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Perception of health professionals about shared care between primary care and home care

Percepção dos profissionais da saúde sobre cuidado compartilhado entre a atenção primária e atenção domiciliar

Percepción de los profesionales de la salud sobre la atención compartida entre la atención primaria y la atención en el hogar

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ABSTRACT

Objective: to understand how health professionals perceive the shared care between the teams of Primary Health Care and Home Care Service.

Method: descriptive study, with a qualitative approach, carried out with 17 professionals, in the municipality of Campo Grande, MS. Data were collected from August to October 2019, through semi-structured audio-recorded interviews and submitted to content analysis.

Results: lack of knowledge, lack of qualification, lack of ordering of care and weakness in counter-referral were some of the challenges mentioned for shared care. However, interinstitutional visits, communication, discussion of cases, action planning, were perceived as strategies to carry it out.

Final considerations: professionals perceive that home care is permeated by limitations and weaknesses in relation to the effectuation of shared care between the different health teams.

Keywords: Primary health care. Nursing. Home nursing. Family health. Home care services.

RESUMO

Objetivo: compreender de que modo os profissionais de saúde percebem o cuidado compartilhado entre as equipes da Atenção Primária à Saúde e Serviço de Atenção Domiciliar.

Método: estudo descritivo, de abordagem qualitativa, realizado com 17 profissionais, no município de Campo Grande, MS. Os dados foram coletados no período de agosto a outubro de 2019, mediante entrevistas semiestruturadas audiogravadas e submetidos à análise de conteúdo.

Resultados: desconhecimentos, falta de qualificação, ausência da ordenação da assistência e, fragilidade na contrarreferência foram alguns desafios citados para o cuidado compartilhado. No entanto, visitas interinstitucionais, comunicação, discussão dos casos, planejamento das ações, foram percebidas como estratégias para efetivá-lo.

Considerações finais: os profissionais percebem que a atenção domiciliar é permeada por limitações e fragilidades em relação à efetivação do cuidado compartilhado entre as diferentes equipes de saúde.

Palavras-chave: Atenção primária à saúde. Enfermagem. Assistência domiciliar. Saúde da família. Serviços de assistência domiciliar.

RESUMEN

Objetivo: comprender cómo los profesionales de la salud perciben la atención compartida entre los equipos de Atención Primaria y Servicio de Atención Domiciliaria.

Método: estudio descriptivo con abordaje cualitativo, realizado con 17 profesionales, en el municipio de Campo Grande, MS. Los datos se recolectaron de agosto a octubre de 2019, a través de entrevistas semiestructuradas grabadas en audio y se sometieron a análisis de contenido.

Resultados: las incógnitas, la falta de calificación, la falta de pedidos de asistencia y la debilidad en la contrarreferencia fueron algunos de los desafíos mencionados para la atención compartida. Sin embargo, las visitas interinstitucionales, la comunicación, la discusión de casos, la planificación de acciones, fueron percibidas como estrategias para llevarlo a cabo.

Consideraciones finales: los profesionales perciben que la atención domiciliaria está impregnada de limitaciones y debilidades con relación a la efectividad de la atención compartida entre los diferentes equipos de salud.

Palabras clave: Atención primaria de salud. Enfermería. Atención domiciliaria de salud. Salud de la familia. Servicios de atención de salud a domicilio.

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INTRODUCTION

Home care began in the late 19th century as a practice of North American nurses, and in 1976 it was implemented as a care modality in the United States of America. However, there are records that the oldest organization to provide this type of assistance was located in England, in 1848[1].

In the Brazilian scenario, home care began with the work of visiting nurses to patients with tuberculosis in the mid-1920s[2]. However, the first organized experience of Home Care (HC) only took place in 1949, with the implementation of the Emergency Home Medical Care Service (*Serviço de Assistência Médica Domiciliar de Urgência* - SAMDU)[3]. In turn, in 1994, the Family Health Program (*Programa Saúde da Família* - PSF) was created as a strategy for reorienting health care services through the expansion of Primary Health Care (PHC) in the country, and strengthening the principles of the SUS[4].

It should be noted that, in Brazil, PHC is the main gateway to the Health Care Network (HCN) and is responsible for coordinating care and ordering the actions and services provided by the different points of care. In this context, the PSF, later called the Family Health Strategy (*Estratégia Saúde da Família* - ESF), brought back to the care scenario the valuation of practices such as home visits and gave rise to the creation of the HC, whose services are organized into three levels of care that complement each other. In the first one - HC 1, care must be offered by the Family Health teams (FHt) that work in the PHC, including Primary Care teams (PCt). These can be supported by the Expanded Center for Family Health and Primary Care (Ecfh-PC) (*Núcleo Ampliado de Saúde da Família e Atenção Básica* - Nasf-AB), specialty and rehabilitation clinics[4].

In the second and third level (HC 2 and HC 3), care must be offered with the support of the Home Care Service (HCS) represented by the Multiprofessional Home Care Teams (MHCT) consisting of a physician, nurse, physiotherapist or social assistant and nursing technicians, and the Multiprofessional Support Team (MST), which must have a minimum composition of three professionals, including a social worker, physiotherapist, speech therapist, nutritionist, dentist, psychologist, pharmacist or occupational therapist[4].

However, although the different levels are established, the planning and execution of care actions must be shared between the HCN points, with the PHC as the care coordinator and orderer. It should be noted that the actions developed by the HCS teams do not replace those that must be carried out by the FHt, regardless of the level of care that the patient needs, so that they result in comprehensive, continuous, resolute and quality care[5–7].

In this regard, the question is: how do shared care actions occur between the PHC and HCS teams? Thus, in order to answer this question, this study aims to understand how health professionals perceive shared care between the Primary Health Care and Home Care Service teams.

METHOD

This is a descriptive study, qualitative, and in its elaboration and description of the method, the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ) were considered.

Health professionals of secondary and higher education from two Family Health Units (FHU) participated in this study, one consisting of two teams and the other of four. The services, at the time of data collection, were offered by general practitioners, nurses, dentists, social workers, oral health assistants, nursing technicians and community health agents.

Professionals from a team from the Expanded Center for Family Health and Primary Care (Ecfh-PC) composed by eight professionals and a team of the Home Care Service (HCS) with nine professionals also participated in the research. It should be noted that both teams worked in the same health region, selected for convenience, in a large city in the Midwest region of Brazil.

At the time of the research, the city under study was divided into seven health regions, which consisted of 68 Basic Health Units (BHU), of which 52 were FHU (with 143 FHt and 12 teams from Ecfh-PC). It also had four Regional Health Centers (RHC) and six Emergency Care Units (ECU), including the HCS, which was made up of qualified teams located inside hospitals and in the Municipal Public Health Department.

All health professionals, with secondary and higher education, linked to the teams working in the region selected for convenience, were eligible to participate in the study. The only established inclusion criterion required that they had a minimum of six months of experience in one of the care modalities (FHt, Ecfh-PC and HCS). It should be noted that no exclusion criteria were established.

To access the participants, telephone contact was initially made with a reference professional for the management of each team, to whom all information about the research was provided. And this professional, in turn, undertook to schedule a face-to-face meeting with the team members to present the study theme, objectives, data collection procedure, type of desired participation and invitation to participate the research. For those who could not participate in the meeting, contact was made individually via telephone and WhatsApp application.

Data collection covered the period from August to October 2019, through semi-structured interviews, previously scheduled according to the participant's preference/availability and so as not to interfere with the service routine. The interviews were audio-recorded after authorization from the participant and carried out in a private room at the workplace, being conducted by three research nurses, with no relationship with the participants, and with experience in qualitative interviews. They lasted an average of 30 minutes and only the participant and the interviewer were present.

During the interviews, it was used a script, addressing sociodemographic characteristics and issues related to professional practice and the object under study, and support questions divided into the following axes were also used: 1) offer of HC; 2) team responsibilities; 3) team access to local health facilities; 4) provision of shared care between the teams of the FHU, Ecfh-PC and HCS; 5) performance of shared care with other HCN services; 6) shared care plan; 7) team meeting; 8) aspects that favor shared care in HC.

The search for new information occurred until the moment when the data started to become repetitive and the research objective had already been reached. Subsequently, the interviews were transcribed in full and submitted to content analysis, thematic modality, following the pre-established steps that included pre-analysis, material exploration and treatment of results[8].

In the pre-analysis, the organization, transcription, and separation of the material was carried out, followed by a floating reading of the data set in order to identify aspects related to the objective of the study. Subsequently, from the selected speeches, it was carried out the identification of meaning cores[8], six of which were related to strategies for the realization of shared care, and four, to the challenges for the effectuation of shared care.

In the exploration of the material, it was carried out the classification and aggregation of data, through a rigorous reading process, with identification of common and specific aspects, giving rise to previous categories. Finally, through the articulation of empirical data with theoretical material, considering the research objective and the themes that emerged[8], the following categories were created: "challenges for shared care"; and "strategies for shared care".

The project was approved by the Research Ethics Committee (CAAE 02623818.4.0000.0021). To ensure the confidentiality and anonymity of the participants, the letter I was used to designate "interviewee", followed by the indicative number of the sequence in which the interviews were carried out and the acronym of the service, that is, I01- PHC, and so on.

RESULTS

Among the 18 professionals eligible for the study, one was excluded due to loss of recording, totaling 17 participants, six of whom belonged to the FHU teams, seven to the HCS team and four to the Ecfh-PC team. Participants were aged between 26 and 55 years (average 36.4 years), being 11 female. As for the workload, 12 of them worked 40 hours a week. Regarding the professional category, four were nurses, two physicians, two nursing technicians, two community health agents, two physiotherapists, an occupational therapist, a speech therapist, a physical education professional, a social worker, and a psychologist.

Regarding schooling, 14 interviewees had completed higher education, as follows: three had a Specialization in Family Health/Public Health; nine were specialists in other areas of health; and one had a master's degree in family health. The time working on the team ranged from six to 180 months (average of 36 months).

Challenges for shared care

Regarding the challenges for shared care, the professionals highlighted some factors that interfere in the work process and directly impact its performance in the context of home care: lack of knowledge of the different teams' attributions; lack of qualification of professionals working in PHC to carry out the care coordination attribute; non-understanding of the monitoring criteria by the HCS, associated with the absence of the ordering of care to maintain intercommunication with the other HCN points.

> *HCS is a new service [...] many people in the network [professionals] do not know it [...] we hold meetings with the units to show the service, now that they are starting to know what HCS is, what are the criteria, how it works [...] (I02-HCS).*

> *[...] when they [FHU] pass the case, we get there and we see that many times the person was even able to go to the unit, or that it is not that urgent, or sometimes it is not even the case for the Ecfh-PC [...] assuming that this service is not a gateway, the health unit already had to have this mapping in the screening, realizing what the cases really are for the Ecfh-PC, what is the emergency of this case (I10-Ecfh-PC).*

> *[...] I don't know how the referral to the HCS is done [...] (I13-FHU).*

> *[...] we have difficulty in asking them [PHC] to fulfill their role, such as the regular visit of the family health*

strategy, vaccination at home, when was the flu vaccination, we had to ask the unit to go there vaccinate a patient who is from the same area who had not been vaccinated before. The biggest difficulty today is that when we take on a patient, everyone disappears, the patient is the responsibility of the HCS, so only the HCS does it, everyone leaves that patient for us to take care, and it is not the main goal, because the goal is that we are a support team, admit for a while and discharge the patient to continue his normal follow-up by the basic unit (I05-HCS).

In turn, some participants revealed that the inconsistency between population density and the teams' capacity to serve, insufficient human resources, deficiency in the provision of transport for professionals to travel, and the weakness in carrying out the counter-referral also made difficult shared care within the HCN.

[...] we know that there is a failure to have some places uncovered by the teams, not having a basic reference unit for the patient and the lack of human resources[...] (I06-HCS).

[...] there is no car, there is no displacement, our car only comes one day, a period [...] so we have to give priority to the most severe cases [...] (I08-Ecfh-PC).

The counter-referral is terrible, we learn from the patients, the units outside SESAU, the other sectors come to us for emergencies, so there is no such counter-referral, we need to look with the patient himself, how is he doing, what he is doing, if he is going [...] because from the units, from the sectors we do not receive any information (I09-Ecfh-PC).

It was also identified that the lack of routine for the discussion of cases between the teams did not favor the professionals' participation and interaction.

[...] it's very difficult to keep in touch with them [FHU] [...] we managed it by phone or passed the case on to our coordinator, she gets in touch, or also as a last resort, we go in person to the basic health unit (I03-HCS).

Strategies for shared care

Regarding the strategies for shared care, the participants said that, despite the challenges faced, they were already implementing some actions/strategies that favored the performance of shared care within the HCN, and others that they considered necessary to improve this sharing.

In this sense, I15-FHU highlighted that visits by HCS teams to health institutions where the patient was being assisted, using dialogue with professionals who worked in different points of the HCN, improved the care of patient in HC.

[...] patient who leaves the hospital, who needs HCS, a first contact is already made there, I work with them, because in HCS there is already a whole team, so we really support each other, what HCS can go there to do, go there and do it, what I can request, go there in return, I do it too. The two work together on top of the patient (I15-FHU).

The communication between the PHC and HCS teams, regarding the supply of inputs for the HC, was perceived as a strategy for promoting shared care.

[...] when nursing needs something like bandage, they contact the Medical Specialties Center to see what material they have to give the patient or for us to do, I think this is already shared care (I04-HCS).

[...] we [PHC] pass the case to them [Ecfh-PC], they come and schedule a visit and the team goes, I needed these days to order the patient's food, she did not feed through a tube, had taken it a long time ago, now she had to come back (I17-FHU).

In addition, the participants pointed out the importance of identifying the individual's health needs in order to carry out agreements that cooperate with the work process of the teams, and to plan actions that strengthen the operationalization of reference and counter-referral, considered an indispensable tool for the shared care between the different HCN points.

[...] I made the visit, saw the need for a wheelchair and a bath chair [...] the team's physiotherapist has already included this patient in the regulation system. A day is scheduled for him to go and make an appointment for the measurements of the chairs, we organize, we make an appointment for him to be seen [...] if I see that the patient needs social support, from the Social Assistance Reference Center (SARC), even from the Municipal Department of Social Assistance, we communicate them by telephone. And so, we take care together (I03-HCS).

[...] we already had a basic unit that was understaffed, they could not go to the patient's house to apply a dressing every day, we agreed that we would go twice a week and they [FHU] once to monitor the evolution, teach the mother to do, and it worked, closed the wound (I04-HCS).

We have already had cases in which the patient needed a Psychosocial Care Center (PCC), we call a PCC that is a reference, we talk, they guide how we are going to refer this patient, or they make a home visit (I07-HCS).

[...] the PCC, comes to the unit, talks about a patient who is from the territory, establishes ways to continue monitoring this patient in the territory. The school looks for that student who has any suspicion of attention deficit disorder with hyperactivity, autism, when we are available to go to school, the school receives it well (I10-Ecfh-PC).

The professionals also highlighted the importance of the discussion between the teams about the cases being followed up, considering it a strategy that favors shared care.

[...] at the Medical Specialties Center there is the dressing part, we were able to exchange ideas with the nurse there, who is very receptive to us, they manage to donate some supplies that we need to use, or she guides us in some things, because they are more specialists in certain dressings, so in this part we are able to provide shared care, with a way we are trying (I07-HCS).

Our team here is very united, works well, has a good relationship, but verbal, arrives, passes the case, discusses, and requests the visit. Some professionals require a written referral, but with Ecfh-PC it is usually more verbal, sometimes we do it at coffee time "Oh, let's make that visit, this patient needs your support" (I12-FHU).

And in relation to conducts that could be improved within the service, the professionals' statements pointed out to the need to plan the care and prepare the Singular Therapeutic Project (STP) to enhance shared care.

[...] when admitting a patient to home care, it would be important to plan the care, outline the goals of all professionals involved in care for that individual in the service [...] reach a consensus on the length of stay and therapeutic plan [...] (I01-HCS).

I think like this: that my team needs to improve the creation of STP so that it is not just the critically ill patients, I say my team, I also include myself, because we always think that there is no time to do things. I think we need to create more STP and establish goals and responsibilities for more patients that I know that need and organize our day of visits [...] (I09-Ecfh-PC).

The shared care of the patient at home is much done by mouth [...] it is more complete when we create the STP, because we create the goals, objectives, even when it is to fulfill [...] the definitions of roles is what facilitates the work shared between us and the basic family health unit (I11-Ecfh-PC).

Sometimes not carried out, and considered challenges, difficulties and weaknesses experienced by professionals, some actions were highlighted as strategies that could strengthen the HC and favor shared care between the teams, with these suggestions being referred to as a possibility to increase resoluteness and better organize the service.

The main interventions proposed were related to the need to establish service routines and flows, for example, the establishment of days to offer care and discussion of cases between the teams, a guiding instrument for home care, and strengthening of communication for monitoring the outcomes.

There could be a greater interaction between everyone [FHU/ Ecfh-PC and HCS], easier contact [...] a consensus for one team to pass one day and the other a day later, the patient could evolve faster (I04-HCS).

I think it had to have an instrument for every patient at home, from the most serious to the most basic, sometimes it is only an elderly patient, who is only restricted to the home, he has a limitation, if an arthrosis, he does not have a serious clinical condition [...] if we were able to formalize an instrument that stratified patients first and were able to define goals and responsibilities of professionals, both Ecfh-PC and the family health strategy it would be ideal (I09-Ecfh-PC).

[...] being a patient from our micro area, I think they [HCS] also had to send a return to the unit, like "we did the care for the patient, at the home", even if it was by e-mail for the management and the management to be forwarding to the responsible nurse, so that we know what they are doing, because I don't know [...] (I17-FHU).

Given the findings, it can be understood that the shared care provided by the professionals was based on two distinct but complementary realities, and that the professionals experienced difficulties in its execution, however, they were able to establish and plan strategies to deal with such challenges and promote a better offer of this care.

DISCUSSION

The results of this research made it possible to identify some factors that influence the performance of shared care between the different teams that assist patients and families at home.

The lack of knowledge about the services that make up the care network and about the activities that need to be developed according to the responsibility of each team constitute aspects that negatively influence the performance of comprehensive, continued and shared care, in addition to detune with the attributes of PHC[7].

In turn, the deficiency in the qualification of professionals was also considered an obstacle that could harm the achievement of the PHC attributes and shared care. A similar situation was identified in a study carried out in Barretos-SP, which showed that the lack of professionals with generalist training in PHC impairs care[9]. The absence, in most cases, of specific qualification requirements to work in PHC can be a factor that hinders the operationalization of shared care between the different points of the HCN.

Regarding these difficulties, the interviewees mentioned the fact that the PHC teams do not determine the coordination of care. With this regard, a study carried out in Barretos-SP identified that the PHC was not responsible for regular care, including in cases of users with chronic conditions. They also emphasized that home visits carried out by community health agents were based on bureaucratic routines, with the aim only of identifying the presence of any complications or specific problems, without considering actions to prevent complications and health promotion, and that the professional only stopped by to ask if everything was fine[9].

With regard to the functioning of the HCS, the professionals consider it necessary for there to be greater dissemination among professionals working in the different points of the HCN, in relation to the flow of care and patient admission criteria, as they believe that this can contribute to comprehensiveness and longitudinality of care and for access to first contact. This is because the lack of knowledge about the specific responsibilities of the different points of the HCN weakens the continuity of care due to the lack of integration between services and professionals[9]. It is noteworthy that, just as members of a professional category alone cannot meet all the needs of a patient and their family, an isolated service is also not capable, which justifies the importance of networking[10] for the comprehensiveness and qualification of care.

In addition, defining the roles of the members of each team is essential for the effectiveness of interpersonal relationships and the effectiveness of health systems. These actions can prevent the occurrence of unnecessary referrals, strengthen shared care, favor the access and reception of users at the appropriate point of the HCN according to their real need[11].

The identification of the presence of some factors, including insufficient human and material resources, low capacity to serve the teams and weakness in carrying out the counter-referral, is in line with the results of a study carried out in southern Brazil, with 15 nurses from the FHS, which pointed out these same aspects as harmful to the execution of comprehensive care[12]. Another similar study, carried out in a municipality in the Metropolitan Region of Belo Horizonte, also pointed out that the low coverage of the FHS related to limited resources and organizational problems collaborates to weaken the assistance offered by the PHC[13].

It should be noted that functional and structural difficulties limit care, especially with regard to the lack of organization and problems related to communication[10]. These factors directly influence the management of cases, especially the more complex ones, and hinder the provision of safe intersectoral and multidisciplinary care with good prognoses[14].

Likewise, a study carried out with HCS managers and coordinators in the state of Minas Gerais showed that they recognize the existence of difficulties in communication with other services that make up the HCN, and that the weakness of this integration compromises the continuity of health care and also their resoluteness and quality[15]. Pertinent to that, training courses focused on stimulating and developing communication skills, using practical simulations, and standardizing the presentation of data related to patients by different teams can help to share care.

Regarding the lack of systematization by professionals in relation to the failure in the counter-referral for the sharing of care, it was also found in another study, which observed the occurrence of informal referrals, after hospital discharge, to other rehabilitation services, in addition to the fact that the family becomes responsible for the search for services, without counting on the guidance of the PHC[9].

With regard to the availability of material resources, a study carried out in Minas Gerais showed that managers see that the availability of material resources is sufficient for the operationalization of HC, which demonstrates a distorted view of the real meaning of change in the process of structuring shared care, resulting in material assistance and neglect for other facets of relevance in the HCS, such as comprehensive and continued care[15].

Other aspects to be highlighted in the present study are the lack of frequency established for the general meeting between the PHC teams, aiming at the organization and work planning, the difficulty of carrying out the joint discussion of cases under follow-up, which weaken communication between the different HCN points and are characterized as

barriers that impact comprehensive and shared care[12]. In this sense, the opportunity to discuss cases, especially complex ones, from the perspective of different teams, can favor the development of a more effective care plan and guide the division of responsibilities, according to the specificities of the different points of the HCN.

Thus, it is highlighted as a priority, the need for teams to rethink the planning of the work process for shared care, in order to include moments that provide periodic meetings between the teams that perform the HC to discuss the cases that are assisted at home.

The challenge of comprehensive care for individuals who need HC is also present in the international scenario, as evidenced in a study carried out in Norway, which pointed out limitations of knowledge regarding the need for care that patients receive at home and the way these individuals are attended, which results in gaps that make it difficult to assess the quality and effectiveness of services provided in this environment[16].

In this sense, the joint elaboration of an individualized/personalized care plan by professionals working in HC is of great value for the quality of care provided. This is because each professional takes a different look at the demands and complexity of health problems experienced by the individual and his family, contributing to health promotion, care and prevention of injuries[10]. This plan should even provide for the instrumentalization of people responsible for home care, which includes teaching them and helping them to develop skills for daily care in this environment, in order to adequately guarantee its continuity even when the team is not present[17].

This attitude makes possible for care to be shared with family members as well. The importance of developing a care plan was also detected in a study carried out in a medium-sized city in southern Brazil, which indicated that the development of care plans provides health teams with greater performance in their care practices and in individual care[18].

The fact that communication related to the dispensation of medical-hospital supplies to patients in HC has been listed as an action with the potential to favor interaction between the PHC and HCS teams is promising. Thus, the exchange of information, even if related to the need for supplies, allows professionals to identify those specific to each case, and include them in the construction of the shared care plan[12].

Also, in relation to the planning of care actions, the participants highlighted that the STP, although not used in all follow-up cases, is a fundamental tool for the performance of comprehensive and shared care. Because, in addition to helping the organization of care, the STP contributes to the management of care in complex cases that are difficult to solve[19], being a central and structuring element for the network articulation; guiding instrument for the plan preparation and execution of shared care.

The construction of the STP can stimulate skills and the capacity for dialogue, enhancing communication between those involved in care, in order to accommodate the demands and exercise the individual and/or their family to take the lead in care. In addition, with this tool it is possible to identify the weaknesses of the HCN, and list needs to be addressed through permanent education, aiming to equip the teams in the best way possible for their care practice.

In this sense, shared care can change the fragmentation of care, and contribute to the strengthening of network care. Therefore, it is important that professionals assume care with practices integrated to all health professions, aiming at comprehensiveness[10].

Finally, the participants also highlighted other actions needed to improve the quality of HC, which are related to the organization and systematization of the work process, with an emphasis on the governability of the professionals involved, although this is limited.

For the effective functioning of the HC and sharing of care, it is essential to jointly organize the work process of the teams, with agreements, elaboration of flows and protocols between the different HCN points in the city[14]. However, the clinical experience and suggestions of the different professionals involved should be valued, as they imply the feasibility of the working flows of this care modality. This is because inexperience in HC and lack of knowledge about the unique characteristics of this service can influence, difficult and even hinder shared care between the teams from occurring.

Thus, acting in isolation and without knowing/considering what is already being done or without prioritizing comprehensive and continued care, teams may believe that they are adequately fulfilling their role/function, but, in reality, some care may even be being duplicated, while others, neglected.

FINAL CONSIDERATIONS

Professionals perceive HC as a care modality permeated by limitations and weaknesses in relation to the effectuation of shared care between the different teams and HCN points involved.

Given this, and the importance of shared action for de-hospitalization and establishment of a quality HC, it is concluded that, although its organization is a complex

process that requires involvement and commitment on the part of managers, health professionals who work in different network points, users, and family members, it is fundamental.

According to the results obtained, it is possible to infer that, for the effectuation of shared care, it is necessary to elaborate the STP, to establish specific roles/attributions to all the different members of the teams that perform the HC in a complementary way. For this, it is important to use some strategies indicated, including: closer communication between the PHC and HCS teams, with regard to the supply of inputs for home care; the discussion of cases under follow-up; and, whenever necessary, referrals to other points in the HCN.

In view of these results, it is urgent and strategic to include questions about HC and shared care in the curricular components, considering, in particular, the growing demand for the use of this care modality.

The possible limitations of the study refer to the characteristics of the qualitative method, which does not allow the generalization of its results, which can be reproduced and disseminated, although with caution. However, as HC is a relatively new health care modality, the results found are relevant and can positively support the organization of this service in other contexts.

Finally, it is suggested that further studies be carried out, especially of intervention, in order to enable the construction of workflows and instruments that favor the sharing of care actions carried out by health teams at home environments.

REFERENCES

1. Oliveira SG, Kruse MHL, Sartor SF, Echevarría-Guanilo ME. Afirmações sobre a atenção domiciliar no panorama mundial: revisão narrativa. Enferm Global. 2015 [cited 2020 Sep 10];14(39):360-89. Available from: https://revistas.um.es/eglobal/article/view/202571/177441
2. Oliveira SG, Kruse MHL. Genesis of home care in Brazil at the start of the twentieth century. Rev Gaúcha Enferm. 2016;37(2):e58553. doi: https://doi.org/10.1590/1983-1447.2016.02.58553
3. Feuerwerker LCM, Merhy EE. [Home care's contribution to alternative health care networks: deinstitutionalization and transformation of practices]. Rev Panam Salud Pública. 2008;24(3):180-8. Portuguese. doi: https://doi.org/10.1590/s1020-49892008000900004
4. Ministério da Saúde (BR). Portaria nº 825 de 25 de abril de 2016. Redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde (SUS) e atualiza as equipes habilitadas. Diário Oficial União. 2016 abr 26 [cited 2020 Sep 10];153(78 Seção 1):33-8. Available from: https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=26/04/2016&jornal=1&pagina=33&totalArquivos=112
5. Figueiredo SC, Limeira RRT, Carvalho LGA, Morais Junior RC, Ribeiro ILA, Chaves SPL, et al. Profile of patients attended by the speech therapists of the home care service. Rev CEFAC. 2018;20(5):613-20. doi: https://doi.org/10.1590/1982-021620182055918
6. Marques BL, Tomasi YT, Saraiva SS, Boing AF, Geremia DS. Guidelines to pregnant women: the importance of the shared care in primary health care. Esc Anna Nery. 2021;25(1):e20200098. doi: https://doi.org/10.1590/2177-9465-ean-2020-0098
7. Starfield B. Atenção Primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO, Ministério da Saúde; 2002 [cited 2020 May 7]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/atencao_primaria_p1.pdf
8. Bardin, L. Análise de conteúdo. São Paulo: Edições 70; 2016.
9. Bousquat A, Giovanella L, Campos SEM, Almeida PF, Martins CL, Mota PHS, et al. Primary health care and the coordination of care in health regions: managers' and users' perspective. Ciênc Saúde Coletiva. 2017;22(4):1141-54. doi: https://doi.org/10.1590/1413-81232017224.28632016
10. Sousa SM, Bernardino E, Crozeta K, Peres AM, Lacerda MR. Integrality of care: challenges for the nurse practice. Rev Bras Enferm. 2017;70(3):504-10. doi: https://doi.org/10.1590/0034-7167-2016-0380
11. Silveira RP, Siqueira DF, Mello AL, Cunha FA, Terra MG. Sharing care in psychosocial care: perception of workers and users. SMAD: Rev Eletrôn Saúde Mental Álcool Drog. 2019;15(2):69-76. doi: https://doi.org/10.11606/issn.1806-6976.smad.2019.000431
12. Figueira AB, Barlem ELD, Amestoy SC, Silveira RS, Tomaschewski-Barlem JG, Ramos AM. Health advocacy by nurses in the Family Health Strategy: barriers and facilitators. Rev Bras Enferm. 2018;71(1):57-64. doi: https://doi.org/10.1590/0034-7167-2016-0119
13. Viegas APB, Carmo RF, Luz ZMP. Fatores que influenciam o acesso aos serviços de saúde na visão de profissionais e usuários de uma unidade básica de referência. Saúde Soc. 2015;24(1):100-12. doi: https://doi.org/10.1590/S0104-12902015000100008
14. Schenker M, Costa DH. Avanços e desafios da atenção à saúde da população idosa com doenças crônicas na Atenção Primária à Saúde. Ciênc Saúde Coletiva. 2019;24(4):1369-80. doi: https://doi.org/10.1590/1413-81232018244.01222019
15. Silva AE, Sena RR, Braga PP, Paiva PA, Dias OV. Challenges in ways of thinking and doing home care management in Minas Gerais. Ciênc Cuid Saúde. 2017;16(1):e33190. doi: https://doi.org/10.4025/cienccuidsaude.v16i1.33190
16. Næss G, Kirkevold M, Hammer W, Straand J, Wyller TB. Nursing care needs and services utilised by home-dwelling elderly with complex health problems: observational study. Health Serv Res. 2017;17:645. doi: https://doi.org/10.1186/s12913-017-2600-x
17. Andrade AM, Silva KL, Seixas CT, Braga PP. Nursing practice in home care: an integrative literature review. Rev Bras Enferm. 2017;70(1):210-9. doi: https://doi.org/10.1590/0034-7167-2016-0214
18. Silva RLDT, Arruda GO, Barreto MS, Oliveira MLF, Matsuda LM, Marcon SS. Elaboration of care plan as a differential in care practice for hypertensive patients. Acta Paul Enferm. 2016;29(5):494-505. doi: https://doi.org/10.1590/1982-0194201600070
19. Silva AI, Loccioni MFL, Orlandini RF, Rodrigues J, Peres GM, Maftum MA. Singular therapeutic project for professionals in the family health strategy. Cogitare Enferm. 2016;21(3):e45437. doi: https://doi.org/10.5380/ce.v21i3.45437

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