Home care for older adults: perspectives of nurses under the Family Health Strategy

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Abstract

Objective: To analyze the perceptions of nurses under the Family Health Strategy regarding Home Care offered to older adults. Method: A descriptive, qualitative study involving semi-structured interviews of nurses to elucidate the perceptions of these professionals about home care was conducted. The Discourse of the Collective Subject method, anchored in Social Representation theory, was employed. Results: A sample of 14 nurses, predominantly women, Family and Community Health experts, who made weekly home-care visits, was studied. Participants reported the importance of care, of appreciating the patient´s situation and of delivering health services. The nurses also reported performing a range of procedures during visits. After the home visits, the professionals made notes in the patient medical records, discussed cases with the multidisciplinary team or scheduled the next visits. Most participants stressed the importance of humanized care and technical knowledge. Treatment continuity and building ties were positive aspects cited. Regarding drawbacks, lack of resources was the most commonly cited aspect. Conclusion: The participants acknowledged the importance of Home Care in the Family Health Strategy offered to older adults, a practice which promotes deeper understanding of patients, provides treatment continuity, but that also faces challenges in practice.

Keywords: Home Health Nursing. Family Health. Aged.

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INTRODUCTION

The Family Health Strategy (ESF) in Brazil plays a key role in restructuring primary care services toward expanding and improving access to healthcare. This approach places emphasis on working closer with families, promoting stronger bonds and facilitating access to health services[1]. The ESF is based upon multidisciplinary teams that include health professionals such as general practitioners, nurses, nursing technicians and community health workers. This make-up reflects a comprehensive approach to meeting the health needs of the population[2,3].

A broad strategy for long-term care provision for older adults should be developed, with a preference for models that offer continual support to users with a range of healthcare needs[4,5]. Recognizing the importance of family care is crucial for improving support for caregivers, encompassing instrumental, emotional and financial aspects. In addition, this strategy should address the regulation of care as a profession, centering on full training and proper support to cater to the growing demand for professionals in this area[5,6].

Home-based Care (HC) represents an essential service provided on site, specifically within users´ homes, delivering on the ESF commitment to provide personalized, accessible health care, particularly to older adults[1,2]. This approach secures the right to comprehensive quality care for all[7,8].

In Brazil, HC began with nurses treating tuberculosis patients around 1920[9,10]. This practice is helpful for vulnerable groups, particularly individuals who are aged or suffering from chronic diseases. These patients often face mobility difficulties, financial limitations and cultural barriers that impact their access to health services[11].

Home care comprises a host of actions and services that promote health, prevent diseases, treat illnesses and aid rehabilitation and, notably, foster humanized relationships with patients[12]. This modality of care not only facilitates continued access to health services for users, but also contributes significantly to patient quality of life (QoL) and caregiver satisfaction. Moreover, this service helps reduces emergency department visits, hospitalizations and readmissions[13].

Nursing professionals that provide HC are prepared to address holistic health aspects, including psychosocial medical domains and QoL[14]. This approach provides a broader understanding of the living conditions of patients and strengthens ties with health professionals, resulting in better treatment and greater satisfaction[15].

Despite robust evidence supporting the benefits of HC, it is important to recognize the challenges associated with implementing this practice. These obstacles include logistics difficulties, insufficient resources and the need for specific training for professionals[16,17]. It is vital to overcome these barriers and invest in valorizing HC as an effective strategy for improving primary care, especially among the older population.

Against this backdrop, the objective of the present study was to analyze the perceptions of nurses on ESF teams regarding the HC offered to older adults. The study results can help inform the development of policies and practices promoting effective sustainable implementation of HC in an effort to improve care access, service quality and health outcomes for patients.

METHOD

A descriptive, qualitative study analyzing nurses´ professional perceptions regarding HC was conducted in primary care. A non-probabilistic sample design was adopted. The data saturation method was used during interviews, where saturation occurs when the data topics and categories repeat, become redundant and further collection yields no new information[18].

The study was carried out in the medium-sized city of Itatiba, located in the interior of São Paulo State, Brazil. The city is part of the Metropolitan Region of Campinas and situated around 80 kilometers Northeast of the state capital. In 2019, the city had a population of roughly 120,858 individuals, as estimated by the Brazilian Institute of Geography and Statistics (IBGE). The city has 12 Family Health Units (USF), all of which were included in the study.

The study was approved by the Ethics Committee for Research in Humans of the Universidade Estadual Paulista (UNESP), Araraquara School of Dentistry - UNESP (CAAE: 69122923.6.0000.5416, Permit no.: 6.773.591). Written informed consent was obtained from all study participants. The steps contained in the COREQ (*COnsolidated criteria for REporting Qualitative research*) checklist were followed.

Data collection was performed via individual face-to-face interviews recorded on a digital device. This collection was carried out at each health unit and interviews were conducted in the office of each nurse. This arrangement was adopted in order to ensure a calm environment and minimize any local interference. Also, the professionals interviewed were not acquainted with the interviewer, thus preventing potential conflicts of interest. The interview method allowed face-to-face interviews in which interviewees could freely express their thoughts and arguments without any interference.

During the interviews, a script containing questions on HC was followed. The questionnaires were identified by number so as to guarantee secrecy and anonymity of the participants. Data collection took place between July and October 2023. Recordings were transferred to a computer for transcription of discourse for analysis.

The questions were devised in an objective open-ended form, as recommended by Lefevre[18]. Questions were pre-tested in a pilot study and applied by the same previously-trained interviewer. The following questions were posed:

1) What is your age? 2) What is your gender? 3) How long have you been working in this ESF team? 4) Do you hold any specialization qualifications? 5) Do you make home visits to older adults? 6) If yes, when are these visits made? 7) What is your view about making home visits to older adults? 8) What procedures do you perform during home visits to these patients? 9) After making the visits, how do you proceed? 10) Which professional competencies do you deem necessary to provide home care to older adults? 11) What are the positive aspects of home care for older adults? 12) What are the negative aspects of home care for older adults?

Data analysis was performed by descriptive analysis and analysis based on the quali-quantitative technique of the Discourse of the Collective Subject (DCS)[19] with the aid of open access *Qualiquantisoft*® software to analyze the data from the qualitative studies.

According to Lefevre[18], the DCS is grounded in the theory of Social Representation, its sociological precepts and the analysis of collected oral discourse, extracted from each individual statement. The method is based on the belief that, in any social group, individuals share ideas, opinions, beliefs and expressions, where these shared opinions can be pooled collectively into a synthesis-discourse. This discourse reflects the similar contents and arguments among individuals on a given issue, i.e., derived from many individual statements to produce a collective statement. Thus, the raw material of this technique stems from the interviews conducted.

The synthesis-discourse, or collective statement, is written in the first person singular to produce in the recipient the impression of a collective thought, directly expressed by the "voice" of a single collective subject[19]. Use of the software precludes coded identification of interviewees. This presentation of discourse is possible because, in the theory of Social Representation, the collective discourse is the externalizing of social entities internalized and incorporated by individuals, lived by them, in current interactions[18]. After data collection, each individual written statement was analyzed to yield the collective thought. Key-expressions were first selected.

The Key-expressions are continuous or non-continuous passages of individual discourse which reveal the essence of the content of the statement. These are fundamental for producing the DSC and, thus, should be collected carefully, with removal of non-essential content from the discourse to obtain only the essence of the thought. This screening should be done in a discerning fashion, avoiding the tendency to select almost all or almost nothing from the individual discourse. The Central Ideas were selected from the Key-expressions[18,19].

The Central Idea is the name or expression which best summarizes what the individual wished to state about the issue. After selection, similar or complementary central ideas were pooled into a single central idea, corresponding to a category of response to the question posed at the interview. Having obtained the Central Idea, which represents a category of thought, the related Key-Expressions were pooled together into a synthesis discourse. This synthesis discourse, expressed in the first person singular, represents the DSC, where the thinking of a group or collective is expressed as if a singular entity. The DSC should be produced for each of the categories (Central Ideas) identified by the researcher[18,19].

In addition to the qualitative data analysis, a quantitative analysis was carried out using descriptive statistics to obtain a distribution of relative frequencies of results, organized according to categories of each question.

DATA AVAILABILITY

The complete dataset underpinning the results of the present study is available upon request from the corresponding author.

RESULTS

All nurses (n=26) working at the Family Health Units of the city were invited to take part. Professionals engaged in the teams for the selected regions were eligible for inclusion. Nurses working on a temporary basis (n=5) to cover for permanent staff who were on leave of absence or vacation were excluded. Some participants (n=7) refused to take part. Thus, a final sample of 14 nurses participated in the study.

The descriptive categories reflecting the nurses´ perceptions on the HC offered to older adults are presented by category in the table below.

Table 1. Sociodemographic characteristics of participants (n=14) and synthesis of results of DSC by category associated with each question. Itatiba, São Paulo state, 2024.

Questions	n (%)
1) What is your gender?	
a) Female	12 (85.7)
b) Male	2 (14.3)
2) What is your age (years)?	
a) 20 - 30	2 (14.3)
b) 31 – 40	5 (35.8)
c) 41 – 50	4 (28.5)
d) 51- 60	3 (21.4)
3) How long have you been working in this ESF team?	
a) 0 – 12 months	3 (21.4)
b) 25 – 36 months	6 (42.9)
c) 37 - 48 months	3 (21.4)
d) 49 – 60 months	2 (14.3)
4) Do you hold any specialization qualifications?	
a) Obstetrics	1 (7.2)
b) Public Health	5 (35.8)
c) Family and Community Health	8 (57.0)
5) Do you make home visits to older adults?	
a) Yes	14 (100.0)

to be continued

Continuation of Table 1

Questions	n (%)
6) If yes, when are these visits made?	
a) Weekly	11 (78.6)
b) Fortnightly	3 (21.4)
7) What is your view regarding making home visits to older adults?	
a) Important	6 (42.8)
b) Appreciating the patient´s circumstances	5 (35.8)
c) Provision of care	3 (21.4)
8) What procedures do you perform during home visits to these patients?	
a) Various procedures	14 (100.0)
9) After making the visits, how do you proceed?	
a) Make notes in medical record	4 (28.5)
b) Perform follow-up of outcome	2 (14.3)
c) Discuss with team	5 (35.8)
d) Schedule next visit	3 (21.4)
10) Which professional competencies do you deem necessary to provide home care to older adults?	
a) Humanized care	8 (57.0)
b) Theoretical knowledge	5 (35.8)
c) Multiprofessional team-working	1 (7.2)
11) What are the positive aspects of home care for older adults?	
a) Treatment continuity	9 (64.2)
b) Strengthening bonds	5 (35.8)
12) What are the negative aspects of home care for older adults?	
a) Lack of resources/infrastructure	8 (57.1)
b) Insufficient time	3 (21.4)
c) Resistant families	2 (14.3)
d) No negative aspects	1 (7.2)

Participants were predominantly women (n=12; 85.7%), aged 31-40 years (n=5; 35.8%), 25-36 months in current position (n= 6; 42.9%), specialists in Family and Community Health (n=8; 57.0%), and all nurses made home care visits (n=14; 100%), typically on a weekly basis (n=11; 78.6%).

Six (42.8%) participants cited the importance of home-based care.

> "Of the utmost importance in the family health strategy, home care is necessary when the patient has mobility issues", another participant stated: "It´s really important for patients and the family, for home-bound patients."

Appreciating the patient´s circumstances (n=5; 35.8%) was also reported:

> "I think it´s a necessary strategy, where we can appreciate the patient´s setting and their difficulties and weaknesses". "Through this type of care, we can appreciate what that patient´s life is like, and understand all their life context and difficulties."

In addition to these aspects, the provision of care (n=3; 21.4%) was also cited:

> "Offering the same care and quality of life to home-bound patients as the other patients", "this

care can allow treatment continuity, providing accessibility to the population with vulnerabilities (poor mobility, social, health needs)."

All of the nurses interviewed (n=14;100.0%) reported performing various types of procedure during visits, including measuring blood pressure, general checkups, laser therapy, changing catheters and dressings, and advising patients/family members:

"I usually change dressings, perform laser therapy, replace catheters, measure blood pressure and blood sugar levels, and provide general advice.".

After the home visits, follow-ups differ, with some professionals (n=4; 28.5%) making notes in the medical record of patients seen:

"I update progress on the medical record so no Information can be lost". "I note down all the procedures and instructions I have given in the patient´s medical record."

Some nurses reported following up the outcome of the visit (n=2; 14.3%):

"I usually follow-up the outcome of the case, some patients require specialist care from other professionals, so it's important to know whether the patient was seen and how they are progressing."

Discussion with the team (n=5; 35.8%) is also carried out by participants following home-care visits:

"After the visit I usually hold a meeting with the health team to define each member´s role, then we know what to do and how best to treat the patient", "The team discussion following visits is fundamental and very important for informing what is happening with the patient and actioning the team to resolve the problems."

In addition to these actions, some nurses reported scheduling the next visit (n=3; 21.4%) to ensure all patients are seen in an organized fashion:

"I schedule the next visit, book transport and advise the family so nothing untoward occurs"; "I always talk with the family after consultations in order to schedule the next home visit and so I can closely monitor the patient case."

Most participants (n=8; 57.0%) stated that humanized care is a competence for practicing HC:

"I believe that humanized care, being aware of the patient´s social situation is a core competency", "Showing empathy, patience with patients and family, these individuals are often simple and need more attention because they have difficulties understanding."

Technical knowledge (n=5; 35.8%) and working in a multiprofessional team (n=1; 7,2%) were also cited as competencies for practicing HC:

"Technical knowledge is important for treating these patients because each case has its peculiarities, so it's necessary to be familiar with each technique", "... professional knowledge, because it is already hard to perform some procedures at the patient´s home, se we have to know the techniques well to adapt", "I think it's important to have several professional engaged in this care, because we cannot know everything, the service should also include other professionals such as physiotherapists, speech-therapy pathologists and psychologists."

Treatment continuity was the positive aspect most reported by the nurses (n=9; 64.2%):

"Providing care to home-bound patients who cannot go to the basic health unit allows us to achieve treatment continuity". "Home-based care enables treatment continuity for the patients."

Strengthening bonds (n=5; 35.8%) was another positive point associated with HC:

"Forging a bond, identifying and catering for health needs more swiftly". "The home is where we get to see the patient´s true situation and build ties with them".

Lack of resources/infrastructure (n=8; 57.1%) was the most cited drawback:

> "Lack of infrastructure, understaffing and difficulty obtaining support after these visits". "Resources are the main drawback of home visits, sometimes transport and the proper equipment for the visits are lacking."

Insufficient time (n=3; 21.4%) was also reported as a negative aspect of home-based care:

> "The high level of demand at the health unit can impact home visits somewhat, there isn´t enough time to perform all of the routine activities".

Moreover, some families are resistant during HC (n=2;14,3%):

> "A negative point is that some families do not collaborate for the visit, do not follow instructions, and do not appear to care."

One nurse also reported that HC has no downsides (n=1; 7.2%):

> "I see no downside, an essential care service for some patients."

DISCUSSION

The objective of the present study was to qualitatively analyze, using DSC, nurses´ perceptions about the HC offered to older adults. The professionals in question face a variety of conditions in practicing their jobs, justifying the choice of a qualitative method that employs collective thought to explore the area of health, highlighting the differences and similarities among participant perceptions[18]. This approach is especially indicated to further understanding of the behaviors of specific groups.

Nursing professionals play a key role in HC, since they are trained to address all aspects of health in a holistic manner, encompassing medical, psychosocial and QoL domains[16,20]. This more comprehensive approach strengthens the professional-patient relationship, resulting in more effective treatment and greater patient satisfaction[15,21,22].

Some authors have also noted a similar predominance of females among nurses that make up the ESF teams[23]. The time engaged in the practice of HC in the professionals assessed ranged from 25-36 months. This finding may suggest that these nurses are able to make assertive decisions with greater autonomy and to establish long-term close relationships with the community, resulting in the delivery of integrated care[23,24].

Moreover, it is paramount to associate continuous education as a core competence of nurses in the ESF service. Results showed that most nurses were specialists in Family and Community Health, allowing them to implement changes in health practices that promote improvements in quality of the service, personal growth and constant refinements to meet the demands of the job[24].

It is noteworthy that the majority of the nurses interviewed acknowledged the importance of HC for older adults. This finding is consistent with the literature emphasizing the relevance of home-based care for meeting the needs of patients who find it difficult to get to health units[25-27]. In addition, home visits afford a deeper appreciation of patients´ circumstances and challenges, which can lead to the delivery of more individualized, higher-quality care[20].

The procedures carried out during visits demonstrate the wide variety of services offered by the nursing team, ranging from blood pressure measurements to specialized treatment, such as laser therapy and catheter replacement. This broad service reveals the ability of the nurses to cater for the host of needs of patients within their home environment[14,28,29].

The practices after the visit, such as detailed notes made in patient records, following up on outcomes, engaging in discussions with the team and scheduling the next visit, reflect the importance placed on care continuity and planning. These practices are essential to ensure patients receive adequate care over the long term, even after the initial home visit.

Following up on outcomes of the case is a practice which extends beyond the initial home visit[30]. This entails assessing how the patient is responding to the treatments prescribed or to guidance given at the previous visit. This approach is especially important in cases of chronic conditions or complex situations, where patient progression may be gradual and require continual monitoring. Monitoring the outcome of cases enables the care plan to be adjusted where applicable, ensuring an adaptive patient-centered approach[20].

Discussion with the team is a fundamental component of the coordination of care in HC[31]. After home visits, the health professional involved should meet to share Information, assess patient progress, and define the next steps in the treatment plan. Effective communication among members of the multidisciplinary team is essential to guarantee that all dimensions of the patient´s health are addressed in an integrated way[32]. Team discussion also helps to prevent gaps in care and ensure that all of the patient´s needs are fully met[14].

Scheduling the next home visit is a preventive measure which contributes to efficient organization of home-based care. This involves arranging the dates and times of future visits, as well as planning the resources needed, such as transport and equipment. Scheduling helps prevent delays or interruptions in care and ensures that patients continue to receive care in a regular consistent manner[21,22].

Most participants identified humanized care as a key competence for practicing HC. This underscores the importance of understanding not only the clinical needs of patients, but also their social and emotional situations. Empathy and patience are pivotal qualities when dealing with patients that may be experiencing complex challenges in their lives.

Technical knowledge was also cited as an essential competency. The home setting can pose special challenges, and nurses need to be prepared to adapt their knowledge and skills to different situations. Also, the suggestion of involvement of a multiprofessional team shows the importance of interdisciplinary collaboration to tackle the complex needs of patients.

With regard to positive aspects, treatment continuity and creating closer bonds with patients were identified as significant benefits, results that corroborate the literature[15,33-35].

The results of this study reflect the complexity of HC from the perspective of nursing teams. While the benefits are clear, the practical challenges should not be underestimated. It is key to recognize the importance of home care as a vital extension of primary health care and to invest in resources, training and infrastructure to ensure continued efficacy. Therefore, actions which promote effective sustainable implementation of HC are essential for the advancement of public health.

This study has some limitations, including the non-probabilistic sample design, where only professionals from Itatiba were included. Individuals from different locations might perceive other difficulties with respect to home care practices. Nonetheless, given the dearth of investigations on the subject, this study makes a valuable contribution to the area.

CONCLUSION

The perception of nursing teams regarding Home-based Care offered to older adults reflects clear recognition of its importance within the Family Health Strategy in providing a broader understanding of the patient´s situation and treatment continuity. Professional competences, including humanized care and technical knowledge, were the most cited. However, the study also highlighted the challenges, where it is crucial that policies and practices be developed promoting effective sustainable implementation of Home-based Care, in an effort to improve care access, service quality and health outcomes of older patients.

AUTHOR CONTRIBUTIONS

- Luís Eduardo Genaro - responsible for all aspects of the study, vouching for any issues related to the accuracy or integrity of any part of the study.

- José Victor Marconato - design, interpretation of the data, critical review and approval of the version for publication.
- Felipe Eduardo Pinotti - design, interpretation of the data, critical review and approval of the version for publication.
- Aylton Valsecki Júnior - critical review and approval of version for publication.
- Tânia Adas Saliba - critical review and approval of version for publication.
- Fernanda Lopez Rosell - responsible for all aspects of the study, vouching for any issues related to the accuracy or integrity of any part of the study.

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