NURSING ROLE IN THE COUNTER-REFERRAL OF PATIENTS DISCHARGED FROM THE HOSPITAL

PAPEL DA ENFERMAGEM NA CONTRARREFERÊNCIA DO PACIENTE EGRESSO DO HOSPITAL

ROL DE ENFERMERÍA EN LA CONTRARREFERENCIA DEL PACIENTE EGRESADO DEL HOSPITAL

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ABSTRACT

The nursing role in the counter-referral of patients discharged from the hospital is grounded in the systematic application of the nursing process and in evidence-based care management. Nursing actively participates in coordinating hospital discharge, ensuring continuity of care through the accurate transfer of clinical, therapeutic, and social information across different levels of care, which contributes to patient safety and reduces avoidable readmissions; therefore, liaison nursing plays a strategic role by acting as a link between the hospital and post-discharge services. Its intervention focuses on comprehensive patient assessment, identification of priority needs, and coordination of healthcare resources. This role strengthens interprofessional collaboration and enables an organized transition of care, ensuring that planned interventions are maintained continuously after discharge, since care planning is a methodological process that begins during hospitalization and is consolidated at the time of discharge; it includes clinical, psychosocial, and family assessment, the establishment of measurable goals, and the definition of interventions aimed at continuity of treatment. It also encompasses patient and caregiver education, promoting therapeutic adherence and responsible self-care. The referral and consultation process is supported by referral and counter-referral systems, which are essential to ensure timely, comprehensive, and high-quality care; the use of standardized protocols for transferring clinical and administrative information helps prevent fragmentation of care, duplication of interventions, and errors associated with poor communication between institutions and healthcare professionals. Likewise, nursing supervision represents an evaluative phase of the care process, focused on monitoring and controlling the care plan and therapeutic treatment; through systematic monitoring, multidisciplinary coordination, and, when necessary, home visits, risks are identified, the effectiveness of interventions is assessed, and timely adjustments are made to promote patient recovery. In conclusion, nursing is a central axis in the transition of care, promoting continuous, humanized, and person-centered care grounded in scientific, methodological, and ethical principles that ensure the quality and safety of healthcare delivery.

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RESUMO

O papel da enfermagem na contrarreferência do paciente egresso do hospital fundamenta-se na aplicação sistemática do processo de enfermagem e na gestão do cuidado baseada em evidências científicas. A enfermagem participa ativamente da coordenação da alta hospitalar, assegurando a continuidade do cuidado por meio da adequada transferência de informações clínicas, terapêuticas e sociais entre os diferentes níveis de atenção, contribuindo para a segurança do paciente e para a redução de reinternações evitáveis; por isso, a enfermagem de ligação desempenha função estratégica ao atuar como elo entre o hospital e os serviços pós-alta. Sua intervenção centra-se na avaliação integral do paciente, na identificação de necessidades prioritárias e na coordenação de recursos de saúde. Esse papel fortalece o trabalho interprofissional e possibilita uma transição assistencial organizada, garantindo que os cuidados planejados sejam mantidos de forma contínua após a alta, uma vez que o planejamento da atenção ao paciente constitui um processo metodológico que se inicia durante a hospitalização e se consolida no momento da alta; inclui avaliação clínica, psicossocial e familiar, estabelecimento de metas mensuráveis e definição de intervenções voltadas à continuidade do tratamento. Também contempla a educação do paciente e do cuidador, promovendo adesão terapêutica e autocuidado responsável. O processo de encaminhamento e consulta fundamenta-se nos sistemas de referência e contrarreferência, essenciais para assegurar uma atenção oportuna, integral e de qualidade; a utilização de protocolos padronizados para a transferência de informações clínicas e administrativas evita a fragmentação do cuidado, a duplicidade de intervenções e erros associados à comunicação deficiente entre instituições e profissionais de saúde. Da mesma forma, a supervisão em enfermagem representa uma fase avaliativa do processo assistencial, orientada ao acompanhamento e controle do plano de cuidados e do tratamento terapêutico; por meio do monitoramento sistemático, da coordenação multidisciplinar e, quando necessário, da visita domiciliar, identificam-se riscos, avalia-se a eficácia das intervenções e realizam-se ajustes oportunos que favorecem a recuperação do paciente. Conclui-se que a enfermagem constitui eixo central na transição do cuidado, promovendo uma atenção contínua, humanizada e centrada na pessoa, fundamentada em princípios científicos, metodológicos e éticos que garantem a qualidade e a segurança da assistência à saúde.

Palavras-chave: Enfermagem Primária. Planejamento da Atenção ao Paciente. Papel da Enfermagem. Encaminhamento e Consulta. Supervisão em Enfermagem.

RESUMEN

El rol de enfermería en la contrarreferencia del paciente egresado del hospital se fundamenta en la aplicación sistemática del proceso enfermero y en la gestión del cuidado basada en evidencia científica. La enfermería participa activamente en la coordinación del egreso hospitalario, asegurando la continuidad del cuidado mediante la correcta transferencia de información clínica, terapéutica y social entre los distintos niveles de atención, lo que contribuye a la seguridad del paciente y a la disminución de reingresos evitables, es por ello que la enfermería de enlace cumple una función estratégica al actuar como nexo entre el hospital y los servicios posteriores al alta. Su intervención se centra en la valoración integral del paciente, la identificación de necesidades prioritarias y la coordinación de recursos sanitarios. Este rol fortalece el trabajo interprofesional y permite una transición asistencial organizada, garantizando que los cuidados planificados se mantengan de manera continua tras el egreso debido a que la planificación de atención al paciente constituye un proceso metodológico que inicia durante la hospitalización y se consolida al momento del alta; incluye la valoración clínica, psicosocial y familiar, el

establecimiento de objetivos medibles y la definición de intervenciones orientadas a la continuidad del tratamiento. Asimismo, contempla la educación del paciente y del cuidador, promoviendo la adherencia terapéutica y el autocuidado responsable. Para ello el proceso de derivación y consulta se sustenta en los sistemas de referencia y contrarreferencia, el cual es esencial para asegurar una atención oportuna, integral y de calidad, la utilización de protocolos estandarizados para la transferencia de información clínica y administrativa permite evitar la fragmentación del cuidado, la duplicidad de intervenciones y los errores asociados a una comunicación deficiente entre instituciones y profesionales de la salud. Así mismo la supervisión en enfermería representa una fase evaluativa del proceso de atención, orientada al seguimiento y control del plan de cuidados y del tratamiento terapéutico. A través del monitoreo sistemático, la coordinación multidisciplinaria y, cuando es necesario, la visita domiciliaria para la identifican riesgos, se evalúa la eficacia de las intervenciones y se realizan ajustes oportunos que favorecen la recuperación del paciente. En conclusión, la enfermería es un eje central en la transición del cuidado, promoviendo una atención continua, humanizada y centrada en la persona, sustentada en principios científicos, metodológicos y éticos que garantizan la calidad y seguridad de la atención sanitaria.

Palabras clave: Enfermería Primaria. Planificación de Atención al Paciente. Rol de Enfermería. Derivación y Consulta. Supervisión de Enfermería.

1 LIAISON NURSING

The Pan American Health Organization (PAHO); emphasizes the need to implement strategies to increase the role of nursing staff in order to take advantage of the total set of their skills from an interprofessional approach, through the composition and effective distribution of functions (Lejía, 2020). The mission of nursing is to provide care to promote and maintain health, thus preventing physical and emotional problems that can lead to chronic psychosocial problems. The nurse intervenes in the critical moments required by post-caregivers in the process of reconstructing their daily lives and redefining their identity (Mora, 2017).

In the design of this type of strategies for the redistribution of interventions, nursing personnel assume greater attributions, faculties, and functions within the health team with an interprofessional approach. Therefore, it is imperative to generate schemes that contribute to the inclusion of new labor roles where they consider the expansion of functions in professional practice and the strengthening of regulatory mechanisms to protect, as well as support their practice and retention schemes in community areas, the development of competencies and the generation of training and continuing education plans and programs (Lejía, 2020).

A liaison person is a health professional designated to coordinate the patient's discharge from hospital, monitor the care provided, and transfer information from the hospital to primary care professionals. Liaison nurses are extremely important at hospital discharge to ensure that patients receive the planned care, as needed, regardless of where they will be cared for or the professionals who will assist them, and also so that services at different levels of health care can operate as a network. in an articulated and coherent way (Aued, 2019). The general role of liaison nurses, regardless of the area of action, has six domains of practice in this professional field, being: care coordinator; educator; communicator; counselor; patient advocate; change agent; collaborator; negotiator; team member and clinician, which refers to the nurse who assists the patient based on a person-centered approach.

It is argued that knowledge of the activities carried out by liaison nurses at hospital discharge can be useful to outline strategies for coping with discontinuity of care. As well as the identification of the patient who needs the liaison service, and of the professionals of the care team and can even be an intermediary with a member of the patient's family.

1.1 HOSPITAL DISCHARGE PLANNING

Liaison nurses initiate hospital discharge planning, after identifying the patient who needs their services or after receiving the referral request (Aued, 2019). Transfer of information between the hospital and the other services: The liaison services of the hospital complexes have a computer system in which they share the patient's health conditions with an out-of-hospital service, which subsequently carries out the due referrals.

Education and the transition of care in patients discharged from the emergency department is today a challenge that doctors and nurses in the hospital and community settings must face together. It cannot continue to leave this responsibility in the hands of patients, as the step is too great and should not be minimized among all parties involved in care and care. The conditioning factors that a successful transition has tend to be values, beliefs, culture, preparation, resources, providing information, providing emotional support, planning; At the social level, the lack of family support is evident. Health personnel must intervene to promote and manage health, allowing the patient to correctly manage the therapeutic scheme. For the transition process to occur naturally, it is necessary to understand the factors that negatively affect the patient. In addition, the health professional in charge should focus their efforts on teaching and support in moments of vulnerability for both the patient and the family, by mobilizing resources, materials, and organizations (López, 2022).

1.2 INSTITUTIONAL COMMUNICATION

The elements that structure and form the communication process can influence you in a negative or positive way and interfere with the effectiveness of the process. In addition, communication is a complex and dynamic process, it has an evolution, it has no beginning or end and is restricted to two or more people (Broca, 2016). Based on the essential actions for patient safety, they mention in their purpose that: communication can be electronic, oral or written. The most error-prone communications are patient care prescriptions given verbally and over the phone, including dietary request or change. Another type of error-prone communication is laboratory or cabinet results information that is communicated verbally or by telephone. When communication is timely, accurate, complete, unambiguous, and understood by the recipient, it reduces errors and results in improved patient safety (C N S, 2022: 17).

1.3 COMMUNICATION

The difficulties of exchanging information and collaborating at hospital discharge are well known, with reports of delays or non-reception by primary care physicians (Budinich, 2020). It is essential that the hospital has a discharge process program in place to monitor patients' progress in their transitions from their care plan and ensure that they are correctly assigned to the hospital, if a patient does not meet the expected progression or is delayed, the manager follows up with the health professional (Dent, 2016). Effective communication between professionals can avoid possible noises and barriers that can cause an incident or even an adverse event, therefore, harming patient safety. When communication does not occur in its fullness, it can negatively interfere with nursing care, causing the loss of information important aspects of the individual's health-disease process, impairing their treatment and recovery (Broca, 2016).

2 REFERENCE / COUNTER-REFERENCE

According to the norm, it is called the medical-administrative procedure between establishments for the medical care of the three levels of care, to facilitate the sending-reception-return of patients, with the purpose of providing timely, comprehensive and quality health care. The liaison services of hospital complexes have a computer system in which they share the patient's data with other out-of-hospital services that subsequently carry out the due referrals (Aued, 2019). When there is no flow and a defined mechanism for the transfer of information, much of it can be lost along the care network, which can generate duplication in the actions of professionals, consequently increasing health costs, delay in the resolution of problems as well as deficiency in the referral and counter-referral system. Therefore, it is essential that the transfer of information from the patient's discharge planning is coordinated and focused on a professional (Aued, 2019: z). This standard should be implemented in all organizations where clinical indications and laboratory results are received, either in person or by telephone. The implementation focuses on the receiver, since it is he who will carry out the process of listening-writing-reading so that the sender confirms.

It is essential to qualify the transition of care, especially in emergency departments, to guarantee and improve patient follow-up after discharge, especially in primary care, and to avoid future avoidable readmissions (CNS, 2022). Since it is rare for inpatient nurses and home care nurses to interact directly, communication and collaboration for an adequate continuity of care is essential to ensure the patient's safety at home. Some hospitals have nurse liaison or continuity of care coordinator services that help address home care needs. Regardless of whether these services are available or not, good handover communication

begins with the inpatient nurse's interest in ensuring the patient's best health and quality of life, deepening knowledge about how it is handled at home (Atzema, 2017).

Supervision of the care plan The approach, given the complexity, must be multidisciplinary: members of the primary care teams and specific support units, these are different depending on the autonomous community. Given the intrinsic characteristics of home care, it should be taken into account that home visits often go beyond the limits of the purely health, and a coordinated intervention of different health and social professional profiles is a priority. In turn, at the health level, the intervention of the different levels of care and resources of the territory should be coordinated (Arroyo, 2019).

Transitional care refers to the set of actions designed to ensure the coordination and continuity of health care during the transfers of patients between different levels of care in the same or different locations, constituting critical communication nodes, which require comprehensive plans, teams trained in the approach to people with complex health problems and updated information about goals. preferences and clinical status of patients (Budinich, 2020). In this sense, home care is more necessary than ever, but it is also more threatened. The need exists, but the health system, and more specifically primary care, has not been able or has not been able to respond with the speed or intensity that was needed.

Underfunding and the enormous overload of care largely justify this. Faced with this situation, some managers have chosen to incorporate new resources, unrelated to it, which are piling up as independent structures (home hospitalisation, palliative care units, urgent care, chronicity units), dividing care and reducing continuity of care (Arroyo, 2019). The tools and care models developed in each situation must seek efficiency, quality and decisions shared with the patient.

In the healthcare environment, it is vitally important to carry out people-centred care, to have values and preferences, standardised transitional care, coordinated with a focus on characteristics, also on the needs of users, which incorporates their preferences and participation, is essential to achieve continuity of care and optimise the work invested in each device (Budinich, 2020). This requires awareness-raising, training as well as training, both in undergraduate and postgraduate health and social sciences careers, as well as making an explicit additional effort on the part of the institutions and the treating teams as well as investigating locally how the processes are being carried out.

Home visit In order to structure an outline of the process of a home visit in health care, there are three main stages: Planning, execution, and finally, monitoring and evaluation. Planning: first, it is necessary to generate contact with family members, caregiver and/or

patient, in order to define the main reasons for consultation and whether it is really justified to make the visit, in addition to the verbal consent to carry it out (Glasinovic, 2021).

Execution: corresponds to the second stage and is in turn composed of three phases. The initial phase, which consists of generating a link between the health team and the family, along with observing the family and domestic environment, adapting to the circumstances and context. Then comes the development phase of the visit itself, in which it is necessary to explain the objectives of the visit, ask the family about the reasons for consultation and expectations of the visit, agreeing on the main problems together, leaving space for the patient to express their doubts and fears (Glasinovic, 2021). With all this, an initial clinical assessment should be carried out to establish the prioritized biopsychosocial problems, since it is common for not all of them to be addressed.

Evaluation: where the family structure and its relationships are reviewed, it is possible to understand the family context and the knowledge they have about the patient's health-disease, in order to consider the family reality in future decisions, a genogram can be made and to evaluate the support networks, the instrument called ecomap can be used.

2.1 GENOGRAM AND ECOMAP

Support tools for the family doctor According to (Yanes-Rodriguez 2022) the genogram also known as a family chart, family tree, family tree or human pedigree, is considered as a tool to draw the family structure and record information about family members and their relationships, providing a quick view of the development of a family over time, as well as categories of information that are very useful for the problem-solving process (Borrego, 2021). Taking into account the above, we can consider that the genogram can be used as an educational and therapeutic tool to help families better understand an individual's disease or behavior, and the effects that this can have on the family system, as well as allow the individual to make an analysis of family behavior and dynamics (Borrego, 2021).

On the other hand, the ecomap as a set of connected circles, which show the systems that interact with an individual and/or family; it is the visual representation of the presence or absence of support networks and relationships with other systems: extended family, social groups, community, religion, education, and friends (Borrego, 2021). Monitoring and evaluation: this stage includes defining the case manager, responsible for monitoring and coordination and, if the case warrants it, presenting it in a meeting with the sector's health team. In turn, an evaluation and monitoring of the care plan should be carried out with realistic objectives, as observed in the first visit, in a systematic manner (Glasinovic, 2021).

Types of discharge: It is the procedure by which the patient is prepared and helped in all aspects concerning their transfer to another service (hospitalization) or when leaving the hospital.

3 COUNTER-REFERENCE

Counter-referral is the administrative-care procedure inverse to a referral, by which, once the problem has been resolved, in the health establishment of greater complexity, the responsibility for the care of the patient is returned to a health establishment of less complexity, for control and follow-up, this is defined as the coordination procedure between the health units at the three levels of care. where the members give their point of view as follows:

In this regard, nursing points out that:

The preferred form of discharge is that (...) once care is concluded, the patient is contradicted with the format corresponding to the unit where follow-up is to be given (E2-C).

The response of the medical professionals states that:

We make a counter-referral to avoid in all cases the retention of the patient at a level that does not correspond to him (...) if we have already treated his complex condition and send him to the first level to follow up and keep him stable with pharmacological treatment (M4 - C).

Along the same lines, Social Work points out that:

The counter-referral is effective, we manage a dating platform (...) they are foliated through a relationship are scheduled (T7-B).

The contrareferred patient should carry a note specifying the diagnosis and treatment performed, recommendations for subsequent management, and whether or not to return to the unit they are referring to follow-up appointments (T2-C).

In contrast to Molina (2019) who states that the organized flow of sending, transferring, and receiving patients between the three levels of care aims to provide timely, comprehensive, and quality care that goes beyond regional boundaries and institutional settings to guarantee access to health services for the benefit of the referred patient (Molina, 2019). Therefore, it is necessary to implement mechanisms that represent spaces for direct communication between levels, with joint coordination that contributes to improving and standardizing the referral process to corresponding levels. Since the way to carry out the counter-referral in the transition of the patient from the hospital to the first level of care is through the elaboration of the counter-referral form issued by the medical area.

3.1 LINK

The institutional liaison process is one of these moments that aims to transfer the necessary information from the person who was in the care of the person at a second or third level of care, depending on the complexity of the pathology of the patient who makes that transition, the level that will assume the care implies a time of reflection, attitude, availability and attention to understand the real conditions of the person, as well as their current state of health, there are different ways to carry out this process, since each work group assumes it differently and adapts to their work environment.

For their part, nursing professionals mention that:

The communication we have is through institutional links (...) the telephone network links us with hospitals or other care units (E1-C).

We have the coordinations, the coordinator is the one who makes the liaison with the jurisdiction (...) then the jurisdiction with the hospital and we are notified if they are going to receive the patient in that unit (E2-C).

We have our directory of units, that directory contains the name of the care unit, the name of the chief, telephone and address to be able to communicate, that is a network. (E2-C).

Doctors mention that:

We do not handle links with the other units (..) we only issue the reference or counter-reference documents (E10-B).

Those in charge of this liaison are the nursing staff, specifically the head nurse and social work (...) who guide them to the relatives and the patient (M8-D).

The institutional liaison process is carried out by nursing and social work professionals, therefore, they mention that:

The link we have is directly with the hospital (...) but Social Work is a link between the family member and the patient, we help them to reach the referred or counter-referred unit (T2 C).

According to Guerra (2022), a fundamental aspect in the liaison regarding hospital communication is the use of processes and techniques based on the protocols of each unit that is shared as one of the primary functions to guarantee quality and safety in the direct care of people who require it, their effective arrival at the health care units.

4 PROTOCOLS

A protocol, in general terms, is defined as an agreement between professionals who are experts in a certain subject and in which the activities to be carried out in a given task

have been clarified. From this perspective, the actions would be susceptible to protocolizing those physical, verbal and mental activities that are planned and carried out by professionals, including both autonomous and delegated activities (Linares, 2021), therefore, nursing believes in this regard that:

Within the care units there are different protocols that are governed by the Ministry of Health, which depending on the activities is their application (E2-C).

For their part, the doctors mention that:

We as doctors have a role, within that role we have activities already established and the steps to follow according to the protocols of the institution, whether for the patient's admission, discharge or stay, are also assessed in the triage part to see the clinical management and treatment (M1 C).

In turn, social work reports that:

Our main function as a social worker is to be a mediator in any situation, since the beneficiary does not know the protocols, we are the bridge of connection with other service units, facilitating adequate care for users, in this case the person who suffers from a social conflict and requires urgent attention (T3 D).

In contrast to Rocabayera, (2023) a protocol can be defined as a detailed sequence of a process of action, scientific, technical, medical, etc., there are two pillars that support interventions and protocols in the health system, they are the catalogue of benefits and the portfolio of services.

Both concepts are broadly defined and included in the General Health Law (S.S.M, 2022). Likewise, by issuing recommendations based on scientific evidence for the prevention, diagnosis or treatment of diseases, which seek to provide the best diagnostic-therapeutic and rehabilitation opportunities for the Mexican population, regardless of the type of affiliation of the health system they have, it translates into comprehensive equitable management, strengthening the quality, safety and decision-making of health professionals and beneficiaries. thus executing the protocols in a methodical way, for the above the health team has protocols that govern professional action in such a way it is essential to know and apply them.

That is why the main rules and protocols to be followed for the transition of the patient from the hospital to the first level of care are framed by the Ministry of Health, the main one is the referral/counter-referral, taking into account the regulations.

4.1 MANAGEMENT OF THE COUNTER-REFERRAL PROTOCOL

This procedure is mandatory for all personnel of the Ministry of Health, who intervene in the referral and counter-referral of beneficiaries or users in order to guarantee an effective transition between the different hospital units of the Ministry of Health, as well as with other units of the Health Sector, in order to provide adequate care to the beneficiary or user in accordance with their needs (S.S.M, 2023). In this sense, the medical staff reports that they are unaware of the handling of the roles in this protocol:

It is necessary to standardize this protocol, since I do not know what the role of nursing or social work colleagues (M1-C) is.

The protocol used here is different from those of other units (M3-C).

However, social work points out:

The entire procedure must be made known to all those who are responsible (...) ignorance creates complications, knowing the protocol benefits the patient and for us as staff (T4-D).

For its part, nursing refers to the document:

The counter-referral protocol is well defined on paper (...) however, the staff adapts it to the situation of each patient (E1-C).

According to the Ministry of Health, the medical units will maintain close communication both intra-institutional and inter-institutional, with the purpose of requesting support for the referral and counter-referral of beneficiaries or users, in order to correct the deviations detected, make the Referral and Counter-referral process more efficient for a transitional improvement of care.

5 SUPERVISION OF THE PLAN OF CARE

A Standardized Care Plan (PCE) is the protocolization of the actions of family members or the main caregiver, according to the care needs once implemented and monitored, they allow consolidating the evaluation as an axis of improvement of interventions, in this sense the nursing staff reports that:

The care plan is personalized for each patient, we take care of educating the patient and training the primary caregiver (E3-C).

As the nursing staff argues, it is considered that the care plan is focused on both the patient and the primary caregiver, which is why supervision takes a fundamental role for its application in the effective transition to the corresponding level of health, likewise Aguilar (2020) refers that supervision is an activity or set of activities that a person develops when reviewing and/or directing an activity, in order to achieve their maximum effectiveness and

mutual satisfaction. It is a systematic process of control, monitoring, evaluation, guidance, advice and training; of an educational nature; carried out by a person in relation to others, in order to achieve improved care and ensure quality of life (Aguilar, 2020). In such a scenario, the participation of nursing during the patient's recovery was indicated as follows:

In the nursing supervision area of the unit, we handle formats for home visits, check-ups, drugs, infectious pathologies, network and catalog of hospitals (...) through them we verify if this supervision in the field (E4-C) is effective.

For their part, the doctors report that:

We have patients with specific pathologies or cases, such as palliative care which we as doctors carry out the visit and supervision of the treatment together with a multidisciplinary team, we fill out forms for each patient with specific data and deliver them to the nursing area (M2-C).

However, social work mentions that:

In social work, a system is carried out where the patient is scheduled at least once a month, both their disease and treatment are continued, the family member is called and supervision is carried out at home (T1-D).

Nursing supervision is considered a key element, for the supervision process to be effective, it is necessary for the agents (supervisor-supervised) to establish a learning climate, each discipline has an important role in the area to establish an effective link with the patient, considering that the formats are tangible proof of effectiveness when applying supervision, either directly or indirectly, through this, the advances and/or problems detected are made known, they are means of communication implemented by the multidisciplinary health team, to work together and effectively, thus obtaining greater cooperation and satisfaction in the achievement of institutional objectives (Cardoso, 2019). The way in which the home care plan of the patient discharged from the hospital must be supervised to provide continuity of care is through the field staff of the first level of care.

5.1 SUPERVISION OF TREATMENT

Supervision according to Etymology means "to look down from on high", which induces the idea of a global vision. On the other hand, in its most appropriate concept, supervision is a process by which a person who processes a wealth of knowledge and experience assumes the responsibility of directing others to obtain results that are common to them.

Effective supervision requires: planning, organizing, directing, executing and providing constant feedback. It requires perseverance, dedication, perseverance, being

necessary to possess special individual characteristics in the person who fulfills this mission, according to this paradigm the supervision of treatment in the health sector has to be adequate to improve patient outcomes and, thus, ensure that the care provided is very clear and follows best practices. The collaborative nature of multidisciplinary staff and the patient improves the overall quality of healthcare delivery, pharmacological treatment, and physical and mental recovery (Amundarain, 2022).

Medical professionals argue:

Through the TAPS personnel that we have or through the telephone is that they carry out the supervision. (M2-C)

The nursing staff is the one who develops the supervision of the patient's treatment at home or in the transition to another health unit, nursing is the pillar for this task, they also mention that there are specific cases to carry out supervision outside the unit by making home visits, as they refer to:

We have patients with pathologies or specific infectious cases, we carry out the visit and supervision of the treatment together with a multidisciplinary team, nursing, medicine, geriatrics, nutrition, etc. (M2-C).

For its part, nursing, according to its functions, mentions that:

In the supervision area, the nurses of the unit handle formats of home visits, check-ups, drugs, infectious pathologies, network and catalogs of hospitals (...) through them we verify this supervision in the field (E4-C).

Nurses foster a culture of teamwork and collaboration among healthcare professionals. This collaborative approach is crucial in handling complex cases that often require input from multiple specialties.

Also according to social work: A system is carried out where patients are scheduled at least once a month, they are given continuity (T1-C).

For the above and in accordance with the General Health Law, supervision must be systematic, planned and decisive; it must be related to the processes of improving the quality of care, it must also be able to correct deviations with emphasis on those that, due to their severity, put at risk the safety of patients in their therapeutic or pharmacological treatment.

Under this premise, we can affirm that the implementation and monitoring of treatment supervision will have the desired impact by having the appropriate and sufficient structure, with continuous monitoring of the processes and with the periodic measurement of results, redirecting actions when required and promoting the training of the entire multidisciplinary team. To achieve the success of a therapeutic supervision of the treatment, good

communication between doctors, nurses, and health professionals is essential, thus identifying areas of opportunity that allow the best development of the supervision.

6 TREATMENT MONITORING

Treatment monitoring is carried out through a process or a set of actions that make it possible to verify the extent to which the proposed goals are met in the sense of efficiency and effectiveness of disease treatments. It is a permanent action throughout the process of health follow-ups, it allows a periodic review of the work as a whole, both in its efficiency in the management of human and material resources, and its effectiveness in the fulfillment of the objectives proposed for each individual, it is of vital importance that the follow-up is carried out as an integral part of the patient, agreed with those responsible for management; both doctors, nursing staff and multidisciplinary areas (Urzúa, 2020). In this regard, nursing reports that:

The follow-up and continuity of care is sent from a third or second level to a first level of care, that is the correct way to provide a solution to the need they present (E1-C). In the same sense, the opinion of a doctor was: We follow up only if the patient has scheduled consultations and if he belongs to specific programs (...) weight control, healthy child, palliative, infectious, contagious, chronic-degenerative we carry out his medical check-up and give him prescriptions for pharmacological treatment (M7-D).

The above expressions reflect that the members of the health team participate in their specific function, in contrast to Beaver (2019) nursing carries out a general and specific follow-up activity, in addition, it is necessary to keep in mind that nursing will probably have a growing involvement in the areas of follow-up and monitoring of people, this related to the role it has been acquiring over time.

The follow-up or monitoring strategies indicated by social work project that they are deficient, there are no specific follow-up protocols for this surveillance, it is also identified that there is little evidence on their efficacy and effectiveness. It is necessary to delimit the interventions of professionals in the search for available scientific evidence related to the aspects of monitoring and follow-up, in order to apply and develop the appropriate methodology to unify treatment evaluation processes.

6.1 THERAPEUTIC TREATMENT

A therapeutic treatment has as its maximum objective the cure of the patient, it can include the provision of drugs and the indication of various actions (rest, feeding, therapy) to ensure that the disease is reversed in its entirety, when cure is not possible, therapeutic

treatments are used that provide relief to the symptoms (symptomatic treatments) or that improve the quality of life of the person (palliative treatments). For its part, Nursing shares that:

Nursing is the one who helps ensure continuity of care for the patient in their therapeutic treatment (...) as we collaborate with the patient and their caregiver, transitions between different phases of treatment are smoother leading to a more comprehensive and holistic patient experience (E4-C). Through our colleagues in the field, we find out how the patient is doing, if they need a consultation, or improve the therapeutic treatment we provide in the unit (E3-C).

According to what was recorded, the doctors mention that:

We explain to them in consultation what activities they must carry out to successfully complete their treatment (...) thus avoiding complications and to prevent sequelae of a poor therapeutic approach (M3-C).

The answer given by the social worker refers to the following:

Everything that helps us live is therapeutic (T4-D).

In contrast to Ortega (2018), a therapeutic treatment is a continuous process of care, consisting of educational activities carried out by health professionals, created to help patients and their families to carry out their treatment and prevent avoidable complications while maintaining or improving quality of life; it includes psychosocial support. Its fundamental objectives are to provide information, to provide practical knowledge to improve compliance with the therapeutic plan (Ortega, 2018). The essential aspect is to empower patients to manage their disease by acquiring skills (self-treatment, adaptation of treatment when necessary) as opposed to simply providing information. Therapeutic education has been shown to effectively contribute to preventing complications and improving adherence to treatment, which increases quality of life in many diseases.

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