ABSTRACT

Objective: to analyze the care organization in the Home Care of the Family Health Strategy from the perspectives of the elderly and professionals. Method: exploratory study, with a quantitative-qualitative approach, with the participation of 28 professionals and 62 elderly people. Data collection was done through the semi-structured interview and focus group. The analysis used descriptive statistics and thematic coding.

Results: the characteristics and form of care organization do not determine a systematic HC that fully addresses the elderly’s needs. Conclusion: it is important to sensitize professionals and managers of the Family Health Strategy on the specificities of Home Care for qualification of care. Descriptors: Home Care; Elderly’s Health; Family Health Strategy; Caregivers; Health Personnel.

RESUMO


RESUMEN

Objetivo: analizar la organización de la atención en la Atención Domiciliaria de la Estrategia Salud de la Familia desde la perspectiva de los ancianos y profesionales. Método: estudio exploratorio, de enfoque cuantitativo y cualitativo, con la participación de 28 profesionales e 62 ancianos. La recolección de datos se realizó a través de la entrevista semi-estructurada y grupo focal. El análisis utilizó la estadística descriptiva y la codificación temática. Resultados: las características y la forma de organización de la atención no determinan una AD sistemática que responda a las necesidades de los ancianos totalmente. Conclusión: es importante sensibilizar a los profesionales y gestores de la Estrategia Salud de la Familia en los aspectos específicos de atención a domicilio para la calificación de la atención. Descriptores: Atención Domiciliaria de Salud; Salud del Anciano; Estrategia de Salud Familiar; Cuidadores; Personal de Salud.
INTRODUCTION

At the beginning of the 20th century, life expectancy in the country was only 33.5 years. According to the Brazilian Institute of Geography and Statistics (IBGE), it reached more than 73 years in 2009. The proportion of elderly people rose from 9.1% in 1999 to 11.3% in 2009, making up a contingent of over 22 million people, surpassing the elderly population of several European countries.1

Aging associates with the chronicity and progressive occurrence of various diseases, which represents a major challenge to care, especially for the most fragile and needy elderly people. There is also the challenge of sustainability: the simultaneous occurrence of various chronic diseases triggers a high cost of treatment, a particularly serious effect in times of economic crisis. One of the pillars of the strategy for addressing chronic diseases is integrating care in an effort to adapt the organization of health services to the new needs of the elderly.2

In view of that context, the Family Health Strategy (FHS) was designed to reorient health care to the population, promoting quality of life, for example, through the promotion of healthy aging. As the needs and demands of the elderly vary, it is necessary to strengthen networking to take care of the elderly and to care of those with different degrees of incapacity or illness, including at their homes.3 The Ministry of Health (MS) defines Home Care (HC) to the elderly as:

A set of actions carried out by an interdisciplinary team at the user/family’s home, based on the diagnosis of the reality surrounding it, of its potentials and limitations. They provide promotion, prevention, diagnosis, treatment and rehabilitation, thus favoring the development and adaptation of their functions in order to restore their independence and to preserve their autonomy.4

The process of HC directly relates to the aspects regarding the family structure, the home infrastructure and the structure offered by the services for that assistance. When analyzing HC as a modality of care in the Unified Health System (SUS), it is in the process of incipient implantation, characterized by a set of services that do not use common and agreed indicators and parameters.5

One must consider the specificities inherent to home care for the elderly, first with respect to the care space the home becomes, and, secondly, the involved actors who tend to have a more lasting and conflictive relationship since it involves three entities responsible for the health-sickness process: the elderly, the family/carer and the health professional.6

Therefore, due to the importance of organizing home care for the elderly and the family in the FHS, increasing the integrality in health care and changing the practice of professionals, with emphasis on the large number of elderly and family/caregivers who do not feel supported by the health system/team, this study aims to analyze the organization of care in the Home Care of the Family Health Strategy from the perspectives of the elderly and professionals.

This study is relevant considering the need to improve the access and quality of the actions and services of the FHS, such as the HC for the elderly, due to the increasing demand of users for that modality of service and the insufficient support offered by the teams to the families facing elderly people who depend on care at home.

METHOD

Exploratory study, of quantitative-qualitative approach. The study field was the FHS of the municipality of Sobral (CE), Brazil, composed by 34 Family Health Centers (FHC) and four health macro areas.

Recognizing the large amount and diversity of territories of the FHS of Sobral, intentional sampling was used, choosing as the selection criterion the macro area that had the largest number of elderly according to the Basic Attention Information System (SIAB) from 2013. Thus, this research was carried out in the territories of macro area II, including six FHCs of the municipality's headquarters. The collection of information occurred from September 2014 to March 2015.

The subjects of the research consisted of the health professionals who make up the minimum FHS team: physician, nurse, nursing assistant or technician and Community Health Agents (CHA), and the elderly who receive HC by FHS teams. Thus, 28 professionals from the minimum FHS team participated, being four nurses, one nursing assistant and 23 CHA.

There was inclusion of the elderly aged from 60 years and physical difficulty or impossibility of locomotion to the health unit, totaling 62 subjects.

The semi-structured interview and the focus group were the techniques chosen in this study to collect the information. The interviews were carried out at the elderly’s household, identified from the FHS, and used...
RESULTS AND DISCUSSION

Characteristics of HC at the FHS of Sobral-CE from the perspective of the attended elderly

Initially, there was a tabular description of the main characteristics of the operationalization of HC in the FHS of Sobral, according to the perspective of the attended elderly.

Table 1. Characteristics of Home Care performed by the Family Health Strategy according to the attended elderly. Sobral (CE), Brazil, 2015.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Quantity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up time (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>1 - 5</td>
<td>36</td>
<td>58.1</td>
</tr>
<tr>
<td>&gt;5</td>
<td>11</td>
<td>17.7</td>
</tr>
<tr>
<td>&gt;10</td>
<td>10</td>
<td>16.1</td>
</tr>
<tr>
<td>Frequency of Home Visits (HV)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly</td>
<td>8</td>
<td>12.9</td>
</tr>
<tr>
<td>Biweekly</td>
<td>9</td>
<td>14.5</td>
</tr>
<tr>
<td>Monthly</td>
<td>23</td>
<td>37.1</td>
</tr>
<tr>
<td>Bimonthly</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Quarterly</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Biannual</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Annual</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Undefined frequency</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Uninformed</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>HV Duration Time (minutes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 15</td>
<td>8</td>
<td>12.9</td>
</tr>
<tr>
<td>15 - 30</td>
<td>26</td>
<td>41.9</td>
</tr>
<tr>
<td>30 - 45</td>
<td>18</td>
<td>29.0</td>
</tr>
<tr>
<td>45 - 60</td>
<td>6</td>
<td>9.7</td>
</tr>
<tr>
<td>Unperformed</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Uninformed</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Professionals who perform the HV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>41</td>
<td>66.1</td>
</tr>
<tr>
<td>Nurse</td>
<td>37</td>
<td>59.7</td>
</tr>
<tr>
<td>Community Health Agent (CHA)</td>
<td>52</td>
<td>83.9</td>
</tr>
<tr>
<td>Nursing assistant and/or technician</td>
<td>10</td>
<td>16.1</td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>35.5</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>62</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 1 shows that the FHS inserted several elderly in the HC in the last five years, evidencing a growing demand for that mode of care. Furthermore, the FHS team have followed up other elderly people at home for more than 10 years, which reflects the importance of longitudinal care and efficacy of care. Most HVs have an average duration of 15 to 30 minutes, a monthly frequency and are performed mainly by CHA, physicians and nurses, following the MS recommendations.

In some cases, there is no defined frequency for the performance of the HV or they are done with a large interval of time, which can compromise the quality of care and consequently the health status of the elderly. The elderly’s family and caregiver need...
greater support from the health team to perform the agreed care. The home visit is a necessary tool in the FHS, which is essential for the accomplishment of integral care; however, it is not performed with the frequency necessary for an effective follow-up.

There is little participation of nursing assistants and technicians during the HV. Nevertheless, it is necessary to consider that many users, especially the elderly, cannot accurately differentiate the members of the nursing team, considering all of them as nurses. It is important to emphasize that more than one third of the HV counted on other professionals besides the minimum team required, reinforcing the support of other services for the FHS.

The care given to the elderly in a condition of dependency is an activity that leads to changes in the life of the caregivers, which can generate physical, emotional and social stressors. Nursing, as an essential element of the FHS, must be attentive to the health needs of the dependent elderly, as well as closer to the caregivers, in order to guide them, and to follow the care performed, in order to offer comprehensive care support, that is, to the elderly and their family.

The inadequate articulation of the responsibilities of the elderly, caregivers and health professionals, the fragmentation of care and the lack of communication between health professionals and the community can contribute to the hospitalization of the elderly in home care. There is need for an explicit agreement on roles and responsibilities and coordination between all caregivers of an elderly person at home.

The professionals' perspective on the organization of HC to the elderly in the Family Health Strategy of Sobral - CE

Based on the professionals' discourse, one sought to describe the organization and the work process of HC to the elderly in the framework of the FHS of Sobral-CE. The first contact occurs when the family brings the demand for the service, in which the team seeks to organize the Home Visit (HV), a tool to evaluate the health status and the needs of the elderly, elaborate a care plan, Unique Therapeutic Project (UTP) or conduct referrals to other professionals of the Health Care Network (HCN), in order to keep a close relationship with the elderly and the family. This first contact can also occur with the family's search for the CHA, due to his/her proximity to the territory, bringing the demand for HC to the team, generating the communication, to the nurse responsible for that area, who seeks to know the case and, depending on the need, mobilizes the doctor, in an attempt to solve the elderly's health problem. If the minimum team does not obtain a satisfactory result, a care plan is created to take the professional category to the home that can contribute to the needs of the elderly and the family, including the Family Health Support Center (FHSC) and the Program Best at Home.

According to the Ministry of Health, identifying an elderly person who needs home care in Primary Care (PC) comes from his/her clinical situation, along with the degree of functional loss and dependency to perform the Daily Life Activities (DLA). Those users can be identified in the following ways: hospital or home discharged, through CHA visits and at the request of the user, family, neighbors, hospital, among others.

Regarding job demand, the greatest demand is for the medical professional, followed by the physiotherapist, social worker and nutritionist, and there is the importance of those professionals in the follow-up of the elderly at home, since they are patients with chronic diseases and health problems. The team recognizes that those patients require not only a sporadic home visit, but a systematic home-based care according to their needs and the team's ability.

In this sense, the CHAs perform the HVs monthly and, according to the patient's health status, the HVs can become constant. In some health units, the nursing assistant or technician perform weekly or monthly visits to verify the elderly's vital signs and, if there is any alteration, he/she communicates the nurse responsible for that family, who also performs a HV to evaluate the health status of the elderly and develops a care plan. A nurse also reported a transfer of the patient's case to another professional of the multidisciplinary team without previous evaluation, simply passing on the information obtained from the CHA or the nursing assistant or technician.

Thus, the nurse evaluates the domiciled elderly, on average, every three or four months, although the teams wish a monthly evaluation. The nurse performs home care through the Hypertension and Diabetes Program (Hiperda), prescribing medications as established for patients with those pathologies, in addition to requesting laboratory tests when necessary. Since there is need to renew medical prescriptions every six months according to the program, medical
visits are held every six months or in case of an intercurrence.

Therefore, it is necessary to reflect on the role of nurses as caregivers and supervisors of the work of CHAs, nursing assistants and technicians, following the guidelines provided to families, also the performed procedures, especially in the elderly population with functional impairment.

The relationship of the nurse with the elderly and the family needs to play a central role throughout the care process. The relationship is both the context of all care as a therapeutic tool. Nurses construct and rebuild the evaluation and adapt interventions to the health-disease situations that are being confronted.

The process of caring for the elderly with some type of dependence also interferes in the quality of life of caregivers. Thus, nursing must effectively participate in care for the elderly and his/her caregiver, guiding in relation to appropriate behaviors, avoiding evolution of the dependency. It is also noteworthy the referral of caregivers to health services so that he/she receives the necessary support.

Nursing care provided in other out-of-hospital settings and focused on healthy people helps reduce the caregiver's overburden, requiring the nurse's permanent support. The decrease in the caregivers' overload and the increase in the families' functionality degree can be reached after identifying the caregiver's role, strategies of self-care, strategies to provide quality care, intra-family conflict management, communication, relaxation and care skills.

When reporting the team work process in the context of HC, professionals reinforced the issue of orientations to caregivers and the elderly seeking the qualification of care through enlightenment, the construction of multiprofessionality according to the elderly's need, the importance of returns, feedbacks among the professional categories for the continuity of care and the realization of the HV without prior notice to the families, seeking to observe the daily structure of the family and the care provided to the elderly. In that sense, if families had greater assistance from health professionals, regarding emotional support, caregiver overload, and teachings about their relative's illness, relationships would be firmer, with less friction, and there would be greater participation in the health-disease process experienced by the elderly.

The promotion of quality in home care for dependent elderly people relies on fostering partnerships, including nurses, patients and their families, and among the multidisciplinary care team. Thus, the FHS teams of Sobral were concerned with the construction of multiprofessionality according to the elderly's need, reinforcing the importance of communication and the contribution of professional categories to the integrality of care, especially with the implementation of UTP for the most complex cases.

The Unique Therapeutic Project is a set of proposals for articulated therapeutic behaviors, for an individual or collective subject, the result of the collective discussion of an interdisciplinary team, with matrix support, if necessary. The UTP contains four moments: diagnosis, goal setting, division of responsibilities and reassessment.

The FHS teams need to carry out a systematic care follow-up of the elderly and the family, with supervision, agreement of objectives, goals and attributions among the involved ones so that the family resumes the caregiver role, relying on the help of the health system.

**CONCLUSION**

Given the exposed, it is important to reinforce the role of the FHS teams in the training and supervision of caregivers, since the professional will only gain the autonomy of family care when the caregiver is incorporated into the work process of the teams, taking into account ethical and legal issues in home care, since many activities require scientific knowledge and the staff simply teaches and delegates them to the family.

It is necessary to reflect on the actions called home visit, because that tool of the FHS needs a construction. In order to determine a HC, it needs some characteristics such as periodicity, objectives, professionals and well-defined actions for structuring a care plan. There was also need to increase the frequency of nursing team evaluations.

Finally, this study provided a diagnosis of HC to the elderly for the health system of Sobral and brings some contributions to the management of the FHS, such as the need to sensitize professionals, especially nurses, about the relevance and specificities of home care for the elderly and caregiver/family.

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