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DEOSPITALIZATION OF ELDERLY PATIENTS: CHALLENGES FACED BY THE FAMILY IN CONTINUOUS CARE

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ABSTRACT

Introduction: Elderly patients who are undergoing a hospital-home transition process in a situation of dependency and who require continued health care and family support, with a preventive, rehabilitative or palliative purpose, the family member / caregiver presents limitations in the continuity of care, reflecting directly in the integrated health actions, making treatment difficult and sometimes interrupted. **Objective:** To analyze the challenges faced by the family in the continuous care of elderly patients facing hospitalization and the possible impacts on quality of life. **Method:** This is a descriptive, exploratory study with a qualitative approach that will be conducted in September and October 2019, in a public hospital in the city of Vitória da Conquista-BA, with 10 participants, of both sexes, family caregivers or responsible for the elderly who perform care functions in care and who are already over eighteen (18) years old. The collection was performed through a recorded interview, guided by a semi-structured script. Data analysis will be through Bardin content analysis. **Results:** From the analysis of the reports, it was possible to detect the limitations that family caregivers found in the hospital discharge process with elderly patients, who need continuous health care, suggests the institution strategies to enable changes in quality. of life of the elderly, after hospital and home transition, in the improvement of self-care and insertion of family support, with a preventive, rehabilitative or palliative purpose in the health of the elderly. **Conclusion:** This study made it possible to understand that there are weaknesses in the process of dehospitalization in the institution, which involve socioeconomic, cultural and environmental issues of elderly patients and their family caregivers.

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INTRODUCTION

In recent years life expectancy has gradually increased, with advances in health technologies and improvements in sanitary conditions, enabling a longer life span, even the elderly with some type of disability, in which the epidemiological profile of diseases in Brazil, in the age group above 60 years, are the non-communicable chronic diseases (NCDs), with a change in the mortality profile of the elderly population and generating a significant increase in hospitalizations due to diagnoses of cardiovascular diseases, neoplasms and respiratory diseases,

whose treatment is of prolonged duration (CARVALHO *et al*., 2014). Given the current aging situation, this population requires greater attention from family and society in general, and after discharge from hospital, family members face the reality of caring for the disabled elderly, becoming the main caregivers, often requiring self-denial. from social life to dedicate themselves to specific care, which may cause a disorganization of the family nucleus, such care will be mostly developed at home, the family member will need dexterity, management and adaptation of the home environment for care. They go through the need to learn knowledge and practices that are not part of daily life and the difficulty of access to health services to continue treatment. It is known that the task of caring is not easy, but a daily challenge and continuous care must be established, the caregiver will be ahead of providing the improvement in the quality of life of the elderly (SANTOS, 2018). Thus, the presence of the family member / caregiver is necessary to intervene in the actions in continuous care, with the need to guide them, and minimize their limitations and challenges, in order to reduce the complications arising from the underlying pathology of the elderly, hospital readmissions of long durations and control in reducing financial costs whose health policies have been dedicated to the planning of health promotion and preventive actions (MEMORIA; CARVALHO; ROCHA, 2013). Given the above, this study has as its general objective: To analyze the challenges faced by the family in the continuing care of elderly patients facing dehospitalization and the possible impacts on quality of life. And, as specific objectives: Identify the challenges and / or limitations that the family member presents in the continuation of integral health; analyze the factors associated with hospitalization in Brazilian elderly; and understand the organization and functioning of the family and elderly bond.

MATERIALS AND METHODS

Kind of Study: This is a descriptive, exploratory study with a qualitative approach, as it understands that qualitative research encompasses everyday life and common sense experiences, interpreted and reinterpreted by the subjects who experience them (MINAYO, 2010).

Study Place: The research was carried out in 01 (one) public hospital, in Vitória da Conquista / Bahia, in September and October 2019, in specific sectors (male ward, female ward).

Study Participants: Participants were 10 (ten) family members or responsible for the care of the elderly patient. The choice of participants obeyed the following inclusion criteria: Family members or guardians of the elderly who perform a care function in care and who are already over eighteen (18) years old; agree to voluntarily participate in the research by signing the Informed Consent Form (ICF). And, as exclusion criteria, were considered: are not in physical and / or mental conditions to participate in the research. The approach with the participants was made after previous contact with the Sector Coordination to authorize data collection in the Unit. Subsequently, a meeting was scheduled with the unit's coordinator to clarify the research to be developed. As soon as possible, a meeting was scheduled with the research center coordination at the hospital to clarify the research to be developed and schedule the interviews.

Collection Instruments: As data collection instrument, the interview was used with the participants, through a semi-structured script of the study author and composed of specific questions pertinent to the objectives, which helped in approaching the study participants. The interview was recorded using an MP4 type electronic device and later transcribed. The interviews were conducted at the hospital level, in a space that ensured the participants' privacy and information confidentiality, being conditioned to their authorization, by signing the informed consent form, previously clarified with the participants by the researcher.

Analysis: To systematize and analyze the data obtained from the interviews with the participants, the Categorical Thematic Content Analysis technique was used, which according to Bardin (2016), is a set of communication analysis techniques that aims, through systematic and objective procedures. description of message content, to obtain indicators that allow the inference of knowledge regarding the conditions of production / reception of messages. In order to operationalize the data analysis, the three basic phases described by Bardin (2016) were covered as “chronological poles” that make up the Content Analysis technique: the pre-analysis consists of a text organization phase, at this stage. The author has the first contact with the text, performing a floating reading. He formulates his hypotheses and goals; The exploration of the material is performed a classification, codification and categorization of the contents; and the treatment of the results the author makes interferences and interpretations about the subject, using his perception about the subject, as well as what the literature approaches about the subject.

Ethical Aspects: The research took place after judgment and approval by the Research Ethics Committee (CEP), after submission to Plataforma Brasil, respecting the provisions of Resolution 466/12 of the National Health Council, under opinion CAAE N. 18180619.3.0000.5578.

RESULTS

Participant Characterization: The family caregivers interviewed are characterized by being between 30 and 50 years old, with a predominance of women (75%). Regarding marital status, 20% do not live with their partners, being single or divorced. The degree of instruction ranged from elementary school to complete high school. As for employment, only 30% keep their jobs steady.

Family perception about the importance of continuing treatment of their elderly family member: The family, a fundamental part of the care process for the elderly, realizes the importance of continuing treatment at home, given that in the hospital unit there is a risk of infection, with this the family environment becomes the conducive environment, both for continuity of treatment and restoration of health, as follows:

> *It is important to be able to go home soon, you can not stay in this state here in the hospital, it is better to treat soon and be discharged and continue to use medicines at home, in the hospital has a lot of bacteria (E1).*

> *And I think, very importantly, why she needs to survive, right? I can not explain, but he has to continue with the treatment, taking the drugs (E2).*

> *You have to take care, is very right? You have to take care, because if you don't die (E3).*

It is important, because of the wound it can be contaminated and have to amputate the leg (E5).

So, mother is only one, she has to continue the treatment, she has to look after life (E10).

The relatives of the elderly also reported that the continuity of treatment at home enables the elderly to return to a routine of great relevance and significance for them, as they may resume their daily activities, as well as their social reintegration as follows:

I think it is important for him to be healed, to get strong, to get well soon and to go to work on his little rock (E6).

I think it is important, because she is doing the treatments she can go to church, cook, is what she likes the most (E7).

I think so, despite her age, she is very active and likes to take care of herself (E8).

Facilities and difficulties faced by family after discharge from family member: The reports of the participants of this study demonstrate their difficulties for continuity of care after hospital discharge, since, in some statements, the lack of guidance by the multiprofessional team at the hospital level regarding the provision of care, which may hinder the continuous treatment process at home. The facilities are related to the support of primary health care and social support networks in this transition from continuity to treatment, as shown in the following reports:

We have a lot of difficulties, he lives alone, we have no conditions, we are unemployed, I have a brother his son, who is an alcoholic, gives work, I'm afraid of taking him home and not knowing how to do things, the facilities is that the neighbors who help with bathing, buying some diapers, helping to take to the health center (E1).

There is difficulty daughter, already have to talk to many, we make the guts the heart, I have a special daughter, my husband is sick, we do not have much money, we live in the countryside, everything is far to be able to treat her, I have a sister with depression can't take care of our mother alone, it's me alone, I don't know how to move her oxygen and easily we have a church group that helps give bath, help buy the little things, the girl from the post helps us too (E2).

There are many difficulties, we have no money, but I was told that there in the post, the staff of the station, will give a help and make the bandages, and if she ruin the ambulance can bring her here to the city (E3).

There is a bit of difficulty and right now there is an exam to do, we have to pay, I'm chasing to get it done, we can't even eat right, and it's really easy, the girl from the little post goes there. his house, bandages him, takes his pressure (E6).

There are difficulties, for sure, go to the health center we go back without the medicine, if you don't find it, you have to buy it and we have no money. Easy is that my daughters take care of her, I work all day, I do my best to recover (E7).

We have a problem, children live far away, and so it is getting harder and harder, we have no emotional, physical and financial conditions that is slow. I'm afraid of not being able to move the colostomy bag and leave the place, staying open. We want to take her to Rio de Janeiro, where she has my brothers, who can help take care of her, but she doesn't want to, her problem is wanting to stay in the city where she was born. And in RJ it's easier to take care of her (E8).

Factors that may interfere in not being able to take care of the elderly family member at home: In this category, the reports confirmed that the activities performed by family caregivers are extremely important to continue the treatment of the elderly. It has been observed that many caregivers recognize that after assuming this role their social life has been completely interfered with. Some of the respondents had to leave employment or even move to care for their family member. These reports reveal that the care process at home has its difficulties, and the main one is related to changes in their routines to meet the demands of the sick elderly, a factor that makes it impossible for the family member to perform paid work activity and, consequently, impacts on family income, as reported:

It can interfere, because money we do not have, he is bedridden can not do anything alone, I have to stop working to take care of him, sometimes I can not fix some nozzles to make money, lack of money hinders (E1).

She lives far from my house, there is no way to take care of her I have my wife and children, she is alone, I had to drop everything to take care of her (E4).

The factor of the distance from the city, he lives in the village, he does not want to go live with any children, we are in five children, none can stop, to take care of him, only me who is currently unemployed (E5).

The lack of money owner, I need to work, there is no one who takes care of it, then I have to leave the city to be with him (E6).

Other factors that interfere in the caregiver's daily life were also mentioned, especially regarding behavioral disorders, agitation, aggressiveness and stubbornness presented by the elderly. With the lack of psychological, physical and financial support, these factors significantly interfere in the process of caring for the elderly. The following statements highlight the challenges that family members face daily.

In our city the hospital does not have my father's treatment, I can only get some medicine from the post down his street, if he needs to go to the hospital in a hurry and can't survive, I'm afraid of him dying (E3).

We do not know how to take care of her, I can not read, sometimes have a medicine to take and people do not say what the time will be, she cries too much, is sad, afraid to die the porridge (E7).

The issue of her living alone, she doesn't want her son to take care of her, I'm afraid she might get up on her own and get sick, not knowing how to take her medicine, she's very nervous, agitated by anything (E8).

She doesn't understand that it is for her own good to take care, to lose weight, she thinks that taking only medicine solves, she has to do a bit of things, keeps cursing me when I speak (E9).

The emotional issue, I have no head for anything else, the context of being away from it (E10).

The results also demonstrate that the role of the caregiver is exhausting, revealed by the contradiction in perspective in the continued care of the elderly after the process of dehospitalization. The participants of this study report that, due to the factors mentioned above, there may be interruptions in the treatment of elderly family members, which is why they constantly live with the fear of the distressing progression of the disease, which may lead them to death.

Sure! Yes we can not have money and if she dies? (E1)

I get scared of losing my mother. (E2).

He can die, right? (E3).

If she is alone, because I work in the fields, she will not be healed (E4).

We are poor, medicines are all expensive, they need to do it soon, they can die if they don't buy (E6).

She can even die if no one takes care of her (E8).

DISCUSSIONS

The population of people over the age of 60 years has been affected by chronic diseases that generate limitations after illness, a situation that differs from what happened in the decade. According to the project Health, Welfare and Aging (SABE) a study from the University of São Paulo (USP), the results of the evaluations showed an increase in chronic diseases and may be linked to behavioral factors, such as; stress, physical inactivity and obesity, on the other hand, it was identified that the elderly population has more access to health services and diagnosis than their predecessors (LEBRÃO; LAURENTI, 2015). This relationship, however, of pathophysiological changes in the elderly and access to public health in the country has led to an increase in hospital bed occupancy. Changes and instability in the hemodynamics of the elderly makes them look for the urgency and emergency network as their first choice, skipping the primary care stage, which is the gateway for users of the single health system (RIBEIRO *et al*., 2018). Another point that should be highlighted is the frequency of hospitalizations among the elderly where they present some variability according to male and female gender, where older male populations are more likely to seek outpatient and outpatient services of medium and high complexity, than the female. Several studies show that women seek primary care services, but have a higher degree of homogeneity in relation to respiratory, circulatory and digestive diseases, accounting for approximately 60% of the causes of hospitalization in both sexes (BORGES, VARGAS, 2011). Considering these aspects, women constitute the majority of the elderly population in all Brazilian regions, highlighting the process of feminization of old age, which has been widely analyzed and discussed, in which the elderly realized that they can live longer and better, performing maintenance of health functionality, such as: physical activity practices, adequate nutrition, preventive exams performed regularly and clinical follow-up. Contributing to healthier aging (ALMEIDA *et al*., 2015).

Most of the hospitalized elderly are classified in a degree of dependence at the intermediate level, for basic human needs care actions. The work of nursing care enables the prediction of various aspects related to the process of clinical improvement and continuity of care, and especially regarding the prescription of individualized care to the clientele, should be characterized in order to favor the maintenance of health and reducing the demand for tertiary care, consequently the population will age more healthily with good hospital discharge planning (BARRETO; CARREIRA; MARCONI, 2015). The difficulties in dehospitalizing the elderly patient are related to the three scenarios: clinical; social and financial The clinics are summarized in the inadequate elaboration of age-adjusted prognosis and dependencies for treatment continuity. The social ones would be the difficulty of family structure, with the absence of family members and / or capable caregivers. The financial issue refers to the high costs in daily care that the patient and family need to bear. These difficulties reflect directly on the high rates of long stay (TEXEIRA; VIEIRA; ANDRADE, 2013). Thus, it becomes a challenge to take care of the elderly in the gerontological perspective, amid the difficulties arising from health services, which can make them more susceptible to disabilities resulting from physical, social, affective and health conditions (PINHEIRO; SANTO; CHIBANTE, 2016). Therefore, good planning should be established after hospital discharge so that one can effectively intervene with effective strategies for continuing home care. Otherwise, the elderly individual will have disability, dependence, increased risk of hospitalization, institutionalization and death, in addition to increased individual and health system costs (PINHEIRO; SANTO; CHIBANTE, 2016). The family is the place where there is a process of unconditional bonds, enabling its members to live and participate in a full, committed and responsible sense, guaranteeing them the maintenance of harmonious bonds and the preservation of the physical and emotional integrity of each one of their families. If these conditions are lacking, there may be a loss of the family's ability to provide the care and support that the elderly need (ARAÚJO *et al*., 2015).

The fundamental concepts to know if the elderly maintain their preserved quality of life are evaluated in the abilities: functional, independence and autonomy. It is noteworthy about the parameter of global functionality on which the concept of health of the elderly is based, which is considered healthy when it is able to perform its activities alone, independently and autonomously, even if it has diseases (NUNES *et al*., 2018). Briefly, it is found that the elderly with chronic non-communicable disease will not necessarily need help with basic tasks such as dressing, bathing, eating, but family support is of great importance in the development of progressive limitations. that can occur, helping the elderly to rediscover themselves, making it possible to live their own life with the highest quality possible (MEMORIA; CARVALHO; ROCHA, 2013). According to Anício (2013), families

constitute an important source of psychosocial and physical support for the elderly. The loving interaction between grandchildren, grandparents and other family members contributes to everyone's health. However, the Brazilian family is undergoing a transformation process resulting from conjuncture and cultural changes. The new family configurations have a great coherence, in which, in the past, there was the constitution of parents, children, grandchildren and grandparents, all in the same home, with the purpose of care and affection, as social changes over the years have taken place. readjusted, gaining a new family scenario, from these changes results from a new attention to the development of the needs of the elderly. It is known that the aging process results in vulnerability characterized by dependence, but there is an elderly person whose need has their own socioeconomic capacities and determines the option to live alone (PERSEGUINO; HORTA; RIBEIRO, 2016).

According to Article 3 of the Statute of the Elderly - Law 107441/03, the obligation of the family, the community, society and the Public Power to ensure to the elderly, with absolute priority, the realization of the right to life, health, food, education, culture, sport, leisure, work, citizenship, freedom, dignity, respect and family and community life (BRASIL, 2008). When faced with the hospitalized elderly with the loss of functional capacity, the family member will provide care. If for some reason family members cannot, do not want to have the responsibility to care or do not realize the need for care to the elderly, it will directly impact health, leaving the elderly vulnerable and not having the physical, psychological economic conditions to maintain their quality. of life. In this social context, the professional caregiver of the elderly emerges, not necessarily being the family member or who has family ties and need monitoring or care, helping in the development of daily activities in order to ensure a better quality of life and the maintenance of their integration with them. the society (HISAKO *et al*., 2013). The caregiver is a professional of special qualities, expressed by the strong trait of love for humanity, solidarity and donation. The occupation of caregiver is part of the Brazilian Classification of Occupations - CBO under code 5162, which defines the caregiver as someone who "takes care of the goals established by specialized institutions or direct caregivers, ensuring welfare, health, food, personal hygiene, education, culture, recreation and leisure of the assisted person". It is the person, family or community, who cares for another person of any age who is in need of care for being bedridden, with physical or mental limitations, with or without pay. The need for the presence of family companion and / or caregiver in the processes of admission, hospitalization and discharge to the elderly should be considered of paramount importance, according to the Ministry of Health through Ordinance No. 280 of April 7, 1999, not only for accompany the elderly, but also to be oriented in their role as lay caregiver (BRASIL, 2013). Thus, family support aims to combat the harmful effects of any kind of detention and promote the integration of the elderly in society. Managing the care of elderly people with chronic diseases and their limitations requires the support of family members to learn and the multiprofessional team with all the support having technical assistance, administrative knowledge and problem solving skills, the family caregiver should have notions to ensure continuous treatment and generate quality of life for their elderly family member (TEXEIRA; VIEIRA; ANDRADE, 2013).

Conclusion

This study made it possible to understand that there are weaknesses in the process of dehospitalization in the institution, which involve socioeconomic, cultural and environmental issues of elderly patients and their family caregivers. We observed, through the reports of family caregivers, that in the transition process the institution's multidisciplinary team had its attention focused on the procedures to be performed for the benefit of the sick elderly, not considering the needs and particularities of family caregivers, and there was no training. and very clear guidelines for carrying out the activities, which makes the continuity of treatment of the elderly at home fragile. Thus, we suggest that further studies be conducted in order to broaden the look at the burden, fears and chronic stress on the health of these family caregivers, identifying strategies that enable the proper care to be provided, efficiently, effectively and without burden to the caregiver. the care.

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