ABSTRACT

Objective: to describe the experience of the implementation of a pioneering service of hospital discharge guidance in the state health network. Method: this is a descriptive study, experience report type, about the implementation of the discharge guidance service at the Albert Schweitzer State Hospital (HEAS), located in the city of Rio de Janeiro, Brazil. Results: this service started in May 2010 and one of its goals was to decrease hospital readmission due to conditions related to primary care. Through the experience of the service operation, a significant reduction in hospital readmissions was observed, as well as the continuity of the treatment started in the hospital and followed at home after specific guidance given by the multidisciplinary team. Conclusion: thus, it can be empirically concluded that the aim of the service was fulfilled. However, a quantitative assessment is required in order to describe the reality observed by nurses at this service. Descriptors: Hospital Readmission; Discharge Planning; Services Structure.

RESUMO

Objetivo: descrever a experiência da implementação de um serviço pioneiro de orientação de alta na rede estadual de saúde. Método: estudo descritivo, tipo relato de experiência, sobre a implementação do serviço de orientação de alta do Hospital Estadual Albert Schweitzer (HEAS), localizado no Município do Rio de Janeiro, Brasil. Resultados: esse serviço foi iniciado em maio de 2010 tendo como um dos objetivos diminuir a readmissão hospitalar por causas sensíveis da atenção primária. Pela vivência do funcionamento do serviço observou-se a sensível diminuição das readmissões hospitalares e a continuidade do tratamento iniciado no hospital e seguido no domicílio após orientações específicas pela equipe multidisciplinar. Conclusão: assim, pode-se concluir empiricamente que o objetivo do serviço foi atendido; no entanto, é necessária uma avaliação quantitativa para descrever a realidade observada pelas enfermeiras do serviço. Descriptores: Readmissão Hospitalar; Planejamento da Alta; Estrutura de Serviços.
INTRODUCTION

The principle of completeness of the Unified Health System (UHS) aims to organize health policies and services articulating promotion, prevention, treatment and rehabilitation through the integrated actions of health services. This way, expanding the notion of completeness, there is the proposal for two dimensions centered on health needs. The first, “focused completeness”, reflects the multidisciplinary team effort spatially located in health services (Basic Health Unit, Family Health Program, Hospital). In the second dimension, “macro completeness” is proposed, which entails articulations of each health service with a more complex network of services and institutions, not necessarily in the “health sector”.

The search for completeness is linked to the proposal for humanization. According to the Ministry of Health, it is the reorganization of work processes, workers’ training and qualification, guarantee of users’ rights and citizenship through the control and participation of the population and also the implementation of practices based on completeness.

In view of this context, seeking to improve quality and the integration, and taking the needs of the population into account, a pioneering service of discharge guidance for patients admitted in the state health service was created in May, 2010. In this service, at the moment of discharge, users are referred to the service and guided by a multidisciplinary team. The aim is to optimize domiciliary care. In addition, users are referred to medical follow-up in the primary care network in order to continue the treatment started during hospitalization.

The discharge guidance service arose from the need to reduce hospital readmissions. Although there were no studies on the hospital unit, reality showed that many patients were readmitted for treatable causes at primary level of health care. As a nurse of the medical unit, I witnessed several readmissions by the same previous diagnoses. Moreover, there was the difficulty of planning the discharge assistance due to the lack of human resources in the nursing area. Consequently, after the articulation of the unit manager with health representatives of the city, it was opted for the establishment of this service. It works outside the hospitalization sector, on the ground floor of the hospital. The aim is to guide users on domiciliary care, thus preventing the worsening of diseases by promoting health and the rehabilitation of the patients.

OBJECTIVE

- To describe the experience of the implementation of a pioneering service of hospital discharge guidance in the state health network.

METHOD

This article was drawn from the dissertation “Analysis of effectiveness of the post-discharge guidance service of a state hospital in Rio de Janeiro” submitted to the Healthcare Science Master’s Program of the Aurora Afonso Costa Nursing School, Fluminense Federal University (UFF). Niteroi, RJ, Brazil. 2012.

This is a descriptive study, experience report type, about the implementation of the discharge guidance service in the Albert Schweitzer State Hospital (HEAS), located in the city of Rio de Janeiro. This is a large unit that belongs to the State Civil Defense Department network (SEDEC). Currently, its service orientation is supported by the embracement and risk classification policy, for moderate and high risk conditions (yellow and red standards).

The HEAS offers emergency care in the following areas: medical clinic; orthopedics; pediatrics; maternity care; nursery; intensive therapy unit for adults and children; dentistry; and general surgery. Generally, these services lead to hospitalization in clinics, which generates distress, anxiety, uncertainty and misinformation for the patients and their families, among other disorders. The following question then arises: How to change or at least minimize this situation? The UHS National Policy for Humanization of Health Care and Management believes in the inseparability between: ways to produce health and ways to manage work processes; health care and management; clinic and policies; and health production and subjectivity production. This policy aims to bring innovations in managerial practices and health production practices; proposing the challenge of overcoming limits and the attempt to try new ways of service organization and new methods of power production and circulation to the different teams involved in these practices.

Working with the principle of transversality, HumanizaSUS uses tools and arrangements to consolidate networks, links and the co-responsibility among users, workers and managers. By directing strategies...
and methods of articulation of actions, knowledge, and subjects, it is possible to effectively enhance and guarantee integral, efficient and humanized health care.3

**DISCHARGE ROOM PROJECT**

In view of this approach, the General Director of the HEAS launched a proposal to the representatives of the multidisciplinary team. This suggestion consisted in developing and creating a place where family members and users, at the time of admission, had contact with a multidisciplinary team. This team consists of nurses, a psychologist, a social worker, a physiotherapist, and an administrative officer. This measure aims to embrace users and family members and inform them about the hospital routine. When the patients are discharged, these professionals will complement the guidance already received during the hospitalization period. In case ambulatory care appointments are required, the service will be scheduled by the system of vacancies regulation of the state (SISREG). Subsequently, the patients will be informed about the doctor's appointment and a relative will be summoned to the discharge room in order to retrieve the referral form.

This new service promotes the strengthening of health system networks, the humanization process and the establishment of new arrangements and sustainable pacts. Workers and managers will be involved, which will lead to innovations in health care and management activities.

In order to serve this clientele, the service works from Monday to Sunday during the day shift, in which all discharges are concentrated. The service offers highly-skilled professionals from the fields of nursing, social work, physiotherapy, psychology, in addition to an administrative technician trained to use the system of vacancies regulation in the city of Rio de Janeiro. These professionals act in an interdisciplinary way in order to discuss the health conditions of each user and proceed jointly suiting every need for the reality exposed.

**Service goals**

- The goals of the service that stand out are: continuity of treatment after discharge; reduction in the recurrence of hospitalizations; effectiveness of referrals; and co-responsibility of the users and their family members in the treatment process.

- **Activities developed**
  
  Guidance activities are performed at admission and discharge. These specific activities include:
  
  - At admission: providing guidelines to family members by offering a brochure with information about the routine and rules of the institution.
  
  - At discharge: providing guidance with respect to the procedures relevant to each case. In cases of ambulatory care treatment, patients will be referred to the city health network through the SISREG. Patients will be advised to acquire free medicines or directed to a low-cost pharmacy.
  
  - Guidance provided by the multidisciplinary team according to its specificity.

- **Logistics**

  For the service to work the following material resources are used: a room; tables; chairs; a computer; a telephone line; an air conditioning unit; cabinets; printed material of the service; and a printer. The human capital consists of: a nurse; a psychologist; a social worker; a physiotherapist; and an administrative officer, with a professional of each area working on each day of the program.

- **Financial funding from the UHS**

  Financial funding has not been enforced yet, because the service is still being adjusted. Once these adjustments are performed by the billing department, services such as appointments with the areas that record the service in printed material will be paid. The value will be determined by the ambulatory care reference table of the UHS.

**FINAL CONSIDERATIONS**

A total of 1,318 users have already been assisted at this service since its implementation until September 2010. Therefore, it is observed that the demand has been increasing and the need for the service assessment has been growing.

By creating this new service, it was possible to observe that the practices developed have contributed to promote better home care for patients discharged. As a result, the number of readmissions due to conditions related to primary care has decreased. These readmissions represent a set of health problems in which the effective action of primary care would lower the risk of hospitalization through simple measures of health education and medical follow-up in the primary care network.4 However, it was not
possible to find indicators with this data in order to demonstrate the reality observed. This fact led to a research project approved by the Research Ethics Committee under the No. CAAE: 0268.0.258.000-11, which is being carried out aiming to analyze the implementation of this service, searching for indicators that prove its efficacy.

Furthermore, it is important to point out that, in a worldwide context, there is the constant concern with readmissions because they are expensive, both financially for the health system and emotionally for the patients. The search for alternatives to minimize these inconveniences may be useful to reduce costs and improve the quality of health care provided in health services.

REFERENCES


