Original Article

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

ROLE OF NURSES FOR CONTINUITY OF CARE AFTER HOSPITAL DISCHARGE

Magaly Del Carmen Gallardo Guzmán[1]
Alexandra Ferreira[2]
Selma Regina de Andrade[2]

[1]Hospital Clínico Magallanes. Punta Arenas, Magallanes, Chile.
[2]Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Enfermagem. Florianópolis, Santa Catarina, Brasil.

ABSTRACT

Objective: to recognize the role of nurses to maintain continuity of care for users after hospital discharge.
Method: an exploratory, descriptive study with a qualitative approach. The study was applied at hospital discharge originating from the most complex health center in Magallanes, the *Hospital Clinico Magallanes*, Chile. Data were collected through interviews with nurses, carried out between May and August 2018. To analyze the material, the content analysis technique was used.
Results: three categories emerged, which bring together what nurses mention in their discourse: How they see the implementation of hospital nursing services, which facilitate continuity of care in the healthcare network of discharged patients (known as care networks); Who they identify in the nursing service for continuity of care after discharge (care networks), which these nursing professionals make and suggestions for their performance; and How care networks affect users in continuity of care after discharge.
Conclusion: the role of nurses is key in patient discharge from hospital. With autonomy and competencies for comprehensive care, professionals facilitate the healthcare transition; manage hospital discharge, convening the institutional nursing network and the emerging networks with primary health care; aspire to develop strategies for an inter-level care network, with systematic participation.

DESCRIPTORS: Patient discharge. Nurse's role. Continuity of patient care. Comprehensive health care. Nursing. Health services.

HOW CITED: Guzmán MCG, Andrade SR, Ferreira A. Role of nurses for continuity of care after hospital discharge. Texto Contexto Enferm [Internet]. 2020 [cited YEAR MONTH DAY]; 29(Spe):e20190268. Available from: https://doi.org/10.1590/1980-265X-TCE-2019-0268

ROL ENFERMERO PARA CONTINUIDAD DEL CUIDADO EN EL ALTA HOSPITALARIA

RESUMEN

Objetivo: reconocer rol enfermero para mantener la continuidad del cuidado del usuario con alta hospitalaria.
Método: estudio de carácter exploratorio, descriptivo, con abordaje cualitativo. El estudio se aplicó en el alta hospitalaria, que se origina en el centro de salud de mayor complejidad de Magallanes, el Hospital Clínico de Magallanes, Chile. Los datos fueron recolectados a través de entrevistas con enfermeras, que se realizaron entre mayo y agosto de 2018. Para el análisis del material, se utilizó la técnica análisis de contenido.
Resultados: se obtienen tres categorías, que reúnen lo que los enfermeros mencionan en su discurso: Como ven la implementación de servicios de enfermería hospitalaria, que facilitan continuidad de la atención en la red asistencial del paciente con alta hospitalaria (conocido como redes de cuidado); A quiénes identifican en el servicio de enfermería para la continuidad de la atención post alta (redes de cuidado), que hacen estos profesionales de enfermería y sugerencias para su desempeño; y Como redes de cuidado afectan al usuario en la continuidad de su cuidado post alta.
Conclusión: el rol enfermero es clave en el alta hospitalaria del paciente. Con autonomía y competencias para la atención integral, el profesional facilita la transición asistencial; gestiona el alta hospitalaria, convocando la red de enfermería institucional y las incipientes redes con Atención Primaria de Salud; aspira a desarrollar estrategias para una red de cuidado interniveles, con participación sistemica.

DESCRITORES: Alta del paciente. Rol de la enfermera. Continuidad de la atención al paciente. Atención integral de salud. Enfermería. Servicios de salud.

PAPEL DO ENFERMEIRO PARA A CONTINUIDADE DO CUIDADO NA ALTA HOSPITALAR

RESUMO

Objetivo: reconhecer o papel do enfermeiro em manter a continuidade do cuidado do usuário com a alta hospitalar.
Método: estudo descritivo, exploratório, com abordagem qualitativa. O estudo foi aplicado na alta hospitalar, originária da unidade de saúde mais complexa de Magallanes, o Hospital Clinico de Magallanes, Chile. Os dados foram coletados por meio de entrevistas com enfermeiros, realizadas entre maio e agosto de 2018. Para a análise do material, foi utilizada a técnica de análise de conteúdo.
Resultados: foram obtidas três categorias, que reúnem as expressões dos enfermeiros: Como vêem a implantação dos serviços de enfermagem hospitalar, que facilitam a continuidade do cuidado na rede de atenção do paciente com alta hospitalar (denominada rede de atenção); Quem eles identificam no serviço de enfermagem para a continuidade dos cuidados pós-alta (redes de atenção), que esses profissionais de enfermagem fazem e sugestões para seu desempenho; e, Como as redes de atendimento afetam o usuário na continuidade de seus cuidados pós-alta.
Conclusão: o papel da enfermagem é fundamental na alta hospitalar do paciente. Com autonomia e competências para o cuidado integral, o profissional facilita a transição da assistência à saúde; gerencia a alta hospitalar, convocando a rede institucional de enfermagem e as redes emergentes com a atenção primária à saúde; aspira a desenvolver estratégias para uma rede de atenção inter-nível, com participação sistemática.

DESCRITORES: Alta do paciente. Papel da enfermeira. Continuidade do atendimento ao paciente. Assistência médica abrangente. Enfermagem. Serviços de saúde.

INTRODUCTION

In Chile, from the 2001-2005 health reform the need arises to improve access, equity and opportunity to the emerging health requirement of the population, with efficient use of resources and effectiveness in health actions. To that end, it was necessary to move from the traditional health-disease model to a comprehensive care model, a model that translated into comprehensive health services, which would ensure compliance with the general guarantee regime, respond to the rational use of resources and improve user satisfaction.[1]

The main strategies for implementing this model were to deal with healthcare network rearticulation to guarantee timely access and resolution with quality and safety; suitability for coordinated and complementary work between primary care and outpatient specialties; establishments designed for the complexity and scope of their portfolios, with a communication system for the beneficiary to flow safely and efficiently through this network; referral and counter-referral system; strengthening the resolving capacity of primary health care (PHC), with an emphasis on promotion and prevention; hospital transformation, a key strategy that involved moving towards a model that promotes and enhances outpatient resolution of health problems.

This great undertaking is inspired by the requirements of international health organizations such as the Pan American Health Organization (PAHO) and the World Health Organization (WHO), which for decades have promoted improvements in the health status of the population in the Latin American Region. Calling on the development of contexts to implement processes of care with a comprehensive approach, PAHO urges to overcome fragmentation in health systems. Their diagnoses indicate that programs focused on specific diseases and risks predominate, which are approached with vertical models.[2] Faced with this focus on disease, acute episode care and hospital care, which is complicated by problems in the distribution of resources, the WHO maintains that a paradigm shift in care models is necessary and recommends urgency to assume a people-centered approach and integrated services. Otherwise, it would lead to a state of increasingly fragmented, inefficient and unsustainable services over time.[2]

Thus, it defines that the focus of person-centered care is to understand and practice health care from the point of view of people, families, caregivers, community as participants and beneficiaries of health systems that inspire trust. It also requires that patients receive information and support to make decisions and participate in their own care.[1–3]

A key element in this context is the concept of healthcare network. The healthcare network, made up of establishments and public or private devices that sign an agreement with the health service, work in a coordinated and complementary manner to provide solutions to the health problems of the beneficiary population. It must guarantee timely access and resolution with quality and security anywhere on the network.[1,4]

Promoting comprehensive health services is to manage and provide health services so that people receive a continuum of promotion, prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different levels and sites of health system care, and according to their needs throughout the life course.[2,5] Comprehensive care service is obtained by maintaining continuity of care. It corresponds to the degree to which a series of discrete health care events are experienced by people as coherent and connected to each other over time, and are consistent with their needs and health preferences.[2]

In other words, the Chilean Ministry of Health (MoH) requires continuity of care. From the perspective of people, they experience a series of health care events as coherent and connected to each other in time; from the perspective of health systems, it corresponds to clinical, functional and professional continuity. Continuity of care means providing and safeguarding care in different settings

from home to hospital centers.[5] Continuity of care, and within continuity of care, is a key element to guarantee the quality of the health services that citizens receive and so that they are perceived as quality services.[6]

An analysis of the ethical discourse, carried out in relation to Spanish legislation, concludes that nursing work is defined in terms of equity, recognition of human rights, the right to health, accessibility and continuity of care for persons.[7]

In Chile, the code of ethics states that the nurse shares with society the responsibility to initiate and support actions to satisfy the health and social needs of the population, particularly those of vulnerable groups.[8]

Essential functions of nursing are advocacy, fostering a safe environment, research, participation in health policies and in the management of patients and health systems, and training.[9–10] We can identify the nursing role as facilitator for continuity of care, seeking to detect key elements in the care process, to provide professional services at any level of care, in order to guarantee safety, respect for patients and information for continuity of care.[11–12]

In this sense, it is proposed to answer the following research question: how does continuity of care occur after hospital discharge? Therefore, this study aims to recognize the nursing role to maintain continuity of care for users after hospital discharge.

METHOD

This is an exploratory, descriptive study with a qualitative approach, seeking to recognize the role of nurses to maintain continuity of care for users after hospital discharge. The study was applied in hospital discharge originating from the most complex health center in Magallanes, the *Hospital Clinico de Magallanes* (HCM), Punta Arenas.

Nursing professionals working in inpatient clinical services at that hospital participated in the study. The sample was selected with a non-probabilistic and intentional sampling technique, to collect the perception and meaning of the specialist who knows, from the professional and participating competence, the phenomenon under study. Nurses who were working, for a period of two or more months, in the fourth shift or day system in hospitalized medical-surgical service; nurs working in adult and child units of the HCM; and who reported availability to participate in the research, in the period provided for the interviews were invited.

Nurses who had a relationship of technical or administrative dependency with researcher; and nurses who had less than two months of professional practice in an HCM hospitalization clinical service were not invited.

The interviewees were contacted directly, at which point the objective of the investigation was made known and the Informed Consent Form was given for signature on the day of the first session. The interview, through a semi-structured script with open-ended questions, was recorded in its entirety and transcribed exclusively by a researcher. Subsequently, a copy was delivered, for the knowledge and agreement of the interviewee, who had two weeks to make their objections, corrections or suggestions. The interviews were conducted between May and August 2018, with an average duration of 50 minutes.

To organize the analysis of the material, the content analysis technique was used,[13] through pre-analysis, exploration of the material and treatment of results and interpretations. After a general reading of the content of the interviews, registration units were identified, corresponding to content segments, that spoke of continuity of care and the role of the nurse in continuity of care. To that end, a grid was designed where the responses that constituted the codes were grouped. Subsequently, they were ordered by color according to selection criteria, to compose subcategories and to finally organize them so that they form homogeneous and exclusive categories among themselves.

Concerning ethical requirement, current institutional regulations regarding Law 20,584 on the Rights and Duties of the Patients were complied with, and there was a Ethics Committee Certificate of Approval, Office of the Vice President for Research and Graduate Studies, University of Magallanes. To keep the participants anonymous, codes made up of letters and numbers were used.

RESULTS

Eight nurses who perform daily nursing discharges in HCM clinical services participated with great commitment. The nursing role, linked to continuity of care in the healthcare network, emerges from statements, which is understood in the context of a comprehensive care service and that in HCM is known as care networks.

Eight subcategories emerged from the codification process that gave rise to three categories, associated with the nursing role in continuity of care: Comprehensive health service: perception and meaning; Comprehensive health service: role and role performance; and Comprehensive health service: incidence on users.

Comprehensive health service: perception and meaning

This category refers to how nurses see the implementation of hospital nursing services that facilitate continuity of care in the healthcare network of patients after hospital discharge, known as care networks in HCM. It is made up of two subcategories: *How they see care networks* and *Meaning of knowing that patients go to care networks*.

How they see care networks

In the first subcategory, the interviewees express how they perceive the existence of hospital nursing services for continuity of care in the healthcare network.

[…] *then it is a work that is long, that is slow* […] *before there was not so much connection between primary, secondary, tertiary level, now it has improved. There is more communication with PHC* […] *one notices that it is much easier to coordinate things* […] *colleagues are interested in trying to give continuity to* […] *it is not so difficult... nor so expensive* (I1).

[…] *now there are more* […] *all the parts of care networks that we have here is very good for the patients,* […] *more staff is needed, because sometimes they lack space* (I5).

Meaning of knowing that patients go to care networks

In the second subcategory, nurses express how they value knowing that patients receive nursing services for continuity of care in the healthcare network.

[…] *it also gives us assurance* [...] *that all the work that was invested in these users will continue... and will continue well* [...] *when one already knows that the patient is discharged and continues... and that well it's super rewarding for you as a professional* (I1).

[…] *before we were blinded by that, before we did not give it importance that this patient had to have a continuity in his home* […] *there is also the disposition of us to receive that user if he returns in 3 or 4 days to ask us something* […] *it begins with awareness… and concern arises… it's good because you start to see things* (I4).

Comprehensive health service: role and role performance

In this category, nurses speak of those whom they identify in the nursing service for continuity of care after discharge (care networks), which these nursing professionals make and suggestions for

their performance. It is made up of four subcategories: *What care networks do*; *Identifying the role of care networks*; *Suggestions to improve the role*; and *How a care network facilitates work*.

What care networks do

In this subcategory, nurses state what they have observed that a care network (nurse care network) does and can do.

[…] *they have to coordinate with PHC* […] *they will evaluate it if it will require… if it is prostrate* […] *one discharges, everything must be coordinated before the patient leaves and leaves the hospital* (I2).

[…] *what they do, what they need, and they are at home, the family is with them ... the boys live longer* [...] *or live here hospitalized* [...] *than monthly or whatever ... they give them their supplies* [...] *everything well ordered, as more regulated* (I6).

They allow to maintain continuity of care after discharge (I8).

Identifying the role of care networks

The interviewees mentioned nursing services that they related as networks of care. Among the main services, the nurses mentioned home hospitalization (HH), Advanced Cure (AC), diabetes polyclinic, anticoagulant treatment polyclinic (TACO), pain relief and palliative care program (PR AND PC), Ambulatory Medical Unit (AMU), case management nurse:

[…] *advanced cure, home hospitalization not from the care network?* [...] *diabetes poly... because if it has to be controlled afterwards* (I2).

[…] *have systems that allow continuity such as home hospitalization, advanced cures, AMU* [Ambulatory Medical Unit] (I8).

Suggestions to improve the role

In the third subcategory, nurses mention suggestions and proposals that could be implemented, highlighting:

[...] *it would be good to do a training* [about networks and continuity] […] *create an advanced healing only email, to which the substitute has access… or the person who is carrying out that work in that minute* (I1).

[…] *having a number to call as well as directly to Damianovic* (PHC) *and coordinate* […] *for example, the discharge colleague, that she will no longer receive all discharges* [liaison nurse] […] *that is as the center as manager* […] *that it be a single channel, because with many people involved there tends to be a disorder* (I2).

[…] *the important thing we are realizing that we need an electronic clinical record,* […] *if it were regional it would already be a step forward that we would have at least in the region* [electronic clinical record] (I4).

How a care network facilitates work

On the other hand, nurses refer to how a care network can collaborate or improve continuity of care, the synthesis of which was grouped into the fourth subcategory: *How a care network facilitates work*:

[…] *having an order and that would facilitate continuity of care,* [...] *unlike the arrival of the patient, you see that it was done... that it was being done... to be able to continue here from the perspective of nursing* (I3).

[...] *who have been very supportive of decongesting* […] *that there are personnel, nurses who coordinate all discharges* […] *one refers them so that there is a greater follow-up of these patients and then refer them to PHC* (I5).

Comprehensive health service: incidence on users

Finally, through the third category, it is described how care networks affect users in continuity of their care from the nursing perspective. It is made up of two subcategories: *Beneficial effect on patients*; and *Consequence of lack of care networks*.

Beneficial effect on patients

In this subcategory, nurses state how a care network can be effective in terms of quality of patient care:

[…] *to never see the patient re-enter the same conditions* [...] *directly affects the patient's recovery* [...] *safety for patients and family members of patients* (I1).

[…] *that the patient is inserted into something, that they will be able to turn to someone when they need it* (I3).

Consequence of lack of care networks

In the second subcategory, nurses mention events that show problems that need an effective care network. The most frequent events they comment on include attending the control at the wrong level; loss of information leading to errors in continuity of chronic treatments; double prescription:

[…] *patients sometimes don't get where they need to go with the paper, because they lost it on the way* (I1).

[...] *it often happens that the patient does not return for their medications... that is also an indicator that something is happening* [...] *but we do not have feedback* [...] *we as clinical nurses are realizing that there is a lack of coordination with PHC* (I3).

DISCUSSION

In the concept of comprehensive and continuous nursing care, nurses report different perceptions about their role as discharge managers and the presence of professionals who contribute to support continuity of care of patient discharge from the facility. They value cost effectiveness, processes of change in the establishment, degrees of visibility about the professional contribution to continuity, gaps. The interviewees refer to continuity both in the sense of how patients experience it, and also from the perspective of the health system, which corresponds to clinical, functional and professional continuity.[5] It can be seen that authors recognize the meaning of networking as an element of comprehensive care. Their working life takes place in an environment that values teamwork and is organized as a system that is still functionally quite fragmented.[12,14]

The hallmark of professional training for comprehensive work[10] is perceived and is present in various ways in the discourse of their declaration of principles, the sense that networking is natural for this professional, for instance, when they comment on the effects for patients due to the loss of continuity of care and suggest as a solution implementation or strengthening of health networks.

User perception of continuity of care, at the Hospital Complex of Cartagena (Spain), assessed user satisfaction with continuity of care using a validated instrument; obtained that 94% of the respondents presented acceptable general satisfaction with continuity of care, and only 6% presented low satisfaction. In the set of 131 patients, made up of a group of exposed, to whom nurses gave a report with data on the planning of nursing care on leaving the hospital and another group of unexposed

patients, to whom no report was delivered at discharge, found that care report completion slightly influences satisfaction with continuity of care.[15]

In these results, we can also infer the effectiveness of the nursing work in discharges, and confirm or refute the nurses' perception regarding their work at nursing discharge. In a bibliographic review carried out in Spain,[16] it is stated that although in the analyzed studies there was no detailed assessment of aspects of the discharge report that make it useful to guarantee continuity of care, it was necessary to establish active communication channels with nursing staff from PHC, to implement improvement measures. In other words, the establishment of an effective communication system is a heartfelt demand from hospital nurses. This coincides with what nurses highlight in their comments regarding positive assessment of existence of nursing networks that guarantee continuity of care.

Regarding role and role performance in comprehensive health service, the interviewees mentioned nursing services associated with network care. This study refers to actions that relate to the nurse's facilitating role for effective post-discharge care and puts the scope of this healthcare transition process into perspective as emerging and susceptible to improvement.

Safe and quality post-discharge continuity of care is the goal of their efforts, implicitly avoiding complications. Nursing literature associates preventable causes, among others, with discharge planning, user training or support network, and early follow-up process in various modalities.[12,17] A study conducted with elderly patients showed their preparation for discharge by performing a personalized intervention. They used abbreviated geriatric assessment, resource management and liaison with PHC as strategies. It was concluded that discharge preparation was a protection factor for the presentation of any adverse event before 30 days after discharge.[18]

Discharge with protocolized record of poor patient safety facilitates family participation, avoids re-entry and makes the patient's autonomous role visible.[19] However, in the study on user satisfaction in continuity of care,[15] was evaluated positively. When correlating satisfaction with the assistance report, it is shown that it slightly influences the perception of satisfaction in continuity of care. The fact that the report is delivered manually and/or explained does not seem to affect this result. Although in the case of this study, it is not part of the job of assessing user satisfaction, we can bear in mind that nurses refer to the perception of a more auspicious future for continuity of care. There is a presence of nurses who provide continuity and development of the autonomous field of the profession.

The article about re-engineering applied to the health network of more than 60 establishments in Madrid[6] states that continuity of care, and within continuity of care, is key to guaranteeing the quality of health services. In this sense, they implement various measures for effective follow-up such as telephone calls to patients in the first 24-48 after discharge, PHC nurse with access to the hospital medical report, daily dispatch of hospital discharges.

A work carried out in telemedicine that analyzed the use of ICTs in care inferred the usefulness of the telephone as a means of follow-up;[20] and sought association of health outcomes (quality of life, mortality and the use of resources) with telecare, telephone support and usual care. It was found that telephone follow-up exceeded in effectiveness, what is called habitual care, and close to the favorable result of telecare, whose highest score was related to better quality of life. We found no differences in mortality or use of resources, except for a marginal increase in visits to the PHC doctor. Innovation in care strategies arise in the diversity of health problems and limited resources.[21]

Concerning continuity and technology, the Chilean network system contemplates that discharge patients resume their care in the open health centers of specialties or in PHC. For which there is formal written (interconsultation) and digital communication (appointment schedule) with the outpatient specialty center. But there is no formal system with the health centers of the primary health level, so it depends only on users, who return to their control in the office where they are registered, carrying medical epicrisis. In this registry, discharge nurses have written instructions usually about times for

drug administration. Referral and counter-referral processes exist for the ambulatory network of the system, and is intended to be of communication so that the beneficiary flows safely and efficiently.[4]

In the discharge process, the multidisciplinary and basically medical team, nurse-midwives are mentioned. After the doctor decrees that the patient is in a position to leave closed care, in Chile, by the Law of Rights and Duties of the Patients, a medical epicrisis is issued. At that moment, the nursing establishment takes over most of the hospital patient's discharges, thereby assuming, from the fragmentation and its competencies, to provide resources for user continuity of care.[5,11] The literature that mentions the implementation of different discharge care systems mentions a discharge management nurse, the role of liaison nurses, telephone follow-up from the hospital or coordinated with another PHC nurse.[6]

In a review study,[22] selected descriptive and randomized studies that showed the status of the discharge process and strategies aimed at improving it. They chose ten settings, for which there is evidence of benefits for certain interventions: epicrisis; Medication Indication Reconciliation (MIR); discharge planning; follow-up; telephone call; discharge support nurse; geriatric assessment and comprehensive interventions after discharge; training; palliative care support; multidisciplinary interventions. It is observed that in eight of the ten strategies the nurse is present.

Following the aforementioned, as a result of the interviews, nurses point to different colleagues who contribute to their preparation process for mediate discharge, identifying them as care networks, a group of professionals from the specialty ambulatory system that provide advice, chronic patient rescue, coordination for continuity of control and another group that is responsible for continuity of care of complex patients in the community. Along with this, they visualize the existence of nurses who are in the PHC health centers, with whom they would like to implement a continuous information system in both directions. In this last initiative, they recognize that there are different degrees of development; from not realizing it, to using incipient contact networks that have been implemented with a nurse case manager.

In the analysis of the nursing role for continuity, a vocation for networking is revealed, and it is suggested the creation of linking strategies so that communication and information flow, focused on avoiding discontinuity of care. Furthermore, international nursing networks describe the role of nurses as a communication strategy that articulates, develops cooperation and synergy between people and organizations, seeking the development of assistance, management, research, education. It supposes solidarity, trust, respect as values for health. It demonstrates the power of nursing to work together and oriented towards common goals. It is based on communication technologies and management tools, to ensure continuity of care, both in moments of grace and in adversity.[7,23–26]

It is possible to assimilate this result referring to the effectiveness of a care system that can fully assist user discharge, with studies related to liaison nurses, or systems created to manage hospital discharge, which in a more structured way plan patient discharge and follow-up. Among them, in Spain, a study suggests that there would be a healthcare gap in patients with hospital discharge, which is why there are difficulties in guaranteeing correct compliance with the indications given at discharge.[6] It is mentioned that some of the consequences of this healthcare gap between the hospital and the PHC are: duplication of interventions at both levels of care; patients not taking their medication correctly; not getting the care they need; risk of worsening the process with hospital readmission. Furthermore, this gap produces uncertainty and dissatisfaction both in patients and in their family members or caregivers.[6]

It is important to highlight that the activities carried out by nurses for continuity of care in PHC in Spain, in general, are defined through the clinical assessment of patients and contact with nurses from the patients' area of origin by phone or email before discharge. This requires training

as an educator and teamwork. Continuous care for PHC presupposes availability of resources and experience in managing care of complex patients and their families.[25]

In the case of the local study, the interviewees show that this hospital establishment does not have implementation of a formal system for coordinated follow-up with PHC; when mentioning it as a demand felt by the nursing establishment, given that in their experience, the lack of follow-up and feedback affects continuity of care and implies risk for patients.

A descriptive study conducted in the in the province of Quebec, Canada, which described the activities carried out by liaison nurses for continuity of care after hospital discharge, highlights that nurses participate in identifying patients who need post-hospital care, transferring patient information for other level services, in addition to coordinating hospital discharge planning.[27]

Although in this study readmission could not be correlated with scheduled discharge, it can be observed that the risk of a loss of continuity of care is present, given by an insufficient inter-level coordination system and problems in self-care behavior of the population. Which, also, is valued by the nurses of this study, who recognize the benefit of a comprehensive system of care for continuity of care and the effects and effectiveness for patients.

Limitations include the scarce publication of previous studies on the subject, at the national level. As a recommendation, it would be interesting to work in a study to understand continuity of care from the perspective of users with hospital discharge and that of their family.

CONCLUSION

It was possible to recognize the role of nurses to maintain continuity of care for hospital discharge users. Within the framework of health care networks, the role of nurses gives life to care networks or nursing networks, which offer support to continuity of care for hospital discharge patients. With competencies to provide a comprehensive health service, they focus on caring for people who have a diversity of requirements. Correlating services with structural regulations, nurses develop healthcare management focused on user demand for continuity of care.

In the daily work of nurses, they manage hospital discharge continuity in a system without protocol for continuity with PHC; strive to ensure that users have safe and quality opportunities to maintain continuity of care after discharge; resort to the capabilities of patients and family support; convene the hospital nursing network; and naturally aspire to link with care network systems, beyond the hospital intramural.

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NOTES

ORIGIN OF THE ARTICLE

Article extracted from the thesis - *Continuidad de la atención en el alta hospitalaria*, international MINTER modality presented to the Graduate Program in Nursing, *Universidade Federal de Santa Catarina*, in 2019.

CONTRIBUTION OF AUTHORITY

Study design: Guzmán MCG, Andrade SR.
Data collect: Guzmán MCG, Andrade SR.
Analysis and interpretation of data: Guzmán MCG, Andrade SR.
Discussion of results: Guzmán MCG, Andrade SR.
Writing and/or critical review of the content: Guzmán MCG, Andrade SR, Ferreira A.
Final review and approval of the final version: Guzmán MCG, Andrade SR, Ferreira A.

FUNDING INFORMATION

This study was financed by the *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior* - Brazil (CAPES) - Finance Code 001

APPROVAL OF ETHICS COMMITTEE IN RESEARCH

Approved by the Research Ethics Committee of *Universidad de Magalhanes*, Chile.

CONFLICT OF INTEREST

There is no conflict of interest.

HISTORICAL

Received: September 08, 2019.
Approved: February 11, 2020.

CORRESPONDING AUTHOR

Selma Regina de Andrade
selma.regina@ufsc.br