Dehospitalisation at a general hospital in Minas Gerais: challenges and prospects

A desospitalização em um hospital público geral de Minas Gerais: desafios e possibilidades

Desinstitucionalización en un hospital general público de Minas Gerais: retos y posibilidades

Kênia Lara Silva[a]
Roseni Rosângela de Sena[a]
Wesley Souza Castro[a]

ABSTRACT

Objective: To analyse the dehospitalisation process at a general public hospital in Minas Gerais, Brazil, from the perspective of managers, health workers, users and their families.

Methods: This is a qualitative, exploratory, descriptive study based on the principles of methodological and theoretical dialectics. The participants were 24 hospital health workers and 15 companions of users going through the process of dehospitalisation. Data were collected from April to June 2015 using semi-structured interviews and a field journal records and subsequently subjected to content analysis.

Results: Analysis of the empirical material led to the construction of the following categories: Dehospitalisation: viewpoint of the institution and Family organisation for the dehospitalisation process.

Conclusion: The study reveals a deficiency in the implementation, systematisation, internal reorganisation and continuity of care after dehospitalisation. Current dehospitalisation strategies do not favour comprehensiveness and continuity of home care.

Keywords: Deinstitutionalization. Home care services. Continuity of patient care.

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RESUMO

Objetivo: Analisar o processo de desospitalização em um hospital público geral de Minas Gerais na perspectiva dos diretores, dos profissionais de saúde e dos familiares.

Método: Estudo descritivo e exploratório, utilizando a abordagem qualitativa, com orientação teórico-metodológica da dialética. Participaram do estudo 24 profissionais de saúde e 15 familiares de usuários em processo de desospitalização. A coleta de dados ocorreu entre os meses de abril a junho em 2015, com entrevistas semiestruturadas e registros em diário de campo. Os dados foram submetidos à análise de conteúdo temática.

Resultados: A análise do material empírico permitu a construção das categorias: Desospitalização: perspectiva da instituição e Organização da família para o processo de desospitalização.

Conclusão: Existem fragilidades no processo que envolve questões de implementação, sistematização, reorganização interna e continuidade após a desospitalização. Assim, as estratégias utilizadas para a desospitalização têm sido insuficientes para favorecer a integralidade e a continuidade do cuidado no domicílio.

Palavras-chave: Desinstitucionalização. Serviços de assistência domiciliar. Continuidade da assistência ao paciente.

RESUMEN

Objetivo: Analizar el proceso de desinstitucionalización de un hospital general público de Minas Gerais desde la perspectiva de los gestores, de los profesionales de la salud y de los familiares.

Métodos: Estudio descriptivo y exploratorio de enfoque cualitativo con orientación teórico- metodológica de la dialéctica. Participaron 24 profesionales de la salud y 15 familiares de usuarios en proceso de desinstitucionalización. La recogida de datos se llevó a cabo entre abril y junio de 2015 con entrevistas semiestructuradas y registros en el diario de campo . Los datos recogidos fueron sometidos a análisis de contenido temático.

Resultados: El análisis de los materiales empíricos permitu la construcción de categorías: la desinstitucionalización: Perspectiva institución y organización de la familia al proceso de desinstitucionalización.

Conclusión: Se concluye que en el procesohay fragilidades que involucran cuestiones de implementación, sistematización, reorganización interna y continuidad después de la desinstitucionalización. Las estrategias empleadas para la desinstitucionalización no han sido suficientes para promover la integralidad y continuidad de los cuidados domiciliarios.

Palabras clave: Desinstitucionalización. Servicios de atención de salud a domicilio. Continuidad de la atención al paciente.

[a] Universidade Federal de Minas Gerais (UFMG), Escola de Enfermagem. Belo Horizonte, Minas Gerais, Brasil.

INTRODUCTION

Dehospitalisation is associated with humanisation and hastens home recovery in order to rationalise the use of hospital beds[1-4]. The global trend in home care is being supported by a strategy widely adopted by hospitals through the process of dehospitalisation[2]. Healthcare costs are very high, which forces countries to give priority to hospital beds for acute and decompensated diseases[3].

One of the central axes of home care is dehospitalisation because it hastens hospital discharge and enables continued care at home provided by home care teams[4]. Home care is defined in the Ordinance of the Ministry of Health No. 825, 25 April 2016, as "*a healthcare modality integrated with the healthcare network based a set of actions for the prevention and treatment of diseases, rehabilitation, palliation, and health promotion at home to ensure the continuity of care*"[5]. The actions defined in this normative instrument guarantee the continuity of care within the healthcare network.

The relationship between home care and the hospital network is strategic for dehospitalisation because it allows hospitalised patients to continue their treatment at home in a comprehensive and responsible manner, shortening their length of stay[4]. Dehospitalisation, however, also presents challenges in relation to the caregiver and acceptance of the family. This activity is often voluntary, has no estimated duration, alters family life, and can cause physical and psychological burnout, organisational, personal and collective changes, and negative consequences for the life of the caregiver[4-6].

Considering the importance of dehospitalisation, this article seeks to answer the following question: How does the process of dehospitalisation occur in a public hospital? The assumption is that the hospital, the healthcare network, and the family members should establish mechanisms of coordination and support to ensure the family accepts deshospitalisation more readily.

The purpose of this paper is to analyse the process of dehospitalisation at a public general hospital in Minas Gerais, from the perspective of the directors, health workers, and family members of patients.

METHOD

This is a descriptive, exploratory, qualitative study guided by theoretical and methodological dialectics. Descriptive research allows analysis of the dehospitalisation process in the hospital setting as a social phenomenon involving the institution, users, their families and the healthcare network[7]. The dialectical method was adopted to reveal contradictions in the dehospitalisation process at the hospital, where healthcare workers, users, and family members coexist in a given time and space[8].

The setting was initially selected as one of the scenarios of an inter-institutional research project, of which the results of this paper are a part. The research sector was the medical clinic that receives users from surgery, neurology, intensive care, and the emergency unit of the scenario hospital. The clinical medicine unit was selected because its users have the characteristics required for dehospitalisation and the proposal of the unit is family guidance and user referral to the healthcare network after discharge to continue with home care.

The participants of this study were two directors, two sector coordinators, and 20 workers directly involved in dehospitalisation, either by deciding to discharge or refer patients to the healthcare network. Of these workers, 10 were nurses, two were social workers, and eight were physicians. The workers who were on sick leave or on holidays were excluded.

Fifteen relatives of the users in the dehospitalisation process were also included. The users were not interviewed because most were in an altered state of critical judgment and/or in a situation that lacked privacy for conversation.

The family members included in this study were accompanying users with the following characteristics: receiving care from nurses, physicians, social workers, during a hospital stay that exceeded seven days, over 18 years of age, in a stable condition, referred for continued care at the Home Care Service ("SAD") in Belo Horizonte, and residents in Belo Horizonte. Data were collected at the hospital from April to June 2015.

The data collection instruments were interview and field journal. The interview was conducted by the researcher of this study in a private location, using a semi-structured script. The interviews were recorded to extract any interpretations from the statements of dehospitalisation and expectations of home care. Different scripts were used for the health workers, directors and family members, according to the purpose of the study. The recording produced 6 hours, 10 minutes, and 22 seconds of interviews.

The researcher used the field journal to record daily observations during field work. The field journal contained personal impressions, results of informal conversations, observations of behaviour that contradicted the statements, opinions of the participants on investigated points, and other content.

All participants were notified of the goals and purposes of the studies and signed an informed consent statement. To ensure anonymity, their names were encoded and the

names of the people cited in the interviews were deleted. In terms of encoding, the names of health workers, directors, and sector coordinators were replaced with colours: white (social worker), yellow (sector coordinator), red (physician), blue (nurse) and lilac (director), followed by a number according to the order of the interviews when there was more than a professional by category. For the relatives of users going through the dehospitalisation process, the names were replaced by flowers followed by a number according to the order of the interview.

Data were analysed using the thematic content analysis technique as proposed by Bardin[9]. Thematic content analysis was conducted in three stages, namely pre-analysis, exploration of material, and processing of results[9].

All stages of this research observed Resolution No. 466/2012 of the National Health Council (CNS)[10]. The research was initially submitted to the research ethics committee of the institution of higher education as an addendum of the research project entitled, "*Atenção domiciliar em saúde: efeitos e movimentos na oferta e demanda no SUS*" CAAE: 07698212.7.0000.5149, opinion number: 938.240, and later submitted to the research ethics committee of the hospital that served as the study scenario. This paper is the product of the master's thesis entitled, "*A desospitalização em um hospital público geral de Minas Gerais: início da atenção domiciliar*"[11].

RESULTS AND DISCUSSION

The analysis of the empirical material resulted in the following categories: Dehospitalisation: viewpoint of the institution and Family organisation for the dehospitalisation process.

Dehospitalisation: viewpoint of the institution

This category revealed characteristics of the dehospitalisation process in the studied hospital scenario. Dehospitalisation proved to be a complex process that depends on relations between hospital management, health workers, users, their families, and the healthcare network. Data analysis revealed that, paradoxically, despite efforts to the contrary, dehospitalisation at the institution has weak points in terms of implementing, systematising, and reorganising the internal processes.

The directors and health workers of the institution referred to attempts to establish an institutional policy of dehospitalisation at the hospital. The institution has been building a procedural work system based on how the workers organise themselves to dehospitalise users, the criteria for dehospitalisation, and any difficulties encountered during the process.

So, there is definitely a political intention within the model to implement it, but we still have some weak points in terms of the coverage we can achieve here internally with our users, for a more regular, more stable systematisation of the dehospitalisation alternatives, and that does not only involve internal reorganisation, internal work processes, or preparation fir discharge, etc., but also the responsibility of transferring care to another level (LILAC 1).

There is an institutional disposition to provide a qualified discharge, it is an ongoing discussion that we have. We know who the partners we have are. It´s the Family Health Programme, the NASF [Family Health Support Unit], the PAD [Home Care Programme]. We know who our partners are. We have the contacts, we have a good relationship with the regional network, the next regional unit (LILAC 2).

In the case of a patient with cerebral vascular accident, for example, who has highly specific multi-professional care, we can, for example, prepare discharge internally and organise it with the home care teams of both districts for them to receive the case. So this passage, that transfer of care is steadier, more continuous (LILAC 2).

Data analysis showed that dehospitalisation initiatives seek to provide a safer discharge for professionals, users, and their families. In this respect, literature highlights that the transition from hospital care to primary care requires a connection between the care networks. Moreover, a more effective transition depends on the appropriate referral[12]. Planning a responsible discharge with established criteria favours the continuity care at home[13].

The statements contained information on how the multidisciplinary teams plan and organise dehospitalisation for users. A director and two physicians stated the following:

Yes, every Tuesday, we've got a bed rounds in the morning and everyone discusses the cases on this floor, all of them. Even to assess anything that is pending, tests, all together with nursing with social services and with the coordinator also to help with discharge (RED 4).

We have weekly meetings to discuss all the admitted cases, it's a multidisciplinary meeting with physicians, nurses, social worker, the nutrition team often participates. The team of speech therapists often participates, physical therapy team and we try to put together the missing points (RED 3).

We have weekly meetings with horizontal staff, physicians and other members of the multidisciplinary team who take

care of patients, precisely to assess the stage of treatment of the approached patient, the trends that need to be addressed to streamline discharge safely, and the necessary resources for patients to remain stable at post-discharge and prevent re-admission here (LILAC 2).

The statements reveal the use of criteria for dehospitalisation. The health workers stated they use clinical criteria for the dehospitalisation of users to their homes. The main criterion is the clinical and laboratory improvement of patient health, but each professional establishes conducts to define whether the user is fit for dehospitalisation. Despite attempts to establish clearly defined criteria for certain situations, dehospitalisation lacks explicit criteria and depends solely on a case-by-case analysis.

Criteria, we always work with criteria. But they are not always explicit criteria, that's true. And sometimes we have to instil the criteria for dehospitalisation. But that's not always shared with everyone. I'll give you an example of a criterion that is explicit. My line of care is the elderly with orthopaedic trauma. Some of the admitted patients have internal fractures of the lower limbs, most of them. And my criterion is to discharge patients after they complete a minimal motor rehabilitation programme at the institution. Sometimes that takes a day for one patient and two, three, four days for others, and it requires sitting by the bedside. Take a shower, stand up, walk with a walking aid. So this is a very clear criterion for me. And there are other criteria involving clinical issues that I think need to be assessed on a case-by-case basis. So I cannot explicitly say what their criteria are. Understand? (YELLOW 2)

Well, we use the criterion, the most widely used is the clinical criterion depending on patient health, clinical and laboratory improvement, we consider whether the patient is fit to be released, to be dehospitalised (RED 1).

Yes, the best criteria that we use is mostly whether patients have a family member, whether their clinical condition is good, stable, for them to go home. Because when the patient has a family member present, this family member takes care of them It's much better to discharge patients than to keep them at the hospital, running the risk of getting an infection, and even get worse. But we have patients with a clinical condition that allows them to leave, but there is no family member present and that is our greatest problem. So at the meeting, we try to discuss what we can do, with the opinion of other physicians. (BLUE 4)

Data analysis showed that the aim of the weekly meetings between the health workers at the hospital was to provide quality care to patients by defining diagnoses and professional conduct, and programming the discharge process. Even with these weekly meetings, the definitions of the dehospitalisation process still depend directly on the deliberations of physicians. The field journal contains the following record:

Mobilisation for discharge occurs the day before and on the actual day. Dehospitalisation is a transfer of care and all transfers have the potential for problems. After the interview, the physician said that the moment of discharge is not routinely valued or given the attention it deserves. The discharge model at the hospital is still centred on the physician. The other professionals have to wait for the doctor's order (Journal entry, p. 8, 22/05/15).

The report referred to the contradiction between the current care model at the hospital and other healthcare institutions where decisions are centred around the medical professional. Historically, decisions regarding user conduct are linked to the physician, as the representative of a logic of knowledge and highly specific practices, with a focus on disease and the excessive use of technological equipment and medicines[14].

The main weaknesses identified in the process of dehospitalisation referred to the lack of unanimity with regard to criteria for dehospitalisation among physicians and other professionals, the challenges of preparing for discharge, and the incipient process of training caregivers and family members. Respondents stated that these weaknesses cause uncertainty among the family members regarding home care.

But there are limitations. Both here at the hospital and outside here and here it is not all the professionals we, in the clinical staff so I am not only working from the medical professional viewpoint, but not everyone defends dehospitalisation as the best alternative at times (LILAC 2).

Some patients here, for example, will be discharged, will leave with a tracheotomy and leave with the probe. So the family has to know how to administer medication, if there is any, how to administer the diet. At what time, how it is administered and prepared at home, and then there is the issue of diet. And the matter of physical therapy, the matter of aspiration, how aspiration works, how to remove the tracheotomy plug for washing. I think the patient can't leave here without having a family capable of doing these

things. If the patient has a sore, then there is the issue of nursing, especially the palliative care team, which is of paramount importance at this time. Because they follow up on the matter of the wound, provide guidance, show how to dress it, how to clean it. What to use and so on (BLUE 3).

He learns how to handle the patient in the bath, change of decubitus, bandage. He clarifies any doubts in relation to diet. We set up training with the nutrition team, especially the nutrition nurse, who shows how to feed with the probe. We also schedule physical therapy. Physical therapy teaches the first aspiration for the patient (BLUE 1).

So, that way, the more intensive mobilisation actually happens the day before and the day of discharge. Naturally, the family members find it difficult to understand all the instructions, the flows they must follow, etc. (YELLOW 2)

And we discuss a bit so that in fact treatment is an alliance. It is an alliance between the team and the patient and the family of this patient. So especially in the clinical medicine where patients are very elderly, very dependent there is a huge impact of a structure where there is a family disruption (LILAC 1).

Family members receive guidance at the hospital to provide care to users at home after dehospitalisation regarding care at bath time, change of decubitus, bandages, feeding, caring for the feeding tube, suction, and handling the tracheotomy. Training is provided by the nursing staff, the nutrition team, and the physical therapy team at the hospital.

The professionals showed concern about providing this guidance to the family members before dehospitalisation to ensure the same patient safety level during home care. This conduct implies the participation of all the professionals who provide care to users and contact with their families. Prior training at the hospital is important for home caregivers to ensure the can care for the patient correctly at home[15].

The participants also mentioned difficulties regarding conditions of the families to take care of the users at home. The health workers stated that some users remain at the hospital for several months because their families have financial difficulties, which hinders or prevents them from providing home care.

Difficulties in this process, in my view, the main difficulty is the social problem (RED 4).

It's a lot about the social issue, the patients here at the hospital have, lots of homeless people. A lot of patients faced with a situation of disability that means dependence. And that is difficult for the family to organise, sometimes they don't have the financial resources, they don't have the home structure to receive the user (RED 5).

Now I think the weaknesses are related to the actual difficulties even if they are related to the social issue. You must have seen that even with every effort to dehospitalise, we have patients who stay for 6 months, 8 months, because of the lack of family capacity (LILAC 2).

The social condition of the families is a determining factor in dehospitalisation and continuity of care. Literature reveals that home care can reduce hospital costs, but it can also increase the costs of care in the family, which can impair dehospitalisation[3]. Moreover, in the process of dehospitalisation the caregiver must be an explicit cause for concern. Providing care at home is physically and psychologically draining and can become a burden for the caregiver and the other members of the family. In many situations, dehospitalisation is prevented or delayed because there is no caregiver available to ensure continuity of care at home.

The health team has the critical role of providing psychological support and coping and stress prevention strategies to improve the quality of life of caregivers[16]. Strategies and policies of the institutions and the healthcare and social security network must be able to support the caregiver who is providing continued care at home and ensure the responsible and shared transfer of this care. According to literature, the implementation of services, especially for palliative care, for the patient and caregiver, can reduce burnout, improve the quality of life and mental health of caregivers, and help elaborate family bereavement[17].

In this regard, network-based support is critical for the process of dehospitalisation. According to the collected data, the hospital and other services of the healthcare network are establishing a relationship based on regulatory mechanisms to ensure user referrals.

It is generally the same process, we contact the primary care unit when it is a more complex patient, and will need home care or the home care programme and the actual community healthcare workers, the social service contacts them, that is how it works, it is a decision that the family participates in. The family often gets training here before receiving, taking the patient and that's how I think it works (RED 3).

It is indirect, we don't have direct contact with the physician, physician with the home care programme. It is done through social services, all patients who fit the criteria for

inclusion in the home care programme, we usually signal the social worker, we provide a full report of the case with the patient's comorbidities, the reason for admission. What his sector proposal is, post-dehospitalisation. The social worker contacts the healthcare unit of origin reference of the home care programme. Forwards our report and schedules a first visit, usually in two to three days at most after dehospitalisation (RED 2).

That is a good question. The process here follows the information in the request form, which is standard in the whole municipality. It is even entered into the system. This contact is made eminently via social services. And it's up to the doctor to fill out the form, the home care teams. As the form is brief, they generally recommend that the admission report accompany the referral for the next team to understand the expanded clinical context of the patient. Not only the specific profile for home monitoring that generated this referral. But the flow today is to fill out the form, hand it to the sector supervisor, and the supervisor refers to social services. Social services refer to the referral team according to GIS-based district information. What is the team, the district in which the patient will be inserted. And that does not have more intensive interaction between the team provides care here and the team that will take on the case. It is bureaucratic, with paper, fax (YELLOW 1).

The statements revealed that the relationship needed to ensure dehospitalisation are mostly driven by the social worker who connects the services for referral. This relationship has its weaknesses because of the bureaucratic nature of referring responsibilities. This characteristic reveals a contradiction in the perspective of building a network that can sustain continued care.

Therefore, it is important to stress that the responsibility for hospital discharge is based on transferring care by providing guidelines to users, their family members, and caregivers to ensure the continuity of care, reinforce autonomy, and promote self-care[13]. The institutions, separately, have difficulties achieving their mission and seem to be unable to join forces that should be shared to overcome their greatest adversities[18].

In summary, the findings of this category reveal the intention of the studied hospital to construct institutional policies for dehospitalisation; however, contradictory elements were also detected in terms of how these decisions are made and the challenges of working as a network. Part of the process has the decisive involvement of the caregivers and family members, which is discussed in the next category.

Family organisation for the dehospitalisation process

Data analysis shed light on how the family members organise themselves to provide home care for dehospitalised users, with all the arrangements and difficulties they encounter in this process.

The reports indicated the structural home adjustments, the construction of a social support network, and the day-to-day changes needed for dehospitalisation and the continuity of care at home.

So I put a few bars in the bathroom, to lift the toilet, there is already a support bar for support, to pull. We have already bought the bars to put around the shower (CHERRY BLOSSOM 6).

I know that I will have to do something in the bathroom there. Fix the bathroom there. I have to build a bathroom because he can't walk (VIOLET 4).

I had to adapt the bathroom, knocked down a wall for access with the wheelchair (BROMELIAD 2).

We're thinking about how it will be when he returns home, about putting up those iron bars. The home adjustments and everything, things that we don´t have at home. (IRIS 3).

Just the two of us, the family, as well as living far away, it doesn't help, each one has a problem, so you know how it is, each one comes up with an excuse and so, it´s just my brother and I. The neighbours help a lot, too (DAISY 10).

The home adjustments needed for dehospitalisation can financially burden families and hinder their acceptance of care at home. The field journal contains the following statement of a family member after the interview.

He was doing a small renovation at his father's house. He said that the situation grabbed him by surprise. The family member reported he did not have the financial resources to renovate at that time, but admits it is necessary (Journal entry, p.10, 17/06/15).

One of the greatest challenges for home care is the changes to daily life and work imposed by this form of care. Other studies show that this situation can lead family members to abandon their jobs and forces them to reconcile housework with care, alter hours and the home environment, and encounter difficulties related to leisure[3, 15].

So probably me and my mum we're going to be responsible at least on weekdays. And with the help of my sister of my other two sisters, at night, something like that. We intend, of course, at least when I am at home. When I'm not working I will be responsible for his care. My brother-in-law told me already, for example, to bathe and those things, he's going to drop by to help me carry him (IRIS 3).

Yes, there is. Sometimes my grandmother sometimes even his children (+) help me move him around, holding him (+) change the bandages and (+) the bandages we (+) some we have to buy and some we get from the unit itself (HYDRANGEA 8).

With respect to the care, we are 10 brothers and sisters. Two probably won't participate that such treatment. But the rest everyone will participate somehow, each of use with certain tasks and work days, let[s put it that way. For the mother, the zeal in her care is there (CHERRY BLOSSOM 6).

I take care of her and from Thursday to Saturday it is a neighbour of mine who helps me which is actually my son's aunt, lives on the same block and she helps me. Then I pass the duties to her (TULIP 1).

The results of the study showed that the role of the primary caregiver at home is hard and exhausting, and may interfere significantly with the quality of life of the family[16]. This full-time activity becomes continuous, repetitive, and burdensome due to the impossibility of sharing care with other family members, feelings of impotence toward the person being cared for, lack of formal and informal support, and family conflicts. Moreover, there is some dispute regarding the treatment plan created by the healthcare teams, the users, and the families[19].

The relationship of the family with the home care workers was mentioned in the reports of the families of users in the process of dehospitalisation.

This, I never, we never needed it, but at this time, we will probably need these services of the public health network for the elderly at home, inside the home (IRIS 3).

To tell you the truth they go sometimes, but it is not that frequent. But they go, you know? I think they could go more often. But we also understand that they don't have much time, the demand must be huge. But I always go to the doctor when I need to fill a prescription, if she does go home. I'll have to go there because it looks like she's using a cream now that the tissue necrotised, when the black tissue is gone and it turns red they change it, I think it's a gel, and the follow up is done there. Depending on her length of stay here. It's more, it´s that (BROMELIAD 2).

Look at the health unit. Because she already has a treatment there, and it is mostly the nutritionist who was there, the social worker, too, but doctor not yet (TULIP 1).

What I expect of the unified health system is to get more people to help at the health unit, there in the neighbourhood where he lives you can't rely on visits and the people from the unit (CAMELLIA 5).

We are going to make the request, because we need it because we can´t afford everything, privately, private. So we will use it, yes, whatever we can use. (CHERRY BLOSSOM 6).

According to the statements, the families have problems with acceptance, especially when the patient is dependent, weak, needs a feeding tube, adult nappies, has a tracheotomy, or underwent surgery. These difficulties often reveal that the families are not prepared to assume care at home.

Similarly, according to literature, families feel insecure and afraid of taking over care at home, despite the experience and learning at the hospital[15]. To remedy this problem, the network must provide a network of support to the caregivers and families in the process of dehospitalisation.

In this respect, we can say the following:

"The integration of healthcare with regionalised and integrated networks is an indispensable condition for the qualification and continuity of healthcare and essential to overcome care-related gaps and the rationalisation and optimisation of the available care resources"(20:2760).

Thus, continued care is the responsibility of all the points of healthcare through referrals and contra-referrals[13]. The home care network must be fully articulated to effectively ensure comprehensiveness and continuity of care for users and greater reassurance for families.

In summary, the results of this category resonate with the perspectives of the directors and health workers. The challenges and difficulties of families and caregivers in the process of dehospitalisation are acknowledged and indicative of the construction of institutional strategies for coping. The main features were preparing for discharge, training for caregivers, and attempts to coordinate with the other services of the network. However, these strategies were insufficient to address the dilemmas of family and

caregiver responsibility for the provision of care after dehospitalisation, especially in terms of adjustments, arrangements, and changes required for this new stage.

The process of dehospitalisation proved contradictory since the healthcare system must encourage the pursuit of alternatives to reduce hospital stays and, consequently, diminish the expenses of institutions[17]. However, an "un-"responsible dehospitalisation can be a burden, whether by transferring responsibilities to families that are unprepared or by producing post-discharge complications that can cause re-admission.

Based on the dialectical perspective that guided this study, it is understood that this contradiction should be addressed and discussed in the study scenario and other hospitals to find alternatives that enable dehospitalisation and enhance the continuity and comprehensiveness of care at the hospital and in the healthcare network.

FINAL CONSIDERATIONS

This study shed valuable light on the perception of directors, health workers, and families of users on the process of dehospitalisation, and the proposal of a dehospitalisation policy at the study scenario. The interviews with the health workers revealed how they guide the families and users through dehospitalisation. They also highlighted the lack of appropriate coordination with the home care network to ensure comprehensiveness and the continuity of care at home.

The study assumptions indicated that, to improve family acceptance of dehospitalisation, it is important to establish coordination and support mechanisms between the hospital, the home care network, and the families. Their mechanisms, however, proved insufficient to improve comprehensiveness and the continuity of care at home. The creation of more effective mechanisms and strategies between the hospital and the home care network is recommended for the health workers and families of users to safely and confidently assume the case of users at home. The study scenario is still undergoing a process of implementation, with potentialities and challenges.

The limitation of this study is related to the use of only one hospital, and similar studies should be conducted at other institutions from the perspective of the other services of the home care network, considering the importance of comprehensiveness, continuity of care, and strengthening health professionals, users, and their families for the provision of care at home.

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Corresponding author:
Wesley Souza Castro
E-mail: wesleyenf@yahoo.com.br

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