



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

HOME VISIT AND HEALTH EDUCATION, PROMOTION OF QUALITY OF LIFE IN ONCOLOGY PATIENTS

VISITA DOMICILIAR E EDUCAÇÃO EM SAÚDE, PROMOVENDO QUALIDADE DE VIDA EM PACIENTES ONCOLÓGICOS

VISITA DOMICILIARIA Y EDUCACIÓN PARA LA SALUD, PROMOViendo LA CALIDAD DE VIDA EN PACIENTES ONCOLÓGICOS

Marina Gomes dos Santos¹, Patrícia dos Santos Claro Fuly²

ABSTRACT

Objective: to discuss the importance of health education as a tool for improving the quality of life of oncology patients. **Method:** participant research with simple descriptive approach, conducted with 30 patients of the female, male and hematology clinic. The data were collected through home visits and periodic telephone follow-up and subjected to content analysis. The research project was approved by the Committee of Ethics in Research, under certificate CAAE: 0391.0.258.000-11. **Results:** after the completion of the home visits, in which health education actions were implemented, it was possible to observe: reduction of nausea; improved appetite, mood and sleep quality; and enhanced willingness to perform daily life activities and self-care. **Conclusion:** on the basis of the results achieved, it is possible to infer that the actions performed were appropriate, since they provided quality of survival to the participants through the reduction of suffering and increased comfort. **Descriptors:** Nursing; Home Visit; Health Education; Cancer.

RESUMO

Objetivo: discutir a importância da educação em saúde como ferramenta para melhora da qualidade de vida de pacientes oncológicos. **Método:** pesquisa participante, com abordagem metodológica do tipo descritiva simples, desenvolvida com 30 pacientes da clínica médica feminina, masculina e hematológica. Os dados foram colhidos através de visita domiciliar e acompanhamento telefônico periódico e submetidos a análise de conteúdo. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE: 0391.0.258.000-11. **Resultados:** após a realização das atividades de visita domiciliar, em que foram implementadas ações de educação em saúde, obteve-se: redução de náuseas; melhora do apetite, humor e sono; e melhor disposição para a realização de atividades de vida diária e autocuidado. **Conclusão:** com base nos resultados alcançados, é possível inferir que as ações desenvolvidas foram pertinentes, uma vez que propiciaram aos participantes uma sobrevivência de qualidade por meio da redução do sofrimento e aumento do conforto. **Descritores:** Enfermagem; Visita Domiciliar; Educação em Saúde; Câncer.

RESUMEN

Objetivo: discutir la importancia de la educación para la salud como una herramienta para mejorar la calidad de vida de los pacientes oncológicos. **Método:** investigación participante, con enfoque metodológico descriptivo simple, llevada a cabo con 30 pacientes de la clínica médica femenina, masculina y hematológica. Los datos fueron recogidos mediante visitas domiciliarias y seguimiento telefónico periódico y sometidos a análisis de contenido. El proyecto de investigación fue aprobado por el Comité de Ética en la Investigación, con el certificado CAAE: 0391.0.258.000-11. **Resultados:** después de llevar a cabo las actividades de visitas domiciliarias, en las que fueron implementadas acciones de educación para la salud, se observó: reducción de náuseas; mejora del apetito, estado de ánimo y calidad del sueño; y mejor disposición para la realización de actividades de la vida diaria y autocuidado. **Conclusión:** con base en los resultados obtenidos, es posible inferir que las acciones desarrolladas fueron apropiadas, ya que proporcionaron a los participantes una supervivencia de calidad a través de la reducción del sufrimiento y aumento del confort. **Descritores:** Enfermería; Visita Domiciliar; Educación para la Salud; Cáncer.

¹Nurse, Aurora de Afonso Costa Nursing School, Fluminense Federal University (EEAAC/UFF), Niterói, RJ, Brazil. E-mail: marinagsantos@gmail.com; ²Nurse, PhD. in Nursing, Aurora de Afonso Costa Nursing School, Fluminense Federal University (EEAAC/UFF), Niterói, RJ, Brazil. E-mail: patriciafuly@enf.uff.br

INTRODUCTION

Over the years, the population and health professionals have become increasingly reflective with regard to the type of healthcare provided in the hospital environment. Generally speaking, this healthcare offers a technician and decontextualized approach toward users' life history. Therefore, there is a need for health actions oriented to a more humanized practice.¹ The implementation of management models in health services is essential. These models should be focused on users care, with actions aimed at the promotion, protection and recovery of health, mainly in low and medium complexity health units. Thus, it becomes necessary to reverse the hospital healthcare model—which is still hegemonic—in order to provide comprehensive and equal healthcare assuring autonomy and quality of life to those needing healthcare.^{2,3}

Home visits are an out-of-hospital follow-up strategy that aims to provide healthcare to families and the community. The two latter are understood as entities that influence individuals' processes of becoming sick, since they are governed by the relationships established in the contexts in which they live.⁴ Home visits do not only represent a space for recognition of health and socioenvironmental conditions, but also for health education, in which the relevance of the educational guidelines that can be shared during the visit stand out.

Health education is defined from the way people live and understand life, their values and beliefs. This practice is used by nursing as a means for establishing a dialogic-reflexive relationship between nurses and clients, in which the latter can be aware of their health-disease condition and perceive themselves as subject in the transformation of their own lives.^{5,6} It is an instrument for the promotion of quality of life, linking technical and popular knowledge, surpassing the healthcare biomedical conceptualization and covering multi-determinants of the health-disease-healthcare process. This way, health education should be understood as a complex process that links a set of knowledge and diverse practices in order to provide the highest health level.

Health education in the home environment, particularly offered to oncology patients, represent a strategy for the identification of extrinsic factors (tobacco, alcohol, inappropriate eating habits, physical inactivity, and socioeconomic status, among others) and intrinsic factors (age, sex,

ethnicity or race, and genetic inheritance). These factors affect the general health of these individuals and contribute to the reduction of comfort and quality of life. Their identification allows the nurses—in partnership with the individuals and family members—to perform modifications that will be significant for the increase of patients' well-being.

In this way, it is essential to take home healthcare into account in its various actions, i.e., providing health guidelines, educational assistance, and more humanized healthcare, among others; aiming at the promotion and maintenance of health. At the same time, this type of healthcare allows the individuals to stay at their homes, which ultimately give them better quality of life. As a result, in many cases it enables faster improvement, greater comfort or even a more worthy end of life.

Nursing Care Systematization (NCS) is a working method that aims at improving the quality of nursing care. It is performed in the home environment as a way to ensure a qualified and optimized healthcare and best therapeutic adhesion, thus obtaining better results. Consequently, there are fewer incidences of complications and better quality of life in patients and/or family members. It is a scientific basis for carrying out nursing practices, because it allows nurses to take into account their patients individually, in a humanized and holistic manner.

The Ordinance No. 358/2009 of the Federal Nursing Council (COFEN), which provides for the NCS and the implementation of the Nursing Process in private or public environments in which nursing professional care takes place, complements the above mentioned. According to the Article 2 of this document, the Nursing Process is organized in five interrelated, interdependent and recurring steps, namely: data collection (or nursing history); nursing diagnosis; planning; implementation; and evaluation.¹²

Article 3 states that:

The Nursing Process must be based on a theoretical support to guide data collection, the establishment of nursing diagnoses and planning of actions or nursing interventions; and that provides the basis for the evaluation of nursing results achieved.

The use of nursing taxonomies aims to provide dynamic interaction during the performance of the Nursing Process, namely: classification systems of nursing diagnoses (North American Nursing Diagnosis Association - NANDA); classification of nursing interventions (Nursing Interventions

Classification - NIC); and classification of nursing outcomes (Nursing Outcomes Classification - NOC). The classification systems provide standardized language used in the process and the product of reasoning and clinical judgment about the human responses to health problems and vital processes. This way, these systems facilitate the detection, intervention and evaluation of healthcare according to the problem presented by the individuals, organizing and guiding nursing actions toward the individual needs.¹⁴

The Nursing Process is based on a systematic healthcare method. It refers to an action performed in systematized terms. It is an organized, planned and scientific work in which the four dimensions of nursing are met: teaching; performing; researching; and providing healthcare.¹³

The focus of nursing care is individuals' well-being and self-fulfillment. It is assumed that nurses do not make individuals become healthy with their diagnoses and interventions; individuals themselves become healthy by means of their own behaviors. This way, in order to foster changes in behaviors that influence health, individuals and nurses together identify the most accurate diagnoses with potential to guide nursing care, so that positive results are achieved. Nursing interventions concerning the diagnoses of human responses offer additional resources beyond the treatment of medical conditions, from which individuals' health can be promoted, protected and recovered.¹⁰

OBJECTIVE

- The goal of this study is to discuss the importance of health education as a tool for improving the quality of life of oncology patients.

METHOD

This is a participant research with simple descriptive approach, characterized by the relationship between the researchers and the subjects studied. The study was initially conducted with the assessment of potential clients admitted at the Antônio Pedro University Hospital (HUAP). The goal was to recognize possible subjects for performing follow-up in the home environment after hospital discharge. The research included a sample of 30 patients, of which five (16.6%) had been treated at the Hematology Clinic.

In order to participate in the research, the subjects had to meet the following eligibility criteria: domicile; living in the cities of Niterói or São Gonçalo; age equal or greater than 18 years old; being capable to perform

self-care; and agreeing to participate in the study, with consequent signing of an informed consent form.

The participation in the research was exclusively voluntary, as specified in the informed consent form. This document was delivered to the patients and/or guardians and they signed it before the start of the research. In this way, every patient or guardian might refuse to participate or discontinue/exclude their participation in the research at any time, without any kind of prejudice or cost to the patients and/or their family members, and all the data collected would be readily excluded from research.

The data were collected through home visits and periodic telephone follow-up and, subsequently, subjected to content analysis. This analysis technique aims to show the frequency, presence or absence of certain characteristics assessed by the researcher, such as risk factors and health social determinants, so that the influence of these factors on quality of life of oncology patients can be identified.

The data were analyzed statistically through their variables and the characteristics of the elements studied—which vary from element to element—and numeric or non-numeric values were attributed to these characteristics. After the analysis of these data and their validation, the desired information was obtained, which was statistically assessed by means of multivariate analysis aiming at processing the information in order to have it simplified and synthesized.⁷

In compliance with the Ordinance No. 196/96 of the National Health Council, this study was submitted to the Committee of Ethics in Research of the Medical School (HUAP) and approved on 2nd December 2011, under certificate CAAE: 0391.0.258.000-11. An informed consent form was drawn up, delivered, read, and signed by all participants and/or family members/guardians. The research was conducted from January to March 2012, with patients living in the cities of Niterói and São Gonçalo, State of Rio de Janeiro, Brazil.

RESULTS

The patients from the Hematology Clinic that participated in this research were mostly females and with an average age of 55 years. The most frequent medical diagnoses were: lung cancer; breast cancer; skin cancer (melanoma); and acute myelogenous leukemia. The members of this group presented complicating characteristics in their treatments, but which could be previously

understood as risk factors for the development of cancer. These characteristics were: active and passive smoking; alcoholism; sedentary lifestyle; inappropriate eating habits with low nutritional value; stress; and hereditary cancer diagnosis.

On the basis of medical diagnoses and information collected from each individual at the hospital, at home and from subsequent telephone contacts, diagnoses (NANDA) were made, the goals of the care plan were outlined—which allowed its subsequent

evaluation (NOC)—and nursing interventions (NIC) were drawn up. In addition to these items, Table 1 shows the results achieved (NOC).

Nursing diagnoses are intended to the clinical judgment of user, family and community's answers to vital processes or health current or potential problems. With respect to problems, they will provide the basis for the solution of the nursing interventions, achieving the results for which the nurses are responsible.⁸

NANDA	NOC	NIC	NOC
Chronic Pain; Inappropriate nutrition, lower intake than the body needs; Death-related anxiety; Situational low self-esteem; Impaired Comfort.	Management of Pain (3-4); Level of Comfort (2-3); Level of Depression (2-3); Pain Level (2-3); Personal Well-being (2-3); Sleep (2-3); Appetite (2-3); Sensory Function: Gustatory and Olfactory (2-3); Severity of Nausea and Vomiting (2-4); Acceptance: Health State (3-4); Self-control of Anxiety (3-4); Level of Anxiety (2-3); Psychosocial Adjustment: Life Change (2-4); Self-esteem (3-4).	Management of Pain; Administration of Painkillers; Medicines Management; Nutrition; Control of Eating Disorders; Anxiety Reduction; Maintenance of the Family Process; Improved Self-esteem; Increased Socialization; Improved Body Image; Improvement of the Roll.	Management of Pain (4); Level of Comfort (2-3); Level of Depression (3-4); Pain level (3); Personal Well-being (2-3); Sleep (3); Appetite (2-3); Sensory Function: Gustatory and Olfactory (2-3); Severity of Nausea and Vomiting (3-4); Acceptance: Health State (3-4); Self-control of Anxiety (3-4); Level of Anxiety (3); Psychosocial Adjustment: Life Change (3-4); Self-esteem (3-4).

Figure 1. Main diagnoses, results and nursing interventions in oncology patients.

It is possible to infer that the actions performed with this group were satisfactory, since, through telephone contacts, it was possible to obtain important information, such as: improved sleep quality, mood and appetite; and enhanced willingness to perform daily life activities, such as hygiene, self-care in general terms and food preparation. It is important to clarify that all changes reported had a low deviation with respect to the initial state. However, any change in this group, even though minimal, was extremely valuable, because it demonstrated that the actions were generating positive results. In addition to the nurses, family members and patients could notice the changes and they felt better and demonstrated satisfaction.

DISCUSSION

When we thought about the guidelines and interventions to be carried out with our patients, it was necessary to understand in advance that people with chronic diseases face permanent lifestyle changes, threats to the dignity and self-esteem, the disruption of normal life transitions, and the depletion of resources. This is a huge stressor that has the potential to let the parties involved (clients and family members or significant persons) disorganized and affected. However, it can also provide an opportunity for greater growth

and cohesion, and nurses—while educators and healthcare professionals—can be a tool orienting clients and families through a path of mutual support and individual autonomy.⁹

Nursing care focused on patients' well-being and self-fulfillment is a *sine qua non* condition. With the aid of nurses' interventions, individuals become responsible for the change in their state of health due to behavioral modifications. These interventions are drawn up on the basis of the NANDA, NOC, and NIC, aiming to achieve positive health results, i.e., promoting, protecting and restoring individuals' health.¹⁰

Nursing is perceived in a space socially shared, and its social commitment unfolds according to the continuity in time and space, making the profession to be recognized. This recognition arises from the development characterized by continuous adaptations to the growing demands of society and these adaptations are based on scientific and technological knowledge. Thus, in the 21st century, nurses' training should envision a continuing acquisition of knowledge in order to perform effectively within the health teams focused on a greater interest, namely patients being cared for by them.¹¹

The major limitations found in this study were the low number of patients admitted at the Hematology Clinic of the Antônio Pedro

University Hospital who fulfilled the eligibility criteria during the period of research, and the difficulty of access to some residences, since they were located in risk areas and/or with complicated access. However, it is essential to understand that the home environment is an excellent space for healthcare, since it allows a greater rapprochement between professionals and users and a greater understanding of patients' reality, thus enabling a more effective and efficient performance in accordance with the needs of each subject.

This study proves to be relevant, because it helps to demonstrate the importance of home visits as a continuation of the treatment initiated in the hospital environment. The role of nurses is essential, because, by means of health guidelines, it provides sufficient information to the individuals in order to understand their health-disease process in its various dimensions. This way, these subjects will be able to be independent with respect to healthcare, thus acquiring autonomy and greater quality of life.

CONCLUSION

The proposed goal was attained, since through home visits and health actions carried out and guidelines provided throughout the research, it was possible to achieve satisfactory results, evaluated on the basis of the changes of habits of life, or even in the willingness for modification and improvement of quality of life and family relationships/links. It was possible to generate closer ties and increase or create a support network for the patients. At the same time, it was possible to extend the knowledge about the pathology that affected every individual, treatments, healthcare, and prognoses.

The materials used provided theoretical foundation to the research and legitimized its relevance, bearing in mind that they show the main medical diagnoses found, nursing interventions, risk factors, and the results achieved. This study relied on a relatively small sample group compared to the total number of patients admitted at the HUAP; however, this sample was sufficient to prove and show the importance of home visits and health education as tools for improvement of quality of life. Nurses are of the utmost importance in order to make these actions effective. They contribute to health promotion, prevention, education, and rehabilitation. At the same time, they encourage self-care, autonomy and family involvement as a way to create or re-establish

family support networks that are essential for sick individuals.

REFERENCES

1. Rehem TCMSB, Trad LAB. Assistência domiciliar em saúde: subsídios para um projeto de atenção básica brasileira. Revista Ciência e Saúde Coletiva [Internet]. 2005 [cited 2011 Apr10];10:231-42, Available from: <http://www.scielo.br/pdf/csc/v10s0/a24v10s0.pdf>.
2. Christovam BP, Isaura SP, Oiveira DC. Gerência do Cuidado de Enfermagem em Cenários Hospitalares: a construção de um conceito. Revista da Escola de Enfermagem da USP [Internet]. 2012 2012 June [cited 2010 Nov 10];46(3):734-41. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342012000300028&lng=en. <http://dx.doi.org/10.1590/S0080-62342012000300028>.
3. Mazza MMPR. A visita domiciliária como instrumento de assistência de saúde. Revista Brasileira de Crescimento e Desenvolvimento Humano [Internet]. 1994 [cited 2011 Apr 10];4(2):60-8. <http://www.revistas.usp.br/jhgd/article/download/38143/40877>.
4. Sakata KN, Almeida MCP, Alvarenga AM, Craco PF, Pereira MJB. Concepções da equipe de saúde da família sobre as visitas domiciliares. Revista Brasileira de Enfermagem [Internet]. 2007 [cited 2010 Nov 12];60(6):659-64. Available from: <http://www.scielo.br/pdf/reben/v60n6/07.pdf>.
5. Alves GG, Aerts D. As práticas educativas em saúde e a Estratégia Saúde da Família. Revista Ciência e Saúde Coletiva [Internet]. 2011 [cited 2012 Apr30]; 16(1):319-325. Available from: <http://www.scielo.br/pdf/csc/v16n1/v16n1a34.pdf>.
6. Souza LB, Torres CA, Pinheiro PNC, Pinheiro AB. Práticas de educação em saúde no Brasil: a atuação da Enfermagem. Revista de Enfermagem da UERJ, Rio de Janeiro [Internet]. 2010 [cited 2012 Apr 30];18(1):55-60. Available from: <http://www.facenf.uerj.br/v18n1/v18n1a10.pdf>.
7. Ponte VM, Oliveira MC, Moura HJ, Barbosa JV. Análise das metodologias e técnicas de pesquisas adotadas nos estudos brasileiros sobre balanced scorecard: um estudo dos artigos publicados no período de 1999 a 2006. Associação Nacional dos Programas de Pós-Graduação de Ciências Contábeis. I Congresso

Santos MG dos, Fuly PSC.

Home visit and health education, promotion...

ANPCONT [Internet]. 2007 [cited 2011 Oct 14]. Available from: <http://www.anpcont.com.br/site/docs/congressol/03/EPC079.pdf>.

8. Rejane MBD, Maria GPA, Mayana CBG, Gabriela MM. Revisão de literatura sobre diagnósticos de enfermagem. J Nurs UFPE on line [Internet]. 2010 [cited 2012 Oct 03];4(esp):1023-30. Available from: http://www.ufpe.br/revistaenfermagem/index.php/revista/article/viewFile/883/pdf_83

DOI: 10.5205/reuol.883-8025-2-LE.0403esp201012

9. Carpenito LJ. Plano de cuidados e documentação: diagnósticos de enfermagem e problemas colaborativos. Tradução Ana Maria Vasconcellos Thorell. -2nd ed. Porto Alegre. Artes Médicas Sul, 1999. 739p.

10. NANDA - North American Nursing Diagnosis Association. Diagnósticos de Enfermagem da NANDA: definições e classificação 2009-2011/ NANDA International; tradução Regina Machado Garcez. Porto Alegre (RS): Artmed; 2010. 456p.

11. Andrea BR, Patrícia PO, Márcia WM, Renata GSB, Priscilla SCO, Paula H. Conhecimento de enfermeiros de uma unidade de oncologia sobre cuidados paliativos. Revista de Enfermagem UFPE online [Internet]. 2012 [cited 2012 Oct 03];6(6):1280-8. Available from: <http://www.ufpe.br/revistaenfermagem/index.php/revista/article/viewArticle/2453> DOI: 10.5205/reuol.2365-18138-1-LE.0606201203.

12. Brasil. Resolução nº. 358, de 15 de outubro de 2009. Dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de Enfermagem, e dá outras providências. Brasília, DF: COFEN [Internet]. 2009 [cited 2012 Oct 15]. Available from: http://novo.portalcofen.gov.br/resoluco-cofen-3582009_4384.html

13. Cartilha - SAE. Sistematização da Assistência de Enfermagem. Conselho Regional de Enfermagem de São Paulo (COREN-SP), 2008. 12p.

14. Chianca TCM, Rocha AM, Pimentel MO. Sistematização da Assistência de Enfermagem e o Sistema único de saúde. In: Anais do 7º Simpósio Nacional de Diagnósticos de Enfermagem; Belo Horizonte (MG), Brasil; 29 abr - 1 maio; 2004. Belo Horizonte (MG): ABEn; 2004. p. 24-52.

Submission: 2012/11/16

Accepted: 2014/01/29

Publishing: 2014/04/01

Corresponding Address

Marina Gomes dos Santos
Rua Doutor Constantino Nami Kalil, 179
Bairro Santa Rosa
CEP: 24240-800 – Niterói (RJ), Brazil