


PRACTICES OF HOSPITAL NURSES FOR CONTINUITY OF CARE IN PRIMARY CARE: AN EXPLORATORY STUDY

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ABSTRACT

Objective: to know the practices developed by hospital nurses for continuity of care for Primary Care.

Method: this is an exploratory, qualitative research conducted in university hospitals in São Paulo and Curitiba, Brazil. For data collection, a semi-structured interview was conducted with the Director of Nursing and an online questionnaire through open-ended and closed-ended questions, with nurses between August 2018 and July 2019. The analyzes of the interviews were carried out as proposed by Minayo based on in the theoretical framework of continuity of care.

Results: the research was conducted at three university hospitals, and one Director of Nursing and 48 nurses participated. From analysis of nurses' answers, two categories of analysis emerged: identification of post-discharge patients' care needs and the necessary competencies for continuity of care. Where it was perceived since patients' admission, nurses' concern for continuity of post-hospital discharge care, establishing flows together with nurses of the Internal Center for Regulation/Discharge Management Service for the Health Department of the municipality, which forwards to patients' reference health unit.

Conclusion: although nurses are professionals who actively participates in care at various points in the health care network and recognizes the importance of continuing post-discharge care, they remain a fragile point in the care chain, and it is necessary to strengthen this mechanism with Primary Care, optimize home care and avoid hospitalizations.

DESCRIPTORS: Nurse. Continuity of Patient Care. Primary health care. Hospital. Nursing Care.

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PRÁTICAS DA ENFERMEIRA HOSPITALAR PARA A CONTINUIDADE DO CUIDADO NA ATENÇÃO PRIMÁRIA: UM ESTUDO EXPLORATÓRIO

RESUMO

Objetivo: conhecer as práticas desenvolvidas pelas Enfermeiras hospitalares, para a continuidade do cuidado para a Atenção Primária.

Método: pesquisa exploratória, qualitativa, realizada em hospitais universitários de São Paulo e Curitiba, Brasil. Para a coleta de dados foi realizada entrevista semiestruturada com a Diretora de Enfermagem e questionário *on-line* através de perguntas abertas e fechadas, com as Enfermeiras Assistenciais, no período entre agosto de 2018 e julho de 2019. As análises das entrevistas foram realizadas conforme proposto por Minayo com base no referencial teórico da continuidade do cuidado.

Resultados: a pesquisa foi realizada em três hospitais universitários e participaram uma Diretora de Enfermagem e 48 Enfermeiros. Da análise das respostas dos enfermeiros, emergiram duas categorias de análise: identificação das necessidades de cuidados do paciente pós-alta e competências necessárias para a continuidade do cuidado. Onde se percebeu desde a admissão do paciente, a preocupação do enfermeiro para a continuidade do cuidado pós-alta hospitalar, estabelecendo fluxos junto com a Enfermeira do Núcleo Interno de Regulação/Serviço de Gestão de Alta para a Secretaria de Saúde do município que, encaminha à unidade de saúde de referência do paciente.

Conclusão: embora o Enfermeiro seja um profissional que participe ativamente do cuidado em vários pontos da rede de atenção à saúde e reconheça a importância da continuidade do cuidado pós-alta, continua como um ponto frágil na cadeia de cuidados, sendo necessário fortalecer este mecanismo com a Atenção Primária, otimizar o cuidado domiciliar e evitar reinternações.

DESCRITORES: Enfermeira. Continuidade da assistência ao paciente. Atenção primária à saúde. Hospital. Cuidados de enfermagem.

PRÁCTICAS DE ENFERMERÍA HOSPITALARIA PARA LA CONTINUIDAD DE LA ATENCIÓN EN ATENCIÓN PRIMARIA: UN ESTUDIO EXPLORATORIO

RESUMEN

Objetivo: conocer las prácticas desarrolladas por enfermeras hospitalarias, para la continuidad de la atención de Atención Primaria.

Método: investigación exploratoria, cualitativa, realizada en hospitales universitarios de São Paulo y Curitiba, Brasil. Para la recolección de datos, se realizó una entrevista semiestructurada con el Director de Enfermería y un cuestionario en línea a través de preguntas abiertas y cerradas, con los enfermeros asistentes, en el período comprendido entre agosto de 2018 y julio de 2019. Los análisis de las entrevistas se realizaron de acuerdo con a propuesto por Minayo con base en el marco teórico de la continuidad asistencial.

Resultados: la investigación se llevó a cabo en tres hospitales universitarios y participaron una Directora de Enfermería y 48 enfermeras. Del análisis de las respuestas de las enfermeras surgieron dos categorías de análisis: la identificación de las necesidades asistenciales del paciente post alta y las habilidades necesarias para la continuidad asistencial. Donde se notó desde el ingreso del paciente, la preocupación de la enfermera por la continuidad de la atención al alta hospitalaria, establecer flujos junto con la enfermera del Centro de Regulación Interna/Servicio de Gestión de Egresos al Departamento de Salud del municipio, que lo remite a la unidad de salud de referencia del paciente.

Conclusión: si bien los enfermeros son profesionales que participan activamente en la atención en varios puntos de la red asistencial y reconocen la importancia de la continuidad de la atención postabital, sigue siendo un punto débil de la cadena asistencial, es necesario fortalecer este mecanismo con Atención Primaria, optimizar la atención domiciliar y evitar reingresos.

DESCRITORES: Enfermeras y Enfermeros. Continuidad de la Atención al Paciente. Atención Primaria de Salud. Hospital. Atención de Enfermería.

INTRODUCTION

The Brazilian health system aims to be comprehensive and enable the population access to the health services network. To provide comprehensive care, especially to older adults and people with chronic diseases, trained professionals are needed, working in the different points of the Health Care Network (RAS - *Rede de Atenção à Saúde*), with the Brazilian National Primary Care Policy (*Política Nacional da Atenção Básica*) as the care administrator. This demand generates the need to train nurses with a new profile to assist patients, either in the hospital or in Primary Health Care (PHC).

At each point of the network, health services are organized to welcome the population and solve health problems, constituting RAS, organizational arrangements of health actions and services of different technological densities, which integrated through technical, logistical and management support systems, seek to ensure comprehensiveness of care¹. To articulate the points of RAS and respond to individuals' health demands, line of care was proposed. This is the design designed to express the programmatic care flows safe and guaranteed to users.

In the articulation between the elements of RAS' organizational structure, PHC stands out as a communication center with the other points of care, priority gateway to the health system, network order and care coordinator. Thus, it can favor quality of care and continuity of care in the health network.

The aging of the population, the increase in chronic diseases, the inflation of emergency care units and the increase in costs with hospital readmission are considered important arguments to find more effective strategies to integrate the hospital network with PHC and continuity of care, in order to improve home care and optimize hospitalizations.

Brazilian studies²⁻⁴ have shown that there has not been the articulation of care for PHC at hospital discharge and the counter-referral to PHC, according to the recommendation sum by the Brazilian Unified Health System (SUS – *Sistema Único de Saúde*) and the World Health Organization (WHO)⁵⁻⁶.

Home Nutritional Therapy (HNT) exception by the Better at Home Program (*Programa Melhor em Casa*) of the Ministry of Health, which has been expanding its scope every day and the articulation of the hospital with the other services of the care network, is still little incipient, demonstrating that, although there is concern with post-discharge follow-up, this activity is done by PHC service⁷.

The coordination of the transition of care is especially important for patients with various health needs and multiple comorbidities, who often rely on technologies and devices for continuity of care in their homes or other care contexts, requiring trained professionals and support resources at discharge³.

In Portugal and Canada, nurses from health services perform counter-referral and are responsible for continuity of care at hospital discharge⁸⁻⁹.

In Spain, since 1985, the Hospital Network for Public Use (XHUP - *Rede Hospitalária de Utilização Pública*) was created, aiming at improving access of older adults to the network of hospital services¹⁰ and the Home Care and Support Teams Program (HCPES - *Programa de Atenção Domiciliária e Equipes de Suporte*) to assist patients who needed intensive care at home. In hospitals, since 1992, the Socio-Sanitary Interdisciplinary Functional Units (UFISS - *Unidades Funcionais Interdisciplinares Sócio-Sanitárias*) were formed, integrating health services to social assistance. These units are composed of multidisciplinary teams (physician, nurse and social worker) that support the different hospital services, especially those whose continuity of care after discharge is essential¹¹.

In Andalusia (Spain), hospital services and coordination of care by a multidisciplinary team aim to facilitate transfer of care to home for patients and their caregivers, minimizing the elements of fragmentation, discontinuity and/or duplication of user care. Multidisciplinary team nurses manage care at hospital discharge and promotes continuity of care at home. These nurses were called case management nurses or hospital liaison nurses (HLN)¹².

The activities that are carried out in Spain by HLN in this study will be designated as continuity of care nurses.

These experiences brought concerns, which increased over the years, raising the following question: do hospital nurses in Brazil develop, in their practices, continuity of hospital care for PHC? Therefore, the purpose of this study was to know the practices developed by hospital nurses for continuity of care for PHC.

METHOD

This is a descriptive, exploratory and prospective research, with a qualitative approach to know the practices of continuity of care nurses. The descriptive approach was used to describe the settings and practices developed by nurses and provide greater familiarity with the problem and qualitative to know nurses' perceptions about the way they live and build their practices¹³.

The study took place in August 2018 and July 2019 at three university hospitals, two located in the city of São Paulo (SP) and the other in Curitiba (PR), Brazil.

Nurses and the Director of Nursing of one of the hospitals participated. With the Director of Nursing, an interview was conducted and, with nurses, a questionnaire was applied due to the quantitative and deadline for the study.

Nurses who worked as care workers, who worked in the morning or early hours, with a minimum workload of 30 hours and a maximum of 40 hours per week, with employment in hospital institutions, for at least one year in medical, surgical, pediatric, oncologic, neurological, terminal patients, outpatients, and emergency care units, who performed the hospital discharge plan were included. Nurses on night shifts, vacations, away or sick leave were excluded.

First, telephone contact was made with the Nursing Directorate of hospital institutions to present the research project and contact nurses. The invitation to request the participation of nurses was personally made by the researcher.

For nurses who agreed to participate in the research, an email was requested to invite them and send a web link, to have access to the electronic platform Survey Monkey¹⁴, hired by the researcher, for the answers. By clicking on the link, the Informed Consent Form (ICF) was automatically opened, the completion of which was a mandatory condition for access to subsequent pages.

For data collection with the Director of Nursing, a script containing questions about activities developed by nurses at hospital discharge was used. The interview was conducted after participants signed the ICF, used on average 20 minutes, in a private place, recorded in an audio device, in line with participants, later transcribed to a document in Microsoft Word[®] format.

For data collection with nurses, an online questionnaire was used with open-ended and closed-ended questions about patients' clinical assessment at admission and hospital discharge; resources needed for continuity of care for PHC and hospital discharge plan. The electronic questionnaire was elaborated on the platform Survey Monkey, electronic tool of private access, which enabled the application, collection and analysis of data online with privacy and data security¹⁴.

The questions contained: identification of hospital nurses' profile; clinical assessment at patient admission and discharge; discharge plan; communication and post-discharge follow-up. Each question should be answered in order for participants to move on to the following question. Only the researchers involved in the research had access to the answers. The estimated time for filling was 15 to 20 minutes.

Data were analyzed according to Minayo's Thematic Analysis¹³, which consisted of discovering the meaning nuclei for the object studied. In the first stage, all the material collected in the interview and questionnaire was read in depth; later, significant expressions/words or categories were sought, with continuity nursing practices as a reference.

In compliance with Resolution 466/12, this project was submitted and approved by an Institutional Review Board, and authorization from each of the institutions investigated was requested. To preserve participants' confidentiality, the discourses were coded using letters to designate the Director of Nursing (DN), liaison nurses (LN) and nurses (N) and using numbers, indicating the sequence of insertion in the study.

RESULTS

In order to meet the research, a Director in Nursing and 48 nurses participated in the study, 46 women and two men. Participants were between 27 and 63 years old; had at least four years and a maximum of 37 years of experience with nurses; 25 had a specialization course, 13, master's degrees and three, doctoral degrees.

From analysis of interviewees' answers and taking as theoretical framework the practices of continuity of care nurses, the following categories of analysis emerged: identification of the needs of patient care after discharge and skills necessary for continuity of care.

Identification of post-discharge patient care needs

In one of the hospitals, LN and, later, the Discharge Management Service, were implemented. Nurses, in this hospital, had the practice of monitoring the hospitalization of patients who present complex health problems and, together with the multidisciplinary team, carried out the planning of hospital discharge for continuity of care for PHC. This nurse should have care and management experience to act as a continuity of care nurse.

In the period of hospitalization, continuity of care nurses performed patients' clinical assessment; identified diagnosis and treatment; conducted an interview with patients and family; sought the necessary resources for post-discharge home care. These nurses were notified of the need for continuity of care: during the shift; during the visit to patients in the inpatient unit; by the multidisciplinary team; computerized system, telephone and in writing.

Some reports unblock these activities [...], *I perform an active search daily, aiming at the early identification of patients who need specific care continuity. I fill out the contraindication form. Attached the contraindication form in patients' medical records. I discuss with the multidisciplinary team the needs presented by a patient and question whether there is any more specific need or any other case that requires counter-referral. It is worth noting that all members of the multidisciplinary team can communicate the need for continuity of care, identifying the medical records with the specific form, communicating personally to liaison nurses or by phone [landline or mobile] (LN10).*

The Discharge Management Service, implemented by continuity of care nurses, was proposed to ensure continuity of care for PHC. To this end, a counter-referral protocol and direct communication with the Municipal Health Department was developed. From the discharge plan, carried out by continuity of care nurses, the Discharge Management Service forwards, by email, a summary of medical discharge, nursing and other professionals to the Municipal Health Department of the municipality, which forwards to patients' health unit [...] *during a work day, we discuss about the need for patients to have a continuity of care after hospital discharge. We nurses ask continuity of care nurses for discharge patients who go discharge dwell with enteral tube and some type of ostomy, who can already schedule visits and make available the necessary materials at home (LN12).*

The areas of the hospital assisted by the Discharge Management Service are: children's units; cardiology; neurology; nephrology; urology; chemotherapy; prompt service; medical clinic; infectious diseases; mechanical ventilation; surgical clinic; gynecology.

In the other two hospitals in the study that did not have a continuity of care nurse and a Discharge Management Service, nurses who perform hospital discharge. Most of these (71.43%) considered their responsibility to identify patients who need continuity of care, namely: those who are hospitalized to perform a surgical procedure; with complex wounds; acute or chronic clinical condition; elderly; those who had dependence on nursing care.

[...] after surgery, patients are instructed regarding home care with incision, removal of points, medical return, warning signs for infection, use of medication and biopsy result (N18).

It is perceived that nurses feel a gap in care, diagnose the need, but cannot ensure its effectiveness, due to lack of this care management.

Competencies of continuity of care nurses

The discourses indicate that, for continuity of care, nurses should have a look at patients' needs since their admission to the hospital and what they may need after the care received, when they will be with family/caregivers at the mercy of what the community can offer.

After identifying patients who need continuity of care, nurses conduct interviews with patients and their families, identify specific needs and care, perform physical examination and raise the resources available to the family for home care [...] *nurses verify the need for continuity of care and IRC nurses [Internal Regulatory Center] act in some specific cases (N24).*

Nurses demonstrated an expanded view of care that extends beyond hospitalization, i.e., home care, from patients' admission to the hospital, involving their family members or caregivers about the care that will be needed at home after hospital discharge.

[...] since patients' admission, especially patients with high dependence on nursing care, we make a discharge plan targeting who will be the caregivers, what family support or health network, what are the dependencies [feeding by NGT/gastrostomy, hygiene (bed/shower bath, diaper change)], prevention of pressure injury, application of insulin or medications. This care will be guided to family caregivers on dates scheduled by nurses (N26).

In hospital discharge planning, patients and family members are informed about access to supplies and materials, such as medications, wheelchairs, enteral diets, etc., as well as services of RAS, Basic Health Unit/Health Center, Home Care Program (HCP) and Better at Home Program. At hospital discharge, patients and family members are instructed to return to the institution's outpatient clinic or are referred to PHC.

For nursing managers, this situation of this process is very clear: [...] *continuity of care is a very important theme, mainly due to the moment we are experiencing from SUS, to align referral and counter-referral [...] nurses who integrate with other professionals of the outpatient clinic and Primary Care, especially those patients who depend on home care (DN1).*

When patients present an improvement in their clinical condition and the physician discharge them, nurses begin planning their discharge, from the care provided during hospitalization, checking patients' laboratory tests, current clinical status, autonomy, medicines in use, therapeutic plan; in case of needing emergency services, the contact and the reference location are provided.

[...] the discharge schedule is planned at patients' admission, in the hospital where I work, nurses and other health professionals of the unit are in charge if there is a need for continuity of care (N36).

At hospital discharge, the family is asked to follow the guidelines on the care to be performed at home. Most patients are guided on diet, surgical wound care, activities of daily living, description of medicines, and scheduled return. Colostomized patients, with intake bladder tube, with nasoenteral, and curative with papain are instructed to continue care in PHC.

Nurses reported that, in order to carry out continuity of care, it is necessary to have knowledge about the management of complex situations, establish a bond with patients, have good interpersonal communication, seek scientific knowledge, be humble and effective in problem solving, perform humanization, have coherence, clarity, be process facilitator, have experience in hospital care, in the primary care network and in home care, in addition to ability to use health technologies and skill in care planning.

PHC professionals are informed of hospital discharge, most of the time, when patients seek the health unit and needs care at home and, in some cases, receives from the hospital the request of the care program or home care. When patients with chronic disease are discharged and it is necessary to follow-up in primary care, the information is forwarded after hospital discharge.

The Director of Nursing reports on the difficulties often faced by nurses:

The biggest bottleneck I see in SUS is accessibility. From when patients are admitted to the hospital, it is important to know the support they have on the network, in their family and community, and that is when nurses start making the discharge plan (DN1).

DISCUSSION

Seeking to know the practices developed by hospital nurses for continuity of care for PHC, it was observed that this concept has been ubiquitous and is often used as a synonym for coordination and communication. Continuity of care from the hospital to the home or other levels of care is maximized when there is discharge planning, information exchange and integrated coordination of services in the transition period¹⁵.

Research on continuity of care has focused on elderly people with chronic diseases or those with complex conditions, because they need to monitor symptoms and drug monitoring on an ongoing basis. Access to information about the diagnosis of these patients and the establishment of effective communication with caregivers/family members and health professionals enable the coordination of care¹⁶.

In this study, it was possible to identify that hospital nurses performed interviews with patients and family members from admission, assessed the clinical condition, with a view to planning hospital discharge for continuity of care for PHC.

In Curitiba, we found the only hospital in Brazil where there are LN. This professional performs all the planned steps, complying with the proposed protocols including the counter-referral. Furthermore, it monitors the health condition of users so that there are no complications after discharge, prepare clinical nursing reports for all patients and make telephone contact with PHC⁹.

These continuity of care nurses have access to the electronic medical record in a network and the health establishments use the electronic e-health system, which works as a reference and counter-reference tool, linking the municipal health services. In the case of users residing in the municipality of Curitiba, electronic medical records facilitate local counter-referral; however, when users are from another city in the state and access the Emergency Care Unit (ECU), professionals do not have access to users' information and counter-referral can be difficult⁹.

In counter-referral, information about patients varies according to the municipality and occurs through instruments that can be forms, referral manuals, printed medical reports, telephone contact, or information and communication means that interconnect services and allow access to electronic medical records. For counter-referral to be effective, communication is an indispensable factor. When it occurs inappropriately, counter-referral becomes an important barrier to continuity of care at different levels of care⁹.

In hospitals where there is no continuity of care nurses, nurses or Internal Regulation Center (NIR) nurses are called upon to articulate the patient's transition from hospital to PHC. IRC aims to work the management of beds at the hospital level in a centralized way and to serve as an interface between the Health Unit and the corresponding Regulation Centers, in an integrated and agreed upon way, aiming to optimize the use of the hospital bed and has as a guideline to promote continuity of care¹⁷.

In Spain and Portugal, HLN and LN are requested by nurses to carry out clinical and social assessment and to verify the need for continuity of care after discharge through inter-consultation with the multidisciplinary team or active search in the hospital computerized program. In this process, there is the involvement between patients, family and multidisciplinary team for the elaboration of the discharge plan. Nurses have knowledge about the necessary resources after hospital discharge and make contact with professionals and/or nurses in patients' area of origin¹⁸.

Most developed countries are actively exploring innovative approaches to improve care delivery, reduce readmissions and contain health budgets. Nurses, when planning discharge, should estimate the risk of readmissions and reduce hospital costs¹⁹⁻²¹.

At hospital discharge, HLN offer patients and family members a continuity of care report, which contains medical and nursing information, patient data since admission, assessment/clinical process, description of functional patterns, tests and results, prescribed treatment, summary of hospital stay, diagnoses, and also some information for discharge, such as: treatment to be followed, nursing care plan; guidelines for home care; follow-up of home visits; information from the Health Center to which patients are linked¹⁸.

Among the skills and competences to act as HLN or nurses of continuity of care, it is necessary to have experience in the treatment of difficult situations, to have vision, to be proactive, in addition to managing care for complex patients and their families. In addition, they must have knowledge of intra and extra-hospital devices, the ability to work as a team, leadership, computer skills and effective communication with the different levels of intra and extra-hospital complexity. Coordination between the hospital and primary care is done through an electronic platform by primary care nurses¹⁸.

In the United States, the Navigation Program was developed, where nurses act as navigators, accompanying cancer patients and their families during care, providing information related to treatment and eliminating barriers that hinder the progress of processes related to care. This program significantly improved the patient's perception of their treatment and patients felt more involved in their care and better prepared for the future, as they had more knowledge about how cancer affects their lives²².

Nurse navigators use their specialized knowledge, clinical experience and skills to provide patients with care focused on physical, social and emotional aspects. They direct and guide patients, family members and caregivers to joint decision-making with the multidisciplinary team responsible for treatment. They supervise the entire treatment process, empowering patients, providing information and support, acting as a link between them and the team professionals²³.

Moreover, continuity of care nurses must teach and instruct adaptive strategies for family members and caregivers. It is observed that, increasingly, the period of hospitalization is short and families have been faced with the discharge of their sick family members, often with a health condition different from hospitalization, requiring the family member to take over the role of caregivers a set of knowledge and skills to deal with the situation²⁴.

The appropriate transition, using educational strategies implemented in a procedural manner throughout the hospitalization period, reduces the anxiety of family members and increases confidence for care. Thus, it provides continuity of care at home, increases the rate of outpatient follow-up and even decreases unnecessary hospitalizations²⁵.

Family caregivers feel unprepared at the time of hospital discharge. In-sight or telephone meetings with family caregivers can better support their roles as caregivers in post-discharge and create an opportunity to identify the willingness and ability to perform care. Family caregivers need encouragement to affirm their role and identity and generally assume responsibility for sequencing post-discharge care plan tasks²⁶.

It is important that user embracement in PHC is performed by nurses through qualified listening, identification of their needs and teamwork carried out to solve their problem²⁷.

It was noticed by the reports that where the NL was implemented, post-discharge activities and care were facilitated; however, it was found that the nurses interviewed seek this continuity of care to avoid complications and readmissions; they carry out patients' clinical assessment at admission and at hospital discharge, based on clinical and diagnostic data, provide guidance on patient and family care for continuity of care for PHC, in the same way as nurses in Spain, Portugal and Canada.

A study that analyzed telephone follow-up in the post-discharge period of the elderly showed that telemonitoring can be a viable technology in health care, as it makes it possible to monitor the evolution of patients and helps in identifying risk situations, preventing possible complications and readmissions. Another study showed that the participation of LN in the coordination of this process contributed to improve the interaction of services and promote continuity of care²⁸.

It was noticed that the interviewees understand the need and the importance of continuity of care, even though they do not have the necessary organization for this service to be established, seeking within their limits to meet the needs of patients on hospital discharge. They understand that the line of care was built based on the concepts of co-responsibility and integrated care management, covering the fields of promotion, prevention, treatment and rehabilitation. Despite including referral and counter-referral protocols, lines of care are different because they do not work only by established protocols. They require the recognition that service managers can agree on flows, reorganizing the work process, in order to facilitate patients' access to the services they need.

Therefore, it is necessary to guarantee a continuous assistance that promotes comprehensiveness of care, that allows patients' therapeutic itinerary not to be restricted to a predetermined and rigid sequence of interventions, but that the system knows which services that patient has been through and what resources used, aiming to qualify continuity of care, optimizing public time and resources.

So that lines of care are not reduced to mere assistance and technical flows, based on clinical protocols and so that itineraries are not mere thermometers to previously guidelines of care in the care of pathologies, the knowledge about therapeutic itineraries presupposes the sensitivity to capture this relationship, closely related to conceptions about health, disease and good living. If this sensitivity also permeates health practices and the construction of therapeutic projects, then it is possible to talk about possibilities of articulation between knowledge about therapeutic itineraries and the construction of lines of care.

It is essential that nurses have the knowledge to plan hospital discharge, resources needed for home care and computer skills so that the transition is safe and timely, enabling continuity of care for PHC.

Although the results of this study show that there is a latent concern among nurses with the effectiveness of comprehensive care, the study's limitation was the conduct of research in only three university hospitals; it would be interesting to capture this reality in other public and private health institutions to understand how the hospital-home transition process takes place, especially for patients who need special care. This suggestion remains for further investigation.

CONCLUSION

This study made it possible to know the practices of nurses for continuity of care for PHC developed in three university hospitals. It is worth mentioning that, in the researched institutions, individual and health team efforts were perceived to offer their patients comprehensive care, with the available resources; however, continuity of care often depends on the training and availability of PHC teams to constitute the reference system of care, in addition to the resources that the community can offer, either in relation to care (family/caregiver, training), or in terms of available inputs.

Although nurses are professionals who actively participate in care at various points in the health care network, it is necessary to strengthen their contribution to the mechanism of continuity of care for PHC and the articulation, at hospital discharge, between hospital and health unit, seeking to optimize home care and reduce or avoid readmissions.

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