Pilot-experience in home care: bedridden aged patients of a Basic Health Unit, Porto Alegre, Brazil

EXPERIÊNCIA-PILOTO DE ASSISTÊNCIA DOMICILIAR: IDOSOS ACAMADOS DE UMA UNIDADE BÁSICA DE SAÚDE, PORTO ALEGRE, BRASIL

EXPERIENCIA PILOTO DE ASISTENCIA A DOMICILIO: ANCIANOS ENCAMADOS EN UNA UNIDAD BÁSICA DE SALUD, EN PORTO ALEGRE, BRASIL

Giselda Quintana Marques[1], Ivani Bueno de Almeida Freitas[2]

RESUMO

O estudo teve por objetivos: descrever o processo de desenvolvimento do projeto-piloto de assistência a idosos acamados, da Unidade Básica de Saúde IAPI; e identificar aspectos demográficos, sociais e de saúde desses idosos, bem como aspectos relevantes relatados pela equipe, na implantação da assistência domiciliar. A pesquisa teve características descritivas e avaliativas. Foram revisadas as fichas cadastrais e os prontuários dos pacientes atendidos, assim como os registros de avaliação do projeto. A experiência-piloto permitiu o desenvolvimento de habilidades na equipe, foi enriquecedora e de grande responsabilidade para profissionais e cuidadores. Apontou para a continuidade da assistência domiciliar, fazendo-se necessários ajustes na sua organização, com a finalidade de ampliar os espaços de assistência e a qualidade do que vinha sendo ofertado à população.

DESCRITORES

Cuidados de enfermagem.
Idoso.
Serviços de Assistência Domiciliar.

ABSTRACT

The objectives of this study were to describe the development of a pilot-project in home care to bedridden aged patients at a Basic Health Unit, and identify demographic, social and health aspects of these patients, as well as relevant aspects reported by the health team that implemented the home care. The study had descriptive and evaluative characteristics. The patients' enrollment forms and health records and the project's records were analyzed. The pilot-experience permitted to develop the team's skills, in addition to being enriching and of great responsibility for the professionals and caregivers involved. The results indicated the need for continuous home care and adjustments in its organization with the purpose of increasing the areas for health care and improving the population's quality of life.

KEY WORDS

Nursing care.
Aged.
Home Care Services.

RESUMEN

El estudio tuvo por objetivos describir: el proceso de desarrollo del proyecto piloto de asistencia a ancianos encamados, de la Unidad Básica de Salud IAPI; identificar aspectos demográficos, sociales y de salud de esos ancianos; y, identificar los aspectos relevantes relatados por el equipo, en la implantación de la asistencia a domicilio. La investigación tuvo características descriptivas y de evaluación. Fueron revisadas las fichas de inscripción de los pacientes atendidos, así como los registros de evaluación del proyecto. La experiencia piloto permitió el desarrollo de habilidades en el equipo, fue enriquecedora y de gran responsabilidad para los profesionales y cuidadores. El resultado apuntó para la continuidad de la asistencia a domicilio, siendo necesario realizar ajustes en su organización, con la finalidad de ampliar los espacios de asistencia y la calidad de lo que estaba siendo ofrecido a la población.

DESCRIPTORES

Atención de enfermería.
Anciano.
Servicios de Atención de Salud a Domicilio.

[1] Doctoral Student in Nursing, School of Nursing, Federal University of Rio Grande do Sul. Nurse at IAPI Health Center. Porto Alegre Municipal Health Department. Porto Alegre, RS, Brazil. gqmarques@terra.com.br [2] M.Sc. in Collective Health. Nurse at IAPI Health Center. Porto Alegre Municipal Health Department. Professor of the Nursing Course at Faculty of Nursing, Universidade Vale do Rio dos Sinos. Porto Alegre, RS, Brazil. ivanifreitas@terra.com.br

Portuguese / English: www.scielo.br/reeusp

Received: 08/28/2008
Approved: 02/05/2009

INTRODUCTION

The process of human aging has been a topic of discussion in nearly every country in the world, with alarming properties in Brazil, since the life expectancy of people has increased significantly. This is due to improved conditions of life, sanitation, work and education, as well as technological conditions that made it possible for people to live longer and with more quality.

In Brazil, the decrease of a situation with high fecundity and high mortality has caused significant changes in the population pyramid, characterized by a progressive increase of the adult and elderly population. The United Nations, since 1982, consider that every individual aged 60 or older is an elderly person; Brazil adopted the same age range to characterize its own elderly population[1].

The changes in the population pyramid caused a series of social, cultural and epidemiological consequences that neither society nor institutions are ready to face. The fast transition in healthcare profiles, with the predominance of non-transmissible chronic diseases, and the increasing importance of risk factors for health have demanded preventive and curative actions from society and the state at several levels.

Although aging does not actually mean becoming ill and dependent, it clearly indicates higher fragility and vulnerability, which increase with the chronologic age of the individual, allied to the social and environmental context the elderly patient is inserted in. In most cases, the family takes responsibility for the weakened elderly patients, even though it is not fully prepared for this situation. This care is perceived in the daily routine and involves functional, social, economic, material and affective support[2].

The healthcare system, through its institutions, has tried to redefine its priorities, establishing strategies capable of treating and preventing diseases that cause disability, seeking out forms of healthcare that increase the autonomy of the subjects and promote quality of life for the population[3].

The number of seniors in Brazil amounted to 10% of the Brazilian population in 2006. At the time, this number was over 18 million people, with an increase of 5 million in a 10-year period (1995-2005). A large share of this population lives in the South and Southeast regions of Brazil, with 1,330,034 living in the state of Rio Grande do Sul and 425,066 in the city of Porto Alegre[4].

Providing healthcare for seniors is more costly than for other age ranges. The average value per hospitalization (Unique Health System - SUS) in the 2000-2005 period for prolonged or chronic care, in Brazil and in the Southern states, was respectively R$ 4,155.00 – R$ 8,630.00 (U$ 2,282.96 – U$ 4,741.75) and R$ 1,430.00 – R$ 3,124.00 (U$ 785.71– U$1,716.48)[5]. In Porto Alegre, the hospitalization costs for ages 1 to 49 years varied from R$ 673.95 to R$ 958.25 (U$ 370.30 – U$ 526.51) in 2007, whereas the costs for patients aged 60 or older varied from R$ 1,025.36 to R$ 1,530.76 (U$ 563.18 – U$ 840.65)[6].

One of the strategies the services adopt to reduce the financial burden on the State and change the traditional way of healthcare production is to include homecare procedures in the list of healthcare modalities, which is characterized by having healthcare teams visit the household of the users with the purpose of assessing theirs and their families' needs, considering the availability of the service and being a part of the healthcare plan and its orientations. The precepts of homecare include complex actions that demand technical knowledge and regular visits by the healthcare team, according to the needs assessed[7].

This modality has resulted in more comfort and security for the elderly patients and their families, and also provided humanized care and quality of life when compared to institutional care[8-9]. However, the execution of this perspective requires a situational diagnosis that favors quantitative and qualitative information in order to effectively contribute to an actual assessment of the reality of the health situation of the elderly population and its family and home dynamics. The orientations yielded by this information allow for decision-making, so that healthcare planning can be organized according to the principle of equity by prioritizing those who need care most.

The permanence of the seniors at home is very important to keep them encouraged to lead their lives, reducing the difficulties and limits imposed by advancing age.

The permanence of the seniors at home is very important to keep them encouraged to lead their lives, reducing the difficulties and limits imposed by advancing age. Their welfare will depend on family back-up. The family is still a source of nourishment and care for seniors all over the world. Their availability to live together and take the responsibility for care delivery is essential.

Therefore, homecare has become a challenge for family caregivers, herein named primary caregivers[10], as well as healthcare services, as it demands the former to take the main responsibility for the seniors and total dedication to perform most of the healthcare tasks, day and night. The healthcare services are required to redesign their actions and to have a vision beyond the services the Healthcare Units currently offer.

However, the implementation of new interventions in the healthcare field requires the professionals to adopt a paradigm that is consonant with the social and healthcare needs of the population, aligned with the principles of the Unique Healthcare System and that is not restricted to actions performed in the Healthcare Units and emphasis on the biological aspects.

The need to respond to the constant demands of relatives of bedridden seniors residing in the area of the IAPI Basic Healthcare Unit who requested home visits for medi-

cal or nursing care for their elderly relatives, added to the fact that the IAPI BHU is located in a region of the city with the second highest number of elderly patients – 11,000 people – caused the coordination of that Unit to present a homecare project for bedridden patients consisting of three stages [11]: identifying the socioeconomic profile and the levels of dependence of handicapped seniors, according to the territory; identifying common necessities that can be attended in different healthcare modalities; proposing a homecare project and establishing service protocols.

GOALS

As the purpose of this study, we sought to describe the process of construction and development of the healthcare project for bedridden seniors at the IAPI BHU, emphasizing the specific goals:

a) Describing the process of construction of the homecare services for bedridden seniors;

b) Identifying the demographic, social and health aspects of the seniors who receive care in the project;

c) Identifying the relevant aspects for the implantation of homecare, as reported by the team.

METHOD

This study consists of a descriptive stage and a qualitative approach of the theme, inserted in the project named Homecare: A case study in the city of Porto Alegre. It was developed in the Graduate Program in Collective Healthcare at Universidade Vale do Rio dos Sinos/RS, approved and filed under #132 in 02/06/2007 by the Review Board of the Municipal Health Secretariat of Porto Alegre.

The study had descriptive and evaluative characteristics of the construction process of homecare for bedridden seniors. The evaluative research uses scientific methods, and is defined as the procedure that executes an ex-post judgment of an intervention, usually with the purpose of helping in decision-making. It is related with assessing the pertinence, the theoretical fundamentals, the productivity, the effects and the relations established between the intervention and the social context it is situated in[12].

The study assessed aspects of the organization of work, contemplating the relations between workers, families, the Healthcare Units and other sectors involved with the project. The clinical evaluation of the bedridden patients was not considered, as the number of registries in the medical records was insufficient.

Data from the patients at the Project of Homecare for Bedridden Seniors who received care from May to December 2003 were collected from medical records and registry forms, as well as from the evaluation registries of the project (secondary data).

The study assessed 25 registry forms and 21 medical records, since 4 patients were not monitored by the project. Data such as age, gender, housing conditions, availability of a room only for themselves and a family or hired caregiver, the degree of dependence to perform daily activities and the need for systematic monitoring by the healthcare team were collected in the medical records, as well as the conditions in the household for care delivery. The main nursing interventions requested by the family were identified. The evaluation instrument contained open-ended and multiple-choice questions. The professionals' evaluation records were also analyzed.

The institutional documents were used to support the project, as they covered the regulations of the Healthcare sectors and homecare projects, including protocols and spreadsheets.

The study offered no risk to the participants, preserving their anonymity and the confidential character of the information contained within the registry forms and the medical records, according to the ethical aspects of National Healthcare Council Regulation 196/96[13].

RESULTS

Description of the construction process of homecare to bedridden seniors at the IAPI BHU

The construction process of homecare required a diagnostic survey, named Characterization of Elderly Patients in an area under the responsibility of a Healthcare Unit: socioeconomic aspects and degree of dependence for care[14], which identified the needs of the bedridden seniors and established the priorities and different modalities of homecare.

From there, the pilot project was built with a proposed duration of one year, with the participation of nurses, physical therapists and speech pathologists. Also, undergraduate Nursing students from schools in the capital and neighboring cities took part in the homecare routines, according to the precepts of Curricular Internship #2 course.

With the assessment and discussion of the experience[15], the pilot project supported the establishment of a program that provided care to bedridden people in all age ranges, named Homecare Program to Bedridden Patients – *Programa de Atendimento Domiciliar ao Acamado (PADA)*, in 2005.

Organization of the administrative infrastructure to provide homecare to seniors

A room was made available within the physical area of the Senior Healthcare Service of the Unit, where the healthcare records, service spreadsheets, files, medical records and materials were organized. The room was also used to hold weekly meetings to discuss cases and to adjust the homecare protocols. A coordinator was defined for the project – the speech pathologist, at first – with the di-

rect participation of the Nursing Service Coordination, who organized, along with her team, the materials and inputs in field briefcases, as well as the nursing care schedules.

An instrument was elaborated for the registry of seniors who requested care; this registry was evaluated by the project coordinator. She had it discussed in the meetings, where the homecare teams were established. The professionals visited the patients, mainly in pairs. In the initial assessments, attempts were made to have professionals from different functional categories broaden the perspectives and to the service priorities. After the visit, the professionals filled out a form, establishing the priorities and the type of monitoring required. If homecare monitoring was deemed unnecessary, the relatives were oriented about the criteria of the project and the reasons for not including the patient in the service. The reasons for this decision were then added to the patient's registry form.

The inclusion criteria for elderly patients were: being 60 years of age or older, being bedridden, living in the neighboring area around the Unit (in a perimeter within a 20-minute walk), preferably without the need for transportation, having an appointed physician for the treatment, not receiving endovenous therapy and having a caregiver who could take responsibility for the healthcare contract. The criteria for dismissal were: absence of a caregiver, not complying with the healthcare contract provided by the homecare plan, having a clinical condition that allowed the patient to go to the Healthcare unit, moving to another household outside the BHU area, absence of conditions at home that could promote health, being discharged from care or death[16].

In the initial assessments, attempts were made to have professionals from different functional categories broaden the perspectives and to the service priorities.

The materials were organized in briefcases according to the type of service (gall bladder catheterization, nasoenteral catheterization, bandages, clinical visit, etc). Each professional was responsible for checking the material and inputs and for returning the briefcase after the visits. The visits and the service provided were registered in a record, according to the approach of each professional, and on the standard form of the Outpatient Information System of the Unique Health System – *Sistema de Informações Ambulatoriais do Sistema Único de Saúde (SIA/SUS)*. The medical records were organized after the first assessment visit and filed alphanumerically as the seniors were registered in the project.

A blackboard was used to organize the visits, with the following information: name of the senior receiving care, name of the main caregiver, address and telephone for contact, names of the professionals responsible for the healthcare and the dates of the visits. The patients were visited, mostly, without the use of transportation. If the use of a vehicle was necessary, it could be scheduled on a weekly basis, according to the information on the blackboard.

Patients were followed in their evolution and outcome according to the service spreadsheets elaborated by the professionals. Also, relevant aspects of the patients and their care were noted on the spreadsheets, as necessary.

In-service Education

In-service Education occurred during the weekly meetings and case discussions, by reading materials that were brought by the team members and the interns, in visits to homecare services and with lectures.

The presence of undergraduate Nursing students promoted a permanent process of education, opening spaces for theoretical-practical discussions and integrating students and professionals.

Demographic, social and health aspects of the seniors

This project had 25 seniors registered, 18 of them being women (86%) and 7 men (33%). Of them, 21 seniors received care by the team and 4 were not assessed. The patients were concentrated in the 75 – 84 years age range.

Most of them lived in the area around the Unit. The households had been built in the 1950s, being apartment buildings with 3 stories at most, with no elevator or intercom systems, and houses with one or two stories. The type of household was thus divided: 11 seniors lived in apartments (52%) and 10 lived in houses (48%), with one or two stories.

In the apartments, ladders provided access between floors, without rails, with tight and slippery steps made mostly of concrete. Lighting during the day was good in the apartments and hallways. As there was no intercom system nor blocking of outer doors, the apartments could be accessed when a dweller came down to open the door of the building. In the two-story houses, the bedridden seniors stayed on the ground floor, in a room reserved especially for them.

Regarding the existence of a room in the house to be used exclusively by the elderly patient, with the presence of a caregiver, 17 (81%) had this type of room available, with the primary caregiver being a relative who lived in the same household. Only one elderly lady lived by herself, receiving care from a relative who lived next door.

It could be noted that the family was involved daily with the household chores and the care for the bedridden senior. They took over the routines of personal care, hygiene, dressing, dieting, administration of medication, changing bandages, mobilization in bed, moving the patient from the bed to an armchair and, in some cases, they took the patients out for walks and sunbathing. Only one family had a hired professional, who would perform the routines of hygiene, bandages and walks in two shifts every day.

Difficulties to obtain materials and equipment, as well the environmental adaptations, were observed in different

aspects. The families reorganized physical aspects in the house so that the seniors had a room for themselves, but the small spaces between the bed and the furniture and small bathrooms and bedrooms made it difficult for the patients to leave their beds, or even to use wheelchairs. Another important issue identified in the study was the creativity of the caregivers to provide technologies, even if at times in an improvised way, that would help with the care provision.

Transporting the seniors to the Healthcare unit to receive care was difficult, due to the architectural impediments of the households, the conditions of the patient and the financial aspects involved in hiring private transportation, since the Municipal Secretariat of Health did not have public transportation available for this purpose.

The instrumental nursing activities requested most often in care provision for the seniors who took part in the study included those related to sequelae of non-transmissible chronic diseases after hospital discharge, such as: care with enteric and gall bladder catheters, with tracheotomy, bandages on surgical wounds, removal of stitches, orientation and care provision for pressure ulcers, among others. Also, the nurses were asked questions about the organization of the household environment for homecare and to support the caregivers, as they often lacked the necessary knowledge and were anxious about their new function. In physical therapy, the care was focused on moving the bedridden patient from the bed to the armchair and on the posture of the caregiver to avoid postural injuries during care provision. The speech pathology was based on the diagnosis and minimal orientations to the caregiver at home. The relatives also needed to solve their doubts about the organization of the household environment, bonding and emotional support, due to the anxiety caused by the function of having to take care of household chores.

The families were capable of seeing to the daily care demands when supported by the healthcare professionals, who were expected to provide guidance and support to seniors and caregivers, so that care could be performed easily and without burdens for either side. As such, the integration of those involved in the process would be beneficial for both the patients and their health.

Overall, families felt alone and exhausted while performing the arduous task of providing care to the bedridden patient. When this task was under the responsibility of few people, it made them feel more tired, since providing care to patients at home is a task that demands a social network that may not exist, or that the family may not know about.

The difficulties that cause anxiety in the family were predominantly related to providing care to the wounds and the feeding tubes.

The cost of the treatment, allied to the lay caregivers' lack of knowledge about possible complications in the patient's situation, caused insecurity and stress. The families were observed to have pressing needs for information, understanding what was going on and how they should act in such a situation.

RESULTS AND DISCUSSION

Relevant aspects made evident in homecare development

The age range of the elderly patients in the program is in accordance with IBGE data[4], which show that the highest growth index among seniors (2.4 million) occurred at the age of 80, in 2005. The data also show the incidence of chronic diseases, poorer functional capacities, less autonomy and, consequently, greater demands for attention and time from family and society. Regarding gender, there is a ratio of 100 women for every 62 men in this age range.

The number of women over 60 years of age, when compared to men, has been higher for a long time. Women's life expectancy at birth is higher than men's by four years. It has been increasingly common to observe a feminization of aging in Brazil[5].

Although this study found only one elderly lady living by herself, the Southern region of Brazil is characterized by 47.7% of its families being *empty nests* (childless couples or people living by themselves). In the Northern and Northeastern regions of the country, most seniors live with their relatives, in proportions of 70.5% and 68.3%[4].

The overburdening of primary caregivers with the daily care activities for bedridden patients has been reported in literature, with accounts of their suffering, lifestyle changes, transportation expenses and the dependency of the bedridden patient on the caregiver[17-18]. Reports of insecurity, the need to receive information and guidance on homecare were also described in Brazilian studies[17,19].

The risk of diseases, disability, death of spouses, isolation and death increases in old age. As time passes, it is impossible to avoid the decay of the body, as diseases occur more easily as the person becomes older, and recovery is much slower. In general, diseases in seniors are chronic and multiple, demanding continuous interventions of multidisciplinary teams. Dealing with such issues is part of the arsenal of skills each professional or team should develop when they set off to provide care to elderly patients.

However, as the healthcare service was not fully organized, it had difficulties to respond to the demands of the seniors registered in the project. This difficulty was evident in the necessity of transporting the bedridden patient to the Healthcare Unit or Hospital; having a home assessment by a physician in cases of aggravated conditions; having a dietician for diet adjustments and nutritional monitoring; and having a social worker to report social needs and close partnerships with institutions, added to the team's lack of preparation to deal with cases where healthcare for the senior was neglected.

By proposing a homecare project, the team aimed to support families in providing care to their seniors, so that the complications and sequelae could be lessened and an educational space for the exchange of knowledge could be created. This would reduce anxieties, with respect for beliefs, values and practices the caregivers already perform, and integrate the cultural and professional care, strengthening the healthcare space of the family.

Certain aspects would strengthen the project, such as:

• Acknowledging the great necessity and the importance of this type of care, for seniors, caregivers and relatives who need to solve their doubts, share their concerns and plan the healthcare routine;

• Increasing the range of competences and the exchange of knowledge between the family and the team;

• The fact that the project was started without a full team, upon the initiative of the nursing staff of the Unit;

• The motivation of the professionals involved, breaking away from the healthcare model, executed only within the boundaries of the Healthcare Unit;

• Attempts to strengthen the inter-sectorial aspects of the public services;

• The rewarding aspects of the experience for the involved professionals, both in interpersonal and technical relationships and the establishment of partnerships, highlighting the great responsibility of professionals and caregivers when providing homecare;

• The beginning of a permanent education program for the professionals involved in the project;

• The qualification and increase of service delivery as a result of partnerships with Nursing Schools in the scope of curricular internships;

• The elaboration of administrative instruments by the team, which qualified the provision of service and made it possible.

• Improvements in the relationship between the families and the service, the quality of life of the bedridden patients and the security and self-confidence of the caregivers, as a result of collective work.

However, not all aspects made evident were as contributive as those described above. Certain weaknesses were noted, regarding:

• Absence of the following professionals in the team: physician, dietician and social worker;

• Slow responses to the necessity of medical assessments at home;

• Difficulties in obtaining social transportation to move the senior to the Healthcare Services;

• Absence of documents establishing the responsibility of the caregiver and the limits for the work of the team;

• Sub-registries in the medical records without a single standard, with every professional doing it according to the specifics of his/her field or profession;

• Absence of a standardized instrument that could characterize the provision of care and the environment;

• The professionals had difficulties to manage their activities in the Healthcare Unit and the needs to perform the home visits more than once a week, especially when the number of families requesting care from the teams increased.

• The development of the project depended almost exclusively on the professionals involved, with little participation by others.

• The need for instruments, materials and equipment that could increase and qualify the care provided (homecare form, tubes, pressure relievers, material for bandages, hospital beds, nebulizers, wheelchairs, walkers, crutches, inhalators, games, among others);

• The lack of partnerships with volunteers to provide activities for the seniors and support for caregivers in daily and instrumental activities. Although this type of care was not actually performed, it was considered, so that volunteers could work with the elderly patients, performing the following activities: reading, games, exchange of experiences, craftwork, among others, as well as remaining in the house while the caregiver performed the household chores, visited the Healthcare Unit or performed the instrumental activities of daily life.

FINAL CONSIDERATIONS

With this study, the authors believe that it is possible to apprehend relevant factors about the demographic, social and health reality of the seniors who took part in the project, yielding essential information for its re-structuring.

The seniors in this study were predominantly females in the 75 – 84 age range, living in the neighboring area of the Healthcare Unit. The relative was the main caregiver, assuming all care functions for the bedridden senior, in addition to household chores. The main reasons for requesting homecare were non-transmissible chronic diseases and their sequelae. The difficulties that caused anxiety in the family were mostly related with wound care, feeding tubes and obtaining transportation to take the elderly patient to the Healthcare Services. The families were observed to be capable of meeting the daily demands of care when supported by healthcare professionals.

As observed, the healthcare interventions carried out by the homecare project for bedridden seniors sometimes exerted a strengthening and sometimes a weakening influence.

The team intended to support the families to provide care to their elderly relatives, reducing the complications and sequelae, creating educational spaces for exchanging knowledge, minimizing anxiety and strengthening the family's care spaces. For the professionals involved in the project and for the caregivers, the experience was reportedly rewarding, noting the great responsibility assumed by both sides to provide care at home. The collective work improved the relationship of the families with the Healthcare Units as well as the quality of life of the seniors, and the caregivers' sense of security and self-confidence.

It is worth noting that the project was a fertile ground for the establishment of partnerships between universities and the healthcare unit, promoting a space of integration for the qualification of human resources, professionals and work processes, in addition to promoting scientific production.

The evaluation of the project called for its continuity; however, the revision of the weakening aspects was essential for this continuity, with certain adjustments being necessary in the organization so that the spaces of care and the quality of the services offered to the population could be increased. Although it was not possible to describe individual improvements in the patients' clinical situation due to the use of secondary sources, improvements were observed in the conditions of hygiene, patient mobility, reorganization of spaces and psychological aspects of the families, who felt supported and more secure.

It should also be noted that, in addition to the strong instrumental and normative focus, the Nursing staff was present in most situations of home care delivery, broadening the caregiving families' spectrum of action, as the cases involved mostly people with bone-joint and neurological problems.

The authors' reflection on this fact is supported by elements like the nursing staff's immature discussion on the work processes and the Healthcare Unit's lack of preparation to support the teams, according to several aspects.

Since its inception, the main purpose of providing homecare was to break away from the ready-made menu. Although the professionals were insecure, they wanted change, and painstakingly sought for humanized care, loaded with citizenship. For that, they had to break away from the rigid structures within the Unit and within themselves.

After the evaluation of this experience, the healthcare team of the PADA/IAPI became involved with the creation of a group that strives to provide integral care, in response to efforts to commit themselves more and more to life and to ethical-political healthcare delivery.

The challenges imposed by the professionals' commitment in their experience of healthcare work, demanded new work organization strategies from the team. These strategies had to break away from the medical-based biological model, restricted to the physical area of the Unit. This human commitment to care delivery evidenced that skill alone was insufficient to meet the citizens' rights to quality of life and dignified death. The team's internal educational practices, in addition to the live work performed, favored the conciliation between ethics and skills, reducing the fragmentation and the dichotomy of care between professional and lay caregivers.

The authors' final note is that the experience reported herein shows the reaction of the healthcare actors to the political action of recognition of life in their field of expertise, incipiently incorporating elements that make up integral healthcare.

REFERENCES

1. Brasil. Ministério da Saúde. Secretaria de Assistência à Saúde. Guia operacional e portarias relacionadas. Brasília; 2002.

2. Silveira TM, Caldas CP, Carneiro TF. Cuidando de idosos altamente dependentes na comunidade: um estudo sobre cuidadores familiares principais. Cad Saúde Pública. 2006;22(8): 1629-38.

3. Püschel VAA, Ide CAC, Chaves EC. Modelos clínicos e psicossocial de atenção ao indivíduo e à família na assistência domiciliar: bases conceituais. Rev Esc Enferm USP. 2006;40(2):261-8.

4. Instituto Brasileiro de Geografia e Estatística (IBGE). Síntese de indicadores sociais 2006. Rio de Janeiro; 2006.

5. Organização Pan Americana de Saúde (OPAS). Indicadores básicos para a saúde no Brasil: conceitos e aplicações. Brasília; 2008.

6. Brasil. Ministério da Saúde. DATASUS. Sistema de Informações Epidemiológicas e Morbidade [texto na Internet]. [citado 2008 maio 25]. Disponível em: http://tabnet.datasus.gov.br

7. Rehem TCMSB, Trad LAB. Assistência domiciliar em saúde: subsídios para um projeto de atenção básica brasileira. Cienc Saúde Coletiva. 2005;10 Supl:231-42.

8. Silva KL, Sena R, Leite JCA, Seixas CT, Gonçalves AM. Internação domiciliar no Sistema Único de Saúde. Rev Saúde Pública. 2005;39(3):391-7.

9. Fabrício SCC, Wehbe G, Nassur FB, Andrade JI. Assistência domiciliar: a experiência de um hospital privado do interior paulista. Rev Lat Am Enferm. 2004;12(5):721-6.

10. Lahan CF, Silva LA. O cuidador. In: Jacob Filho W, editor. Avaliação global do idoso: manual da Liga Gamia. São Paulo: Atheneu; 2005. p. 171-80.

11. Porto Alegre. Secretaria Municipal da Saúde. Centro de Saúde IAPI. Projeto de Atendimento Domiciliar a Pacientes Acamados. Porto Alegre; 2002.

12. Hartz ZMA. Avaliação em saúde: dos modelos conceituais à prática na análise da implantação de programas. Rio de Janeiro: FIOCRUZ; 1997.

13. Conselho Nacional de Saúde. Resolução n. 196, de 10 de outubro de 1996. Dispõe sobre diretrizes e normas regulamentadoras de pesquisa envolvendo seres humanos. Bioética. 1996;4(2 Supl):15-25.

14. Freitas IB, Marques GQ, Ribeiro A, Boggio E. Caracterização de idosos de uma área descrita de uma unidade básica de saúde: níveis de dependência e tendências socioeconômicas. Saúde (Porto Alegre). 2004;1(1):65-70.

15. Porto Alegre. Secretaria Municipal da Saúde. Centro de Saúde IAPI. Relatório de avaliação do projeto-piloto de assistência domiciliar a idosos acamados. Porto Alegre; 2004.

16. Porto Alegre. Secretaria Municipal da Saúde. Centro de Saúde IAPI. Protocolo de procedimentos em nível de atenção primária para o atendimento domiciliar ao idoso acamado. Porto Alegre; 2002.

17. Diogo MJD'E, Ceolim MF, Cintra FA. Orientações para idosas que cuidam de idosos no domicílio: relato de experiência. Rev Esc Enferm USP. 2005;39(1):97-102.

18. Veras RP, Caldas CP, Dantas SB, Sancho LG, Sicsú B, Motta LB, et al. Avaliação dos gastos com o cuidado do idoso com demência. Rev Psiquiatr Clín (São Paulo). 2007;34(1):5-12.

19. Maffioletti VLR, Loyola CMD, Nigri F. Os sentidos e destinos do cuidar na preparação dos cuidadores de idosos. Ciênc Saúde Coletiva. 2006;11(4):1085-92.

Correspondence addressed to: Giselda Quintana Marques
Avenida Rachel Wolfrid, 220 - Protásio Alves
CEP 90260-240 - Porto Alegre, RS, Brazil