Cogitare Enfermagem

ORIGINAL ARTICLE

Practice and time management of primary health care nurses in continuity of care*

HIGHLIGHTS

1. Most of the investigated activities are habitual in the nurses' routine.
2. Early relationships with users and among services support continued care.
3. It is estimated that 30 to 42.5 minutes are dedicated to the actions performed.
4. There is collaboration and quality in the continuity of care.

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ABSTRACT

Objective: To investigate the practice and estimated time by primary health care nurses to perform continuity of care actions after hospital discharge. **Method:** A questionnaire (Web Survey) containing 17 validated activities was applied to 51 nurses from two municipalities in the State of São Paulo - Brazil, in 2022. The analysis was conducted through measures of central tendency, parametric and non-parametric tests. **Results:** 80.3% of the actions occur collaboratively; coordinating team care, guiding users about the Health Care Network, and scheduling home visits were predominant activities. The quality of the actions was perceived as good and very good, with the reported time of 30 to 42.5 minutes. **Conclusion:** Actions for continuity of care are developed daily by primary health care nurses and require significant time in daily practice. The findings contribute to the management of the nursing process and workforce.

KEYWORDS: Primary Health Care; Continuity of Patient Care; Patient Discharge; Practice Management; Workload.

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INTRODUCTION

The continuity of care for patients discharged from the hospital requires coordinated actions in the informational, relational, and managerial dimensions to promote good experiences in meeting the needs and preferences of users, in the coherence of care, and in the integration of different services[1-2].

In primary health care (PHC), the dimensions can be exemplified by the discharge summary, the bond between professional and user, and the longitudinal follow-up of therapeutic interventions[3]. Timely access and reduced waiting time for consultations in PHC are also actions that improve the user's perception of continuity of care and prevent the search for urgent and emergency services[4]. In this sense, the promotion of continued care can benefit the interaction between professionals/services, diagnosis and adherence to clinical recommendations, quality of care, user/family satisfaction, and cost reduction[3,5].

In the national and international context, the nurse has taken on a strategic role in case management that requires continuity at different points of health care[6-8]. In addition to coordinating care, he is recognized as a professional capable of bringing users closer to other providers and health services by mediating and facilitating/educating teams and the community[9-10].

This practice, however, requires collaboration from different professionals, effective communication, and coordination of interventions with health teams and services[6-7]. Moreover, an analysis of Brazilian dissertations and theses found that coordination actions and bonding with users need to be improved[11] and authors highlighted the workload faced by primary care nurses, in some scenarios, due to, among other factors, the multiple tasks assumed[12-13]. This aspect is so important that institutions have invested in exclusive professionals to develop coordination and continuity of care activities considering the difficulty of nurses to incorporate this additional demand[8,14].

Despite the relevance of the topic and advances in the practice of primary care nurses, the literature on the activities performed to coordinate and continue care according to user needs is still limited. A synthesis of evidence, published recently, identified that low- and middle-income countries need to expand studies on coordination and continuity of care, especially in the context of primary care[7].

In light of this gap, Brazilian researchers mapped and validated actions to be developed by primary care nurses in the continuity of care for users after hospital discharge. There are 17 actions that support informational, relational, and managerial continuity in the professional practice of nurses as care coordinators[15]. This study innovates by adopting this list of activities to recognize the practice of primary care nurses, interprofessional work, and the time spent on continuity of care actions for users. Thus, it proposes contributions in response to the following questions: After hospital discharge, what is the frequency and timing of continuity of care activities performed by primary care nurses for users? Is there interprofessional collaboration in these actions? What are the qualifying and hindering aspects and how much time do they dedicate to the practice of continuing care? Its objective is to investigate the practice and estimated time by primary health care nurses to carry out continuity of care actions for users after hospital discharge.

METHOD

This web survey was designed in accordance with the guidelines of the Checklist for Reporting of Survey Studies (CROSS)[16]. The fields of investigation considered were units of Primary Health Care (PHC) and Rehabilitation Strategies from two municipalities in the interior of the State of São Paulo.

PHC 1 comprises 25 teams distributed across five Basic Health Units (BHU), 18 Family Health Strategies (FHS), one Multiprofessional Home Care Team (MHCT), and one Street Clinic, with a total of 46 nurses. It operates under the management model of Social Health Organizations (SHO), aligned with the Health Department of the municipality. In the responsible discharge process, the Home Care Service (HCS) is responsible for following up with users who require medium to high complexity care and directs those with lower complexity to the relevant health unit via email.

PHC 2, managed by the Municipal Health Department of the municipality, is organized into 28 Basic Health Units (BHU), five Expanded Family Health and Basic Care Centers (EFHB-CC), currently referred to as multiprofessional Primary Health Care teams (eMulti), two Street Clinics, and the Home Care Service (HCS), where 89 nurses work. In this process, coordination for continuity of care occurs between the Primary Health Care (PHC) and other healthcare providers, such as Home Care, Hospital Care, and the Mobile Emergency Care Service (MECS), through referral and counter-referral.

Nurses were considered eligible with at least three months of experience, involved in the responsible discharge process and actions related to continuity of care, excluding those on vacation or absent at the time of data collection. Thus, 40 nurses from PHC 1 and 56 from PHC 2 were invited to participate in the study.

A semi-structured questionnaire was developed based on a validated listing[15] of 17 activities to be performed by PHC nurses for continuity of care. It was structured into three parts: the Informed Consent Form (ICF), which provided clarifications about the research; the characterization of participants, including demographic and professional data; and finally, the presentation of the list of activities.

The following were considered as variables of interest: frequency (always, sometimes, and never); moment (day of receipt of the hospital discharge plan by PHC when they are carried out); execution (specific action by the nurse or collaborative); collaborating professionals; average estimated time for execution in minutes; perception of the quality of actions; and difficulties experienced in conducting the process. The instrument was entered into the Google Forms® application and tested with three nurses from the Primary Health Care (PHC) setting. After making minor adjustments, the final version was obtained.

Preliminary contact was made with the nursing managers of the health districts and the FHS of both locations to present the project and study objectives. Subsequently, to recruit potential participants, awareness was raised with eligible nurses presenting the study's purposes, possible contributions, and the data collection instrument. Two strategies were adopted: in-person, during a Continuing Education session (PHC 1), and remotely, via Google Meet, on previously agreed-upon dates and times (PHC 2).

Invitations to professionals were sent via email, along with an access link, and were mediated by the coordinator of permanent education (PHC 1) and managers of the health units (PHC 2). Reminders were sent every 10 days. To avoid multiple responses

from the same participant, the name of the unit, team, and personal and professional identification email were used. Data were collected from July to August 2022.

Data analysis was performed using Stats Direct Statistical Software, version 3.3.5 (StatsDirect Ltd, Wirral, UK), at a significance level of 5% ($p < 0.05$). Absolute frequencies were calculated for categorical variables, and measures of central tendency (mean, median, and interquartile range) were calculated for numerical variables. The Chi-square test was applied in the comparisons between the PHC and the Exact Fisher test/ two-tailed unpaired t-test when there were values less than 5. For numerical variables, comparisons were made using the Mann-Whitney and Kruskal-Wallis tests, followed by the Conover-Iman post hoc test. For the responses to open-ended questions, categorization was carried out.

The project was appreciated by the managers of Primary Health Care in the investigated municipalities and approved by the Research Ethics Committee (CAAE 08412019.4.0000.5415) and received an opinion. 3.699.970/2019.

RESULTS

Fifty-one questionnaires were returned, yielding a response rate of 53.1%. Among those who reported their professional qualifications, 35 were specialists, seven had completed a residency in Management in Primary Care, and two had only an undergraduate degree. Other participant data is presented in Table 1.

Table 1. Profile of the nurses from the PHC study field. Catanduva, SP, Brazil, 2022

Variables	PHC 1 (n= 24)	PHC 2 (n=27)	P-value
Gender (n)			NS
Female	23	26	
Male	1	1	
Age (years)			
M(SD)	32.1(6.6)	36.3(8.3)	NS
Time of practice (years) M (SD)			
As a nurse	5.9(4.2)	8.9(6)	≤ 0.05†
In PHC	4.5(3.7)	6.8(5.1)	NS
Place of action (N)			
Street Clinic	1	-	
MHCT	1	7	
BHU	5	18	
FHU	17	2	

Legend: (n=51); PHC: Primary Health Care; M: mean; SD: Standard deviation; NS: not significant; † Two-Tailed Unpaired T-Test; MHCT: Multiprofessional Home Care Team; BHU: Basic Health Unit; FHU: Family Health Unit.
Source: The authors (2022).

Table 2 lists 17 validated activities performed by nurses in PHC, distributed according to the occasion on which they are conducted, that is, on the day of receiving the discharge plan or on subsequent days.

Activities A1, A2, and A3 are performed according to the report of most nurses on the same day that PHC confirms receipt of the hospital discharge plan; 10/17 actions occur predominantly on the first day after receiving this plan. Guidance to the user/family regarding the flows/processes to obtain equipment/supplies (A7) is provided both on the day of receiving the discharge plan and on the first subsequent day.

Table 2. Timing of activities (value of N) from the receipt of the hospital discharge plan by the investigated PHC. Catanduva, SP, Brazil, 2022

Activities	Day PA	D1	D2-D3	Other
A1. Request user/family attendance†	23	18	3	3
A2.Review the discharge plan received	24	14	4	9
A3.Establish active search routine‡	23	11	5	10
A4.Schedule the home visit	13	23	6	5
A5.Conduct initial home visit	7	16	11	15
A6.Identify needs/equipment	9	18	9	12
A7.Guide user/family - flows	18	18	4	9
A8.Explain service processes	14	22	4	9
A9.Train caregivers	12	21	4	11
A10. Perform procedures at home	7	11	10	13
A11.Organize meetings with the team	13	8	10	11
A12.Participate in interprofessional meetings	11	7	10	14
A13. Coordinate the team's attendances	12	18	6	8
A14.Plan care with the HCS†,	14	18	6	10
A15.Conduct educational actions - team	7	12	8	12
A16.Participate in meetings with managers	8	9	4	12
A17.Evaluate user service	11	9	12	12

Legend: (n=51); PA: Discharge Plan; D1: first day after receiving the discharge plan and so on; HCS: Home Care Service; † $p < 0.05$; ‡ $p < 0.01$ (Chi-square Test); Missing data.
Source: The authors (2022).

Already 3/17 of the activities, such as participating in and/or coordinating interprofessional planning meetings (A12), participating in meetings with managers at different levels of health care (A16), and evaluating user/family care and discussing strategies with the health team for care qualification (A17), are conducted on various days of service. There was a statistically significant difference between the PHC for the timing of activities A1 ($p<0.05$), A3($p<0.01$), and A14 ($p<0.05$), in the option day of discharge plan - PHC1>PHC2.

Regarding the frequency of activities performed after hospital discharge, it was observed that 14 out of 17 activities are consistently conducted by nurses. The actions A1- Request user/family attendance at the reference unit (26/51), A15 - conduct educational actions for professional development (25/51), and A16 - participate in meetings with managers at different levels of health care to coordinate actions/flows/protocols related to continuity of care (27/51) were reported more frequently as occasional and less frequently as always (respectively, A1- 22/51, A15 -19/51, and A16 -16/51).

The number of responses for the option never for these last two activities stands out (A15- 7/51 and A16- 8/51, respectively); and also, the statistically significant difference between the PHC in the distribution of frequencies for activities A3 - Establish as routine active search and A10 - Perform procedures at home, option always, PHC1>PHC2 ($p<0.01$, Chi-square Test).

Considering the total number of responses for activities performed in the PHC (n = 867), 80.3% of them are conducted collaboratively, while 19.7% are performed solely by the nurse. Participating in meetings at different levels of healthcare to coordinate actions, flows, and protocols related to continuity of care (n=19) were the activities most referred to as having exclusive participation by nurses. Other actions include getting informed about the discharge plan received from the hospital institution and recommending adjustments, if necessary, to this service (n=18); coordinating the team's care and home visits (n=16); and if necessary, planning care with other services in the health care network (rehabilitation, MHCT, and others) for care integration (n=15).

A significant difference was found ($p \leq 0.01$ – Chi-square test) between the PHC regarding professional participation in actions. A PHC1 conducts its activities more collaboratively (84.8%) compared to PHC2 (76.2%). Among the 12 health team professionals mentioned, the ones who most collaborate in actions are nursing assistants and technicians (17.6%), physician (17.1%), community health agent (CHA) (10.9%), social worker (9.4%), nutritionist (8%), psychologist (7.5%), and physiotherapist (7.2%). There was no significant difference (Mann-Whitney Test) in team composition between the PHC.

Table 3 highlights the findings regarding the quality aspects of the actions developed from the participants' perspective. The nurses from PHC1 assigned an average score ranging from Md 3.5(1) (good) to 4(1) (very good). In PHC 2, the score was 3(1) (good) for the entire set of activities. The intergroup comparative analysis (PHC1 and PHC2) did not show significant differences (Kruskal-Wallis Test). When there were intragroup differences (PHC1 x PHC2), the assigned values were lower in PHC2 compared to PHC1.

The average time reported for conducting activities in PHC1 ranged from 30 to 60 minutes, totaling an average of Md 42.5(40) minutes. For PHC2, there was a variation from Md 12.5(20) to 60(30) minutes with an average total time of Md 30(25) minutes. In the intertemporal analysis of the 17 activities, a statistically significant difference was found in 68 (50%) of the 136 possible comparisons in PHC2 (Post Conover-Iman test). Regarding the intergroup times (PHC1 x PHC2), a significant difference was observed ($p \leq 0.05$ and $p \leq 0.01$) for activities 1-4 and 8.

Of the total responses from study participants, 12.7% reported experiencing difficulties in conducting activities in PHC, mainly related to caregiver training 10 (9.1%), user/family attendance 9 (8.2%), discharge plan review 9 (8.2%), home procedures 9 (8.2%), and educational actions with professionals 8 (7.2%). Differences were found between PHC (PHC1 - 7.8% and PHC2 17%; $p \leq 0.01$ – Chi-square test).

They were related to: 1. hospital-PHC interaction (patient discharge before the arrival of the qualified discharge email; discharge plan without specificity); 2. work dynamics in the units (arrival of discharges during peak hours; high number of spontaneous demand attendances; increased demand for non-exclusive nursing activities); and 3. user/family (difficulty in location; breaking of family bonds; commitment and resistance of family members to follow guidelines; caregiver overload).

Table 3. Perceived quality and time referred (in minutes) by PHC nurses for conducting activities after hospital discharge. Catanduva, SP, Brazil, 2022

ACTIVITIES	PHC1		PHC2	
	Quali	Time	Quali	Time
	MD (IIQ)		MD (IIQ)	
A1. Request user/family attendance	3.5(1)	30(36)‡	3(1)	12.5(20)
A2.Review the discharge plan received	3.5(1)	30(45)‡	3(-)	20(20)
A3. Establish active search routine	4(1)†	30(40)‡	3(-)	15(20)
A4.Schedule the home visit	3.5(1)	30(45)‡	3(1)	20(20)
A5.Conduct initial home visit	4(1)	40(40)	3(1)	60(30)
A6.Identify needs/equipment	3.5(1)	60(45)	3(1)	30(30)
A7. Guide user/family – flow/processes	3.5(1)	60(45)	3(1)	30(10)
A8. Explain service processes	4(1)	40(45)‡	3(1)	20(20)
A9. Train caregivers	4(1)	60(40)	3(1)	30(20)
A10. Perform procedures at home	4(1)‡	30(40)	3(1)	35(30)
A11.Organize meetings with the team	4(1)	60(30)	3(1)	30(30)
A12.Participate in interprofessional meetings	4(1)‡	60(35)	3(1)	30(-)
A13. Coordinate the team's attendances	4(1)‡	60(40)	3(1)	30(22.5)
A14. Plan care with HCS	4(1)‡	60(45)	3(1)	30(7.5)
A15. Conduct educational actions - team	3.5(1)	60(40)	3(1)	30(30)
A16.Participate in meetings with managers	3.5(1)†	45(40)	3(1)	60(30)
A17. Evaluate user service	4(1)†	30(35)	3(1)	30(30)
Average total time – Md(IIQ)		42.5(40)		30(25)

Legend: (n=51); PHC: Primary Health Care; Quali - quality; MD - median; IIQ - interquartile range (IIQ= Q3-Q1; HCS: Home Care Service; † $p<0.01$; ‡ $p<0.05$ (Mann-Whitney Test); Quality scores: 1. very deficient; 2. deficient; 3. good; 4. very good; 5. Excellent.
Source: The authors (2022).

DISCUSSION

This study allowed us to understand how nurses in the PHC of two Brazilian municipalities act to continue care for the user after hospital discharge, identifying the estimated time for this practice. Most of the investigated activities were indicated as habitual in the nurses' routine, which contributes to the quality of health care[3].

Actions of team coordination, guidance to users about the health care network (HCN), and scheduling home visits were highlighted. These findings reiterate the interdependence between coordination and continuity of care and the preponderant role of the nurse in communication and articulation with professionals and users to promote comprehensive and networked care[6].

Nurses in PHC have been gaining social space and recognition from the health team and the community, becoming a reference for both[17] and for the coordination and continuity of care[9-10]. In this context, it is essential to reflect on the necessary balance between the demands linked to service organization and those related to direct assistance. This means that, by taking on various activities that make up the

unit's operational dynamics, they may face work overload and compromise the quality of care[17].

This mismatch may impact the prioritization of some activities to the detriment of others, as identified in this research. Requesting the user's/family's attendance at the unit, conducting educational actions with the team, and participating in meetings with managers from different points of the HCN were occasional actions in the nurses' practice. It can be inferred that some relational, informational, and managerial aspects of continuity of care are not favored in some scenarios, putting at risk the comprehensiveness and the necessary longitudinal bond for health care[1-2,18].

One of the biggest challenges of PHC is integrating its professionals with users and among the various levels of care[19]. Among the municipalities investigated, active search and home procedures occurred more frequently in PHC 1, where the nurse also acted earlier, after obtaining the discharge plan, requesting the user's attendance at the unit, directing the active search with the CHA, and planning care with the HCS.

Here, the transition from HCS-centered care (PHC 1) and the persistent inefficiency of the referral and counter-referral process between services (PHC 2)[20-21] is considered, as well as the work model, predominantly constituted by FHS in PHC 1, which provides for direct care interventions with the user/family, especially in home visits[9].

This study does not intend to indicate the most effective process or model, it only emphasizes, as other authors do, that early contact with the user and the articulation between services favor the continuity of care[3,18] and need to be improved.

Collaborative practice improves work and communication among teams, ensures coordinated, more predictable, and safer care[7]. In this study, collaboration among the nursing team, doctors, and CHA was predominantly mentioned; which can be expected as they constitute the minimum and reference team in FHS.

Nurses also rated the quality of actions as good or very good; however, specific evaluation tools or the experiences of those involved in care were not used to confirm this perception, which is strongly recommended for monitoring the continuity of care[3]. This aspect could be better explored in other investigations.

Among the 17 activities, they estimated dedicating, on average, 30 minutes in PHC 2 and 42.5 minutes in PHC 1 for each of them. No studies measuring this variable were identified in this context for a comparison of findings. It is interesting to mention that the perception regarding time may differ when compared to the timing technique, showing higher or lower values[22].

In PHC 1, collaboration and the quality of continuity actions were more expressive, and nurses spent more time recruiting users, reviewing discharge plans, scheduling home visits, and providing guidance to them. It is possible that professional experience influenced these results, and in this sense, nurses with less time in practice spend more time than those more experienced; or they qualify these actions by dedicating more time to them. Researchers also indicate that collaborative teams, properly sized, supported by management and with resources and resolutive networks, will likely experience the workload positively and/or reduced[12].

Participants faced difficulties, especially in PHC 2, in performing actions and continuing care. Among them, the demand for services and non-exclusive activities is increasing, the bond and collaboration of the user/family/caregiver are critical aspects, and the interaction between professionals and services in HCN is fragile. Other studies

have also addressed these issues[20,23]; however, the present investigation highlights the workload of nurses, specifically the time spent on coordination and continuity of care. Thus, it contributes to the management of practice and to the planning of the nursing workforce in PHC.

Despite the various strategies employed to engage coordinators, managers, and nurses from the investigated municipalities and encourage broad participation from eligible professionals, the low adherence of nurses may represent a limitation of this study. Furthermore, the findings may differ from other regions of the state and the country.

CONCLUSION

This research provides an overview of activities developed by nurses in PHC for continuity of care in distinct scenarios, allowing comparisons between practices and the time required. It supports decisions for improving processes, resources, and, consequently, healthcare.

The results expand knowledge about the role of nurses in continued care and highlight the dedication required to organize and coordinate assistance in PHC, providing comprehensive and timely care. The study contributes to the management of nursing work processes within PHC and highlights the relevance of collaborative teamwork for nursing and healthcare.

It is noteworthy that the estimated time does not represent a standard value for the investigated actions. New studies are needed to expand this dimension and acknowledge the perspectives of both the health team and users.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Mauro AD, Cucolo DF, Perroca MG.** Drafting the work or revising it critically for important intellectual content - **Mauro AD, Cucolo DF, Perroca MG.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Mauro AD, Cucolo DF, Perroca MG.** All authors approved the final version of the text.

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