

NURSING ACTIONS FOR CONTINUITY OF CARE IN PRIMARY HEALTH CARE: A VALIDATION STUDY

Adriéli Donati Mauro¹ 
Danielle Fabiana Cucolo² 
Marcia Galan Perroca¹ 

¹Faculdade de Medicina de São José do Rio Preto, Programa de Pós-graduação em Enfermagem. São José do Rio Preto, São Paulo, Brasil.

²Pontifícia Universidade Católica de Campinas, Programa de Pós-graduação. Campinas, São Paulo, Brasil.

ABSTRACT

Objective: to map and validate, together with specialists, actions to be performed by the Primary Health Care nurse for the continuity of care to the user, after hospital discharge.

Method: validation study with qualitative/quantitative approach. The nursing actions were mapped through two focus groups with 11 nurses; one in a Basic Health Unit and 10 in Family Health Strategies in the municipality of Catanduva, SP, Brazil (qualitative stage) and complemented by other sources. The analysis of the reports occurred through the use of content analysis. The Delphi technique was adopted for content validation by 11 experts with a pre-established consensus of 0.80 and calculation of the content validity index (quantitative stage). The data was collected between December 2019 and March 2022.

Results: nine categories emerged related to the active search for the user/family; scheduling and conducting home visits; matrix support; organization of follow-up; training of caregivers/family members; coordination of the health team; strengthening of professional/patient/family relationships and participation in educational and evaluative actions. The mapping of the actions generated 18 items. There were two rounds of the Delphi Technique. In the first, the content validity index ranged from 0.73 to 1.0 and, in the next, from 0.90 to 1.0.

Conclusion: the validation of 17 of the proposed actions can guide the practice of nurses and contribute to the monitoring and strengthening of continued care and in a network centered on the strengths of users/families/community.

DESCRIPTORS: Continuity of patient care. Process assessment (health care). Patient discharge. Nurse's role. Patient-centered care.

HOW CITED: Mauro AD, Cucolo DF, Perroca MG. Nursing actions for continuity of care in primary health care: a validation study. *Texto Contexto Enferm* [Internet]. 2023 [cited YEAR MONTH DAY]; 32;32: e20230058. Available from: <https://doi.org/10.1590/1980-265X-TCE-2023-0058en>

AÇÕES DO ENFERMEIRO PARA CONTINUIDADE DO CUIDADO NA ATENÇÃO PRIMÁRIA EM SAÚDE: ESTUDO DE VALIDAÇÃO

RESUMO

Objetivo: mapear e validar, junto a especialistas, ações a serem realizadas pelo enfermeiro da Atenção Primária à Saúde para a continuidade do cuidado ao usuário, após a alta hospitalar.

Método: estudo de validação com abordagem quali/quantitativa. As ações do enfermeiro foram mapeadas através de dois grupos focais com 11 enfermeiros; um lotado em Unidade Básica de Saúde e 10 em Estratégias de Saúde da Família do município de Catanduva, SP, Brasil (etapa qualitativa) e complementadas por outras fontes. A análise dos relatos ocorreu mediante o uso da análise de conteúdo. Adotou-se a técnica Delphi para a validação de conteúdo por 11 especialistas com consenso pré-estabelecido em 0,80 e cálculo do índice de validade de conteúdo (etapa quantitativa). Os dados foram coletados entre dezembro de 2019 e março de 2022.

Resultados: emergiram nove categorias relativas à busca ativa do usuário/família; agendamento e realização de visita domiciliar; matriciamento; organização do acompanhamento; capacitação dos cuidadores/familiares; coordenação da equipe de saúde; fortalecimento das relações profissionais/paciente/família e participação em ações educativas e avaliativas. O mapeamento das ações gerou 18 itens. Ocorreram duas rodadas da Técnica Delphi. Na primeira, o índice de validade de conteúdo variou de 0,73 a 1,0 e, na seguinte, de 0,90 a 1,0.

Conclusão: a validação de 17, das ações propostas, pode nortear a prática do enfermeiro e contribuir no monitoramento e fortalecimento do cuidado continuado e em rede centrada nas forças dos usuários/famílias/comunidade.

DESCRITORES: Continuidade da assistência ao paciente. Avaliação de processos (cuidados de saúde). Alta do paciente. Papel do profissional de Enfermagem. Assistência centrada no paciente.

ACTUACIONES DE ENFERMEROS PARA LA CONTINUIDAD DE LA ATENCIÓN EN LA ATENCIÓN PRIMARIA DE SALUD: ESTUDIO DE VALIDACIÓN

RESUMEN

Objetivo: mapear y validar, junto con especialistas, las acciones a realizar por el enfermero de la Atención Primaria de Salud para la continuidad del cuidado al usuario, después del alta hospitalaria.

Método: estudio de validación con enfoque cualitativo/cuantitativo. Las acciones del enfermero fueron mapeadas a través de dos grupos focales con 11 enfermeros; uno en una Unidad Básica de Salud y 10 en Estrategias de Salud de la Familia en el municipio de Catanduva, SP, Brasil (etapa cualitativa) y complementado con otras fuentes. El análisis de los informes ocurrió a través del uso del análisis de contenido. La técnica Delphi fue adoptada para la validación de contenido por 11 expertos con consenso preestablecido de 0,80 y cálculo del índice de validez de contenido (paso cuantitativo). Los datos se recopilaron entre diciembre de 2019 y marzo de 2022.

Resultados: surgieron nueve categorías relacionadas con la búsqueda activa del usuario/familia; programar y realizar visitas domiciliarias; soporte de matriz; organización del seguimiento; formación de cuidadores/familiares; coordinación del equipo de salud; fortalecimiento de las relaciones profesional/paciente/familia y participación en acciones educativas y evaluativas. El mapeo de las acciones generó 18 ítems. Hubo dos rondas de la Técnica Delphi. En el primero, el índice de validez de contenido osciló entre 0,73 y 1,0 y, en el siguiente, entre 0,90 y 1,0.

Conclusión: la validación de 17 de las acciones propuestas puede orientar la práctica de los enfermeros y contribuir para el acompañamiento y fortalecimiento del cuidado continuado y en red centrado en las fortalezas de los usuarios/familias/comunidad.

DESCRITORES: Continuidad de la atención al paciente. Evaluación de procesos (atención a la salud). Alta del paciente. Rol de la enfermera. Atención dirigida al paciente.

INTRODUCTION

The continuity of care has been debated worldwide as a responsibility of all levels of health care, above all, it stands out as a principle of primary care (PHC)¹⁻². It is associated with a better user-professional relationship, greater satisfaction and therapeutic adherence, and a reduction in hospital admissions, adverse events, deaths, and costs³⁻⁴.

Defined as the degree of experience that a person has about health care according to their needs and preferences, through interconnected events over time, it combines informational, relational and managerial elements⁵⁻⁶. Informational continuity comprises the segment of information for planning current and future care. It depends on the interaction between professionals, services and from these with the users/family members, protagonists in the care practice. Continuity requires coordinated actions to meet the complex health demands in a timely manner, considering the multiple providers⁵⁻⁶.

The Brazilian health system is structured in care networks (RAS), highlighting PHC as the central point in the management, communication and coordination of care. Likewise, the discussions about coordination of care aiming at continuity, integrality and centrality in the user are intense in the PHC⁷ environment. The National Policy for Basic Care foresees a resolute PHC and traces the continuity and coordination of care between the principles and guidelines for the operationalization in RAS⁸, but does not specify actions pertinent to health teams.

Nurses work in the coordination and continuity of care in the various points of the RAS⁷ and this practice has been driven mainly by the need to expand access to care for vulnerable users/families, especially in maternal and child care and in the management of chronic diseases⁹. A recent review of coordinating actions with users with complex needs in PHC showed three groups of activities: direct care, actions directed to health teams and those that bring users and professionals together. Interpersonal communication and information transfer were identified as transversal actions and, among the critical components, the frequency of activities, relational continuity and home visits stood out¹⁰.

As a theoretical reference to guide the practice of nurses, the strength-based care model (SBC) was adopted to integrate nursing with specific populations in the management of chronic illnesses¹¹ and health promotion¹². This model centers the care on the person (user/family) and recognizes, in addition to health problems, the skills, abilities and resources that can support self-care and the care segment¹³. Furthermore, it adds the movement of empowerment and a culture that favors the promotion of health, the prevention of injuries and the development of self-care as fundamental elements¹⁴. These aspects converge as the principles and guidelines of SUS (Brazilian Unified Health System)⁸, as assumptions of continuous care⁵⁻⁶ and demonstrate the specificity and scientificity that the nursing care require¹².

However, due to the complexity of the work of the PHC nurses, or the uniprofessional training model turned towards professors, the deficiencies in the articulation between the services and the referral and counter-referral process, the shortcomings and the lack of integrated information systems are factors that still limit coordination and continuity of care¹⁵.

It is known that universal health and quality coverage will not be possible without strengthening the actions to continue caring¹⁶ and, also, that nurses can be a reference for other professionals in strengthening this process¹². No investigations have been identified, at this time, on the specific actions of nurses for the continuity of care in the Brazilian PHC reality. And, given these challenges, the question is: according to specialists on the subject, what activities should be carried out by PHC nurses to promote continuity of care, after hospital discharge? In this sense, this study aims to: map and validate, together with specialists, actions that will be carried out by nurses from Primary Health Care for the continuity of care for the user, after hospital discharge.

METHOD

Validation study with a quali/quantitative approach. Initially, qualitative data were collected and interpreted through the focus group technique (FG) to enable the immersion of the investigated phenomenon and the exploration of the experiences of participants¹⁷. In the second stage (quantitative), the content validation study was carried out in which the items of the scale (actions) were analyzed, appropriately representing the construct¹⁸. Activities or actions constitute the behaviors of the nursing team and their combination composes a patient care intervention¹⁹.

The mapping of the activities was conducted from the construct of the nurses for the continuity of care in PHC, complementing the data obtained from the FG with the search for scientific evidence in national and international literature. The list built was submitted to specialist validation (Delphi technique) to evaluate if all the domains of the construct were contemplated through evaluation rounds of questions/answers to a semi-structured questionnaire until the pre-established consensus was reached²⁰.

The scenarios consisted of 10 units of the Family Health Strategy (FHS) and one Basic Health Unit (BHU) in the municipality of Catanduva, SP, Brazil. PHC in this locality is organized in five BHUs; 25 USF and five Expanded Nuclei of Family Health and Primary Care (NASF-AB) under the management of a Social Health Organization. Data collection of the qualitative phase occurred from December 2019 to April 2020; The second stage of the research began in September 2021, ending in March 2022.

To carry out the two FGs, 10 nurses from the USF and one from the UBS participated; indicated, for convenience by the technical coordinator of the PHC units. The sample included professionals (nurses) both who assumed care demands and those who coordinated the unit and the teams, as long as they were active in the units during data collection and were not in the probationary period. The sessions took place in the morning (six participants) and afternoon (five participants), with two distinct and representative groups of a given reality composed of at least four participants, as recommended¹⁷. The meetings took place in the practice context and lasted, on average, for 60 minutes.

One of the researchers (ADM), a specialist with experience in PHC, led the groups, explaining the research objectives and provided guidance on completing the categorization questionnaire, considering sociodemographic and labor variables. They were guided by the following questions: What actions does the PHC nurse perform in the responsible discharge process to continue patient care in the community? How/when is the first contact with the patient and/or family after hospital discharge? Which professionals participate in care planning after responsible discharge?

The transcription of the reports followed the recommendations of the content analysis²¹. Initially, there was a pre-analysis of the speeches by two researchers through a careful reading of the material based on the research objectives and questions. At this moment, hypotheses were formulated from the preliminary perceptions about the reports based on the theory of care based on strengths¹⁴. Subsequently, representative excerpts of nurses' actions were highlighted and common record units were categorized. The researchers' inference and interpretation supported by the theory of forces¹⁴ allowed the construction of sentences about the actions of PHC nurses for the continuity of care.

The phrases/actions generated in the FGs were evaluated for similarities and differences and also complemented with other sources of information, such as: the Classification of Nursing Interventions¹⁹ (8020 – Meeting for evaluation of multidisciplinary care; 7690 – Exchange of information on health care; 7400 – Guidance on the health system; and, 8100 – Referral); the National Policy of Primary Care⁸ and scientific productions that address nurses' actions/activities in the discharge in charge, transition and continuity of care^{9-10,13}.

The related actions were then grouped in chronological order of execution based on the discussion and consensus between the three researchers: one with experience in PHC and two professors with experience in the development and validation of health instruments. Thus, an initial list of PHC nurses' actions for continuity of care was obtained.

After mapping the actions, the composition of the panel of experts began using the Delphi technique. To this end, a search was carried out in national scientific productions regarding the transition and continuity of care and, furthermore, reference professionals were requested through contact with members of research groups linked to universities. Initially, 12 nurses with more than three years of experience in providing care or teaching in PHC, Public or Collective Health were invited via electronic message (email) with the provision of a link to access the online form and reminders every 15 days. After 45 days, due to the low adherence of the answers, six more specialists were contacted, following the same criteria, with reminders every 10 days until completing 30 days. Thus, there were a total of 18 guest judges and a 75-day deadline for responses. Of these, 11 agreed to participate; however, in the Delphi 2 phase, one of the specialists withdrew participation and, therefore, the panel was composed of 10 professionals.

The actions generated were structured on a four-point Likert scale ranging from strongly disagree (1) to strongly agree (4). They included the recruitment of the patient/relative to the PHC units, the review of the discharge plan and continued care, involving the interprofessional team; and, home visits to identify needs, provide guidance, procedures and interaction with other services, in addition to coordinating the management of the health team.

The form containing explanations about the research with an option to accept participation, questions concerning professional characterization and the list of 18 actions generated were inserted into the Google Forms application. Experts were asked to assess relevance, clarity, wording and content with the possibility of suggestions. Special attention was also requested to verify the verb used would allow the measurement of the time required by the nurse to carry out the actions.

The project was approved by the Research Ethics Committee of the municipality where the study was carried out, with participants accepting the Terms of Free and Informed Consent (TCLE). As a way of guaranteeing anonymity, professionals were identified as Primary Care nurses, followed by numbers (EAP1, EAP2, ...).

The calculations were processed using the SAS System for Windows (Statistical Analysis System), version 9.2. A descriptive analysis of categorical and numerical variables was performed with measures of central tendency.

The congruence of the judges' opinions was obtained through the Content Validity Index (CVI-I) calculated through the proportion of agreement in each of the items/actions, considering the sum of ratings 3 and 4 of the responses on the Likert scale, and dividing by the number of judges in each round of the Delphi technique¹⁸. This index was adjusted using the modified Kappa (K*), avoiding agreement by chance, and its minimum value was established at 0.80¹⁸. For the Kappa interpretation, the following intervals were assumed: ≤ 0.40 (poor), $0.40 - 0.59$ (moderate), $0.60 - 0.74$ (good) and >0.74 (excellent)²².

RESULTS

The content analysis of the FGs with 11 PHC nurses made it possible to extract nine categories (actions) related to the continuity of care (Chart 1).

Chart 1 – Categories (actions) that emerged from the Focus Groups with Primary Health Care nurses and their excerpts. Catanduva, S P, Brazil, 2021. (n=11).

Categories (actions)	Excerpts – FG* Nurse PHC
Contacts the family to attend the referral unit (PHC) [†] after hospital discharge.	[...] <i>After receiving the discharge we evaluated and then we contacted the Family [...]</i> (EAP4). [...] <i>I ask a responsible person to look for the unit so that we can be scheduling a visit [...]</i> (EAP5).
Schedules and conducts the first home visit to assess social needs and conditions.	[...] <i>Through the home visit, we go to the residence and assess the needs and conditions [...]</i> (EAB4).
Delegates the active search to the Community Health Agent through home visits.	[...] <i>If the family member does not come, we ask the community agent to make an active Search</i> (EAP9).
Forwards the case to Matrix Support – Interprofessional Planning.	[...] <i>we start planning from the moment we receive e-mail, we have already matrixed in the team meeting or NASF[‡] [...]</i> (EAP9).
Holds a meeting with the unit's team to organize the follow-up.	<i>The actions would be these [...]</i> meeting, matrixing, planning and involving other professionals [...]
It supports the family by training caregivers for home health care.	[...] <i>We evaluate, teach and guide the family members to be performing this dressing, because it is impossible for us to be going every day in this residence [...]</i> (EAP2).
Coordinates the health teams performing the distribution of activities.	[...] <i>Planning, implementation together with the team through matrix support, organization of the entire work process and continuity planning the next dates of follow-up</i> (EAP8).
Strengthens the relationships between professionals, patient and family to achieve the objectives / (Interaction: team / patient / family).	[...] <i>From the first visit in the first evaluation, we already present ourselves as the team of the nearest unit and explain to them, we are here to make the first evaluation and [...]</i> all patient care is done together with the family member (EAP8).
Participates in educational actions for the continuity of care.	[...] <i>is that when you need a training right to perform some procedure and we answer that we do not have this training they provide [...]</i> (EAP9).

*FG: Focus Group; †PHC: Primary Health Care; ‡NASF: Extended Center for Family Health.

From the literature^{9–10,13}, it is possible to identify other actions related to health needs, discharge plan, equipment and supplies, information sharing, coordination of care, need for transportation and training of family members, among others.

After reviewing the wording, we opted for the presentation of the verb in the infinitive, at the beginning of the sentence, and execution sequence close to that performed by the nurses in the practice setting. At the end, the list generated 18 items which were submitted to the appreciation of specialists.

The participants were 11 female professionals (six clinical nurses and five professors), with a mean age of 38.9 (8.7) years, mean time of professional activity of 15.3 (8.1) years and of work in PHC of 8.7 (5.6) years. Six of them reported having a doctorate (one in progress), three with a Master's degree (one in progress) and two with Specialization.

There were two rounds of the Delphi Technique. In the first, the judges considered the actions pertinent (72.7 to 100%) and clear (81.8 to 100%) with mean values of the scores ranging from 3.0 to 4.0 (-) (Table 1).

Table 1 – Relevance, clarity and mean values of nurses' activities in PHC obtained in the Delphi 1 phase. Catanduva, S P, Brazil, 2022. (n=11).

Activities	Pertinence (%)	Clarity (%)	*M(DP)	†Md(IIQ)
1. Request patient attendance	100	100	3(-)	3(-)
2. Review discharge plan	100	90.9	3.9(0.3)	4(-)
3. Discuss the need for active search	100	90.9	3.7(0.5)	4(1)
4. Schedule the home visit	100	81.8	3.8(0.4)	4(-)
5. Perform initial home visit	100	100	4(-)	4(-)
6. Identify health needs	100	81.8	3.5(0.9)	4(1)
7. Guiding patient/family: processes	100	100	3.8(0.4)	4(-)
8. Explain the care system	100	100	3.9(0.3)	4(-)
9. Empowering caregivers	100	100	3.8(0.6)	4(-)
10. Perform procedures – home	100	90.9	3.9(0.3)	4(-)
11. Participate in interprofessional meeting	100	81.8	3.7(0.5)	4(1)
12. Organize/coordinate team meetings	100	81.8	3.7(0.5)	4(1)
13. Coordinate team attendances	91,9	100	3.7(0.9)	4(-)
14. Identify return schedule	81,8	90.9	3.4(1.2)	4(-)
15. Identify transportation needs	72,7	100	3.3(1.3)	4(2)
16. Plan rehabilitation/SAD care‡	81,8	100	3.7(0.9)	4(-)
17. Carry out educational actions: professionals	100	90.9	3.9(0.3)	4(-)
18. Attend meetings with managers	100	100	3.9(0.3)	4(-)

*M (SD):mean(standard deviation), †Md (IQR): median (Interquartile range) IQR = Q3-Q1; ‡SAD: Home Care Service.

In this phase 1, the CVI-I ranged from 0.73 to 1.0 (12 activities) with K* values between 0.7 and 1.0. Identifying the need for transport with CVI-I of 0.73 was not validated, considering the minimum agreement value of 0.80 (Table 2).

Table 2 – Content Validity Index and modified Kappa regarding the answers obtained about the activities of the PHC nurse in the Delphi 1 phase. Catanduva, São Paulo, Brazil, 2022. (n=11).

Activities	CVI-I*	Pc†	K*‡
1. Request patient attendance	1.00	-	1.00
2. Review discharge plan	1.00	-	1.00
3. Discuss the need for active search	1.00	-	1.00
4. Schedule the home visit	1.00	-	1.00
5. Perform initial home visit	1.00	-	1.00
6. Identify health needs	0.91	0.005	0.91

Table 2 – Cont.

Activities	CVI-I*	Pc†	K*‡
7.Guiding patient/family:processes	1.00	-	1.00
8. Explain the care system	1.00	-	1.00
9. Empowering caregivers	0.91	0.005	0.91
10. Perform procedures – home	1.00	-	1.00
11.Participate in interprofessional meeting	1.00	-	1.00
12. Organize/coordinate team meetings	1.00	-	1.00
13. Coordinate team attendances	0.91	0.005	0.91
14. Identify return schedule	0.82	0.027	0.81
15. Identify transportation needs	0.73	0.081	0.70
16.Plan rehabilitation/SAD care§	0.91	0.005	0.91
17.Carry out educational actions: professionals	1.00	-	1.00
18.Attend meetings with managers	1.00	-	1.00

CVI-I: content validity index of the items; †Pc: probability of random agreement; ‡K: Modified Kappa; §SAD: Home Care Service.

Based on the experts' comments, some items were improved or modified for the second version of the activity listing. It was decided to exclude items 14 (Identify return appointment) and 15 (Identify the need for transport), as they were already included in items 8 (Explain the service system) and 16 (Plan care with rehabilitation/SAD). Also, a new item regarding the evaluation of the process was included, and five activities were forwarded for further appreciation.

10 judges participated in the second round of the Delphi Technique. They considered the five actions pertinent (90 to 100%) and clear (80 to 100%). Mean values ranged from 3.4 (1.0) – Explaining the functioning of the care process in the health care network – to 3.8 (0.4) for Guiding the team to carry out an active search and follow-up of the patient and plan care together with other services in the care network (Multidisciplinary Home Care Team – EMAD). In it, a variation of the CVI from 0.90 to 1.0 was found (Table 3).

Table 3 – Content Validity Index and modified Kappa regarding the answers obtained about the activities of the PHC nurse in the Delphi 2 phase. Catanduva, S P, Brazil, 2022. (n=10).

Activities	CVI-I*	Pc†	K*‡
1.Guide the team to carry out the active search and follow-up of the patient	1.00	0.001	1.00
2. Plan the home visit to identify needs	1.00	0.001	1.00
3. Explain the functioning of care in the health care network	0.90	0.031	0.90
4. Plan care together with other services of the care network: (EMAD)	1.00	0.001	1.00
5. Evaluate the care to the user/family and qualify the care.	0.90	0.001	0.90

CVI-I: index of content validity of the items; †Pc: probability of random agreement; ‡K: Modified Kappa.

While all five actions were validated, some terms in the wording were changed or added at the judges' suggestions. The new listing is presented in Chart 2.

Chart 2 – List of activities to be performed by PHC nurses for continuity of care, validated by the judges. Catanduva, S P, Brazil, 2022. (n=11).

ACTIVITIES	
1	Request, by telephone, the attendance of the user/family member to the reference unit
2	To find out about the discharge plan received from the hospital institution and to recommend adjustments, if necessary, to this service.
3	Guide the team to establish as a routine the active search and follow-up of the user who received/will be discharged.
4	Plan the home visit with the health team to identify the health needs and social conditions of the user.
5	Conduct the initial home visit to assess care needs and social conditions.
6	Identify the health needs, the use of equipment and/or supplies and the degree of autonomy of the user/family for the implementation of care at home.
7	Guide user/family on flows/processes to obtain equipment/supplies and, if necessary, make the request.
8	Explain the functioning of the care process in the health care network and the scheduling for return/follow-up.
9	To train caregivers for home health care through verbal, written and demonstration of procedures, when necessary, welcoming and clarifying doubts and complaints.
10	Perform follow-up visits and/or nursing procedures at home.
11	Organize meetings with the health unit team to share user information, discuss the situation and plan interventions.
12	Participate and/or coordinate interprofessional planning meetings.
13	Coordinate the care of the team of your health unit and home visits.
14	If necessary, plan care with other services of the health care network (rehabilitation, Multiprofessional Home Care Team – EMAD and others) for the integration of care.
15	Carry out educational actions for the development of professionals focused on the process of responsible discharge and continuity of care.
16	Participate in meetings with managers and/or representatives of the different levels of health care to articulate actions/flows/protocols related to hospital discharge, transition and continuity of care.
17	Evaluate the care needs of the user/family and discuss with the health team the strategies for care qualification.

DISCUSSION

The activities to be carried out by PHC nurses for the continuity of care after hospital discharge were mapped in this study and, after two cycles of evaluations by specialists; 17 of them were validated. They ratified the priority care coordination actions^{7,10,15} for care centered on the needs of users/families/community⁶.

Recruiting users/relatives to continue care at the health units through telephone search or direct contact with the team should be an action of nurses in the first days, after hospital discharge, to recognize daily demands and help in adapting to life and patients. care²³. For family members/caregivers of people with neurological sequelae, the feeling of unpreparedness and lack of support from PHC prevails in the national context, in relation to home care²³.

The trajectory of users in the RAS is still focused on the search for specialized services and the difficulty of accessing consultations, exams, in addition to the fragility of the counter-referral process,

and these issues represent a rupture in the lines of care and ties with the PHC^{15,24}. The active search of users/relatives aims to strengthen relational continuity, i.e, their bond with professionals/services.

The information necessary to continue post-hospital care, when duly documented (discharge plan) and shared with the reference health units, should be evaluated by the PHC nurses to forward the demands and relevant interventions. Deficiencies in discharge planning, such as: absence, outdatedness and illegibility of records, data limited to the request for resources and lack of involvement of the user and services in its development justify, above all, this assessment by the nurse^{15,25}. Differently from the Spanish reality, in which PHC and hospital care services share data through a computerized and integrated system²⁶; informational continuity is an important challenge in the Brazilian RAS. The active search of users/family members aims to strengthen relational continuity, that is, their bond with professionals/services.

The transfer of health information has been marked by informality, via e-mail or telephone, and by the responsibility of users/family members for the transfer of information about care²⁵. Among the activities listed and validated by the judges, PHC nurses must dedicate themselves to sharing information and educational activities with users/family members and the team so that care is continued. However, given the high workload, in some contexts, nurses prioritize acute demands to the detriment of health education¹¹.

The performance of home visits¹ is confirmed as a critical action to the practice of PHC nurses. This enables direct and integral assistance to the user, family and caregivers, in addition to the recognition of individual skills and resources for the development of user autonomy¹⁰, promoting, from the SBC perspective, the culture of self-determination and self-care¹⁴.

The other validated activities corroborate the coordination of direct and indirect care⁹⁻¹⁰. This means that PHC nurses should identify eligible users/families to continue providing care, establish needs, plan and execute care inherent to the profession, in addition to developing educational actions, engagement relationships, planning and promoting (self) care with users /families, health teams and managers¹⁰.

Developing a sense of integrality and continuity of care in health teams is a premise for the empowerment and engagement of professionals and users/family members. This movement demands access to information and learning to expand the capacity for criticism and choices¹⁴.

The nurse is highlighted for the connection activities between the subjects involved in the care and the different levels of care, which contributes to the strengthening of comprehensive, continuous, and person-centered care. In this sense, continuity and coordination of care must go hand in hand⁶⁻⁷. It is important to emphasize that all professionals at different points of the RAS must participate in the coordination of care and, in PHC, this is a daily practice in teams¹⁵.

In this study, the judges' comments contributed to the addition of an activity and were crucial in reviewing the wording and grouping items. The added activity "Assessing the care needs of the user/family and discussing strategies for qualifying care with the health team" was indicated considering the user/family experience as fundamental, as well as the collaboration of the team in improving the process. In the perception of users from two Latin American countries (Brazil and Colombia), the transfer of information and the coherence of care between levels of care are weak points that indicate a lack of counter-referral and commitment to continuous monitoring of care. On the other hand, relational continuity was better evaluated considering, as a predictive factor, the adequate disposition of professionals²⁷.

Measuring and improving managerial, relational and informational continuity should be a concern of all health systems to achieve greater equity and quality in user care¹⁶. In addition, continuity of care is an important indicator for the sustainability of health services, reducing costs and risks of rehospitalization^{3,28}.

The activities listed for the continuity of care in PHC should already be part of the nurses' scope of practice and, considering the SBC model, the actions should direct the assessment and interventions based on personal strengths and external to the condition of each user/family. The validated list can contribute to the training of nurses in PHC, especially in the coordination and continuity of care after discharge, and also in monitoring and strengthening actions inherent to the practice of health teams.

This research was developed in the pandemic scenario, and, as it depends on adherence to the validation rounds (Delphi technique), it was necessary to increase the number of invited judges to meet the number of evaluators suggested in the literature²⁰. The role of nurses in PHC is widely explored in the literature⁷⁻¹⁰, but evidence on the activities and time dedicated to continuing care remains scarce.

In addition, Brazilian studies are mostly focused on the approach to the continuity of care in hospital care, and investigations involving PHC are important due to the role assumed in the Brazilian health system and, mainly, due to the existing gaps in the coordination of care and in the bond with users assigned to this level of care^{9-10,15}. This is a theme that still needs to be widely explored for its conceptual and political consolidation and, above all, for the strengthening of the RAS^{27,29}.

CONCLUSION

Seventeen activities to be carried out by the PHC nurse were validated for the continuity of care for the user, after hospital discharge, considering the Brazilian reality. The nurse's role in coordinating care through interrelational, informational and managerial actions is evidenced, enabling the continuity of care for users and family members. This list of actions can guide the practice of nurses in PHC, contributing to teaching, process management and the consolidation of continued care, centered on strengths and RAS.

Among the limitations of the study, it is mentioned that some specific contextual factors such as the implementation of call centers, which still lack data available in the scientific literature, were not considered. The activities of the other members of the health team who work in collaboration with the nurse were also not explored. It was limited to the demands of the PHC nurse for further analysis of the time dedicated by this professional in the process. And, because it is a cross-sectional study, the complexity and dynamics of health care can increase other non-validated activities over time.

It is suggested that other studies be carried out, in different regions of the country, with the aim of verifying the viability and impacts of actions with users/families/community. Investigating the performance of the health team and the perception of users/families about continuing care activities are also fundamental for political and practical advances in PHC and RAS.

REFERENCES

1. Walker RL, Faris P, Spenceley S, Lewanczuk R, Wedel R, Love R, et al. Association between continuity and access in primary care: a retrospective cohort study. *CMAJ Open* [Internet]. 2020 [cited 2023 Jan 13];8(4):E722-E730. Available from: <https://www.cmajopen.ca/content/cmajo/8/4/E722.full.pdf>
2. Alyafei A, Al Marri SS. Continuity of care at the Primary Health Care Level: narrative review. *J Family Med Prim Care Open Acc* [Internet]. 2020 [cited 2023 Jan 20];4:146. Available from: https://www.gavinpublishers.com/assets/articles_pdf/1591599821article_pdf867427708.pdf
3. Chan KS, Wan EYF, Chin WY, Cheng WHG, Ho MK, Yu EYT, et al. Effects of continuity of care on health outcomes among patients with diabetes mellitus and/or hypertension: a systematic review. *BMC Fam Pract* [Internet]. 2021 [cited 2023 May 13];22:145. Available from: <https://doi.org/10.1186/s12875-021-01493-x>

4. Gheno J, Weis AH. Care transtion in hospital discharge for adult patients: integrative literature review. *Texto Contexto Enferm* [Internet]. 2021 [cited 2021 Dec 6];30:e20210030. Available from: <https://doi.org/10.1590/1980-265X-TCE-2021-0030>
5. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. *BMJ* [Internet]. 2003 [cited 2021 Oct 15];327:1219-21. Available from: <https://doi.org/10.1136/bmj.327.7425.1219>
6. World Health Organization. Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services. [Internet]. World Health Organization; 2018 [cited 2021 Oct 10]. Available from: <https://apps.who.int/iris/handle/10665/274628>
7. Santos MTD, Halberstadt BMK, Trindade CRPD, Lima MADDs, Aued GK. Continuity and coordination of care: conceptual interface and nurses' contributions. *Rev Esc Enferm USP* [Internet]. 2022 [cited 2023 Jan 20];56:e20220100. Available from: <https://doi.org/10.1590/1980-220X-REEUSP-2022-0100en>
8. Ministério da Saúde (BR). Gabinete do Ministro. Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília: Ministério da Saúde; 2017 [cited 2019 Feb 27]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html
9. Swanson, M, Wong, ST, Martin-Misener, R, Browne, AJ. The role of registered nurses in primary care and public health collaboration: A scoping review. *Nursing Open* [Internet]. 2020 [cited 2022 Aug 12];7(4):1197-207. Available from: <https://doi.org/10.1002/nop2.496>
10. Karam M, Chouinard MC, Poitras ME, Couturier Y, Vedel I, Grgurevic N, et al. Nursing Care Coordination for Patients with Complex Needs in Primary Healthcare: A Scoping Review. *Int J Integr Care* [Internet]. 2021 [cited 2022 Aug 6];21(1):16. Available from: <https://doi.org/10.5334/ijic.5518>
11. Nohra RG, Rothan-Tondeur M. A Novel Empowerment System for Patients Living with a Chronic Disease in a Precarious Context. *Int J Environ Res Public Health* [Internet]. 2022 [cited 2022 Aug 12];20(1):601. Available from: <https://doi.org/10.3390/ijerph20010601>
12. Silva OBM, Bernardino E, Encarnação P, Lima LS, Silva OLS, Rorato C. Strengths-based nursing and healthcare: Perception of women in a usual risk maternity hospital. *Cogitare Enferm* [Internet]. 2022 [cited 2022 Sep 12];27:e78853. Available from: <https://doi.org/10.5380/ce.v27i0.78853>
13. Aued GK, Bernardino E, Silva OBM da, Martins MM, Peres AM, Lima LS de. Liaison nurse competences at hospital discharge. *Rev Gaúcha Enferm* [Internet]. 2021 [cited 2022 Mar 6];42(spe):e20200211. Available from: <https://doi.org/10.1590/1983-1447.2021.20200211>
14. Gottlieb LN. O cuidar em enfermagem baseado nas forças: saúde e cura para a pessoa e família. Portugal: Lusodidacta; 2016.
15. Ribeiro SP, Cavalcanti MLT. Primary Health Care and coordination of care: device to increase access and improve quality. *Cien Saude Colet* [Internet]. 2020 [cited 2022 Apr 12];25(5):1799-808. Available from: <https://doi.org/10.1590/1413-81232020255.34122019>
16. Schwarz D, Hirschhorn LR, Kim J, Ratcliffe HL, Bitton A. Continuity in primary care: a critical but neglected component for achieving high-quality universal health coverage. *BMJ Global Health* [Internet]. 2019 [cited 2022 Mar 12];4:e001435. Available from: <https://doi.org/10.1136/bmjgh-2019-001435>
17. Hennink MM, Kaiser BN, Weber MB. What influences saturation? estimating sample sizes in focus group research. *Qual Health Res* [Internet]. 2019 [cited 2022 Mar 12];29(10):1483-96. Available from: <https://doi.org/10.1177/1049732318821692>

18. Polit DF, Beck CT, Owen SV. Is the CVI an acceptable indicator of content validity? Appraisal and recommendations. *Res Nurs Health* [Internet]. 2007 [cited 2022 Mar 12];30(4):459-67. Available from: <https://doi.org/10.1002/nur.20199>
19. Wagner CM, Bulechek GM, Butcher HK, Dochterman J. *Classificação das Intervenções de Enfermagem – NIC*. 7th ed. Barueri: GEN; 2020.
20. Keeney S, Hasson F, McKenna H. Consulting the oracle: ten lessons from using the Delphi technique in nursing research. *J Adv Nurs* [Internet]. 2006 [cited 2022 Mar 12];53(2):205-12. Available from: <https://doi.org/10.1111/j.1365-2648.2006.03716.x>
21. Bardin L. *Análise de conteúdo*. São Paulo: Edições 70; 2011.
22. Fleiss JL, Levin B, Paik MC. *Statistical methods for rates and proportions*. New Jersey: John Wiley & Sons; 2013.
23. Fisher MMJB, Marcon SS, Barreto MS, Batista VC, Marquete VF, Souza RR, et al. Caring for a family member with stroke sequelae: the first days at home after hospital discharge. *Rev Min Enferm* [Internet]. 2021 [cited 2022 Mar 22];25:e-1385. Available from: <https://doi.org/10.5935/1415.2762.20210033>
24. Belga SMMF, Jorge AOS, Silva KL. Con Continuity of care from the hospital: interdisciplinarity and devices for integrality in health care networks. *Saúde Debate* [Internet]. 2022 [cited 2021 May 15];46(133):551-70. Available from: <https://doi.org/10.1590/0103-1104202213321>
25. Mauro AD, Cucolo DF, Perroca MG. Hospital – primary care articulation in care transition: both sides of the process. *Rev Esc Enferm USP* [Internet]. 2021 [cited 2022 Mar 12];55:e20210145. Available from: <https://doi.org/10.1590/1980-220X-REEUSP-2021-0145>
26. Costa MFBNA, Ciosak SI, Andrade SR, Soares CF, Pérez EIB, Tomás SC, et al. The continuity of hospital nursing care for Primary Health Care in Spain. *Rev Esc Enferm USP* [Internet]. 2019 [cited 2022 Mar 12];53:e03477. Available from: <https://doi.org/10.1590/s1980-220x2018017803477>
27. Vargas I, Garcia-Subirats I, Mogollón-Pérez AS, Paepe P, Silva MRF, Jean-Pierre Unger JP, et al. Patient perceptions of continuity of health care and associated factors. Cross-sectional study in municipalities of central Colombia and north-eastern Brazil. *Health Policy Plan* [Internet]. 2017 [cited 2023 May 15];32(4):549-62. Available from: <https://doi.org/10.1093/heapol/czw168>
28. Liang D, Zhu W, Qian Y, Zhang D, Petersen JD, Zhang W, et al. Continuity of Care and Healthcare Costs among Patients with Chronic Disease: Evidence from Primary Care Settings in China. *Int J Integr Care* [Internet]. 2022. [cited 2023 May 16];22(4):4. Available from: <https://doi.org/10.5334/ijic.5994>
29. Cechinel-Peiter C, Santos JLG, Lanzoni GMM, Menegon FH, Soder RM, Bernardino E. Continuity of health care: analysis of the production of Brazilian theses and dissertations. *REM* [Internet]. 2021 [cited 2022 Mar 19];25:e-1387. Available from: <https://doi.org/10.5935/1415.2762.20210035>

NOTES

ARTICLE ORIGIN

Extracted from the dissertation – Continuity of patient care after hospital discharge: actions and time demanded by nurses, presented to the Graduate Program in Nursing, of the *Faculdade de Medicina de São José do Rio Preto*, in 2022.

CONTRIBUTION OF AUTHORITY

Study design: Cucolo DF, Perroca MG.

Data collection: Mauro AD.

Data analysis and interpretation: Mauro AD, Cucolo DF, Perroca MG.

Discussion of results: Cucolo DF, Perroca MG.

Writing and/or critical review of the content: Cucolo DF, Perroca MG.

Review and final approval of the final version: Cucolo DF, Perroca MG.

ACKNOWLEDGMENT

To the Research Group “Management of Health and Nursing Services” (GESTSAÚDE) of the Medical School of São José do Rio Preto.

APPROVAL OF ETHICS COMMITTEE IN RESEARCH

Approved by the Research Ethics Committee of the *Faculdade de Medicina de São José do Rio Preto*, opinion n. 3.198.240, CAAE 08412019.4.0000.5415; and by the Research Ethics Committee of the *Faculdades Integradas Padre Albino*, opinion n. 3.699.970/2019, CAAE 25162819.7.0000.5430.

CONFLICT OF INTEREST

There is no conflict of interest.

EDITORS

Associated Editors: Gisele Cristina Manfrini, Maria Lígia dos Reis Bellaguarda.

Editor-in-chief: Elisiane Lorenzini

HISTORICAL

Received: March 19, 2023

Approved: May 23, 2023

CORRESPONDING AUTHOR

Adriéli Donati Mauro

drimauro@hotmail.com