

Social demographic characteristics and the elderly care after hospital discharge in the family health system

CARACTERÍSTICAS SÓCIO-DEMOGRÁFICAS DO ATENDIMENTO AO IDOSO APÓS ALTA HOSPITALAR NA ESTRATÉGIA DA SAÚDE DE FAMÍLIA

CARACTERÍSTICAS SOCIODEMOGRÁFICA Y DE LA ATENCIÓN AL ANCIANO DESPUÉS DE LA ALTA HOSPITALARIA EN LA ESTRATEGIA DE LA SALUD DE FAMILIA

Maria José Sanches Marin¹, Fernanda Crizol Bazaglia², Aline Ribeiro Massarico³, Camila Batista Andrade Silva⁴, Rita Tiagor Campos⁵, Simone de Carvalho Santos⁶

ABSTRACT

The objective of this study was to verify the sociodemographic profile of the elderly and the health care service they receive from the Family Health Strategy (FHS) after their discharge. This is a descriptive study, and data collection was performed with 67 aged individuals who were discharged in October, November and December, 2007, and lived in the area covered by the FHS of Marília (São Paulo state). Simple descriptive analysis was used for the presentation of data. The majority of the elderly are female, and their hospitalization occurred as a referral of the Emergency Room due to complication. More than two thirds report they were visited by FHS team professionals, mainly the Community Health Agent (CHA), but they suggested the team should follow up closer. In conclusion, it is necessary to develop a new health care model for the elderly after hospital discharge.

KEY WORDS

Aged.
Health of the elderly.
Family health.
Patient discharge.
Home nursing.

RESUMO

Este estudo teve por objetivo verificar o perfil sócio-demográfico dos idosos e a assistência que recebem após a alta hospitalar da equipe da Estratégia de Saúde da Família (ESF). Trata-se de um estudo descritivo, e a coleta de dados foi realizada com 67 idosos que receberam alta nos meses de outubro, novembro e dezembro de 2007, residentes na área de abrangência da ESF do município de Marília (SP). Para apresentação dos dados, utilizou-se a estatística descritiva simples. A maioria dos idosos é do sexo feminino, e foi internada por encaminhamento do Pronto Socorro e, ao apresentar complicação, procurou o hospital. Mais de dois terços deles afirmaram ter recebido visita de profissionais da equipe da ESF, principalmente do Agente Comunitário de Saúde (ACS), mas sugeriram um acompanhamento mais frequente da equipe. Depreende-se que é preciso avançar na construção de um novo modelo de atenção ao idoso, após alta hospitalar.

DESCRIPTORES

Idoso.
Saúde do idoso.
Saúde da família.
Alta do paciente.
Assistência domiciliar.

RESUMEN

En este estudio se propone verificar el perfil socio-demográfico de los ancianos y la atención que reciben luego del alta hospitalaria por parte del equipo de Estrategia de Salud de la Familia (ESF). Se trata de un estudio descriptivo, la recolección de datos fue realizada a partir de 67 ancianos residentes en el área de influencia de la ESF del municipio de Marília que habían recibido alta en los meses de octubre, noviembre y diciembre de 2007. Para el tratamiento de los datos, se utilizó la estadística descriptiva simple. La mayoría de los ancianos es de sexo femenino y, al experimentar complicaciones, se presentó en el hospital. Más de dos tercios de ellos afirmaron haber recibido visita de profesionales del equipo de ESF, en particular del Agente Comunitario de Salud (ACS), y sugirieron un seguimiento más frecuente del equipo. Se desprende que es preciso avanzar en la construcción de un nuevo modelo de atención.

DESCRIPTORES

Anciano.
Salud del anciano.
Salud de la familia.
Alta del paciente.
Atención domiciliar de salud.

¹ PhD in Nursing. Postdoctoral Fellow at the Federal University of São Paulo, Paulista School of Medicine. Professor at the Faculty of Medicine of Marília. SP, Brazil. marnadia@terra.com.br ² Undergraduate student, Faculty of Medicine of Marília, Nursing Program. Marília, SP, Brazil. fer@famema.br ³ Undergraduate student, Faculty of Medicine of Marília, Nursing Program. Marília, SP, Brazil. aliner@famema.br ⁴ Undergraduate student, Faculty of Medicine of Marília, Nursing Program. Marília, SP, Brazil. cbas@famema.br ⁵ Undergraduate student, Faculty of Medicine of Marília, Nursing Program. Marília, SP, Brazil. rita.tc@uol.com.br ⁶ Specialist in Family Health. Nurse, Family Health Strategy of Marília. Marília, SP, Brazil. simoneenf@flash.tv.br

INTRODUCTION

Significant changes are occurring in the population's age structure, causing a considerable increase in the number of elderly people worldwide. The elderly, even the ones in good health, gradually become debilitated due to physiological changes as age increases, making them susceptible to frequent changes in their health. This has led to epidemiological changes characterized by the increase in chronic-degenerative diseases that demand, for appropriate care, a high quantity of material and professional resources, properly trained to deal with this situation⁽¹⁾.

Elderly people are the most common users of health services and there is evidence that the average cost of their health could cover the cost of health care for three people of a younger age⁽²⁾. Elderly people frequently also require hospitalization, both for chronic-degenerative and severe and traumatic diseases, and have a higher risk of longer hospitalization periods⁽³⁾.

Moreover, care provided in the hospital environment creates dependencies that make the return to home difficult. Thus, the essential aim of elder care is keeping the elderly person at home. If, for any disease, the elderly need hospitalization, the hospital should prepare them as early as possible to be able to return home in a physical, emotional and social condition to be independent⁽⁴⁾.

The assessment of changes in elderly functional capacity during hospitalization and the degree of association of these alterations at discharge indicates that 25.6% had an improvement in functional capacity, 34% did not have functional changes, 19.1% worsened functionally and 21.3% died during the period. These data confirm the fragility of the elderly during hospitalization, an occasion in which they suffer severe changes in their health and face the possibility of complications and even death⁽⁵⁾.

A study that characterized the problems of the elderly at hospital discharge demonstrated that many of them go home with no intention of carrying out care even considered basic to the continuity of treatment, such as the use of medications, feeding and undertaking proper physical activity. The same happens in situations that demand special care, such as cases of ostomies, wounds and use of stents. This occurs, almost always, due to lack of education and social and family support⁽⁶⁻⁷⁾.

Moreover, the one who usually assumes the continuity of care is some member of the family of the aged person. If this person did not participate in the care provided at the hospital and is not aware of the changes that occurred in

the health status of the elderly person or care needed, she/he has difficulty making decisions and the accomplishment of the actions needed in care is impaired.

It is believed that the current care to elderly health should be based on continuity, given that sporadic individual medical care, restricted to complications, has not fulfilled this population's needs. In order to meet the goal of continuity in care, health professionals need to get rid of the standard of isolated, paternalistic and authoritarian care, renewing the work method and adopting, as a philosophy, interdisciplinary team work, with a comprehensive view of the human being, so that the elderly are seen as a whole, including considering their social context.

As an alternative for change in the health care model, the Family Health Strategy (FHS) is being implemented in all of Brazil over the last decade, aiming to reorient primary care and the current health care model⁽⁸⁾. Care, now family-centered, takes into account the physical and social environment, which enables professionals to take a broad view of the health/disease process and of the need for intervention that goes beyond curative practices⁽⁹⁾.

Concerning the quality of health care for the aged in the FHS, few studies are identified in the literature addressing the theme, as it is a recent strategy that is still trying to organize itself structurally and in the training of professionals...

It is expected that the family health team, when acting in a limited and designated area, develop health actions targeting families and their environment, focusing on preventive, curative and rehabilitation aspects, articulating them with other sectors that contribute to the improvement of health conditions⁽¹⁰⁾. The FHS chooses, thus, as a central point, the establishment of bonds and development of ties of commitment and responsibility between health professionals and the population⁽¹¹⁾.

Concerning the quality of health care for the aged in the FHS, few studies are identified in the literature addressing the theme, as it is a recent strategy that is still trying to organize itself structurally and in the training of professionals to act according to the logic of health surveillance.

A study that aimed to analyze the conceptions and practices of the community health agents in elderly health care highlights the report of agents' difficulties in resolving the complaints and a practice preponderantly targeting the scheduling of examinations and medical appointments, medical and nursing reinforcement and the control of medication and treatment⁽¹²⁾.

After a decade of FHS implementation, the existence of a gap in the scientific production that can indicate the state of care to groups with higher risk of becoming ill and dying is clear. Thus, authors have considered this to be the moment to show its effectiveness in the health care to this population, especially regarding the elderly population after hospital discharge, when in a situation of great vulner-

ability and in special need, demanding, most of the time, professional care.

Thus, the present study had the following aims:

- To describe the socio-demographic profile of the elderly living in the area covered by the FHS in the city of Marília after hospital discharge.
- To characterize the care received by the elderly after hospital discharge, their doubts and difficulties.

METHOD

This is a quantitative, cross-sectional and descriptive study, which permits the identification of needs and providing basic data for future studies or actions⁽¹³⁾.

The study was carried out with elderly people who were discharged from the *Hospital das Clínicas* in Marília, SP, Brazil and belong to the scope area of the 28 (twenty-eight) Family Health Units (FHU) of the city. These units, established between 1998 and 2005, are located in areas where the population present higher socio-economic need and, consequentially, a lower possibility of access to health services and higher exposure to the risks of becoming ill and dying. The city of Marília is currently estimated to have (IBGE 2.000) 204,957 inhabitants, of which approximately 84,000 inhabitants receive care at the FHU. In general, the units meet the minimum requirements necessary for their establishment, according to the recommendations of the Ministry of Health, regarding their physical structure, minimum team constitution, development of basic national programs and organization of team work. The schedules are organized according to spontaneous demand (with appointments scheduled with physicians, dentist and nurses), with home visits to disabled users and group activities. There are also weekly team meetings and monthly meetings with participation of the community.

The *Hospital de Clínicas* of Marília is a school-hospital of the Marília Medical School and mainly provides tertiary care, serving as a reference for the whole region (Regional Health Direction - DIR-Marília). In 2006, 2,959 patients were discharged, of whom 1,151 (38.8%) were elderly. Of those, 828 lived in the city of Marília and 349 belonged to the scope area of the Family Health Units. Considering this data and the need to obtain a representative sample, simple random sample size was calculated for a tolerable sample

error equal to 5%⁽¹⁴⁾, obtaining a result of approximately 50 elderly people.

In order to derive an approximate sample from this calculus, all elderly people discharged from the *Hospital de Clínicas* in the months of October, November and December 2007 were studied. Using the list received from the Information Nucleus of the institution, a total of 96 elderly people who lived in the scope area of the FHU in the city of Marília were identified, of which 33 were from October, 39 from November and 24 from December. Of these, 67 were interviewed. Of the others, 18 were not found at the address listed or the address was not found; nine had died and two had been re-hospitalized.

The data collection instrument consisted of questions regarding socio-demographic data, general health condition (age, gender, marital status, schooling, reported cause of hospitalization and hospitalization length), doubts and difficulties found after discharge, satisfaction with and support received from the FHU.

Data collection was carried out at the homes of the studied elderly, after approximately one month of hospital discharge. Of the total interviews, 54 were carried out with the elderly person him or herself and 13 with family members. Data were grouped and presented in tables, using simple descriptive statistics.

The Project was approved by the Research with Human Beings Ethics Committee of the Marília Medical School – protocol n. 580/06. All elderly or responsible persons received clarification as to the aim of the study and, in order to participate, they have signed the Free and Informed Consent Form.

RESULTS

Table 1 shows that 42 (62.7%) of the interviewed elderly people are female and 25 (37.3%) male, with a predominance of elderly people aged 60 to 69 years. The number of women who live without a partner (50.7%) and the number of illiterate elderly people (27 – 40.3%) is highlighted.

Concerning the hospitalization length, 29 elderly people (43.2%) were hospitalized from one to five days, 21 (31.3%) from five to ten days, five were hospitalized from 11 to 15 days and the others, sixteen days or more.

Table 1 - Distribution of socio-demographic data and hospitalization length of the studied elderly according to gender - Marília - 2008

Socio-demographic data	Male gender		Female gender		Total	
	N	%	N	%	N	%
Age group						
60-69 years	09	13.4	18	26.8	27	40.3
60-69 years	13	19.4	13	19.4	26	38.8
80 years or over	03	4.5	11	16.4	14	20.9
Total	25	37.3	42	62.7	67	100
Marital status						
With partner	21	31.3	8	11.9	29	43.2
Without partner	04	5.9	34	50.7	38	56.7
Total	25	37.3	42	62.7	67	100
Schooling						
Illiterate	07	10.4	20	29.8	27	40.3
Incomplete primary education	11	16.4	14	20.8	25	37.3
Complete primary education	04	6.0	05	7.4	09	13.4
Higher Education	01	1.5	01	1.4	02	2.9
Did not report	02	3.0	02	3.0	04	6.0
Total	25	37.3	42	62.7	67	100
Occupation						
None	15	22.3	24	35.8	39	58.2
Housewife	-	-	07	10.4	07	10.4
Rural worker	03	4.4	05	7.4	08	11.9
Cleaning lady	-	-	03	4.4	03	4.4
Trader	04	10.4	-	-	04	6.0
Others	03	4.4	03	4.4	06	9.0
Total			42	62.7	67	100
Hospitalization length						
1 - 5 days	09	13.4	20	29.8	29	43.2
6 - 10 days	09	13.4	12	17.9	21	31.3
11 - 15 days	02	3.0	03	4.4	05	7.4
16 days or more	05	7.4	07	10.4	12	17.9
Total	25	37.3	42	62.7	67	100

In Table 2, the health service which most frequently referred elderly people for hospitalization was the Emergency Unit, in 56.7% of the cases.

Table 2 - Distribution of the health services which referred the elderly for hospitalization - Marília - 2008

Health service	N	%
Emergency Unit	38	56.7
FHS team	13	19.4
Specialty outpatient clinic	05	7.5
Others	11	16.4
Total	67	100

The diseases which were reasons for hospitalization, according to the elderly, grouped according to the International Classification of Diseases – ICD-10, are distributed in Table 3. It is possible to observe that the most frequently cited diseases are those related to the cardiovascular system, followed by nervous system and digestive system diseases.

Table 3 - Distribution of the diseases reported by the studied elderly as reason for hospitalization, grouped according to ICD - 10 - Marília - 2008

Medical diagnosis reported for hospitalization	N	%
Cardiovascular System Diseases	13	19.4
Nervous System Diseases	13	19.4
Digestive System Diseases	12	17.9
Neoplasms	10	14.9
Musculoskeletal System and Conjunctive Diseases	10	14.9
Respiratory Tract Diseases	7	10.4
Endocrinal, Nutritional and Metabolic Diseases	6	9.0
Urogenital System Diseases	5	7.5
Eyes and related diseases	2	3.0

Among the 67 studied elderly people, 21 (31.3%) presented complications after hospital discharge and needed new care to be provided by the health services. When asked about the health care services sought by them, eight looked for hospital services, followed by five (7.5%) who went to the FHS, four (6%) who went to the specialty outpatient

clinic, and two (3%) looked for the Interdisciplinary Hospitalization Program (PROIID), among other services.

In order to verify the care received by the elderly after hospital discharge, some questions were asked. In Table 4, it is observed that only 19 (28.4%) were referred back to the original FHU and almost 30% had doubts about or difficulty in the continuity of care after discharge. Most of them affirmed having received care from the team professionals; however, the Health Community Agent (HCA) was the most reported professional. The studied elderly were asked if they were satisfied with the care provided by the FHU and more than 70% answered in the affirmative.

Table 4 - Distribution of the answers of the studied elderly, according to some aspects indicative of the continuity of care after hospital discharge - Marília - 2008

Aspects indicative of the continuity	N	%
Did you have doubts/difficulties after discharge?	20	29.9
Were you referred back to the original FHU after discharge?	19	28.4
Did you receive care from the FHU team after discharge?	49	73.1
Are you satisfied with the care provided by the FHU?	48	71.6

When asked about the possible contributions of the FHS after hospital discharge, almost half of the elderly and/or family members affirmed that there should be more frequent follow-up, while others desired more specialists, specific care and a supply of materials for procedures. There were also those who said that the FHS team would not have anything else to offer (29 – 30.8%), as observed in Table 5.

Table 5 - Distribution of elderly answers concerning the aspects with which the FHU could contribute after discharge - Marília - 2008

In what could the FHU contribute after discharge?	N	%*
More frequent follow-up	31	46.26
Specialists	6	8.95
Care delivery	6	8.95
Materials supply	5	6.6
In nothing	29	30.85
Others	10	14.92

*The elderly had the possibility of giving one or more answers.

DISCUSSION

The limitations of a cross-sectional and descriptive study should be considered in this study, such as the lack of control over the quality of information given and the intersections among the variables. The presented data cannot represent the dimensions of all problems and difficulties that elderly people can face after hospital discharge, either. Moreover, the lack of studies that outline the situation of the elderly after hospital discharge makes a comparative analysis of the data presented here more difficult. Never-

theless, it is believed that these data can contribute to the characterization of aspects that need to be demonstrated in the search for improving the quality of care.

In the present study, the socio-demographic characteristics of the studied elderly indicate important conditions to propose interventions in health conditions, aiming at the improvement of the life conditions of these people. Data point out the higher number of women (62.7%), with a predominance of the female sex also being reported in epidemiological studies about the process of aging⁽¹⁵⁾, attempts have been made to explain this difference. Some hypotheses suggest that men have higher rates of mortality related to violence, traffic accidents and chronic diseases. Women have the highest rates of morbidity in almost all non-fatal chronic diseases. Moreover, they are more likely to pay attention to the signs and symptoms and to seek care more frequently than men.

In addition, 34 (50.7%) of the elderly women in the study live without a partner. This makes them highly vulnerable to poverty and social isolation, which is possibly due to discrimination in access to education, salary, feeding, significant work, health care, social care measures and political power⁽¹⁶⁾.

Illiteracy or a low level schooling completed is a characteristic of most of the who were interviewed, which represents a serious risk factor due to the complexity of the care they frequently need after discharge.

When asked about the health service responsible for hospitalization, most elderly and/or relatives (38 - 56.7%) reported having been to the emergency service; the FHS team was responsible for only 19.4% of the referrals. From this finding it is inferred that the elderly were hospitalized for emergency situations or that people, when sick, search for emergency services for a more immediate resolution to their problem. The fact that a large number of elderly people, in experiencing complications after discharge, also look for the hospital, seems to support such an inference.

This occurrence deserves more detailed study, including determining to what extent it has been possible for the FHS teams to be considered in referrals for situations that require care in more complex levels of health care.

Most patients remained hospitalized for a period of one to ten days, which could mean that, upon returning home, they were not completely recovered from the drop suffered in their health status at that point, thus requiring professional care. Moreover, the elderly are vulnerable in their health status due to the changes suffered during life: physically, socially and emotionally. Thus, when they have a change in their health status, they need more time to recover and very often have complex needs.

Cardiovascular diseases were the most frequently cited by the elderly as the cause of hospitalization, followed by diseases of the nervous and digestive systems. Most of these diseases, because they are chronic, require a high cost in health care, besides enabling the emergence of complications causing major interference in the degree of indepen-

dence and quality of life. Considering this situation, the FHS team, from the perspective of health surveillance, is a necessary resource to support and monitor these people.

The presence of chronic-degenerative diseases associated with the vulnerability of suffering changes in health status has led the elderly and their family members to present questions and/or difficulties that reveal the complexity of the care they need. In addition, the professional of the FHS team who most frequently provided care to the elderly was the Community Health Agent (CHA).

Although the CHAs perform an important bonding role between the community and the team and may help in directing people's needs, they have limitations in assessing and understanding the complexity of the problems that the elderly and their families can experience in this moment of vulnerability.

It is worth considering the fact that most of the elderly were not referred by the hospital to the original FHU. This should be considered by the health services since, with the operation of the reference and counter-reference system with mechanisms of information exchange, it would avoid doubling efforts and, consequently, there would be improvement in the quality of care as well as a cost reduction.

Concerning responses from the elderly and/or family members related to the aspects with which the FHS could contribute after hospital discharge, almost half affirm that there should be more frequent follow-up. On the other hand, 29 (30.85%) elderly people report that the FHS team could not help them with anything, which is also disturbing, since it can reveal the lack of awareness of these people about the role of the team in this situation. Thus, it can be argued that these users require professional care and, moreover, that the FHS proposal of meeting the health needs of risk groups in a determined area still needs to be improved.

However, the need for monitoring groups vulnerable to changes in their health status after discharge is not re-

stricted to the elderly. Post-discharge surveillance of surgical patients has demonstrated the existence of high rates of surgical site infection, which leads to the need to redirect the policies of prevention and control of complications after discharge⁽¹⁷⁾.

FINAL CONSIDERATIONS

Data presented in this study seem to be a tool to assist in the management of health services, since the elderly population is in a fragile situation and requires actions promoting health and injury prevention, which would contribute to improving their living conditions.

The situation of the elderly is preoccupying, once the complexity and multiplicity of the problems they present, especially in situations that expose them to higher vulnerability, is acknowledged, such as the case of elderly patients discharged from the hospital. This requires interdisciplinary action and, consequentially, a change of posture by the professionals regarding health problems.

Considering the data presented in this study, it is verified that the FHS has yet to advance in the construction of the new model of health care. Even though it is structurally implemented, the process of movement toward a comprehensive care, based on the bonding and accountability, is not yet developed.

It is believed, however, that with investment in education and training of health professionals, through curriculum changes in undergraduate programs and permanent and continuing education, it is possible to face the situation and achieve a new context of health care.

Moreover, there is need to continue this sort of study in order to expand the variables that can indicate what the FHS is effectively providing for the improvement of the living conditions of elderly people.

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Funding

Funded by the Pro-Health Program of the Nursing Program of the Marília Medical School.