Original Article

TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

CONTINUITY OF HOSPITAL DISCHARGE CARE FOR PRIMARY HEALTH CARE: SPANISH PRACTICE

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ABSTRACT

Objective: to understand discharge plan and the facilities and difficulties for continuity of care in Primary Health Care.
Method: a qualitative and exploratory study carried out in Madrid, Barcelona, Murcia, Seville and Granada, with 29 hospital liaison nurses working in university hospitals, between 2016 and 2018. For data collection, an online questionnaire was used with open and closed questions about the profile of nurses; work context; hospital discharge plan; communication between hospital nurses and primary care. All were analyzed based on Thematic Analysis.
Results: hospital liaison nurses from Spain draw up a discharge plan at least 48 hours in advance. They offer a Continuity of Care Report, guide patients, families and caregivers to the necessary care after hospital discharge, coordinate consultations and referrals and carry out home visits. Communication with primary care occurs through the computerized system and telephone. Monitoring takes place using indicators and statistical reports. In cases of readmission, nurses are requested and contacted by nurses in primary care. Communication with primary care is among the facilities. Lack of liaison nurses is among the difficulties.
Conclusion: hospital liaison nurses from Spain carry out a discharge plan and communicate with primary care. When patients are hospitalized, they are called when there is a need for continuity of care for primary care.

DESCRIPTORS: Transitional care. Patient discharge. Continuity of patient care. nurse. Primary health care.

HOW CITED: Costa MFBNA, Ciosak SI, Andrade SR, Soares CF, Pérez EIB, Bernardino E. Continuity of hospital discharge care for primary health care: spanish practice. Texto Contexto Enferm [Internet]. 2020 [cited YEAR MONTH DAY]; 29:e20180332. Available from: https://doi.org/ 10.1590/1980-265X-TCE-2018-0332

CONTINUIDADE DO CUIDADO DA ALTA HOSPITALAR PARA A ATENÇÃO PRIMARIA À SAÚDE: A PRÁTICA ESPANHOLA

RESUMO

Objetivo: compreender o plano de alta e as facilidades e dificuldades para a continuidade do cuidado na atenção primária à saúde.
Método: estudo qualitativo e exploratório, desenvolvido em Madrid, Barcelona, Múrcia, Sevilha e Granada, com 29 enfermeiras hospitalares de enlace que atuam nos hospitais universitários, no período entre 2016 e 2018. Para a coleta de dados foi empregado questionário *on-line*, com questões abertas e fechadas sobre o perfil das enfermeiras; contexto de trabalho; plano de alta hospitalar; a comunicação da enfermeira hospitalar com a atenção primária; e todas analisadas com base na técnica de Análise Temática.
Resultados: as enfermeiras hospitalares de enlace da Espanha elaboram o plano de alta, com pelo menos 48 horas de antecedência; oferecem o Relatório de Continuidade do Cuidado; orientam o paciente, família e cuidadores para os cuidados necessários após a alta hospitalar; coordenam as consultas e os encaminhamentos e realizam visita domiciliar. A comunicação com a atenção primária ocorre pelo sistema informatizado e telefone, e o monitoramento pelos indicadores e relatórios estatísticos. Em casos de reinternação, as enfermeiras são solicitadas e contatadas pelas enfermeiras da atenção primária. Dentre as facilidades, a comunicação com a atenção primária, e dificuldades, a falta de enfermeiras de enlace.
Conclusão: as enfermeiras hospitalares de enlace da Espanha realizam o plano de alta e a comunicação com a atenção primária. Na internação do paciente são acionadas quando há necessidade de continuidade do cuidado para a atenção primária

DESCRITORES: Cuidado transicional. Alta hospitalar. Continuidade da assistência ao paciente. Enfermeiras e Enfermeiros. Atenção Primária à Saúde.

CONTINUIDAD DEL CUIDADO AL ALTA HOSPITALARIA PARA LA ATENCIÓN PRIMARIA DE SALUD: PRÁCTICA ESPAÑOLA

RESUMEN

Objetivo: conocer el plan de alta y las facilidades y dificultades para la continuidad de cuidado en la Atención Primaria de Salud.
Método: estudio cualitativo y exploratorio, desarrollado en Madrid, Barcelona, Murcia, Sevilla y Granada, con 29 enfermeras hospitalarias de enlace que laboran en hospitales universitarios, entre 2016 y 2018. Para la recogida de datos, se utilizó un cuestionario online, con preguntas abiertas y cerradas sobre el perfil de enfermeras; el contexto de trabajo; el plan de alta hospitalaria; la comunicación entre enfermeras hospitalarias y atención primaria. Todos fueron analizados con base en la Análisis Temático.
Resultados: las enfermeras hospitalarias de enlace de España elaboran el plan de alta con al menos 48 horas de antelación; ofrecer el Informe de continuidad de la atención; orientar al paciente, la familia y los cuidadores hacia la atención necesaria después del alta hospitalaria; coordinar consultas y derivaciones y realizar visitas domiciliarias. La comunicación con atención primaria se realiza a través del sistema informático y telefónico, y el seguimiento mediante indicadores e informes estadísticos. En los casos de readmisión, las enfermeras son solicitadas y contactadas por enfermeras de atención primaria. Entre las facilidades, la comunicación con la atención primaria y las dificultades, la falta de vinculación de enfermeras.
Conclusión: enfermeras hospitalarias de enlace de España realizan el plan de alta y se comunican con atención primaria. En la hospitalización del paciente, se desencadenan cuando existe la necesidad de continuidad asistencial para la atención primaria.

DESCRIPTORES: Cuidado de transición. Alta del paciente. Continuidad de la atención al paciente. Enfermeras y Enfermeros. Atención primaria de salud.

INTRODUCTION

Population aging has been one of the biggest challenges. In order to meet the social and health needs generated by this population, it is especially essential to develop public policies in the health sector. In Brazil, the epidemiological profile has shown to be heterogeneous due to the increase in the elderly population, with chronic and disabling diseases, requiring comprehensive health actions from the health system.[1]

A study on population aging in Brazil found that there was a reduction in beds and hospitalizations due to illnesses, mainly due to the circulatory system, which may reflect the improvement in primary care and quality of life. On the other hand, it was noticed that the increase in diseases due to other causes is contributing to a change in the epidemiological picture.[2]

Hospital institutions have sought a standard of excellence when attending patients in increasingly complex health conditions that demand concrete answers in a given context. The clinical competence of nurses can be a strategy to achieve better results in terms of assistance,[3] based on the Systematization of Nursing Care (SNC). Care management is one of the duties of nurses in the care process and that SNC is performed with the aim of improving care.[4]

Nurses, by systematizing assistance, contribute to effective control of complications during hospitalization, care planning, preparation of discharge and orientation of patients and family members for home care. Nursing discharge plans should be considered as a stage of the SNC. They are a way to facilitate the transition of patients in health services and carry out continuity of care. Discharge plans are instruments that allow organization of care, according to the needs of each patient, and begins at admission, with participation of an interdisciplinary team.[5]

Planning hospital discharge makes it possible to reduce costs with hospitalizations, carry out continuity of care from hospital to home, reduce readmissions and minimize risks of hospital infection. Nurses are co-responsible for preparing patients and their families for hospital discharge; however, this practice has been little applied in hospital contexts.[5]

A study carried out in Sydney, Australia, showed that nurses who work in primary care with vulnerable children and families, elderly people with chronic conditions and mental health provide integrated care, including specialized care. Liaison nurses are encouraged to develop various domain areas such as coordinators, educators, communicators, advocates, change agents, managers, employees, negotiators, team leaders and clinicians. The result of the aforementioned study pointed out that the most important domain developed by nurses is that of coordination of care.[6] Liaison nurses have the role of facilitating the intervention of different professionals and services so that patients and their families achieve the planned therapeutic objectives. They coordinate and facilitate continuity of care for these patients with primary care.

Primary Health Care has the following attributes: first contact access, which is the accessibility and use of the service to each new problem or new episode of a problem; longitudinality, which presupposes the existence of a regular source of attention and its use over time; comprehensiveness, which implies making arrangements for patients to receive all types of health care services and coordination, which is the availability of information about previous problems and services and recognition of that information as it is related to needs for this service.[7:49–50]

In Murcia, Spain, to serve the population with chronic diseases (70-80%), high risk (15%) and complex (5%), the health system proposed to implement a set of strategies aimed at continuity of care among assistance levels coordinated by hospital liaison nurses (HLN). It was in this context that *Proceso de Atención a los Pacientes Crónicos Complejos en Aragón* (PCCM – freely translated as Care Process for Complex Chronic Patients in Aragon) was created. Highly complex patients are

those who have many pathologies, use various medications, have fragility and need social and health resources.[8]

International studies[8–9] reinforce the need to plan and provide health care, organizing continuity of care at home. Liaison nurses from Spain prepares hospital discharge and communicates with primary care. This study aimed to understand the discharge plan and the facilities and difficulties for continuity of care in Primary Health Care.

METHOD

This is an exploratory and qualitative research carried out in Madrid at *Hospital Clínico San Carlos*, *Hospital de Getafe*, *Hospital Universitario Severo Ochoa*, *Hospital Doce de Octubre*, *Hospital Puerta de Hierro en Madajahonda*. In Barcelona, at *Hospital Universitario de Bellvitge*, *Hospital Vall d'Hebron* and *Hospital Germans Trias*. In Seville, at *Hospital Virgen del Rocío*. In Granada, at *Hospital Virgen de las Nieves*. In Murcia, at *Hospital Clínico Universitario Virgen de la Arrixaca*, *Hospital General Universitario Morales Meseguer*, and *Hospital de la Veja Lorenzo Guirao*.

Twenty-nine HLNs participated, eight from Madrid, 11 from Barcelona, six from Murcia, two from Seville and two from Granada. They were selected because they provide continuity of care for primary care. Recruitment counted on the collaboration of facilitating nurses in Madrid, Barcelona and Murcia, all with knowledge of the object of study.

Contact with the research sites took place in January 2017 in Madrid and Barcelona, and in February 2018, in Murcia. Contact took place by email and telephone from March and April 2018 in Seville and Granada. During visits to hospitals, the research project was presented, at which time nurses, the Manager or Director were invited.

For data collection, an online questionnaire was used with open and closed questions about the profile of nurses, work context, hospital discharge plan, communication of hospital nurses with primary care; and then were analyzed. The questionnaire, prepared in Portuguese, was translated into Spanish, and was inserted in the Survey Monkey (R) platform. Survey Monkey consists of an electronic private access tool, which proposes creating, applying, collecting, and analyzing data on the Internet with privacy and security.

Participants received an invitation email with a web link, which led to Survey Monkey and immediate opening of a Consent Statement, completion of which was a mandatory condition for opening subsequent pages. Each question in the questionnaire needed to be answered so that the participant could move on to the next. Estimated time to complete was 15 to 20 minutes.

The data were analyzed based on Thematic Analysis, which consists of aggregation of key elements, resulting in defined categories, in line with the objectives of the research and literature on the subject.[10] The categories that emerged were: discharge plan; communication between hospital nurses and primary care; commitment and trust with users; monitoring after hospital discharge; ease and difficulties for continuity of care by HLN.

RESULTS

Twenty-nine HLNs who worked in hospitals in Madrid, Barcelona, Seville, Granada and Murcia, in Spain, participated in this study. Although hospitals have different scope and purposes (university, clinical, general and specialty), we sought to highlight the common elements that made up the practice and performance of HLNs in continuity of care.

Discharge plan for continuity of care

HLNs reported that discharge planning starts from patient hospitalization, throughout hospitalization until when there is knowledge of hospital discharge, and, more specifically, from the detection that patients will need care afterwards, stating that the same should occur as soon as possible, in the first contact and in the initial interview, when assessment of the patients' condition is carried out, considering their clinical situation and intervention needs. The start of this planning also depends on the form and reason for hospitalization, whether it was scheduled or due to an acute event, or referred from another hospital or health center.

HLNs that provide care to chronic and highly complex patients stated that discharge is planned with very little time, at most 48 hours before. In such cases, it is necessary to project a probable discharge date with early referral of patients and caregivers.

Other professionals are involved in the discharge. Predominantly, nurses responsible for patients, followed by physicians, social workers, unit supervising nurses, and physical therapists.

The main elements recorded in discharge planning are main diagnoses, care performed at the hospital and the patients' current clinical situation. In general, autonomy, prior to admission and current, medication in use, the nursing therapeutic plan, and contact in case of emergency are taken into account. It is also possible to consider the patients' cognitive status and social support, clinical history information, and pharmaceutical assistance in a computerized system called HORUS.

Moreover, HLNs perform other activities in preparing for discharge, including: providing for the necessary care at home; identify the treatment that will be performed, and provide the necessary supplies for continuity of treatment, such as oxygen (oxygen therapy) and tubes (vesical, nasoenteral, etc.) as well as guidelines for caregivers and family about care. HLNs must coordinate the necessary consultations and referrals after hospital discharge, and carry out home visits.

Family members and caregivers are interviewed when the family is invited to participate in care plan during hospitalization and discharge. It is at this meeting that family members offer information about the patient's previous situation, the care received and the resources available to them.

HLNs reported explaining the discharge plan for patients at nursing consultation and providing guidance on care and self-care for patients, family members and caregivers or in group activities. Nurses ask for the presence of a family member in consultations. Families receive all verbal and written information on the day of discharge. Sometimes, guidance on the discharge plan is carried out in conjunction with other professionals, such as a physician, the nurse responsible for care or the nurse supervising the unit.

Most HLNs offer patients and family members a Continuity of Care Report at discharge, which contains medical and nursing information, namely: patient data since admission, assessment/clinical process; description of functional patterns; exams and results; prescribed treatment; summary of hospital stay; diagnostics; some information for discharge, such as the treatment to be followed; nursing care plan; guidelines for home care; monitoring of home visits; information from the health center to which a patient is linked.

Communication between liaison nurses and Primary Health Care services

Communication was one of the important aspects for HLNs in continuity of care. Primary Health Care (PHC) services have access to discharge plan information through a computerized electronic/digital medical history system, existing in all the cities studied, which can be accessed by electronic mail, intranet, family information and/or by "liaison workshop". For more complex cases, the traditional means of telephone contact is used. There is also the modality of publishing discharge reports on a

computerized platform. In all Spanish municipalities studied, the computer program is shared between primary and hospital care services.

In some hospitals, Hospital Admission Service sends a list of discharged patients to primary services daily. Services that belong to the hospital's territorial area have access to the hospital intranet, where they can check medical and nursing reports, as well as access to analyzes and inter-consultation reports. In this regard, there is publication of reports of continuity of care on the computerized platform, but also, when necessary, HLNs provide reports or records on paper.

Clinical reports (medical and nursing) for patient follow-up include diagnosis, symptoms, functional, cognitive and social assessment, sample and image results, medication list and information offered by other professionals. There is also information about treatment and complications during hospitalization, all related to the discharge plan and continuity of care. The expected date of discharge and the type of priority for home visits (less than 48 hours after discharge or before five days) can be informed as well as other specific and patient support information. In sum, information includes the clinical, socioeconomic status of patients as well as the need for care, therapeutic plan, and discharge plan.

Information to primary care about patient discharge varies from hospital to hospital, and can occur from the moment of the forecast until the exact moment of discharge. There are cases where it is possible to have information within 24 hours after a patient leaves. In general, it is offered between 24 and 48 hours before its occurrence, depending on the complexity of the patients' clinical condition and their needs at discharge.

A multidisciplinary team is responsible for communicating discharge, with emphasis on physicians, responsible nurses and HLNs. HLNs contact and transmit information to primary care professionals. However, specialized hospitals adopt the criterion that only family members are responsible for interacting with primary services, even though they may use a computerized tool or system.

Monitoring after hospital discharge

Monitoring patient transition after hospital discharge is another important point to promote continuity of care. It is carried out by means of indicators that allow to assess results. The indicators adopted in the study institutions refer to the quality of care; results of patient experience; results of using services and costs, and population health (level of risk, prevalence of chronic processes, prevalence of risk factors, burden of disease, level of dependence, number of drugs, among others).

Statistical reports, complex chronic patients (PCC) and patients with advanced chronic disease and life limited prognosis (MACA), satisfaction survey and the return schedule within 30 days are examples of means of monitoring. In relation to the nurses' work, there is monitoring through the nursing reports carried out on consultations and interventions.

HLNs have the function of effectively coordinating and conveying information between assistance spheres. However, in cases of rehospitalization, nurses are often asked to assist patients, for different reasons and circumstances. Although they are not responsible for the direct care of patients (assignment of the nurse responsible for the inpatient unit) they are requested in all situations, especially those related to changing the patients' health status and the reason for rehospitalization. Among the varied situations are the cases of increased dependence or chronicity for personal care, without the respective family or support capacity to supply it; inadequate handling; worsening health status requiring more complex care; socio-health risky circumstances; readmission in less than a month or on demand of caregivers, i.e., when there is a need to maintain continuity of care.

Most of the time, HLNs proactively detect readmission in the computerized system listing, but they can also receive phone calls from the primary care case nurse.

Facilities and difficulties for continuity of care by hospital liaison nurses

HLNs pointed out elements that allow to facilitate or hinder their continuity of care activities, such as facilities that were considered: communication, the computerized system and institutional support.

In addition to communication that takes place with patients, multidisciplinary/interdisciplinary activities stood out, carried out directly with the professionals of the reference units involved in patient care, discharge planning, until the meetings with primary care case managers, elements that offer autonomy as a team.

Communication becomes effective due to corporate means of quick access (computer, internet and telephone). Communication and interaction between professionals and teamwork favor continuity of care and provide autonomy for planning discharge since patient admission. Valuing this activity by those involved is a facilitating element, especially when there is availability of specific physical space to perform it, and definition of clear circuits of professional/patient/family interaction.

Computerized system with clinical history of patients is considered a facilitating element by most nurses, as well as institutional support, represented by the organizational structure of the hospital, nursing and primary care departments.

On the other hand, nurses pointed out as a restrictive element to their activities, the scarcity of material (beds) and human resources (number of professionals involved in the same process, family economic situation or lack of caregiver, shorter and shorter hospital stay and need for early hospital discharge).

They also reported the lack of complete integration of computerized systems, including the lack of an integrated clinical history between primary care and the hospital. Communication about discharge in a short period of time requires greater time management capacity, especially when patients do not have a home caregiver, which adds an additional difficulty to the whole process of continuity of care.

Concerning HLNs, in addition to the quantity being less than necessary in some hospitals, there are difficulties due to the breadth of the health region covered and the lack of knowledge of other professionals about specific functions of this work activity. There is a lack of clarity and specificity of functions, and the time to carry out liaison activities is considered a scarce resource. In a broader sense, there is the inherent difficulty in changing from a paternalistic to a proactive health model, in which patients are participants in their care/health care process.

DISCUSSION

Although the concept of continuity of care is known in different realities, mainly abroad, in Brazil it is still under construction. In Curitiba, Paraná, a study was carried out to identify, in children and adults, continuity and monitoring of care at hospital discharge. It was observed that children needed more care related to social issues, and adults, to clinical problems. Discharges that required extra-hospital monitoring were small in number because nurses probably had difficulties in identifying patients with needs for continuity and monitoring of care.[11–12]

Nurses must perform referral for PHC at hospital discharge and monitor so that there are no complications. Moreover, issuing clinical nursing reports is important for all patients, avoiding negative consequences for the development of clinical nursing management.

Research exposes that fragmented, punctual and disjointed care between services, with fragility in the flow of information, discontinuity of care, potentiates the production of illness and is unable to meet the population demands.[13–14]

A study carried out at a university hospital in the city of São Paulo, in different sectors of hospitalization, showed that when communication between nurses and the multidisciplinary team

takes place effectively, care becomes more centered on patients, contributing to an organizational climate conducive to interdisciplinarity.[11]

Professional-user interaction is the main element for continuity of care. At the meeting of these subjects, expectations are shared and the understanding of actions for care.[15–16]

Nurses are responsible for establishing communication with users, identifying their needs, with the collaboration of family members. Articulation of care depends on communication, with a focus on understanding and empathy. The relevance of horizontal communication is emphasized as a powerful tool for the promotion of shared decisions and that favors the effectiveness of teamwork, essential elements for comprehensive care.[17–18]

A research carried out in patients with heart failure showed that communication and telephone monitoring were effective, improving their knowledge and self-care[19]; differently from what was presented in the study carried out with patients in the pre- and postoperative period of bariatric surgery, where the failure in the communication process between the multidisciplinary team and patients/families at hospital discharge resulted in absence of outpatient follow-up.[20]

Lack of dialogue between professionals and users as well as service network disconnection impairs continuity of care due to absence of counter-referral. From the perspective of hospitalized patients, continuity of care can be made possible by the practice of responsible discharge and through guidelines that are given to them and their families about treatment. Nurses must take over the role of hospital discharge coordinators in conjunction with the multidisciplinary team so that continuity of care is effective in primary care.[21–22]

In Brazil, as a way to strengthen PHC and achieve the objectives of the Unified Health System (SUS - *Sistema Único de Saúde*), the Family Health Strategy (FHS) was created, which is a primary care model designed to facilitate access to services of health. This is the first contact of users with health services to provide effective care.[21] PHC nurses prepare, monitor and organize the flow of users between different points in the health care network. Furthermore, they offer care in a horizontal, continuous and integrated relationship, through referral and counter-referral processes, as in Spain.[23]

In Brazil, as well as in Spain, there is a series of investigations on indicators of hospital activity as a measure for effectiveness in PHC.

Hospitalizations due to primary care sensitive conditions (HPCSC) represent a set of health problems that, with more effective actions in primary care, would decrease the number of hospital admissions. Decreased admissions, readmissions and length of stay in the hospital are due to prevention, diagnosis and early treatment activities for acute and chronic pathologies.[24]

In Brazil, high rates of HPCSC are associated with a lack of service coverage and/or low resolution of primary care for certain health problems. The FHS has sought to expand the coverage of municipalities and states and integrate services to reduce health problems that can be treated in primary care.[24]

A study carried out in the municipality of São Leopoldo, in the greater Porto Alegre, showed that, between 2003 and 2012, HPCSC decreased, but expenses in health and FHS coverage increased significantly. Hospitalizations depend on social, individual and structural conditions and determinants. Availability of beds and link of users with health services stand out as determinants.[25]

Conducting studies on HPCSC contributes to the improvement and consolidation of this indicator in Brazil. Planning, formulation of policies and strategies aimed at reducing this coefficient are important and contribute to reducing unnecessary hospitalizations, availability of beds for use by non-preventable hospitalizations and reduction of expenses with hospitalizations, allowing for reinvestment in the system.[25]

A study carried out in a general hospital in the health microregion of Cidade Ademar, in the city of São Paulo, showed that, in 2006, people aged 65 years and older were the group for causes of

HPCSC that had the most hospitalization for respiratory infection. HPCSCs are an important indicator not only for primary care, assessment but for the system as a whole, as it identifies possible problems in access and quality of health services.[26]

The FHS has been fulfilling its role of approaching users and families, having the potential to know people and understand them in their social, emotional and family environment. In this context, the relevance of the role of nurses in constructing longitudinal care stands out through their work with users in embracement, nursing consultation, home visits or assistance and the development of educational and health promotion actions.[27–29]

In Barcelona, care coordination has been a priority objective of the health system to improve the quality and efficiency of chronic conditions, which require the intervention of several professionals and services. According to managers and health professionals, care coordination is an agreement between care levels that avoids duplication of services, loss of time and unnecessary displacement of patients. Care coordination is facilitated by communication, knowledge and a good relationship between health professionals, exchange of information through computerized systems, guides and consensual clinical protocols. Professionals emphasize the importance of HLNs as leaders of care coordination.[30]

In Andalusia, a model has been developed since 2002 for home care for people with reduced mobility and terminal patients. HLNs carry out comprehensive assessment, hospital discharge planning, care coordination and post-discharge telephone follow-up. HLNs implemented services in which nurses were responsible for caring for fragile patients, with primary care teams, showing that there was a reduction in mortality and a decrease in hospital readmission.[31]

A project has been proposed since 2012 in the Basque country on the advanced practices developed by HLNs aimed at hospitalized chronic patients. HLNs have developed standardized reports on the use of health professionals in transitional care for PHC. Such reports include treatment, clinical, educational, cognitive, psychological and social assessments.[31]

In Spain, there is a global consensus on the need to redirect health care towards a more comprehensive model that guarantees continuity of care at different levels of care.

This study had as a limitation the data collection in only four regions of Spain (Catalonia, Madrid, Murcia and Andalusia) through a structured questionnaire. Despite this, responses offered by HLNs made it possible to analyze the practices developed for continuity of care in PHC. However, further studies are needed to cover the knowledge and practice of continuing care to other points in the care network.

CONCLUSION

HLNs from Spain draw up a discharge plan at least 48 hours in advance. They guide patients, families and caregivers about the necessary care at home. When there is a need for a new hospitalization, hospital and primary care nurses communicate, mainly by telephone or computerized system. Hospital discharge monitoring is carried out by indicators and statistical reports referring to the clinical condition and care provided to patients, in the computerized system and home visits.

HLNs are called by the team (nurses responsible for patients or physicians) in the admission of patients in situations that offer risk or complications and in hospital discharge, when there is a need for continuity of care. Sometimes, communication difficulties can occur, when the computerized system is not the same as that of the hospital or due to lack of human and material resources.

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NOTES

ORIGIN OF THE ARTICLE

This study is part of the multicenter project "*Estratégias de Integração em Rede: Contribuições do Enfermeiro*", from the Graduate Program in Nursing at *Universidade Federal do Paraná*, and is linked to the project "*As práticas da Enfermeira de Enlace para a continuidade do cuidado: estudo multicêntrico*", from *Universidade Federal de Santa Catarina*, 2016-2021.

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ACKNOWLEDGMENT

Hospital Universitario de Bellvigte – Barcelona, Spain.
Hospital Vall d'Hebron – Barcelona, Spain.
Hospital Germans Trias – Badalona, Spain.
Hospital Clinico San Carlos - Madrid, Spain.
Hospital de Getafe - Madrid. Spain.
Hospital Universitário Severo Ochoa – Madrid, Spain.
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FUNDING INFORMATION

It was funded by the Brazilian National Council for Scientific and Technological Development (CNPq - *Conselho Nacional de Desenvolvimento Científico e Tecnológico*) 2016-2019, Process 406058/2016-4.

APPROVAL OF ETHICS COMMITTEE IN RESEARCH

This study was approved by the Research Ethics Committee with Human Beings of *Universidade Federal do Paraná*, under Opinion 888.681 and CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 36975914.5.0000.0102. It was also approved by the Ethics Committee of *Universidade Federal de Santa Catarina*, under Opinion 1,744,295 and CAAE 54235116.5.0000.0121.

CONFLICT OF INTEREST
There is no conflict of interest.

HISTORICAL
Received: October 01, 2018.
Approved: March 26. 2019.

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