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Nurses' practices in Family Health: continuity of care for users with chronic conditions

Práticas de Enfermeiras na saúde da família: continuidade no cuidado a usuários com condições crônicas

Prácticas de los enfermeros en salud de la familia: continuidad de la atención a pacientes con condiciones crónicas

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ABSTRACT

Objective: to identify nurses' practices in the Family Health Strategy (FHS) aimed at ensuring continuity of care for users with chronic conditions. **Method:** analytical, exploratory study with a qualitative approach, conducted with nurses from a Family Health Strategy unit in Rio de Janeiro, following approval by the Research Ethics Committee. Data were analyzed using Bardin's content analysis method. **Results:** three categories were identified: Challenges in Achieving Comprehensive Care in the Family Health Strategy, Promoting Continuity of Care: Nurses' Practices, and Enhancing Longitudinality: Essential Actions and Services. **Final considerations:** the practices highlighted focused on territorial needs, strengthening bonds, individual empowerment, multi-professional work, active management participation, intersectoral articulation, active listening, and support networks.
Descriptors: National Health Strategies; Nurses; Chronic Disease; Nursing Care.

RESUMO

Objetivo: identificar as práticas de enfermeiras na ESF voltadas à continuidade do cuidado aos usuários com condições crônicas. **Método**: estudo analítico, exploratório, com abordagem qualitativa, realizado com enfermeiras de uma unidade de estratégia de saúde da família do município do Rio de Janeiro, após aprovação do Comitê de Ética e Pesquisa. utilizou-se a análise de conteúdo de Bardin para análise dos dados. **Resultados**: foram identificadas três categorias: Desafios na Jornada pela Integralidade do Cuidado na Estratégia de Saúde da Família, Promovendo a Continuidade do Cuidado: Práticas das Enfermeiras e Potencializando a Longitudinalidade: Ações e Serviços Essenciais. **Considerações finais:** destacaram-se as práticas direcionadas as necessidades territoriais, ao fortalecimento do vínculo, ao protagonismo individual, ao trabalho multiprofissional, a participação ativa da gestão, a articulação intersetorial, a escuta ativa e a rede de apoio.
Descritores: Estratégias de Saúde Nacionais; Enfermeiras e Enfermeiros; Doença Crônica; Cuidados de Enfermagem.

RESUMEN

Objetivo: identificar las prácticas de los enfermeros de la ESF dirigidas a la continuidad de la atención a pacientes con condiciones crónicas. **Método**: estudio analítico, exploratorio, con enfoque cualitativo, realizado con enfermeros de una unidad de la estrategia salud de la familia de la ciudad de Río de Janeiro, con previa aprobación del Comité de Ética e Investigación. Para analizar los datos se utilizó el análisis de contenido de Bardin. **Resultados**: se identificaron tres categorías: Desafíos Diarios para la Atención Integral en la Estrategia Salud de la Familia, Promoción de la Continuidad de la Atención: Prácticas de los Enfermeros y Mejorar la Longitudinalidad: Acciones y Servicios Esenciales. **Consideraciones finales:** se destacaron las prácticas dirigidas a las necesidades territoriales, al fortalecimiento del vínculo, al protagonismo individual, al trabajo multidisciplinario, a la participación activa en la gestión, a la coordinación intersectorial, a la escucha activa y la red de apoyo.
Descriptores: Estrategias de Salud Nacionales; Enfermeras y Enfermeros; Enfermedad Crónica; Atención de Enfermería.

INTRODUCTION

To provide comprehensive health care tailored to the diverse demands of the population within the Unified Health System (SUS), coordination across different levels of care is essential. In 2010, the Health Care Network (HCN) was established as an "organizational arrangement of health actions and services," fostering horizontal relationships across various levels of care complexity and promoting system integration in terms of access, equity, clinical and public health effectiveness, and economic efficiency[1].

In this context, Primary Health Care (PHC) is considered the central hub and coordinator of the HCN, focusing on multiprofessional care and resolving the most common health needs of the population[1].

As the Family Health Strategy (FHS) serves as the primary healthcare model of PHC, the nurse, as a member of the multidisciplinary team, focuses on identifying the specific characteristics of their territory to appropriately identify and

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address each individual's needs. This enables the efficient management of demands within the scope of PHC and in coordination with the HCN, aiming to provide adequate care coordination.

Although the SUS is structured hierarchically, viewing the HCN as a strictly hierarchical system is a misconception. The HCN should be understood as a horizontal network where all care points are equally important, differentiated only by their technological density[2].

However, challenges persist in the referral and counter-referral process due to communication failures among health professionals across different care points, as well as between professionals and users. These issues disrupt service coordination and compromise continuity of care[3].

Such factors contribute to inefficient care coordination, straining the system and complicating follow-up for users, particularly those with chronic conditions. System congestion may arise from poor case management, leading to referrals to higher levels of care for issues that could be resolved at the primary level. Additionally, inadequate information exchange between care levels hinders continuity of care for counter-referred patients[4].

Achieving integrated care across health service levels remains challenging due to persistent barriers in communication, access, and planning, which undermine effective care coordination within the HCN[5].

Given that continuity of care is crucial for achieving comprehensive and effective care—particularly in nursing—it is essential to analyze the practices of Family Health Strategy nurses in ensuring continuity of care for users with chronic conditions.

To deepen scientific understanding of this topic, the following guiding question was developed: What are the strengths and challenges encountered in the practices of FHS nurses in caring for users with chronic conditions?

To address this question, the study aimed to identify nurses' practices in the FHS focused on continuity of care for users with chronic conditions, discussing their strengths and challenges.

METHOD

This analytical, exploratory study with a qualitative approach was conducted with 12 nurses working in an FHS unit in Rio de Janeiro between September 1 and 30, 2023.

Inclusion criteria required that participating nurses be actively employed at the study unit and registered in the National Registry of Health Establishments (CNES) for that unit. Nurse managers or technical nursing supervisors working at the study unit, as well as nurses on vacation or leave during data collection, were excluded.

Of the 24 professionals working at the unit, all meeting the inclusion and exclusion criteria were contacted via text message and personally invited by the researcher. A significant challenge during data collection was the refusal of potential participants. Ultimately, data collection included 12 professionals, while the remaining 12 declined participation, citing scheduling conflicts. Among the participants, nine were team leaders in the FHS, and three were first-year nursing residents also assigned to FHS teams. All participants signed the Free and Informed Consent Form (FICF).

Data collection involved semi-structured interviews, combining objective questions to gather sociodemographic information and open-ended questions to explore the study's topic in depth. To ensure the interview guide aligned with the study's objectives, a pilot test was conducted with FHS nurses from a different programmatic area.

The interviews were conducted by the lead researcher, a female nurse working in an emergency care unit and a master's student at the time of the study. The researcher had no professional ties to the study unit or hierarchical authority over the participants.

Interviews were held in a private setting at the study site, attended only by the participant and interviewer. They were audio-recorded, transcribed for detailed analysis, and lasted approximately one hour. Field notes were also taken during the interviews.

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Content analysis techniques were applied to the interview data, using thematic-categorical content analysis[6,7], structured into three stages. In the first stage, a floating reading of the interview material was conducted to explore and identify evident categorical elements. In the second phase, the aim was to define the Recording Units (RUs), which are expressions or words considered to have representative meaning for the content resulting from the classification and aggregation of the data. In the final stage, connections between the results of the previous phases and the study objectives were established, creating meaning units to construct categories and subcategories[7]. The analysis was conducted manually without software assistance.

As this is a qualitative study, the Consolidated Criteria for Reporting Qualitative Research (COREQ) was used, serving as a checklist to support the proper preparation of reports for this type of study.

The research protocol was approved by the Ethics Committee of the proposing institution (approval no. 6.170.109) and by the Ethics Committee of the Municipal Health Department overseeing the study site (approval no. 6.281.797). To protect participant identities, individual codes were assigned. Twelve codes, ranging from I1 to I12, were used to ensure confidentiality and anonymity, with data managed using Microsoft Office Excel 2016.

RESULTS AND DISCUSSION

Most participants were female (91.67%), and 75% held postgraduate *lato sensu* qualifications (n=9). Regarding professional experience, five participants had between one and five years of nursing practice (41.67%), four had over five years (33.33%), and three had less than one year (25%). In terms of tenure with their current team, seven participants had been with their team for less than one year (58.33%), four between one and five years (33.33%), and one for more than five years (8.33%).

After analyzing the interviews, 391 Recording Units (RUs) were identified and grouped by their meanings into 30 Meaning Units (MUs). These MUs were further organized into three Categories that emerged from the data and aligned with the study's objectives: Challenges in Achieving Comprehensive Care in the FHS, Promoting Continuity of Care: Nurses' Practices, and Enhancing Longitudinality: Essential Actions and Services.

Challenges in Achieving Comprehensive Care in the FHS

Regarding the identified challenges, participants linked workload overload to weakened bonds with users and difficulties in delivering quality care.

> *The demand is very high, there are too many people, so it is not possible to provide quality care. (I9)*

> *You cannot leave constantly because the schedule is full. Appointments all the time, it's a combination of many factors. (I1)*

Within the FHS team, nurses perform multiple roles related to care, material management, and human resources. The increasing workload assigned to these professionals is notable. As FHS team members, nurses must understand their territory, establish bonds with users, and conduct nursing consultations to deliver comprehensive care[8].

> *Sometimes it's about task-related issues. Often, we end up trapped by many work processes, and these processes significantly interfere with building bonds because we don't have enough time to talk effectively with patients. (I11)*

> *The high demand makes it difficult; we can't fully focus on the user. (I12)*

The elevated demand for care, combined with administrative duties, affects the quality of care provided by nurses, hindering proximity to the territory, the creation and maintenance of bonds, and the identification of the population's needs[9]. The shortage of professionals and high turnover rates were also cited as challenges to ensuring continuity of care.

> *Teams are sometimes left without a doctor or nurse, which makes things harder. (I5)*

> *Every time there's a lack of a doctor, I notice that patients lose motivation, so they don't come to their appointments [...] they usually miss or lose interest in participating and continuing care. This is one of the issues because, in their minds, there has to be a doctor; otherwise, it doesn't work. (I7)*

The turnover and shortage of professionals are linked to precarious and unstable employment relationships, excessive workloads, health unit locations in high-risk areas, and hiring through the Consolidation of Labor Laws

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(CLT), as well as through legal entities (PJ) or temporary contracts, highlighting the fragility of employment bonds[10].

Regarding challenges faced by professionals, conflicts among members of the multiprofessional team, lack of commitment from professionals, weakened multidisciplinary work, and insufficient training of Community Health Agents (CHA) were emphasized.

> *It has to come from everyone, not just nursing—this broader perspective from medicine, nutrition, psychology, and physiotherapy. (I9)*
>
> *If everyone understands that teamwork provides the best for the patient, the process flows much better. (I12)*
>
> *A holistic perspective needs to be more multidisciplinary. (I9)*

The findings demonstrate the fragility of collaborative practice, compounded by weakened multiprofessional communication and low professional commitment. These results align with Schimith[11], who identified communication breakdowns among professionals, creating gaps in multiprofessional practice and disrupting the continuity of care.

> *It's hard to find professionals with commitment, especially in primary care. (I6)*
>
> *When there's no effort from the professional to resolve issues, schedule appointments, or provide guidance, there's no dedication in basic care. (I7)*

The lack of cohesion within the team creates room for interpersonal conflicts. According to participants, these challenges are significant and impact the quality of care provided.

> *Interpersonal relationship difficulties also hinder work. I think people don't know how to separate work from social life. (I7)*
>
> *Like when we've had issues with doctors, community agents, and all that—how do we handle it? How do we ensure that professional can work? (I5)*
>
> *When a team member is a relative of the user, and the user doesn't want their relative to know about their condition, it's difficult. We have to mediate situations we're not used to. (I6)*

A committed health team focused on multiprofessional care facilitates the exchange of information and experiences among health professionals, enabling knowledge sharing and improving team communication. This contributes to a more assertive approach to comprehensive care and the delivery of higher-quality services[9].

Another point highlighted by participants was the challenges related to care management, such as failures in user referral and counter-referral processes, difficulties in resource management, and political challenges.

> *Accessing the service—you're in primary care, but you need to move to another level of care, and something blocks that access to the next level. (I4)*
>
> *Fragility in psychotherapy services at the CAP (Psychosocial Care Center). (I7)*
>
> *If access is difficult, the patient will keep returning to primary care because access to another level of care is complicated, preventing us from complementing the comprehensiveness of care. (I3)*
>
> *The delay in SISREG for certain specialties also significantly compromises it. (I4)*

The integration of the Health Care Network (HCN) is another factor hindering comprehensiveness and continuity of care. The lack of communication between services is a critical issue, as counter-referral becomes an obstacle to continuity of care. It relies on secondary and tertiary care professionals to communicate with Family Health teams[12].

> *Appointments are often far from the user's residence. Most of them don't go. Sometimes due to mobility issues. Sometimes due to financial constraints, or work-related reasons. (I12)*

Participants also highlighted the lack of supplies and management difficulties as factors compromising continuity of care.

> *I think when medications are unavailable, it causes a lot of concern. (I5)*
>
> *Bureaucracy complicates things a bit. (I12)*
>
> *If you have management that only wants you to focus on the patient's pathology, you won't get very far. (I5)*

According to the participants, resource scarcity and precarious working conditions hinder the effective functioning of the Unified Health System (SUS), compromise health action planning and service coordination, and contribute to professional dissatisfaction and user distrust in the system[13].

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The interviewed professionals also identified challenges related to users. Data revealed issues such as users' lack of connection with the team, difficulties in accessing users, weakened support networks, resistance or challenges in maintaining continuous care, and the users' social context. These challenges were associated with geographic barriers, personal limitations, and living conditions.

> *Our territory is somewhat far from the unit. It's about five kilometers away, 40 to 50 minutes on foot, and we don't have buses in the area—there's no transportation. (I11)*
>
> *Not having a bond is a significant factor that hinders continuity of care. Without a bond, you can't move forward. (I4)*
>
> *I treated a patient who was completely unbalanced because she hadn't been coming for a while and didn't have a bond with the team. (I10)*

The distance between users' homes and health units was observed as a significant barrier to accessing health services and ensuring longitudinal care in various regions of the country[14].

Another access barrier is the resistance of users who do not live in the community. Access difficulties and the establishment of bonds are often linked to the social context in which users are embedded.

> *In the community, you can form a residents' association. You gather, and you have more opportunities. On the streets, you don't have that—either you come to the unit, or you meet in a public square. So you can make it happen. (I1)*
>
> *Patients who previously had good financial conditions but whose situations changed during the pandemic initially show more resistance to being treated by nurses, preferring only doctors. (I10)*
>
> *The community population is much easier to deal with than the population on the asphalt [urban areas]. In the asphalt, people are more independent, often have better financial conditions, and sometimes don't even live in that area [...] there's less consistency in their care. Those who live in the territory sometimes have private health insurance (I7)*

In some cases, difficulties are observed in ensuring comprehensive care for users with higher socioeconomic status. This highlights resistance to understanding and accepting the FHS model and challenges in building bonds[15]. However, it is essential to emphasize the need for health professionals and care management models to identify and mitigate these barriers, which are exacerbated by competition and the overvaluation of the private sector compared to the public health system.

Given this, it becomes necessary to strengthen strategies aimed at improving health communication with users. This includes clarifying the scope of care provided by the FHS, highlighting the role of each professional and the services offered, to overcome the entrenched biomedical model within this population.

Non-adherence to treatment and resistance to participating in care plans alongside the health team were topics cited by participants.

> *There are patients who do not adhere, even when you take certain steps. Some patients are very resistant. (I5)*
>
> *I think the patient's lifestyle complicates things a lot. (I4)*
>
> *Difficulty understanding their condition. (I6)*
>
> *Patients who do not follow guidance or take responsibility for their care. (I8)*

Although developing a therapeutic plan that meets users' needs and aligns with their realities is crucial for managing chronic conditions, acceptance of their health condition and active participation in the process are key factors for the success of the proposed treatment[15].

> *Identifying and understanding each patient's physical, financial, or cognitive limitations and working around these barriers. (I12)*
>
> *Users in precarious situations lacking basic conditions. (I6)*

Participants noted that failures or lack of adherence to therapeutic plans are also linked to weakened support networks and challenges within family structures.

> *Among the cases I have on my team. They don't usually have financial difficulties, but there are many people living alone, many without a support network, even very elderly individuals. These are the hardest cases to manage because no one is there to encourage them daily. (I2)*
>
> *There are patients who don't have a very present family and can't attend SISREG appointments. (I12)*

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The absence of family involvement in managing chronic conditions among elderly individuals with limitations fosters neglect and gaps in care. However, the health team must strive to build bonds with families to ensure longitudinal care for these users[15].

Thus, the challenges discussed tend to create disorganization in work structures, promote treatment abandonment, weaken bonds between professionals and users, and contribute to worsening health conditions. These issues underscore the need for actions aimed at overcoming these challenges to strengthen the effectiveness and comprehensiveness of health services provided to the population.

Promoting Continuity of Care: Nurses' Practices

This category comprises nine meaning units that illustrate the unique attitudes and strategies developed during nursing care practices, emphasizing their importance and relevance in the healthcare context.

Among the themes that emerged in this category, health promotion and education activities integrated into nurses' guidance were particularly prominent.

> *Encouraging patients to seek other physical activities depending on their chronic condition, like swimming, walking, Shiatsu therapy, or stretching. (I3)*
>
> *Guiding patients to understand that care goes beyond taking medication. (I6)*
>
> *Patients need this guidance first because, in third place, we see there's medication, but the most important aspects are diet and physical activity, with medication coming third. (I8)*

As the FHS represents the first level of healthcare, focusing on health promotion and disease prevention, health education is an indispensable practice for comprehensive care[16].

> *Promoting knowledge that allows patients to engage in dialogue about their care plan. (I11)*
>
> *Then the nurse steps in, taking on a greater role in guidance and health education. (I7)*
>
> *Guidance on dietary changes and physical activity (I8).*
>
> *We conduct health education. (I12)*

Health education should go beyond simply transmitting information or providing technical guidance. It should create a welcoming space that values and respects the knowledge of both professionals and users, fostering stronger bonds with health services and generating knowledge that leads to behavioral changes[17].

Practices were observed that aim to build greater knowledge among users about their conditions, supporting them in becoming active participants in their own care.

> *Helping patients learn to live with a chronic illness and make it as manageable as possible [...] trying to understand, explain, and make the diagnosis less burdensome while staying close to them. (I5)*
>
> *When they understand their problem or illness, they gain more control over it. The more knowledge they have, the more empowered they feel about their condition. They become the center of care. Showing them that their opinion matters. In fact, they are the ones driving their care; our role is smaller. (I2)*
>
> *Helping patients understand that care is a shared responsibility between us and them. They need to grasp this concept. We share and transfer this responsibility with them. (I12)*
>
> *When a patient brings up a concern during a consultation, I explore it. I let them talk for two or three minutes about their perception, and based on that, I develop the care plan. (I11)*
>
> *I try to explain to them so they can feel empowered—empowered about their condition—to understand it better. (I9)*

The construction of knowledge must integrate all perspectives, strengthening social bonds. This cannot be achieved through imposed guidance or rules aimed at changing habits[18].

The implementation of social groups, activities, and actions within the territory was also highlighted as strategies for user engagement, strengthening bonds, and identifying individual needs.

> *We try to organize many groups and provide care outside the unit. (I12)*
>
> *We conduct advanced consultations in the community to ensure better continuity of care and population adherence [...] We hold consultations directly in the territory, talking, bringing scales, blood pressure monitors—using whatever we have available. (I9)*

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We also carry out actions and provide guidance there. In the territory. (I8)

Health promotion activities allow us to work on quality of life and well-being, which ultimately lead to better outcomes. (I11)

Nurses demonstrated commitment to organizing activities within the territory that engage the population and promote well-being. These practices create spaces conducive to knowledge exchange and experience sharing based on users' needs.

Thus, health education emerges as a strategy offering professionals an opportunity to promote collective solutions, with user participation, to address challenges faced by the community and individuals.

The outreach activities mentioned align with the National Primary Care Policy (PNAB)[19], which emphasizes actions in the community or at home to promote health and prevent diseases based on the population's needs.

The use of integrative and complementary health practices was also highlighted. Reports revealed the value and integration of these practices into users' clinical and social contexts to achieve comprehensive care.

It's not just about taking medication; other practices are necessary. I'm a big fan of alternative practices in the public health system. I also use auriculotherapy a lot. (I2)

When we identify a situation requiring alternative practices, either I or my colleague will visit the patient's home to perform auriculotherapy. (I3)

I practice integrative care. I use phytotherapy, acupuncture, and Chinese pinda therapy. (I11)

These actions align with the objectives of the National Policy on Integrative and Complementary Practices in SUS (PNPIC-SUS) and the PHC proposal. These practices reflect a healthcare approach that goes beyond the biomedical model, adopting a holistic, person-centered perspective focused on comprehensive care[20].

Participants also reported monitoring care pathways through spreadsheets, scheduling appointments and exams, making phone calls, and conducting active outreach as strategies to ensure continuity of care.

Requesting exams in advance and asking CHA to deliver them to the patient as a way to facilitate their visit to the unit. (I8)

Not letting them come only when they have a demand, you know? Like, they bring the exam, and we evaluate it. No, I prefer to see them today, schedule them for a month later, explain everything clearly, and then they come back. (I9)

We create spreadsheets, spreadsheets for all care pathways. (I10)

It was observed that the interviewed professionals use these practices to organize their workflow, enabling better control over user attendance, frequency, and follow-up.

The use of technology as an ally was also identified as a strategy to strengthen bonds, facilitate communication, improve workflow organization, and promote continuity of care.

Using the team's phone as a strategy for better contact with patients for scheduling, providing information, and addressing questions. (I7)

Following up via WhatsApp as well. (I6)

We also contact family members by phone.
Communication through calls and WhatsApp helps a lot. (I12)

The crucial role of technology in the workflow of PHC. Health care integrated with technology facilitates data collection, epidemiological surveillance, and the creation and sharing of new knowledge, ultimately improving the quality of care provided[21].

Enhancing Longitudinality: Essential Actions and Services

This category was constructed from the grouping of 145 RUs, representing 37.08% of the total RUs. It emphasizes actions and services identified as essential elements in promoting continuity of care, acting as catalysts for fulfilling the guidelines of the FHS.

Among the topics highlighted by professionals, the holistic perspective, active listening, and the participation of CHAs in home visits were most emphasized for ensuring continuity of care.

The ACS's knowledge about the population facilitates follow-up. (I6)

A good strategy is to consistently perform surveillance and active outreach with community agents. (I7)

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Within the FHS team, the CHA is the professional with the closest proximity to users, which facilitates the identification of risk factors, health issues, vulnerabilities, and living conditions for each user. This information is brought to the health unit and discussed with the multiprofessional team, enhancing health surveillance and continuity of care[22].

> *The health agent's close contact with the population is a great advantage. (I2)*
>
> *Home visits support care delivery. (I1)*
>
> *A good strategy is to consistently perform surveillance and active outreach with community agents. (I7)*

Another relevant point is the opportunity to integrate health education into users' daily lives. Due to their frequent presence in territories and home visits, these professionals have greater ease in providing health promotion and disease prevention guidance directly in the field[22].

However, while this study's findings align with other authors regarding the critical role of CHAs within FHS teams, it is important to note the changes in CHAs coverage as outlined in the 2017 National Primary Care Policy (PNAB).

The 2011 PNAB recommended 100% coverage of the assigned population by CHAs, with up to 750 individuals per CHA. However, starting in 2017, the PNAB revised this recommendation to focus on 100% coverage of the vulnerable population[23].

This change contradicts the principles of the SUS, complicating the guarantee of universality and directly impacting the organization of FHS services, health surveillance, and consequently disrupting continuity of care[23].

The interviews emphasized the importance of a holistic perspective and active listening.

> *And having a holistic view of the family. Often, the worsening of a condition isn't due to the person not taking medication, following a diet, or exercising, but because of their life routine with their family. (I4)*
>
> *Seeing the patient beyond their pathology. (I5)*
>
> *Listening to the patient and making them feel that you are truly present, that they are not just another case, not just someone reporting a complaint to be addressed and dismissed. (I9)*

Identifying the family context in which the user is embedded was considered crucial, highlighting the need to provide care not only to the user but also to their family members to achieve comprehensiveness and longitudinality of care. This enables the creation of a therapeutic plan aligned with the individual and family needs of each user[24].

Another topic addressed was the importance of community support networks in strengthening continuity of care, building bonds, and delivering comprehensive care.

> *Support from local associations for issues beyond illnesses, such as school infrastructure. (I6)*
>
> *Support from churches or neighbors—anything that can help us coordinate care for this patient. (I12)*

These statements underscore the importance of intersectoral actions as a strategy to ensure equity and health promotion, aiming for holistic care. Intersectorality enables the integration of various sectors beyond health, striving for comprehensive care through coordination among different social and political actors, involving diverse resources and levels of complexity[25].

The interviewees highlighted teamwork and management collaboration as indispensable factors for achieving continuity of care:

> *Team meetings to identify patients requiring more attention. (I5)*
>
> *The multidisciplinary team is very important for the process. Because no single professional category can provide comprehensive treatment for the patient. (I12)*
>
> *When the team is united and integrated, better care is possible. (I1)*

Teamwork has emerged as an effective strategy in healthcare, not only in response to changes in the population's epidemiological profile but also to the increasing complexity of needs. This approach enhances comprehensive, high-quality care while also fostering greater professional satisfaction[26].

The professionals also emphasized the importance of management collaboration in ensuring continuity of care, providing adequate services, and maintaining the smooth operation of the unit.

> *A well-organized clinic, with good management of work processes, sectors, and staff, allows for better execution without overburdening professionals. (I7)*

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Management ensures we never run out of materials [...] if we want to organize a large-scale action, we have the resources. (I5)

Support from management and the unit helps a lot. (I1)

In addition to leadership skills and resource, personnel, and material management, this professional's role should be grounded in collaborative practice, seeking integration among services and professionals while strengthening skills and attitudes[27].

In this context, it was observed that the actions and services identified by participants as essential for continuity of care include nurses' direct practices with users, activities in the territory, and multiprofessional teamwork.

The importance of management services and intersectoral actions was also highlighted, aiming for person-centered care that addresses diverse needs while considering complexity and individuality in ensuring continuity of care for users with chronic conditions.

Study limitations

The study's limitations include its focus on a single FHS unit in Rio de Janeiro, the small number of participants, and the inclusion of patients who had previously undergone surgical procedures. These factors limit the generalizability of the results and underscore the need for further research on this topic.

FINAL CONSIDERATIONS

Regarding care practices, participants demonstrated efforts to strengthen bonds, identify expanded health needs, promote autonomy, and encourage users' active participation in their therapeutic plans.

As for essential actions and services for continuity of care, the holistic perspective, active listening, the role of CHAs he territory, and teamwork were highlighted. However, for these actions to be effective, it is necessary to implement ongoing health education processes to address challenges reported by participants, such as insufficient CHA training and conflicts within multiprofessional teams.

Other points raised included the role of intersectoral practices and support networks. While intersectorality was recognized as an essential aspect, participants reported difficulties in ensuring its implementation, citing issues beyond the health sector and challenges in coordinating with other sectors, which impact care comprehensiveness.

Regarding difficulties highlighted by participants, professional turnover, workload overload, conflicts within multiprofessional teams, and insufficient CHA training were observed as factors undermining continuity of care and negatively affecting the quality of services provided.

To improve this scenario, strategies should be adopted to strengthen bonds, raise awareness about the importance of teamwork, and enhance intersectoral actions. This involves management coordination with other sectors to reinforce intersectorality, creating spaces for discussion, continuous training, and encouraging technical-scientific improvement and collaborative practice to ensure continuity of care for users with chronic conditions.

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Conceptualization, F.N.A.S. e S.A.; methodology, F.N.A.S. e S.A.; validation, F.N.A.S. e S.A.; formal analysis, F.N.A.S. e S.A.; investigation, F.N.A.S. e S.A.; resources, S.A.; data curation, F.N.A.S., R.C.A. e S.A.; manuscript writing, F.N.A.S., R.C.A. e S.A.; writing – review and editing, F.N.A.S., R.C.A. e S.A.; visualization, F.N.A.S., R.C.A. e S.A.; supervision, S.A.; project administration, S.A. All authors read and agreed with the published version of the manuscript.