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ORIGINAL ARTICLE

Nurses' strategies for comprehensive care to users in Home Care

As estratégias de enfermeiros para a integralidade da atenção ao usuário na Atenção Domiciliar

Estrategias de enfermería para la atención integral a los usuarios en la Atención Domiciliaria

Gabriéla Saidel Spezzia[1], Carmen Liliam Brum Marques Baptista[1]

ABSTRACT

Objective: To verify the strategies of nurses to achieve comprehensive care for users in Home Care. **Methodology:** This is an exploratory, descriptive field research with a qualitative analysis. A semi-structured research instrument was used for the interview conducted with eight nurses. The information was analyzed using the content analysis method proposed by Minayo. **Results:** The analysis of the interviews resulted in the category called "strategy of integrality in the work process". **Final Considerations:** Comprehensive health care in Home Care is effective through the execution of several actions and strategies in which nursing stands out in the work process, although the majority are developed by a multidisciplinary team, which acts in an interprofessional way.

DESCRIPTORS:
Integrality in Health; Home Nursing Care; Home Health Care.

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Corresponding author:
Gabriéla Saidel Spezzia.
E-mail: gspezzia@furb.br

RESUMO

Objetivo: Verificar quais as estratégias dos enfermeiros para alcançar a integralidade de atenção ao usuário em Atenção Domiciliar. **Metodologia:** Trata-se de uma pesquisa de campo, exploratória, descritiva com análise qualitativa. Utilizou-se um instrumento de pesquisa semiestruturado para a entrevista, conduzida com oito enfermeiros. A análise das informações se deu por intermédio do método de análise de conteúdo proposto por Minayo. **Resultados:** A análise das entrevistas resultou na categoria denominada “estratégia de integralidade no processo de trabalho”. **Considerações**

[1]Universidade Regional de Blumenau. Blumenau, Santa Catarina, Brazil.

Finais: A integralidade de atenção à saúde, na Atenção Domiciliar, se efetiva através da execução de diversas ações e estratégias, em que a enfermagem se destaca amplamente no processo de trabalho, embora a maioria delas sejam desenvolvidas por uma equipe multiprofissional, que age de modo interprofissional.

DESCRITORES:
Integralidade em Saúde; Assistência de Enfermagem Domiciliar; Atenção Domiciliar à Saúde.

RESUMEN

Objetivo: Verificar las estrategias de las enfermeras para lograr el cuidado integral de los usuarios en la Atención Domiciliaria. **Metodología:** Se trata de una investigación de campo básica, exploratoria, descriptiva y con análisis cualitativo. Para la entrevista se utilizó un instrumento de investigación semiestructurado realizado con ocho enfermeros. La información fue analizada mediante el método de análisis de contenido propuesto por Minayo. **Resultados:** El análisis de las entrevistas dio como resultado la categoría denominada "estrategia de integralidad en el proceso de trabajo". **Consideraciones Finales:** La atención integral de la salud en la Atención Domiciliaria es efectiva a través de la ejecución de diversas acciones y estrategias en las que la enfermería destaca ampliamente en el proceso de trabajo, aunque la mayoría de ellas son desarrolladas por un equipo multidisciplinario que actúa de manera interprofesional.

DESCRIPTORES:
Integralidad en Salud; Cuidado de Enfermería en el Hogar; Cuidado de la Salud en el Hogar.

INTRODUCTION

The Unified Health System (SUS), based on the principle of integrality, comprises the person in its entirety, meeting all his health needs[1]. It is in this sense that the health sector has created public policies that are articulated, addressing the person in an integral way and ensuring positive results in their quality of life[1]. In other words, "the health system must be prepared to listen to the user, understand him inserted into his social context and, from there, meet his demands and needs[2]".

Given this, people restricted to bed or home are inserted in a different social context, due to their limitations to reach a health facility. These people cannot take care of themselves and need others for their daily activities. When an person in this condition becomes ill, the SUS provides that health professionals visit their home for evaluation, disease prevention, treatment and rehabilitation[3]. These actions are part of the Home Care (HC), which provides care according to the level of complexity of the patient. Bedridden, stable and complex I (HC1) people are the responsibility of the Family Health Strategy (FHS), and unstable bedridden, sharpened, or with some complexity level II and III (HC2 and HC3), they are the responsibility of the Home Care Service (HCS), guaranteeing these system users a continuity of care[4].

HCS is a complementary service to the care provided in Primary Care (PC) and emergency services. Substitute or complementary to hospital admission, it is responsible for the management

and operation of the Multiprofessional Home Care Teams (MHCT) and Multiprofessional Support Teams (MST)[5].

These services are performed from home visits, when the health professional is inserted in the family nucleus and gets to know the entire process of health and disease of users, allowing to identify the real needs of families[6]. The complete and accurate assessment of the needs of the bedridden patient is the first step to effective home care. For these care, the participation of the nurse becomes essential[7], given that nursing has, in its body of knowledge, the ability to create links with users and relatives, and has the competence to elaborate specific care plans for these people, organizing and coordinating the necessary care assistance[8-9].

Home care is a topic that is rarely addressed today, although it is relevant to the professional nurse, in view of the inversion of the population pyramid, where we perceive the aging of the population, associated with advances in the area causing the population to have a longer survival. As well as a high rate of external causes, which leave a portion of this population dependent on technology in the households, due to complications arising from it. Thus we age and have greater need for care with the chronic conditions that accompany this phase of life, as well as we need more support for care in the face of the de-hospitalization of acute cases that remain with sequelae. Thus, working with family caregivers and professionals who care for the home has become essential to ensure a life with quality and good health results for the population. "HC is indicated for people who, being in clinical stability, need health care in a situation of temporary or permanent bed restriction or home or in a degree of vulnerability in which home care is considered the most appropriate offer for treatment, palliation, rehabilitation and prevention of injuries, with a view to the expansion of autonomy of the user, family and caregiver[6]".

OBJECTIVE

To verify what strategies nurses must achieve the integrality of user care in HC.

METHODOLOGY

Study type and study setting

Given the contributions that this study theme represents to the knowledge of health professionals, this field research was conducted with the objective of verifying what strategies nurses must achieve the integrality of user care in HC.

The municipality where the study was carried out is the 3rd most populous municipality in the state, located in the southern region of the country, its total population estimated, according to IBGE, is 361,261 inhabitants[10]. In 2019, life expectancy in the state of Santa Catarina reached

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79.9 years, surpassing the national average of 76.5 years. This indicates that the inhabitants of the state live, on average, 3.4 years longer than the average of the Brazilian population[11].

Among the services offered in the assistance network of this municipality includes the HCS, which is characterized by a multiprofessional team that works at the home of the user and is characterized by "a set of actions for health promotion, disease prevention and treatment and rehabilitation, with the guarantee of continuity of care[3]". It is considered a complementary service to the care provided in primary care (PC) and emergency services, which may be a substitute or complement to hospitalization[6]. In addition to the municipality, there are 116 family health teams that cover 100% of the territory[11].

Population or sample, inclusion and exclusion criteria

The participants of the research were selected by means of the Snowball Sampling technique. Initially, the appointment was made by the coordinator of HCS, from which the nurses working in this service were contacted. For the nurses linked to the FHS, the same technique was applied, and after the initial interview, each participant indicated another colleague who also performed home care. The contact with participants was established through the WhatsApp platform, and convenient location and date for conducting interviews were scheduled. The inclusion criteria of the participants in the study were: nurses who perform home care and who agreed to participate in the study. As exclusion criteria, nurses who did not perform home care in their care were adopted.

Eight nurses participated in the research, four of them working in HCS and four others in FHS. The nurses selected for the research worked directly on these services, providing home care. In both contexts, these professionals develop an assistance characterized by a comprehensive and systemic approach, covering not only the care of the patient, but also considering the sociocultural and family context in which he is inserted.

Data collection and organization

Data collection took place in the month of August to September 2022, from interviews conducted through a semi-structured script, containing the following questions: 1) How is the care of the patient bedridden in your unit? 2) What do you consider making the care of the bedridden? 3) Which instruments do you use for evaluation of these people? 4) How is the organization of care to the bedded patient?.

Each interview was recorded in audio and then transcribed in an integral form for analysis of the collected content. This research instrument was applied in the work environment of the nurse,

although away from the public, so that he could feel more comfortable participating in the study. To preserve the identity of these professionals, pseudonyms were used as a reference to them throughout this text. The nurses were identified by names that represent important personalities for the history of nursing, the nurses of HCS being named: Calista, King, Florence and Ana Nery and the nurses of FHS: Orem, Wanda Horta, Maria Rosa and Betty Newmann.

Stages of the work and data analysis

The analysis of information was done through the content analysis method proposed by Minayo. After the data collection and the complete transcription of the content, the analysis was carried out in three stages: pre-analysis, exploration of the material and treatment of the data and implementation. The pre-analysis was based on reading and re-reading the data, associating them with the general objective of the research[12]. In the second stage, there was alignment of thought and content grouping. In the last one, there was crude and sensitive interpretation of data.

Ethical aspects

In compliance with the ethical precepts, the research respected the Resolution N 510 of April 7, 2016, of the National Health Council (NHC), thus guaranteeing the bioethical rights of each person participant through the presentation, explanation and signature of the Informed Consent Form (Annex I). The research was approved by the Committee of Ethics in Human Research (CEHR) of the Regional University of Blumenau (FURB), under the number 5.431.982 of 26/05/2022 (CAAE 58504922.0.0000.5370).

RESULTS AND DISCUSSION

The nurses working in HCS and FHS are effective nurses of the public service of the municipality, the coordinating nurse of the service was one of the precursors of the activity in the although home hospitalization was already part of the framework of actions of the FHS since its institutionalization in the municipality in the mid-1990s.

Despite the efforts made to collect data related to the subject under study, it was not possible to obtain sufficient information for demographic analysis and characterization of participants. This limitation can be attributed to factors such as the difficulty of accessing participants, the unavailability of consistent records and the absence of responses to contact attempts. This restriction does not invalidate the present work, but it highlights the need for future investigations that may fill this gap, broadening knowledge on the subject addressed.

The nurses working in HCS and FHS, who provide care to bedridden people, pointed out

some strategies to achieve integrality in this service. Therefore, the results are presented in the form of the category named: Integrality Strategies in the Work Process.

Category: Strategies of Integrality in the Work Process

The analysis of the work process of nurses, especially nurses from FHS and HC, revealed subcategories that detail characteristics of their professional practice, they are: capturing the patient; patient's characteristic; evaluating the patient; including the family; evaluating the family; assessing the environment; multiprofessional team; reference professional; registration; permanence in service; frequency; service discharge, interactions between services and comprehensiveness.

Initially, for this process of patient recruitment to occur, it is necessary that there is a demand for bedridden people needing reception. Patients access the service through referral to the services of the care network, or spontaneous demand from family members and neighbors[4].

During the interviews, nurses participating in this study reported that there are some ways for these users to reach services. In the FHS, for example, family members can request caregivers for their bedridden relatives, users of the health unit. They report the events that occurred in their family unit and request a home visit.

Most often, family members take care of these patients because they are motivated by emotional ties, sense of duty and compassion. Low financial conditions and the difficulty in finding support among other family members also contribute to their assuming this responsibility, especially when they develop a certain empathy for the situation and present feelings of love and dedication to the bedridden patient[13]. Then, the family members, guided by someone from their social life cycle, or by the hospital itself, go to the FHS and ask for help to perform the care, as well as report to the nurses, among them, Orem:

> [...] family members can come here to warn that there is a bedridden patient at home [...] so the family member warns us, sometimes they are discharged from the hospital, the family members bring the discharge from the hospital here [...] (Orem)

Still in the FHS, the other way patients reach the service is through the information that the Community Health Agent (CHA) brings to the health unit. The CHA is a health professional who attends the users' home and observes their needs, he is a link between the community and the health unit. This professional "has a very important role in the reception, because it is a member of the team that is part of the community, which allows the creation of links more easily, providing direct contact with the team[14:01]", as reported by nurses:

> [...] Sometimes the health agent brings that it is most cases [...] (Orem)
>
> There is the Community Health Agent, there are situations that the CHA learned about the event [...] (Wanda Horta)
>
> Another way is the community health agent who brings it to us, who saw that there is a bedridden patient who needs it, right? [...] (Betty Neumann)

In addition to these forms, there is also another way of capturing these patients for HC through the request of hospitals. Discharge reduces the clinical complications and decreases the risk of hospital infections in these patients[4]. With this strategy, HC promotes that patients remain in their usual and familiar environment to receive care, which improves the psychological conditions and health of the user[15,16,17], because "an person inserted into the hospital environment, ends up experiencing a daily environment foreign to their daily and habitual interaction, which may interfere with good results for their therapeutic recovery[15:1131]".

Thus, the hospital refers these patients to a specialized service in HC or to the FHS. The intended location depends on the patient's clinical condition. For example, families of stable patients are directed to seek the health unit in their neighborhood to continue receiving care, while families of unstable patients are directed to seek care from HCS through a National System of Regulation (SISREG), for continuity of treatment. In its guidelines, HC should be incorporated into a regulatory system to articulate with other care networks[5]. Given this, SISREG "is an online system, created for the management of all regulatory complexes going from basic network to hospital admission, aiming at humanization of services, greater flow control and optimization in the use of resources[18:10]". Therefore, hospitals refer patients to PC and specialized, as reported by the interviewees:

> But we have already had, in some situations, the hospital to contact us (Betty Neumann)
>
> A request comes from the hospital [...] saying that the patient will need this home service, it comes through the regulation of the SUS (Calista Roy)
>
> They come referred by a reference, then they leave the hospital and they come with a request for an evaluation from the HCS [...] (King)
>
> [...] so, when he is discharged, the hospital itself already advises, right, that he should look for the health unit, right (Wanda Horta)

After the request of family members in primary care, nurses from FHSs schedule a home visit to assess this patient. At home, they check the state of health and disease that this patient presents, determining its degree of complexity. If the patient meets the criteria of HC2 or HC3, these nurses, through SISREG, request the evaluation of the HCS.

In these direct requests to the HCS, information on the patient, clinical history, current health status and disease, tests and the complications that he had must be included[4]. In the HCS team, there is a specific professional who receives these referrals, analyzes, observes whether it is consistent with the inclusion criteria of the service and schedules a home visit to finalize the admission process. In this sense, the professional must know the eligibility criteria for inclusion in the service and the characteristics of users that can be served by HCS.

HC is indicated for people who need health care in a situation of temporary or permanent bed or home restriction[5]. In summary, this article has previously clarified that patients are classified according to their degree of complexity and are then assigned to their respective service. In this sense, the FHS frames patients with the following characteristics: difficulty or physical impossibility of locomotion to the health unit, care of less complexity with controlled and compensated health problems, lower frequency of professionals and less need for health resources[19]. These characteristics form the first classification modality of HC, that is, HC1.

Patients who require more intensive care, with more frequent visits, continuous monitoring and specific resources, such as the use of equipment, are welcomed by HCS. Thus, patients in acute situations, in chronic conditions, in immediate and late post-surgical process, in treatment of large ulcers, in parenteral nutrition, in non-invasive mechanical ventilation, in palliative care or requiring home medication (intravenous, muscular or subcutaneous, for a pre-established time), present the characteristics of care by HCS[4-20].

However, there are special situations in which the patient is being followed by the FHS but has a clinical condition that indicates the need for home care in HC2 or HC3. Then, the HCS may admit it until there is sufficient stabilization to later refer it back to primary care[4]. The nurses' speeches express this process:

> They are chronic conditions that worsen, or patients who are going to die at home, or who leave the hospital with a situation [...] and they need a brief rehabilitation at home [...] (King)
>
> This patient must be bedridden, bedridden and with some disease that is acute" (Florence)
>
> [...] the chronic bedridden person needs to be in the acute phase for us to be able to provide care at that moment, if chronic patients who are stable should be absorbed by primary care (Ana Nery)

Analyzing the referral request and understanding whether the patient is fit for care in the HCS, the first visit will be scheduled for evaluation of the patient and admission, as reported by nurses:

> We organize our schedule to make the evaluation and admission of the patient (King)
>
> [...] evaluation for the eligibility of this patient for this service (Florence)
>
> At first, an evaluation of the patient is made according to the role that came. In this evaluation, we see if he meets the criteria to stay in the service or not (Calista)

Then, the service professional who is responsible for this assessment informs the family/caregiver that MHCT will make a prior visit to talk about HC. This first home visit should preferably be performed by the complete MHCT, aiming at joint evaluation for elaboration of the therapeutic plan[4].

Thus, the first visit aims to admit the patient in HC, verifying whether the patient meets the criteria for admission to the service and what are the conditions and the ability of family members to assume home care[4]. It should be agreed between health professionals, patients and family members how this care will work and what the requirements to have it. The MHCT will collect all information from the patient, from clinical history to the current situation, through anamnesis and physical examination. Both have a fundamental role in the verification and identification of patient problems, as well as in the entire survey of health and disease history[5] since these methods allow obtaining information about the patient. According to the nurses interviewed, all prioritize knowing what happened with their patients and how they are until the moment of the first visit. To do this, they talk with patients, with family members, look at the discharge summary sent from the hospital or FHS and do the physical examination, as reported below:

> We talk to the family and then the whole physical exam (Florence)
>
> When it is the evaluation visit, it is a longer visit, because we need to collect data from what happened and the patient's entire history [...] (Ana Nery)
>
> [...] discharge summary because, in general, the hospital details well the events that occurred and the situation that the patient is in at discharge and, based on that there, we make an initial orientation [...] (Wanda Horta)
>
> [...] and I think this data collection is important, so we let them talk a lot, and the family tells them what happened until the moment he returned home (Ana Nery)

After the evaluation of the patient and his family structure, MHCT professionals deliberate whether the patient should be admitted and if he meets all the criteria for inclusion in the service. If the user is admitted, MHCT must provide the informed consent form, which the patient or family sign, accepting home care. Besides this, they explain: how the visits will work, days and schedules; which professionals are referred to; what to do if the patient presents urgent and emergency situations or in case of death at home. In addition, the MHCT professionals also provide all contacts

with the team for the guidance of intercurrent situations and clarify that the presence of a caregiver is mandatory for the use of this service, being the responsibility of the family to assume this role or provide this figure[4]. The caregiver is someone who performs and takes responsibility for direct, continuous or regular care to another dependent person. This caregiver may or may not be a family member and may or may not be paid[4,13,20]. Given this, during the interviews, the nurses reported this condition as follows:

> One of the criteria for attending the HCS is that the patient must have a caregiver 24 hours a day, who stays there with him, because if he goes alone we do not admit him (Calista Roy)

> One of the criteria for the patient to come to the HCS needs to have a physically and psychologically qualified caregiver, because we do not assume the role of the caregiver [...] (Ana Nery)

> If there is a caregiver, because sometimes they call us and there is no care, and it is a prerogative of the program to have a caregiver (King)

Given this, and recalling the concept of integrality, it is necessary to approach the person. This means that the health professional should not fail to evaluate the nucleus in which the patient is inserted. Home care should include the family, respecting its traits, particularities and complexities[4]. In this context, "the permanence of a person in the home environment, under conditions of illness with dependence, can change the family dynamics, implying the need for the whole group to reorganize itself to meet the care needs[21:02]". For this reason, nurses also evaluate the characteristics of the family nucleus in which these patients are inserted, as they portray the following:

> You must evaluate this whole social issue of this family and if he is being autonomous to do all this care [...] (Florence)

> [...] he also seeks to know the condition of the family to take care of these patients (Orem)

> I evaluate who cares, how the care is organized and if there is a caregiver (King)

In this context, the family is included in the care of the patient at home, since it is necessary that someone assume the role of caregiver[14]. In addition, "the family has an essential role in care, since its participation or not can delineate the form, effectiveness and evolution of care and quality of life of the patient in HC[4:43]", since the MHCT does not stay at the home of these patients, only performs regular visits, according to your needs. This is also observed in the nurse’s speech below:

> We also include the family, because we are not at the patient's home every day [...], but we guide the family, because care does not depend only on the team

(Calista Roy)

Thus, in the comfort of their home, patients receive constant support from their families, MHCT and surrounding communities. The family should also receive support from MHCT in the face of changes, new routines that it is experiencing[4]. In this sense, the daily care of the patient is taken over by the family members, who usually "wound dressing exchanges, vital data measurement, aspirations, stimulation of communicative skills, functional swallowing stimulus, hygiene, and support to the user in daily life activities[17:05]". To perform some of these procedures, the MHCT nurse tutors the family, offering all necessary support for the development of care, as noted in the following:

> We guide them, in fact we structure them because not everyone has had a bedridden patient at home, right (Calista Roy)
>
> [...] one of the factors that should work a lot on health education with this family (Florence)
>
> [...] we guide the caregiver so that he feels safe to care for the patient (King)
>
> We teach her again how to do it, guide, go there or she comes here to the unit, we talk and teach again (Betty Neumann)

The nurse also, during their home visits, constantly evaluates what environment these patients are inserted into. This is an assignment described in the Home Care Notebook[4], which allows the team to observe the condition and physical infrastructure of the household, to promote actions that improve the quality of life of these users. During the interviews, some nurses described this action:

> There is the question of hygiene that we see [...] if the house is damp, if there is garbage [...] (Pray)
>
> I evaluate the issue of care in relation to the house, right [...]" I really like to know the environment where the patient is inserted [...] (King)
>
> [...] We make a greater assessment, of everything, of the mattress, of how the bed is (high or low), if the mattress is suitable [...] (Maria Rosa)

Thus, after knowing and understanding the health status of each person, their family nuclei and the characteristics of the place where the user remains, it is up to MHCT, together with the family, to elaborate a plan of care appropriate to each situation. HC allows its teams to adopt an integral view of these people, since they are composed of different professions, i.e., they are multiprofessional teams. The HCS is composed of two teams, the first one being the MHCT, which consists of a doctor, a nurse, a physiotherapist and nursing technicians[6]. The second is MST, which will be activated only from the clinical indication of MHCT, to support and complement their

actions. It is composed of the social worker, physiotherapist, speech therapist, nutritionist, dentist, psychologist, pharmacist and occupational therapist[6]. During the interviews, nurses reported that at HCS there are the following teams:

> [...] here there are three multiprofessional teams, MHCT, all of them have a doctor, a nurse, three nursing technicians and a physiotherapist, and there is an EMAP that is a social worker, speech therapist, nutritionist and psychologist [...] it is a large team (Calista Roy)
>
> In addition to our team (MHCT) we have an MST support team (King)
>
> [...] MHCT, which is the main team, will activate MST [...] (Ana Nery)

In the FHS, all health professionals in primary care should be composed of a doctor, nurse, nursing technicians and CHWs[22]. In this regard, nurse Orem reports that:

> This multi-team is a nurse, a technician, the health agent and the doctor (Orem)

Thus, the different health professionals share information about each patient, because only in this way is it possible to impact on the multiple factors that interfere with their health-disease process[4]. In this sense, "the ideal is that each professional act not in isolation, but integrated, with case discussions and a joint action, thinking of all patients, family members and caregivers[23:171]". While sharing information, the team shares various knowledge to contribute to the care plan of these users, as reported by nurses:

> There is communication between the team [...] there is an exchange of information between the professionals, I talk to the doctor, to the physio and everyone will evaluate, and this communication allows everyone to work together, which improves for the patient (Calista Roy)
>
> [...] we do a lot of interconsultations (King)
>
> The doctor and I exchanged some information [...] (Betty Neumann)
>
> [...] we always end up arguing, you know, normally, between doctor and nurse always (Maria Rosa)

According to the complexity of patients assisted in HC, each professional contributes with knowledge of their area of expertise. Although the service has a multiprofessional team, the nurse performs the role of articulator in HCS, involving home care teams, patients and their families for the development of care. The nurse attends the home of these patients before even admitting them to the service, and this allows him to know them, create bonds and develop confidence in their relationships. It is he who is fully inserted in the experience of these family nuclei, who identifies the first needs of users, promotes the first care and, it is him that the family turns to when there are needs. In this sense, unlike other health services, the nurse, in HC, is seen as a reference

professional, as follows:

> [...] there is still this centrist medical model, they think everything is solved by the doctor and here at the HCS we have this well-defined, so the nurse is the very important professional, right, and he can go to the patient's home and identify all his needs, and of course, he will not supply the doctor's care because each one does what his responsibility is (Ana Nery)

> [...] in fact, it ends up being the nurse because he is the professional who most frequents the house (Ana Nery)

It is necessary to record all the interventions performed on the patient. Thus, through the registration, all professionals involved with the case can not only have access to clinical data, but also know which interventions have already been made and what still needs to be done; the registration is therefore a counterproof of what was carried out.

In this sense, to ensure that the HC team follows the patient’s and his family’s evolution, there should be a unique HC chart, which includes all the records of the team, from the admission of the patient until the current moment. This chart should have two ways, one remains with the family and another with MHCT. If the patient is treated by another service belonging to the Health Care Network (HCN), these professionals must register in this same record so that MHCT has knowledge of the clinical information of the user. Therefore, even if the patient has a reference FHS, it should use the same home medical record[4]. It is the responsibility of FHS and HCS professionals to record all procedures performed and patient’s progress in the home care chart, without exceptions. In the following statements, nurses highlight how they record their behaviors:

> At the patient's home, there is the physical medical record [...] what the care was, describes it [...] asks the caregiver to sign, puts the date and signature and proves that we went to the patient to visit (Calista Roy)

> [...] I like to write down what my conduct was, if it was family-oriented, important data, all the guidelines that were given [...] (King)

> [...] I evolve the part that I did on the nursing part, it is just a process of writing, of the objective, of the subjective, of the evaluation and of the plan that was made, a normal thing, nothing much written (Maria Rosa)

These records should be made after the home visits. If, for some reason, health professionals fail to record the behaviors done, they must wait until the next visit to write in the chart, which may compromise the veracity of the information. This is because the frequency of visits, in most cases, is not daily, nor equal for all users of HC. The frequency of these visits is defined by the degree of complexity of the patient, determining the number of visits that will be required for care to be provided and effective[4].

The length of stay in home care may vary between weeks and years[24]. The FHS are

responsible for the HC1 modality, which should carry out regular home visits at least once a month[25]. This time can be reduced if the family, the caregiver and even the CHW request an evaluation from the nurse or doctor for the user.

The MHCT will perform service at least once a week to each user[6]. However, it is the nurses of the HCS who establish the necessary frequency of visits for people assisted in HC, as described by the professionals below:

> I plan for this assistance, [...] and then I myself make this prescription there of how often I will be visiting this family (Florence)

> [...] we make weekly visits [...] according to the complexity of care and the patient's needs (King)

> If the nurse cannot go to monitor every day [...] he follows up weekly (Ana Nery)

In this sense, patients classified as AD2 tend to have temporary stay, since when they stabilize their health status, they are referred for primary care. For users with the HC3 profile, the stay is usually continuous, due to clinical demands and use of semi-permanent equipment[4,26].

After attending patients in a certain period, MHCT and MST analyze and discuss the possibility of discharge from the service of these users for other services. Usually, the cases of stability and improvement of the clinical picture are directed to the PC with the objective that the care is continued by the FHS teams. Users with clinical conditions are sent to hospital institutions to receive the necessary care(4), as nurses describe below:

> We stop treating this patient when he is clinically stable [...] if he is discharged, the health units are responsible for him (Callista Roy)

> A bedridden, chronic and stable patient is already the moment of discharge from HCS (Florence)

> It is the team that defines [...] that patient has already been given all the guidance, he is stable, the process of discharging this patient begins, the family is already informed that he will be discharged [...] (Ana Nery)

In addition to the situations already mentioned, there are other forms of disconnection from DAS, including: change of city, withdrawal of patient and family from receiving HC, death and inadequacy of the care plan, even after attempts to reformulate for stability and bond strengthening[4].

For the discharge process to occur in an assertive way, it is important that the HCS maintains a good relationship with the HCN, facilitating the articulation and transfer of these users. SAD should relate to the other health services that make up the HCN, especially with the PC, hospitals and emergency services, to avoid direct demand from users[6]. In this sense, when asked

about the interactions between services, nurses from HCS and FHS reported, respectively:

> Sometimes we contact the unit to talk about the materials or to pass on the case, sometimes FHS calls to pass on a case, there is an exchange of information on whether it is possible to forward it or not, it is a direct contact (Calista Roy)
>
> But going home every day is not possible, if it is the case in an acute way we refer them to the HCS, they are the ones who leave, go every day (Betty Neumann)

This direct articulation between services allows teams to exchange information about users and facilitates their access to the other services of the network. Given the above, it is observed that nurses connected to HC use more strategies than recommended by the Ministry of Health[27-28], reaching the integrality of care for people restricted to home and home.

Study Limitations

One of the main limitations of this study was the small sample size composed of only 8 nurses working in HC and that can limit and generalize the results. In addition, the different ways of performance of nurses in HC prevent a detailed analysis of all strategies used by nurses in home care.

Contributions to the Area of Nursing, Health or Public Policy

The study contributes to the nursing area to broaden the knowledge and performance of nurses in HC. Allows us to know the various strategies developed by nurses during the process of homework, which enables to approach users of this service in a broad way, reaching the comprehensiveness.

This study also allowed the visualization of interdisciplinary work from the moment it is performed in a team but transcends the performance of professional nuclei and enters the integral vision of the user as the field of action of professionals. The work process clearly exemplifies collaborative and interprofessional practice in the region where the research was developed.

FINAL CONSIDERATIONS

The integrality of health care in HC is effective through the execution of several actions and strategies. Most of them are developed by a multiprofessional team, in which the users inserted in the service are assisted by different professionals from the health area. Thus, each profession develops specific care in its area to integrate the attention to these people. However, this study demonstrates that in HC, professionals do not act in isolation. Instead, they act with a single purpose, interconnecting their knowledge and skills to provide care for a common problem,

characterizing HC as an interprofessional team, with multiprofessional traits. Interprofessionality allows a generic approach, contributing to the achievement of integrality of people restricted to bed or home. Even though the service depends on several professionals, nursing in HC stands out as a reference profession, because it develops fundamental roles for the achievement of integrality to health. Although the nurse does not recognize all the strategies that she implements, she is present in the life of these HCS users from before reception to discharge from service, being the main articulator between user, family and other working professions. Nursing optimizes home care, because it plays a critical look at the process that these users are experiencing.

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