermeros; fortalezas y fragilidades y competencias para la continuidad del cuidado. En el momento del ingreso y del alta, los enfermeros entrevistan y realizan una exploración física del paciente. Los aspectos positivos fueron la comunicación y el conocimiento del contexto familiar por parte del equipo multiprofesional del hospital, y los negativos la falta de un sistema informatizado; la integración de los profesionales del hospital con la atención primaria; la enfermera gestora del alta y el protocolo de contrarreferencia. La continuidad de los cuidados requiere la experiencia profesional de los enfermeros, el conocimiento de la red asistencial, la capacidad de comunicación, el liderazgo y la toma de decisiones. **Conclusión e implicaciones para la práctica**: Los enfermeros entienden la importancia de la continuidad de los cuidados, sin embargo, algunas debilidades encontradas en la institución dificultan la implementación de estas prácticas.

Palabras clave: Continuidad asistencial; Atención transitoria; Alta de pacientes; Hospitales; Atención primaria.

INTRODUCTION

Continuity of care can be conceptualized as the highest level of connection between services in the health care system experienced by patients[1]. In this sense, in Brazil, the Health Care Network (HCN) was created in an attempt to integrate the different health services, in a horizontal manner, with all points of the network, with a continuous, integral, and quality care[2].

Improving the quality of services contributes to reducing costs and avoidable hospitalizations, overcoming fragmentation of care, and ensuring continuity of care[3-4], which depends on factors such as: good communication and exchange of information between professionals and patients; interdisciplinarity; articulation between the points of the HCN; coordination of care and co-responsibility of the patient about their health[5].

Continuity of care addresses patients, families and caregivers, and the health professionals who provide the care. It is a process that requires, above all, coordination and communication between different professionals and people, considering their experiences and abilities[4], relevant aspects for the transition of care from one point of the care network to another, especially in times of pandemic, when safety, social distance and the performance of necessary care must be carefully prioritized[6].

When the continuity of care occurs from the hospital to Primary Health Care (PHC), there is the need to perform discharge planning by the multidisciplinary team, as well as guidelines for care at home[7]. In the discharge plan, nurses guide the patient and family to promote self-care[8]. However, Brazilian nurses report difficulties in providing continuity of care due to lack of knowledge about the HCN, the absence of clinical protocols and counter-referral[8-9].

In Spain, Portugal and Canada, nurses articulate the hospital service with PHC and are prepared to promote continuity of care[10]. In these countries, Hospital Liaison Nurses (HLN) and Liaison Nurses perform the patient's clinical and social assessment and use protocols at hospital discharge[11].

In Spain, the HLN does this articulation with the PHC nurse by means of a hospital electronic platform, tablet or by phone[11]. In Portugal and Canada, the Liaison Nurse identifies the resources needed at post-discharge for care at home and contacts PHC professionals. This nurse has a computer system that shares the patient's information with an out-of-hospital service that subsequently makes the necessary referrals. Thus, the transfer of information about the patient is carried out by the Liaison Nurse, mostly through the electronic sending of the counter-reference form to an out-of-hospital service[12].

In Brazil, in Curitiba, it was implemented the Liaison Nurse that, since hospitalization, assesses patients who need continuity of care for PHC[9-10]. However, fragmentation in the transition/continuity of care still merits discussion[13]. It is observed that, in most Brazilian hospital institutions, there is no nurse who specifically plays the role of Liaison or Transition Nurse.

The objective of this study, considering that continuity of care should occur according to the needs of individuals and the organization of services, was to understand: "How do nurses' practices in continuity of care occur in a university hospital for Primary Health Care?".

METHOD

This is an exploratory and descriptive study, with qualitative approach, carried out in a university hospital in the South of Brazil, characterized as a general hospital of medium and high complexity, with 238 active beds and that offers clinical and surgical treatments, of Gynecology and Obstetrics, with rooming-in, nursery, Pediatrics, Intensive Care Unit (ICU) adult and neonatal and adult, obstetric/gynecological and pediatric emergencies.

Among the Nursing professionals, 263 are nurses, with distinct functions related to assistance, management, and education. In assistance, the nurse performs hospital discharge, although the position of discharge manager nurse does not exist in this institution.

The director of Nursing and 21 nurses participated in the research, among the 45 invited by convenience, meeting the inclusion and exclusion criteria. Nurses who worked in the Surgical Clinic, Medical Clinic, Pediatric Clinic, Joint Nursing, Gynecology, Adult and Pediatric Emergency units, who were not on vacation or leave, were included. Those who worked the night shift were excluded, due to the reduced number of hospital discharges in this period, and the nurses in the Adult and Neonatal Intensive Care Units, Surgical and Obstetric Center and Obstetric Emergency, because the discharges of these were in-hospital. The Hemodialysis Unit and the outpatient clinics were excluded because there were no hospitalizations in these sectors.

The nurses were personally invited to participate in the study, at which time the project was presented and their email address was requested for later submission of the Free and Informed Consent Term (FICT) and the data collection form on the Survey Monkey platform, a private access electronic tool that proposes the creation, application, collection and analysis of data via the Internet with privacy and data security[14].

This study integrates a multicenter study "The practices of the Liaison Nurse for the continuity of care: multicenter study", with the application of the same collection form with the care nurses of the institution in question. The form has 59 open and closed questions. The main topics addressed were: participants' profile, communication among hospital nurses, and the competences as continuity of care nurse.

The form was available between August and November 2019, and every seven days, nurses, who had not yet responded, received a reminder message on the platform sent by the researchers.

For data collection with the director of Nursing, the interview was conducted in person, using as a guide a script with open questions about the profile of the participant and about discharge management and continuity of care. The interview was recorded on an audio device and transcribed in full to a document in Microsoft Word® format.

The data was analyzed based on Minayo's Content Analysis[15] and, from the junction of the main elements, categories were formed, which are related to the research objectives and the literature

review on the theme. To proceed with the analysis, the participants' answers were extracted from the Survey Monkey Platform and transferred to a spreadsheet in Microsoft Excel® format.

The study complied with Resolution No. 466 of December 12, 2012, and is a cutout of the research "The practices of the Liaison Nurse for the continuity of care: multicenter study," approved by the Ethics Committee on Research with Human Beings, Federal University of Santa Catarina (UFSC), under Opinion No. 3,413,257. To ensure the anonymity of the professionals, beach names were used to name the participants.

RESULTS

Of the 21 participants, 19 were female, with an average age of 36 years and time of work as nurses between eight months and 21 years, ten with specialization, eight with master's degrees, and one with a doctorate. Regarding the time of experience as "discharge nurse manager", eight said they had no experience, eight, the same time as nurses, and five, between five months and eight years.

From data analysis, three categories emerged: practices developed by hospital nurses for continuity of care; strengths and weaknesses for continuity of care; and competencies developed for continuity of care.

Practices developed by hospital nurses for the continuity of care

In the study hospital, there is no position of discharge nurse manager. The care nurses reported that they do not always perform discharge planning due to work overload and the absence of clinical protocols in the institution, but they recognize that it is their attribution.

> *[...] we do not have this nurse with this specific activity [...].* (Gravatá)
>
> *[...] the care nurses perform discharge management [...].* (Mole)
>
> *[...] overload of work, crowded emergency room, resolution of administrative issues, reducing care period [...].* (Joaquina)

Most participants expressed the need for continued care in daily patient visits, collection of clinical data in the medical record and family information. All nurses perform the physical examination and interview with patients and family members in which they consider the patient's past history, comorbidities, socioeconomic status, support network, and assessment of functional capacity to perform activities of daily living.

> *[...] daily visit and evaluation and observation of each patient's needs [...].* (Ponta das Canas)
>
> *[...] based on the patient's life history, socioeconomic and clinical conditions, we try to predict possible protective measures for continuity of care and to avoid readmissions. [...].* (Naufragados)
>
> *[...] personal data, reason for seeking care, comorbidities, personal history, habits, brief physical examination, needs for fall prevention or escape and isolation, etc. [...].* (Barra da Lagoa)
>
> *[...] perceptions and expectations, problems related to basic human needs [...].* (Matadeiro)

Only six nurses considered discharge planning a function of the physician and the social worker. Some nurses reported that discharge planning begins as soon as the patient is admitted to the hospital. Others perform it during hospitalization or only at the moment of discharge, together with the multidisciplinary team. The main professionals involved in hospital discharge are physicians followed by social workers and nurses. When planning for hospital discharge, most nurses interview family members to understand the conditions under which care would be provided at home.

> *[...] in plans that involve intense changes in the family context [...], a conference is held to discuss the needs. This is usually attended by a social worker, psychologist, nurse, doctor, and family members [...].* (Santinho)
>
> *[...] answering questions about how this patient will stay at home, with whom, in whose care, if he or she can afford to keep him or her, if it is possible to return to the clinic, where he or she lives, etc. [...].* (Açores)

At hospital discharge, some care was prescribed by the doctor and nurses, among them: dressings; care with catheters and colostomy; skin care; medical prescription with medication; requests for tests and referrals to specialists.

> *[...] dressing form: explains how the last dressing was performed in the hospital, suggests the dressing to be used, and describes how the dressing should be performed, change period [...].* (Mole)
>
> *[...] hospital discharge summary, discharge card, medical prescription, referrals for appointments, tests, etc. [...].* (Brava)

Communication between the hospital and PHC professionals is rare and, when it occurs, it is done through the hospital's social service. Patient information is provided by physicians in the form of a printed discharge summary, a document that requires the patient to take the information to PHC professionals.

> *[...] only in very specific cases is this contact made with the Basic Unit. But, generally, it is not done. [...].* (Gravatá)

> *[...] the patient carrying the health booklet or forms provided by the hospital [...].* (Brava)
>
> *[...] I believe that there is none in writing, because there is no reference and counter-reference. However, when necessary, and if there is time, contact is made by phone with the BHU [...].* (Santinho)

All the nurses said they were not aware of indicators that adequately assess the continuity of patient care for PHC, however, most of them revealed that they monitor the patient post-discharge by telephone contact and by scheduling appointments and exams at the hospital outpatient clinic.

When a readmission occurs, the health professional is only aware of the fact when the patient is again admitted to the same clinic. On readmission, most nurses stated that they do not inform the PHC professional, even if they have prior knowledge about the resources needed for continuity of care at home, since they have already worked in another health service or in PHC.

> *[...] through informal conversations with Social Service, Medicine, nurse colleagues from the primary health care network [...].* (Santinho)
>
> *[...] for having already worked in primary care [...].* (Solidão)
>
> *[...] information from colleagues and internet [...]. (*Lagoinha do Leste)
>
> *[...] we know of reintegration only when he returns to the same clinic [...].* (Moçambique)

Strengths and weaknesses for continuity of care

Among the strengths found by the nurses for the continuity of care are good communication of the multiprofessional team and knowledge about the family context in which the patient is inserted.

> *[...] good communication among the multiprofessional team [...].* (Mole)
>
> *[...] existence of a multi-professional team within the hospital [...].* (Brava)
>
> *[...] knowledge of the patient's family context [...].* (Santinho)

The weaknesses most cited by the nurses were the excessive workload and administrative processes, the lack of integration of hospital and PHC professionals, the absence of a nurse who manages hospital discharge, the lack of indicators and hospital discharge and counter-referral protocols, as well as the absence of an electronic medical record and computerized system integrated between the hospital and PHC.

> *[...] lack of communication, interaction with other professionals, overload of activities [...].* (Brava)
>
> *[...] lack of time. (*Mole)
>
> *[...] the single medical record would help a lot, it would help a lot. So, if I were to list now the biggest difficulty, I would say that it is this record, the lack of this single record [...].* (Gravatá)
>
> *[...] lack of a specific nurse professional for this function [...].* (Matadeiro)

Competencies for the continuity of care

The nurses expressed that the competence for continuity of care requires care practice, individualized and patient-centered care plan, technical-scientific knowledge about the HCN and the protocols implemented in the hospital institution, integral attention, clear and effective communication with the patient, family and professionals, participation in team meetings, leadership spirit and decision making.

To develop these competencies, training or capacity building with nurses on care management, communication, and information technology are essential. In the hospital under study, these trainings may constitute the permanent health education actions implemented by the Continuing Education Service.

> *[...] capacity building, training, knowledge from various sources [...].* (Barra da Lagoa)
>
> *[...] with active communication between all involved in the patient's care [...].* (Açores)

DISCUSSION

The profile of the nurses in this study resembles the one identified in Portugal about the Liaison Nurse in which the majority is between 35 and 44 years old and female.

The literature highlights the relevance of having, in the hospital, a professional who plays the role of coordinating discharges and articulating the continuity of care with the other points of the HCN, especially with the PHC[12].

Despite this, the care nurses are able to evaluate the patients who require continued care after hospital discharge, an evaluation that is performed during daily visits, in the search for diagnoses in the medical records and in the communication with patients and family members. In Spanish hospital institutions, the HLN are responsible for identifying, among inpatients, those who require continuity of care in PHC, identifying the resources needed for care at home, and providing guidance for self-care[16]. The Liaison Nurses in Portugal assess the patients who need more complex care at the time of the daily visit when they gather clinical data and perform the physical examination. It is recommended that the patient's assessment occurs upon admission or even within the first 48 hours of hospitalization so that discharge planning can begin[17].

The initial and continuous assessment of the patient's needs allows the nurse to plan, in an appropriate manner, the continuity of care, in addition to promoting a bond with the patient and their

family[18]. Regarding discharge planning, it makes it possible to offer individualized activities and information centered on the patient. However, the absence of a discharge plan protocol or counter-reference hinders continuity of care. In hospitals where there is an individualized discharge plan protocol since admission, there has been a reduction of hospital readmissions, which occur due to poor communication between professionals, the patient and the family about orientations and care at home[19].

In this meander, it is emphasized that health education actions, performed by the nurse during discharge planning, are essential to promote self-care and empowerment of the patient and his family, share knowledge, solve doubts related to the health-disease process, and provide pertinent guidance on home care[20].

Although some nurses perform discharge planning, it was not clear in this research that the preparation of the patient for discharge occurs through health education. However, nurses have good communication with patients and families, so that they know the family context and the support network. Still about the preparation for discharge, a study highlighted the relevance of nurses to involve family members in the care during hospitalization with a view to adequate care at home[21]. Family involvement in the recommended post-discharge interventions ensures the success of the care plan and continuity of care at home[19].

At the moment of hospital discharge, patients receive a printed summary of the hospitalization prepared by the physicians and there is rarely communication between the hospital health team and PHC professionals and, when it occurs, it is done by the social worker. Information sharing between services is essential to promote continuity of care and to ensure that PHC professionals are aware of the patients submitted to hospitalization. This communication can be carried out by means of e-mails, telephone calls, detailed discharge reports and integrated computerized system[21]. In the post-discharge period, follow-up by telephone contact, home visits or home care services are important to identify and provide more appropriate resources[18] to continuity of care.

The quality of care depends on factors such as technical competence and the ability of professionals to interact and communicate with patients, family members, and other professionals. Among the strengths revealed by the participants for the continuity of care is the communication between the professionals of the multiprofessional team. A study conducted in Spain with HLN corroborated communication as a facilitator of the continuity of care process, as well as interaction between professionals and teamwork[22].

Knowledge about the patient's family context also emerged in this research as a facilitator for continuity of care. One study highlighted that understanding the patient's support network is essential to understand how the post-discharge care will take place, besides enabling an individualized health education for self-care of patients and family[8].

For the nurses in this study, lack of time and work overload are some of the weaknesses for continuity of care, which, in general, are related to the lack of human resources[23]. The limited number of professionals, the extensive workload, and the work overload collaborate and directly influence the quality of care offered by nurses. Moreover, the work overload interferes with the production of creative and effective actions, which impairs the guarantee of integral access to care at the points of care[24] and continuity of care.

Another weakness highlighted by the participants of this study refers to the lack of articulation among professionals, of reference and counter-reference among the different points of the HCN, and of patient follow-up in the PHC after discharge from the hospital, aspects that strengthen the fragmentation of care[20] This weakness, likewise, has been found in the literature with regard to the care of neonates[25].

The counter-referral service of a quaternary hospital in southern Minas Gerais, implemented in 2017, signaled the challenge of maintaining an integrated and effective system. To improve this reality, the restructuring of referral and counter-referral services, continuing education on the theme, and the creation of a single medical record among all levels of care and throughout Brazil are deemed necessary[26].

One study corroborated the unified electronic medical record as a tool that facilitates communication between different points in the HCN[27]. Counter-referral protocols can also facilitate this dialogue between services of different technological densities. In this sense, the Liaison Nurses, who work at the University Hospital in Curitiba, have implemented a counter-referral protocol in conjunction with the Municipal Health Secretariat. At hospital discharge, they make telephone contact with the PHC nurse to discuss the individual's needs and schedule a consultation. Then the counter-reference form is filled out in two copies, attached to the discharge summary and cover sheet, in which one copy is sent to the PHC coordination, via email, and the other given to the patient. The implementation of the counter-referral protocol was considered very positive because it enables the integration between the points of the HCN and the continuity of care[9].

This study revealed the competencies that should be developed in nurses to work in continuity of care: effective communication with patients, family members, and other professionals; health education; multidisciplinary teamwork; technical and scientific knowledge; and leadership skills, supervision, and ability to articulate with the network. Despite this, the literature complements that there is a need for training nurses to coordinate the most complex cases that require continuity of care[16,28]. The qualification of the professionals is essential to promote quality assistance, achieve the objective of care management and provide integral care[29].

In line with the findings, leadership is one of the main competencies that nurses need to improve, because, in general, it is the nurse who develops the leadership role of his team. The act of leading is present in all of the nurse's activities, from the organization of the service and the relationship with other professionals to decision making. In the hospital environment, the ability to lead has an impact on the service because nurses commonly hold leadership positions[29-30].

Communication is also an important competence for nurses, because teamwork requires nurses to exchange information with the multiprofessional team, the patient and the family member[29], in addition to directly influencing the articulation with other points in the network. Linked to this, the health education that nurses perform with patients and families is made possible by sharing information clearly and effectively, using different communication resources and ensuring that all questions have been answered in order to reduce the levels of anxiety about self-care after hospital discharge[31].

The nurse plays a relevant role in the continuity of care between health services of different technological densities. Thus, it is necessary to expand, value, and qualify the nursing service, aiming at increasingly efficient transitions of care[4].

The research was limited to the scenario of a teaching hospital and, above all, to the care nurses, an aspect that is due to the fact that there is no discharge manager nurse in the investigated institution. However, the study glimpses the important role of hospital nurses in the continuity of care for PHC and the challenges of counter-referral in this process of transition of care.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

The practices developed by the nurses of a teaching hospital for continuity of care are: daily visits to hospitalized patients, interview and physical examination, in addition to hospital discharge planning since admission. At the moment of discharge, patients receive a printed summary of the discharge with important information about the hospitalization and the necessary care at home. Rarely, contact is made by e-mail or telephone with PHC professionals to discuss and/or follow up the patients at this point of the HCN.

The good communication between the hospital's multiprofessional team and the knowledge about the patients' family context were evidenced as strengths for the continuity of care. On the other hand, the lack of integration between the hospital and PHC professionals, the inexistence of an integrated electronic medical record, of a discharge management nurse, of protocols for discharge and counter-referral are among the weaknesses for continuity of care.

Continuity of care requires from nurses: professional practice; technical-scientific knowledge about the HCN and institutional protocols; communication, leadership, and decision-making skills. These competencies can be developed through training and provided by the hospital's Continuing Education Service.

This research allowed us to understand that the continuity of care has been increasingly addressed in the literature, however, in practice, there are still many obstacles that interfere with the continuity of care from the hospital to primary care.

The objectives of this research were achieved, since it was possible to understand the practices of nurses from a university hospital in the continuity of care for PHC.

The results pointed out some weaknesses, among them, the lack of a discharge plan protocol and of a nurse care coordinator, besides the absence of a counter-reference protocol and of a unified electronic medical record with access to the entire HCN.

It was noticed that the professionals know the importance of the continuity of care for PHC, especially for complex patients who need home care.

It was concluded that further research is needed in order to achieve continuity of care in the hospital and PHC contexts, with the objective of overcoming the fragmentation of the HCN and ensuring the comprehensiveness of care.

AUTHOR'S CONTRIBUTIONS

Study design. Lays Souza de Oliveira. Maria Fernanda Baeta Neves Alonso da Costa.

Data collection or production. Lays Souza de Oliveira.

Data analysis. Lays Souza de Oliveira. Maria Fernanda Baeta Neves Alonso da Costa. Patrícia Madalena Vieira Hermida. Selma Regina de Andrade. Juanah Oliveira Debeti. Larissa Martins Novaes de Lima.

Interpretation of results. Patrícia Madalena Vieira Hermida. Selma Regina de Andrade. Juanah Oliveira Debeti. Larissa Martins Novaes de Lima.

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