

# Primary health care: transitional care by professionals to frail elderly and their caregivers after hospital discharge

Atenção primária: cuidado transicional dos profissionais ao idoso frágil e seus cuidadores após alta hospitalar

Atención primaria: atención transitoria de los profesionales a las personas mayores frágiles y a sus cuidadores tras el alta hospitalaria

## RESUMO

**Objetivo:** Analisar a percepção de profissionais da atenção primária em saúde sobre a assistência oferecida a idosos dependentes e seu familiares nos pós alta hospitalar. **Método:** Estudo descritivo, com abordagem qualitativa, realizada com 16 profissionais da atenção primária em saúde, lotados em uma Unidade de Básica previamente selecionada. O período de coleta foi de novembro de 2020 a maio de 2021. Realizou-se entrevistas semiestruturadas, cujo conteúdo foi organizado em categorias temáticas conforme Análise de Conteúdo e discutido à luz da teoria das Transições propostas por Afaf Ibrahim Meleis. **Resultados:** Das análises, emergiram três categorias: ações desenvolvidas no domicílio e compartilhadas com a família; o cuidado para a família e para a pessoa do cuidador; sentimentos, satisfação e desafios da equipe. **Conclusão:** Observou-se que os profissionais têm consciência da importância da integralidade no cuidado da pessoa idosa na transição hospital-domicílio, porém, enfrentam obstáculos estruturais para efetiva-lo.

**DESCRITORES:** Idoso; Atenção primária à saúde; Cuidado transicional; Alta do paciente; Assistência domiciliar.

## ABSTRACT

**Objective:** To analyze the perception of primary health care professionals about the care offered to dependent elderly people and their families after hospital discharge. **Method:** A descriptive study, with a qualitative approach, carried out with 16 primary health care professionals, assigned to a previously selected Basic Health Unit. The collection period was from November 2020 to May 2021. Semi-structured interviews were conducted, the content of which was organized into thematic categories according to Content Analysis and discussed in the light of the Transitions theory proposed by Afaf Ibrahim Meleis. **Results:** Three categories emerged from the analysis: actions developed at home and shared with the family; care for the family and for the person of the caregiver; feelings, satisfaction and challenges of the team. **Conclusion:** It was observed that professionals are aware of the importance of comprehensive care for the elderly in the hospital-home transition, but face structural obstacles to making it a reality.

**DESCRIPTORS:** Elderly; Primary health care; Transitional care; Patient discharge; Home care.

## RESUMEN

**Objetivo:** Analizar la percepción de los profesionales de atención primaria sobre la atención ofrecida a las personas mayores dependientes y sus familias tras el alta hospitalaria. **Método:** Estudio descriptivo, con enfoque cualitativo, realizado con 16 profesionales de atención primaria, adscritos a una Unidad Básica de Salud previamente seleccionada. El periodo de recogida fue de noviembre de 2020 a mayo de 2021. Se realizaron entrevistas semiestructuradas, cuyo contenido fue organizado en categorías temáticas según Análisis de Contenido y discutido a la luz de la teoría de las Transiciones propuesta por Afaf Ibrahim Meleis. **Resultados:** Tres categorías emergieron de los análisis: acciones desarrolladas en casa y compartidas con la familia; cuidados para la familia y para la persona del cuidador; sentimientos, satisfacción y desafíos del equipo. **Conclusión:** Se observó que los profesionales son conscientes de la importancia de la atención integral al anciano en la transición hospital-hogar, pero se enfrentan a obstáculos estructurales para hacerla realidad.

**DESCRIPTORES:** Ancianos; Atención Primaria; Atención Transicional; Alta del paciente; Atención Domiciliaria.

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## INTRODUCTION

The Brazilian population has been aging rapidly, the forecast is that by 2025 the country will have 32 million people aged 60 or over, ranking sixth in the world in terms of the number of elderly people. We know that this population group is more susceptible to chronic degenerative diseases, which cause limitations, dependencies, vulnerable situations, disabilities, weaknesses and affect the most diverse basic activities.<sup>1</sup>

Due to this context, the elderly demand for health services is greater, resulting in numerous hospitalizations, which can have a negative impact on their health, that is, with clinical complications. 1 In 2019, in Brazil, there were more than 2 million hospitalizations of elderly people, with the highest

percentage (43.36%) in elderly people aged 60 to 69 years old.<sup>2</sup> Therefore, care for this population must be a constant concern for professionals and health services, respecting the expectations and needs of the elderly, providing assistance in a globalized manner, with a holistic view of the human being.<sup>3</sup>

From this perspective, the family ends up assuming the role of responsible for caring without having the necessary preparation for this new phase, generating physical and emotional exhaustion. In this way, care ends up being poorly executed, having an impact on the health of the elderly person, the caregiver and the transition process, which is influenced by conditions that may be positive or negative for the transition process.<sup>4-7</sup>

At the time of discharge, the health system ends up assigning responsibility to the family, without, however, make the care

transition together, not paying attention to the continuity of the care process at home, nor how the family will organize itself.<sup>7-8</sup> The way each person deals with the transition is influenced by the individual condition, time and other conditions, which may be personal or environmental, all of which can be harmful to the transitional process.<sup>5,10</sup> For this study, the concept of transition of care used coordinated practices, validated to ensure safety and continuity of care at hospital discharge, seeking to guarantee quality of life and prevent hospital readmissions.<sup>6</sup>

This study will be discussed in light of the transitional theory of Afaf Ibrahim Meleis, an Egyptian-American nurse, who in 1960 began to investigate interventions that facilitate the transition process of individuals and the reasons that lead them to not achieve healthy transitions, making the

process of understanding transitions possible, characterized by its singularities, diversities, complexities and multiple dimensions that generate varied meanings, determined by the perception of each individual. Transitions are the results of changes in life, health, relationships, and environments.<sup>5</sup>

Divided into four fundamental concepts: nature (type, patterns and properties of the transition), transition conditions (facilitators or inhibitors of the process and related to the person, community and society), response patterns (process and result indicators of the transition, nursing therapy drivers) and therapeutic nursing interventions.<sup>5</sup> This theory proposes to increase the autonomy of the elderly and their families, with organized home care, reducing hospitalizations and the complications resulting from them.

For the author, preparing in advance for a change facilitates the experience of a transition, and the lack of this preparation can inhibit this journey. Preparation and knowledge about what to expect from this change and strategies to be used in the transition process is very useful.<sup>5</sup> However, as hospitalizations and their consequences cannot be predicted, care in the transition from hospital to home needs to be the focus of health professionals, which is directly related to this home care.

This theory contributes with important points of use in the practice of care, such as the identification of conditions that can influence the hospital discharge process, facilitating or inhibiting transitions.<sup>10</sup> Therapies that are applied during the home visit by the multidisciplinary team. Conditions that facilitate the transition process include: community support, relevant information obtained from trusted health care providers, advice from respected sources, role models, and clarification of questions.<sup>10</sup> And conditions that are identified as inhibiting a healthy transition such as: insufficient resources to support a situation, inadequate support, unsolicited or negative advice, insufficient or contradictory information.<sup>12</sup>

The present study aims to: Analyze the perception of primary health care professionals about the assistance offered to

dependent elderly people and their families after hospital discharge. Highlighting the importance of studies focused on the health of frail elderly people after hospital discharge, making it feasible to discuss the ways of organizing care for elderly people in PHC with regard to transitional care and its process.

## METHOD

Descriptive, exploratory study with a qualitative approach. To ensure the rigor of this study, the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was followed.<sup>16</sup> Carried out with primary health care professionals who provide home care to elderly people with dependency after hospital discharge. The multidisciplinary primary health care team participated, consisting of: Nurse; Doctor; nursing technicians; Community Health Agent (CHA); Physiotherapist; nutritionist; psychologist.

The study scenario was composed of two basic health units (UBS) in a large municipality located in the Southern Region of Brazil, selected based on the criteria of greater density of elderly people in the coverage area, and situations of vulnerability different from the territories covered, one being high and the other low social vulnerability. Of the 19 professionals who were selected, two professionals did not meet the inclusion criteria, which were: being a public servant, working in primary care for at least one year. Another professional refused to participate in the interview and one professional was using telemedicine due to the COVID-19 pandemic. Thus, of the total number of employees able to participate, 15 interviews were carried out.

Data collection was carried out by the first author (nurse/master's student/researcher) with prior contact via messaging application to schedule the date and time of the interview, according to the interviewee's availability. On the agreed day, the researcher introduced herself, providing credentials, explaining the research objectives and inviting the person to

participate in the study. In the acceptance condition, data collection was carried out in a private room, valuing privacy. The interviews took place at the workplace, from November 2020 to May 2021, with an average duration of 40 to 65 minutes and permission to be recorded in audio was requested, the reactions perceived by the author from the participants were also incorporated into the transcriptions based on the field diary records.

The data collection procedures and the signing of the informed consent form were explained at the beginning of the conversation, as well as the objective of the study. The safety protocol due to the Pandemic was applied in all interviews. A socio-occupational questionnaire and semi-structured script were used, including questions regarding the assistance provided to elderly people with dependency in the hospital-home transition, with open questions to guide the interview, such as: Describe the assistance and procedures performed with this elderly person/family member/caregiver when he/she is discharged from the hospital? / How is support/assistance provided to the family of elderly people? / What is your opinion of the preparation for discharge carried out in the hospital environment at home? / What is the biggest challenge for you in this issue? The data collected was recorded and transcribed in full by the main author and the material was not returned to the participants for validation.

The analysis of material from the interviews was carried out using content analysis.<sup>11</sup> To this end, the stages of pre-analysis, material exploration, treatment and interpretation of results were carried out. The categories of analysis emerged from the narratives. This study is part of a larger project of a doctoral thesis entitled: "Elderly people with functional dependence: qualifying assistance in the hospital-home transition through action research". Approved by the Ethics Committee for Research Involving Human Beings of the State University of Londrina (UEL) on August 13, 2019, under opinion no. 3,504,079.

## RESULTS

Among the 15 participating professionals who made up the two health teams, the majority were women, aged between 25 and 43 years. Regarding the role performed, three were nursing assistants; three nurses; two doctors; three community health agents; two nutritionists, a psychologist and a physiotherapist; the majority had worked in primary care for between 4 and 7 years; Only one professional had a postgraduate degree at the Doctorate level.

Analysis of the content of the interviews allowed the formation of three categories: actions carried out at home; actions shared with the family; feelings and challenges of the healthcare team.

### Actions developed at home and shared with the family

In this category, therapeutic interventions that are carried out with the elderly and their families at home stand out. Professionals reported the assistance they provide to this fragile elderly person with complex care more frequently, such as: medications, multidisciplinary assessment, dressings, guidance to family members and caregivers during home visits, collection of exams, referrals to specialists, among other needs that may be necessary.

*How to apply the dressing, how to administer food, and we guide the change of position, if the patient is bedridden, how to deal with them, we provide the materials. If we see that they need a physiotherapist, we ask for a physiotherapist, we ask for a nutritionist. (NT1)*

*A situation arises, if the patient is 100% bedridden, we can intervene on the diaper issue, request a prescription or urinary device to see how we can resolve the issue of diuresis in bed. We even have to intervene with other services, a church, before we even had a telephone number at the churches that we advised the family to look for and*

*take out a loan, lend and so things get going. (NUR1)*

*Generally, I go to visit, if I'm not going to visit, I call to find out what the patient's situation is like. Every time the diet arrives, I try to deliver the diet, not all units I do this, but some units I deliver, take them home and see how the patients are doing. (NUT1).*

*It's difficult, but we always manage to help the family a lot. When we go on a visit, we can clarify a lot of things that seem simple to us, but that make a lot of difference to them. (NUT2)*

*So, we go to them, guide them, and return. So we will meet once a week, or come back every 15 days, or we provide guidance and when the family needs us, they call us back. (Physio1)*

*I've had a very compromised elderly person. You don't have much to do, so the focus is more on the caregiver, this focus is on the caregiver, on the caregiver's mental health. (PSY1)*

*If the patient is very weak, then it is more urgent to provide care, to have a more attentive look at them at this moment, until the situation stabilizes. (CHA1)*

### Care for the family and the caregiver

Home visits aim to provide contact with the individual's reality and provide educational activities directly with the family and caregivers, within their abilities and possibilities, we will identify some conditions that, during the transition process, can facilitate or inhibit it, as we can see in the participants' statements:

*When the family sees that we are coming to the house, they feel welcomed, and they start looking again. No matter how much they advise and talk at the hospital, the family has doubts and comes to ask for our help. (NT1)*

*I myself can see a lot of who is next door, how many times I went to the residence to see someone, but the*

*one who needed it most was the person who was taking care of them. So I often assisted, I supplemented the person I was caring for, not just the elderly person I went to visit. (NUT2)*

*Now we are in a pandemic, but we have our psychologist who did a really cool job with these caregivers, calling them..." If the patient is confused, we see that they are lost, the caregiver is depressed, let's see what we can do, let's talk. (CHA1)*

*We have to understand that the caregiver themselves also become ill in this process, so we serve many people here on the issue of mental health. (NUR1)*

### Feelings of satisfaction and challenges of the healthcare team

We can see in the participants' statements some critical points in the work process that prevent them from providing care, barriers that range from the lack of human and material resources, to situations that involve other levels of care, something to be widely discussed when it comes to assistance to the elderly in the hospital-home transition process.

*Today I cover six UBS, and that's the average for psychologists. I spend a day inside a UBS, at most. There's no way you can provide support, that suddenly, even if you're bedridden, you could go for follow-up more frequently, it's impossible. (PSY1)*

*(...) I think increasing the number of employees would be cool, we have a lot of employees working overtime, so it delays these trips to the patient's home precisely for this reason, because there are no professionals. Having the professional, having the correct information, having the help of the multidisciplinary team, I think would make it a lot easier. (CHA1)*

*So, we always end up trying to ensure that this patient is satisfied with what they came for, it is not*

*always possible because sometimes the demand is not ours. The demand is for a specialty that has to be put in the queue, but what is possible within what we can do, we try to do. (NT2)*

*It's not enough, but I believe we can provide good service. (NT2)*

*We try to do what we can... identify what this patient's greatest needs are, and try to meet the basics necessary for us to be able to help. (DOC1)*

Some statements express satisfaction with the assistance provided despite some existing obstacles:

*I think it's fantastic because this part of watching supplements and industrialized diets is really cool, because I know they are high quality products. I think it's really cool, I would just like to be able to serve a larger number of patients, for example, sometimes we have some demands that we can't meet. (NUT1)*

*This work at FHS is peaceful and even pleasurable. I think it's a job that rewards us for going and being able to help. The family is very grateful. (NT1)*

*So the care for this elderly person could be better, but given the difficulties we have, I believe we still provide good care. (NT2).*

## DISCUSSION

Within the transition process proposed by Afaf Meleis, there are conditions that are classified as facilitators and inhibitors, and it is necessary to understand them to adapt strategies, strengthening favorable factors and overriding factors that interfere negatively.<sup>10</sup> It was observed in some statements that assistance is provided with the resources that the service has available or within what can be offered, in other reports we can see the satisfaction of these professionals in promoting good assistance within the reality possible in the service.

Some examples of these conditions that can act positively or negatively are attributed to personal beliefs, socioeconomic level and preparation for the transition period; Social support, which ranges from family support to support from health professionals, is also crucial in the transition.<sup>5</sup>

Although health professionals feel insecure when carrying out their care practices in caring for the elderly after hospital discharge, there is a growing effort to provide comprehensive assistance to meet the health needs of this population, through home visits. The concern to promote a healthy transition emerges, with the objective of improving responses to the processes of life, health and illness, with the nurse being a facilitator of the process.<sup>10</sup>

It is important to develop strategies for disease prevention and health promotion, aiming to empower patients and their families, making them co-responsible for treatment and continuity of care, and, thus, promoting greater adherence to therapeutic treatment and safety regarding care in the home environment, so that the transition from hospital to home care becomes more effective.

Transitional theory has collaborated with professional practice, by guiding nurses to identify the needs of individuals in the transition process, through a broad view of care and therapeutic interventions to prevent complications and promote health.<sup>12</sup> This shows how important it is for health levels to prepare teams in the face of the increase in the number of elderly people, who need this assistance at home, especially after hospital discharge.

Within the scope of PHC, it is necessary to incorporate a broader view of the individual. It is necessary to raise awareness among professionals about the importance of observing cognitive aspects, mood, mobility and communication as essential areas for health, expanding the objective of their work beyond chronic diseases.<sup>13</sup> This expanded view of health implies detecting the needs of the elderly population and their families, with responses to these, going beyond the con-

cept centered on medical consultation, indicating the participation of several health professionals in an interdisciplinary and intersectoral perspective, in order to provide assistance based on comprehensive care.

However, in some studies, we can see that the practices reported by professionals aimed at elderly people contradict the expanded conception of the health-disease process, which considers the contribution of different elements related to each other, such as political, social, economic, cultural, environmental, psychological and biological aspects.<sup>3,13</sup> The majority of these caregivers do not have the necessary information and support, which ends up causing overload in the caregiving activity, damaging their quality of life and increasing the risk of illness for those who take on this role.

The lack of preparation of the caregiver/family member can contribute to harm in the patient's recovery, resulting in frequent hospitalizations. Another factor mentioned is the lack of infrastructure at home, making the task of caring even more difficult, lack of adequacy of the physical space of the environment, mainly for the use of bath chairs and wheelchairs, which can result in domestic accidents for the elderly and for the caregiver who requires greater physical effort to provide care.<sup>14-15</sup>

Depending on the nature of the transition, there may be critical points characterized by instability, uncertainty, characterized by new routines. It is important that professionals are aware of each event as critical, so they must use their knowledge and professionalism.<sup>10</sup> In other words, exercising care in its entirety involves the need to rethink health practices that are still characterized by discontinuity in care, management obstacles and setbacks in health policies.

However, with the need for this monitoring, the simple inclusion of pre-established routines, as is the case with other population cycles, is not enough, as they may not express the real needs of the elderly person. It is clear that the focus may

be more focused on the disease and not on a broader view of the situation.

Thus, we mention that the qualification of professionals is of fundamental importance for the transformation of practices, since the simple publication of guidelines has not been able to raise awareness of health services at their secondary and tertiary levels. An effort is needed from managers and the government to provide conditions for professionals, preparing them for new demands.

As a limitation, we note that the study was carried out during the pandemic period, when all home care services were suspended. Even so, it objectively presents the reality experienced in the care of elderly people in the transition from hospital to home care precisely

during this period when many elderly people underwent hospitalizations, and included all members of the PHC multidisciplinary team who work in different social contexts, alerting to important aspects that impact this transition of care contexts.

## CONCLUSION

The results of this study highlighted the challenges of caring for frail elderly people, in their entirety, to improve care after hospital discharge. It demonstrated that political articulation, restructuring of health services and equipment, and improvement of care practices were necessary. There is a need to restructure the care offered by PHC to the elderly and their caregivers, as this requires actions

and services that cover the specificities of these users and their families.

Some strategies to overcome the challenges, to improve the quality of patient care, reduce the fragmentation of the Health Care Network, guarantee the effective comprehensiveness of care through the ordering of flows and communication instruments between hospital services and primary care.

The contribution of transition theory to professional practice is highlighted, making it possible to direct multidisciplinary actions, through planning and implementation of practices and interventions that will contribute to quality care, reducing the risks of negative transitions for this elderly population.

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