

● Original article

DISCHARGE MANAGEMENT TO ENSURE CONTINUITY OF CARE: EXPERIENCE OF PORTUGUESE LIAISON NURSES

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Objective: To describe the activities performed to ensure continuity of care by liaison nurses in hospital services. **Method:** Descriptive exploratory study with 107 nurses conducted from September 2016 to March 2017, in 15 hospitals in Portugal. Data was collected with a semi-structured questionnaire and the absolute frequencies were calculated for data analysis. **Results:** Fifty-one 51 (47.7%) patients who require continuous care were identified by physicians and nursing assistants; 69 (64.5%) health professionals used specific criteria to identify the discharge risk factors. The elements considered in the discharge planning are motor and functional recovery; 54 (30.86%); and caregiver's capacity to provide caregiving activities, 41 (23.43%). Most information related to care continuity is exchanged by email, 58 (25.55%). **Conclusion:** The activities associated with continuity of care are not homogeneous among the professionals who carry out liaison activities, but contribute to the use of more consistent strategies for coping with discontinuity of care.

KEYWORDS: Nursing; Management of professional practice; Continuity of patient care; Patient discharge.

GESTÃO DE ALTA PARA A CONTINUIDADE DO CUIDADO: EXPERIÊNCIA DAS ENFERMEIRAS DE LIGAÇÃO DE PORTUGAL

Objetivo: descrever as atividades de continuidade do cuidado desenvolvidas pelas enfermeiras de ligação nos serviços hospitalar. **Método:** estudo descritivo, exploratório, realizado de setembro/2016 a março/2017, em 15 hospitais de Portugal, com 107 enfermeiras. Os dados foram coletados com um questionário semiestruturado e analisados por meio das frequências absolutas. **Resultados:** 51 (47,7%) dos pacientes que necessitam de cuidados continuados são identificados por médicos e enfermeiras assistenciais, 69 (64,5%) utilizam critérios para a identificação dos riscos para a alta do paciente. Os elementos considerados no planejamento de alta são: reabilitação motora e funcional, 54 (30,86%); e preparo do cuidador, 41 (23,43%). As transferências das informações para continuidade do cuidado ocorrem majoritariamente por correio eletrônico, 58 (25,55%). **Conclusão:** as atividades para a continuidade do cuidado **não são homogêneas entre** os profissionais que realizam atividades de ligação, mas contribuem para estratégias mais consolidadas para o enfrentamento da descontinuidade do cuidado.

DESCRIPTORIOS: Enfermagem; Gerenciamento da prática profissional; Continuidade da assistência ao paciente; Alta do paciente.

GESTIÓN DEL ALTA PARA CONTINUIDAD DE LA ATENCIÓN: EXPERIENCIA DE ENFERMERAS DE COMUNICACIÓN EN PORTUGAL

Objetivo: describir las actividades de continuidad de la atención desarrolladas por las enfermeras de comunicación en el servicio hospitalario. **Método:** estudio descriptivo, exploratorio, realizado de septiembre/2016 a marzo/2017 en 15 hospitales de Portugal con 107 enfermeras. Datos recolectados mediante cuestionario semiestruturado, analizados por frecuencias absolutas. **Resultados:** 51 (47,7%) de los pacientes que precisaban atención continuada son identificados por médicos y enfermeras de atención; 69 (64,5%) utilizan criterios de identificación de riesgos para la alta del paciente. Los elementos considerados en la planificación del alta son: rehabilitación motriz y funcional, 54 (30,86%); y capacitación del cuidador, 41 (23,43%). La transferencia de información para continuidad del cuidado sucede mayormente vía correo electrónico, 58 (25,55%). **Conclusión:** las actividades para continuidad de la atención no son homogéneas entre los profesionales actuantes en la comunicación, pero colaboran con estrategias más sólidas para enfrentar la discontinuación del cuidado.

DESCRIPTORIOS: Enfermería; Gestión de la Práctica Profesional; Continuidad de la Atención al Paciente; Alta del Paciente.

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● INTRODUCTION

Continuity of care is defined by the Portuguese National Health Care Service (NHS) as sequentiality, in time and in healthcare and social security systems, of integrated health and social support interventions.⁽¹⁾ It is a strategy and policy that must be observed by health care services, as it is associated with improved quality of care,⁽²⁾ minimizes costs,⁽³⁾ reduces avoidable hospitalizations among the elderly⁽⁴⁾, as well as hospitalization risks.⁽⁵⁾

Patients experience discontinuity, fragmentation of care when they face many shifts and transitions between institutions and units.⁽²⁾ Thus, to ensure continuity of care, the Portuguese NHS relies on the National Network for Integrated Continuous Care (RNCCI)⁽⁶⁾. The network embraces all forms of continuous, rehabilitation and palliative care for dependent persons who need continuous health care and social support. The RNCCI is composed of the following units: admission, ambulatory, hospital and home teams.⁽⁷⁾

The RNCCI promotes the rehabilitation of dependent persons following an acute episode, train family members in caregiving responsibilities during hospital admission and/or wait for patient's preparation to be admitted to a nursing home.

The referral systems aimed to ensure continuity of care in Portugal are the families, the RNCCI units and the community, especially the Family Health Units (USF). Therefore, in order to standardize the referral process of patients from the hospital to the RNCCI, or to other referral systems, each hospital of the Portuguese National Health System (NHS) counts on a Discharge Management Team (EGA). The EGA is multidisciplinary (composed of at least one nurse, one physician and one social worker) with the purpose of evaluating and confirming the proposal of referral of patients requested by the care teams.⁽⁸⁾

In addition to the EGA nurses, registered nurses (nurses who deliver nursing care to patients) and/or managers who perform liaison functions are responsible for ensuring continuity of care in the discharge management model of Portugal.⁽⁹⁾ Registered nurses identify and evaluate the patients who need continuous care and hence are links between hospital services and the EGA, or between hospital services and the community/family, when patients are not referred to RNCCI units. In turn, EGA nurses carry out the care plan and transfer patients from the hospital setting to external referral systems, which is often the RNCCI.

The EGA of each hospital works in partnership with the care team of the different hospital units in order to plan patients' discharge, according to their needs. The nurses of the discharge management team and registered nurses must work closely together and be sure about what needs to be done to ensure continuity of care, as well as of the means and strategies for achieving it.

Knowledge of the activities developed by liaison nurses of the Portuguese National Health System (NHS) can be useful to design strategies for coping with the undeniable discontinuity of care in Brazil due to the fragile coordination between care services of different levels and a deficient counter-referral system in the country.⁽¹⁰⁻¹¹⁾

This study is part of a multicenter project, pioneer in Brazil, which investigated the experiences of liaison nurses in Portugal, Canada and Spain, with the purpose of elucidating and subsidizing the role of liaison nurses in Brazil, as these professionals can provide a substantial contribution to care continuity.⁽¹²⁾

Thus, this study aims to describe the activities performed by liaison nurses in hospital services to ensure continuity of care.

● METHOD

Descriptive and exploratory study with a quantitative approach, developed in 15 public hospitals in the northern region of mainland Portugal, with nurses of the discharge management team (EGA) and registered nurses and/or managers who perform liaison functions, totaling 107 nurses.

The inclusion criteria were as follows: liaison nurse of the hospital discharge management team in the medical and surgical services of the institutions mentioned.

The nurses were invited to participate in the study by a Portuguese researcher who ensured the anonymity of the participants, explained the objectives of the study to them and handed to them the Free Informed Consent Form and the self-administered semi-structured questionnaire. Data was collected in the nurses' workplace and lasted 15 to 20 minutes. The period of collection was September 2016 to March 2017.

The data collection instrument was the same used in the aforementioned multicenter study in three countries. Small cross-cultural adaptations were necessary to adjust the terms to Portuguese of Portugal and avoid biases. The semi-structured questionnaire was validated by five Portuguese nurses, one researcher and four hospital service managers who did not participate in the study. The questions had the purpose of explaining the profile of the participants of the research, identifying the patient who needs continuity of care, the initial patient assessment, hospital discharge planning, as well as the exchange of information between hospital and out of the hospital services.

In Brazil, the research project was approved by the Research Ethics Committee of Universidade do Paraná under protocol no 1,426,575. In Portugal, the project was submitted to the Ethics Committee for Health of Centro Hospitalar São João and the School of Medicine of Universidade do Porto, and was approved under statement no 157/16. Subsequently, a request for authorization for the research was sent to each participating institution, together with the statements issued by Brazil and Portugal. Three of the 18 hospitals invited refused to participate in the study.

The data collected was entered in an Excel 2010 spreadsheet, analyzed and discussed based on the absolute frequencies obtained.

● RESULTS

Profile of the participants

Of the 107 participants in the study, 83 (77.6%) were women with a mean age of 48 years. Regarding the length of time working in the profession, it ranged from 1 to 40 years, with a mean of 19.7 years. Regarding the type of activity, 98 (91.6%) participants were registered nurses and/or managers who performed liaison functions, and 9 (8.4%) were EGA coordinators. Regarding the educational level, 79 (73.8%) had undergraduate degrees in Nursing; 26 (24.3%) had a master's degree and 2 (1.9%) had doctoral degrees.

Identification of patients who need continuing care after hospital discharge

The need for post-discharge home care is identified by physicians and nurses, 51 (47.7%); followed by the other professionals of the care team, 42 (39.3%), and exclusively by physicians 8 (7.5%).

Of the total number of participants, 69 (64.5%) used criteria to facilitate the identification of potential risks or problems for patient discharge; 27 (25.5%) did not use any criteria for this purpose and the others said that the use of criteria was not applicable.

The criteria to facilitate the identification of potential risks or problems for patient discharge are living alone, 103 (97.2%); dependence in self-care, 101 (94.4%); multiple pressure ulcers, 90 (91.8%); poverty, 95 (91.3%); patients who are victims of abuse or neglect; 94 (90.4%); with a previous history of falls at home, 82 (85.4%); patients suffering from acute chronic diseases, 83 (88.3%).

The most widely means used by EGA professionals, registered nurses and managers to exchange information needed to ensure continuity of care are a specific printed form, 50 (46.7%); use of telephone, electronic mail and printed form, 31 (29%); use of telephone and a specific printed form, 25 (23.4%).

Initial Patient Assessment

Initial patient assessment, in the search for criteria that meet the future needs of continuous care, can be performed by nurses of the discharge management team (EGA), as well as by registered nurses, and consists in physical examination, collection of data from the medical record and interviews. The interviews are performed by 75 (70.1%) of the nurses; 13 (12.1%) do not conduct interviews, and 19 (17.8%) said it is not applicable.

The interviews address the reasons for hospitalization, medical history, family context and history, life habits, current health status, medication use, degree of motor and functional dependence, risk of falls and pressure ulcers, patient's decision-making ability, assessment of swallowing ability, balance and sensory assessment, post-discharge needs, primary caregiver training, patient and caregiver knowledge about prevention of complications and housing conditions.

Physical examination was performed by 78 (72.9%) participants. Thirteen (12.1%) participants did not perform the physical examination of the patients for the following reasons: it is of responsibility of registered or admission nurses (according to national regulations), or else because they are EGA managers or members and use information from the physical examinations performed by registered nurses and available in the patients' records.

Regarding the participation of a family member in the initial patient assessment, 74 (69.2%) nurses usually contact a family member, 13 (12.1%) do not make any contact and the others said that this is not applicable.

Hospital discharge planning

Hospital discharge planning, which consists in assessment, form completion and prediction of discharge date, is performed within the first 48 hours after hospitalization for 71 (66.4%) of the participants. For 30 (28%), there is no hospital discharge prediction and, therefore, the need for continuity of care is identified at the time of hospital discharge. Three 3 (2.8%) participants reported that discharge planning starts in another moment, though not specifying when, and 3 (2.8%) did not answer the question.

For 102 (95.3%) of the respondents, discharge planning also involves other professionals, and meetings are held to discuss the cases; 2 (1.9%) said that there is no involvement of health professionals other than registered nurses, and the other participants did not answer this question.

According to the participants, the professionals who can be involved in the discharge planning process are registered nurses, 84 (78.5%); physicians, 85 (79.4%); social workers, 96 (89.7%); EGA nurses, 85 (79.4%); nutritionists, 30 (27.1%); physiotherapists, 8 (7.5%); psychologist, 3 (2.8%); and physiatrists, 2 (1.9%).

Regarding the presence of a coordinator of discharge planning, 49 (45.8%) said that there is a coordinator, 44 (41.1%) reported that there is no coordinator, 13 (12.1%) said it is not applicable and 1 participant did not answer the question. As for the professional who coordinates the discharge planning process, for 15 (14%) participants this is a responsibility of EGA nurses; for 12 (11.2%) it is a responsibility of the physician; for 10 (9.3%) it is a responsibility of registered nurses, and for 1 (0.9%) it is a responsibility of another professional not specified by the participant.

The main elements included in the discharge planning resulting based on the initial assessment are presented in Table 1.

Table 1 - Main elements of hospital discharge planning. Porto, Portugal, 2016-2017

Main elements of hospital discharge planning	n	%
Caregiver's capacity	41	23.43
Motor and functional recovery	54	30.86
Management of the drug regimen	34	19.43
Treatment of pressure injuries	02	1.14
Recovery of prior autonomy	01	0.57
Self-care training	33	18.86
Degree of dependence	02	1.14
Care to be provided	06	3.43
Main nursing diagnoses	01	0.57
Social status	01	0.57
Total	175	100

For 98 (91.6%) of the participants, a document with information on strategies for continuity of care is handed to the patient upon discharge; for 7 (6.5%), this is not applicable, and the others did not answer the question.

Regarding the contacts with patients' relatives on the day of hospital discharge, 96 (89.7%) of the participants reported that there is some sort of contact with these individuals. This communication is meant to inform the time of hospital discharge, pass on information regarding the care developed during the hospitalization, as well as to train the relatives on post-discharge care. It was found that 3 (2.8%) did not make such contacts; for 7 (6.5%), it is not applicable, and one participant did not answer the question.

Exchange of information between the hospital and the other out of the hospital services

The types of exchange of information between the hospital and out of the hospital services are shown in Table 2.

Table 2 - Main types of exchange of information. Porto, Portugal, 2016-2017

Types of exchange of information	n	%
Email communication between health professionals	58	25.55
Telephone contact	55	24.23
Letter delivered by the patient	44	19.38
Discharge plan delivered by the patient	27	11.89
Printed form	1	0.44
Computer system	41	18.06
Others	1	0.44
Total	227	100

The referral systems aimed to ensure continuity of care are usually family members, RNCCI and FHU units. According to the participants, regarding the moment FHU and RNCCI professionals receive patient information on patient hospital discharge is as follows: For 40 (37.4%), on the day of hospital discharge; for 34 (31.8%), one day before hospital discharge; for 10 (9.3%), one day after hospital discharge; or, less frequently, one week before discharge for 3 (2.8%). Sometimes health professionals are not informed of patient referral, 14 (13.1%).

● DISCUSSION

The identification of patients who need continuing care after hospital discharge should preferably be performed during the first 48 hours of hospitalization.⁽⁷⁾ Apparently, according to more than half of the research participants (66.4%), discharge planning begins within the first 48 hours of patient hospitalization. One element that ensures continuity of care through the different levels is planning discharge as soon as patients are admitted to the hospital.⁽¹³⁾

Identification of patients who require continuing care can be performed by different professionals. Thus, liaison with the EGA can be established by registered nurses and/or nurse managers, since not all services have a discharge planning coordinator. The unavailability of a coordinator can contribute to underreporting of patients to the EGA, which makes access to information more difficult, delaying discharge planning.

Among the criteria used to identify patients who need continuing care and are referred to the RNCCI or other referral systems living alone, previous history of falls and dependence in self-care corroborate data from a study on the profile of the most frequently admitted patients in the RNCCI, as follows: elderly, physically dependent individuals, women, with lack of professional qualification and up to six years of education.⁽¹⁴⁾ Initial patient assessment revealed that most data collected is useful for ensuring continuity of care, as it includes both clinical and sociodemographic information.

Although all the hospitals included in the study count on computer information systems, printed forms are the most frequently means of communication used by registered nurses to request continuity of care. Teamwork in health care is complex, and effective communication is a key point that requires continuous evaluation of the standards, values, habits, rules and experiences lived and shared by team managers and professionals.⁽¹⁵⁾ Establishing a channel for such communication is key to continuity of care.

EGA nurses were the professionals most frequently in charge of coordinating hospital discharge planning, which can be attributed to the fact that the EGA is responsible for the referral of patients to the RNCCI.⁽⁸⁾ Moreover, nurses are recognized for their ability to provide integral care to the patients and to be more capable of understanding the needs and expectations of patients and their families, as well as the ability to optimize health care interventions in a way that integrates and embraces professional, user and community knowledge.⁽¹⁶⁾

Motor and functional recovery are important elements in the planning of hospital discharge, as they minimize the limitations related to the daily activities of the patients. A study on functional capacity in the areas of social, economic, mental health, physical health and daily activities of people aged 75 years or over in Coimbra found that 45.6% of them had severe or total physical activity limitation followed by 23.6% with severe or total limitation for performing routine activities.⁽¹⁷⁾

Caregivers must be able to provide continuous care and this is demonstrated in the ability to identify the possibility of patient recovery, high degree of dependence, low income, among other aspects. The transition from a state of health to a state of illness and patients' dependence on other people or equipment must be considered, as well as the need for family members to adapt to their new role of caregivers, and the importance of enabling them to perform this role⁽¹⁸⁾ as best as possible.

The post-discharge drug regimen is different from the hospital drug regimen, which may imply in changes in the patients' routine. In order to ensure continuity of care in the community or home setting, primary care professionals request accurate information on the changes of medications of patients who have been hospitalized, as well as a complete list of the medications prescribed at hospital discharge.⁽¹³⁾ Interventions to improve therapeutic adherence are a valuable asset to promote the health of the elderly population, with repercussions on the increase of quality of life, reduction of recurrences to emergency services and hospitalization.⁽¹⁹⁾

A study with 55 elderly people from home care teams in the South of Portugal reported that 40 (72.7%) of them did not adhere to drug therapy. Despite the lack of statistical association, factors such as low income, living alone and suffering from depression may have influenced the outcome⁽¹⁹⁾ and thus should be considered by health professionals responsible for hospital discharge planning.

Patients must be prepared to perform self-care activities, since health education must be carried out in all health care areas, in a coordinated way. In tertiary care, registered nurses prepare patients and their families during hospitalization for the moment of discharge. Programs focused on preparing patients and family members for hospital discharge should be encouraged as a strategy for education and a contribution to comprehensive care.⁽²⁰⁾

The exchange of patient information between hospital and out of hospital care services is mostly done by e-mail and through the patients who take their discharge letters to the referral service. It should be emphasized that a continuous flow of communication prevents unnecessary disorders, such as lack of clarity in communications between professionals, as well as a possible admission to other care services.⁽²¹⁾

When discharge letters are delivered to the patients there is a transfer of responsibility for care, and the patient and/or his (her) caregiver is expected to be responsible for the exchange of information. This action may lead to an unsatisfactory transition, with the occurrence of post-discharge adverse events and, consequently, re-hospitalization of patients,⁽²²⁾ The use of an effective means of communication between professionals and a communication that involves the patient and his/her family members would be ideal, as this would include the patients and family members in the process of continuity of care, and they would receive some useful written information.

The present study had some limitations such as non-inclusion of documents that regulate the EGA and the activities of health professionals of continuing care units that compose the RNCCI and participate in the care continuity process. Such documents could provide greater understanding of discharge management in the hospitals investigated.

● CONCLUSION

The findings of the study conducted in health institutions in Portugal regarding the activities developed by EGA nurses and liaison nurses deserve some considerations, particularly because the Portuguese NHS advanced with the creation of a policy of continuing care and the implementation of the RNCCI.

The present study showed that the activities performed to identify the patients who need continuing care, the ways of exchanging information between the healthcare team and the EGA and between the EGA and RNCCI are not homogeneous, despite the existence of national guidelines on the process of continuity of care in hospital and out of the hospital services.

As for the hospital discharge planning, it was found that slightly more than half of it is performed at the recommended time. Thus, it is necessary to investigate the human resources available for this activity, i.e. the registered nurses, their workload, and how is discharge planning conceived by the management of each hospital.

Regarding the elements that compose the hospital discharge plan, this study identified nurses' concern with other patients' needs (not merely their clinical conditions) and their involvement with caregivers and professionals of the FHU and RNCCI, which is essential for patients who require continuing care.

Knowing the experience of professionals who perform liaison activities in patient's hospital discharge, aiming at the continuity of care, will help nurse assistants and managers to design more consolidated strategies in order to address the challenges of discontinuity of care, through appropriate hospital discharge planning, more effective exchange of information among professionals, and coordination between the services.

Further studies are recommended on the factors that interfere in the identification and referral of hospital patients to the RNCCI and other referral systems and on patient follow-up after hospital discharge, in order to evaluate possible readmissions, as well as on the activities of RNCCI continuing care units.

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