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CHALLENGES FOR THE HOME HOSPITALIZATION OF THE ELDERLY FROM THE FAMILY PERSPECTIVE

DESAFIOS PARA O INTERNAMENTO DOMICILIAR DO IDOSO NA PERSPECTIVA DA FAMÍLIA

RETOS PARA LA HOSPITALIZACIÓN DOMICILIARA DE LOS ANCIANOS DESDE LA PERSPECTIVA DE LA FAMILIA

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Objective: to know the experience that permeates the home hospital stay of the elderly from the family perspective. Method: exploratory study with a qualitative approach, developed with ten family caregivers of the elderly registered in a Home Care Service. Data were collected from April to June 2019, through semi-structured individual interviews and submitted to content analysis. Results: home care provides benefits to care, such as comfort from home, affective bonds and support from health professionals. Inexperience in direct care at home, scarcity of material and financial resources and lack of integration between services were described as challenges for care. The actions of training the caregiver for hospital discharge imply the continuity of care and improvement of the necessary skills. Final considerations: the results demonstrated the importance of understanding the potentialities and challenges for families to care for the elderly at home.

Descriptors: Caregiver. Home Care. Nursing. Old.

Objetivo: conhecer as vivências que permeiam o internamento domiciliar do idoso na perspectiva da família. Método: estudo exploratório de abordagem qualitativa, desenvolvido com dez cuidadores familiares de idosos cadastrados em um Serviço de Atenção Domiciliar. Os dados foram coletados de abril a junho de 2019, por meio de entrevista individual semiestruturada e submetida à análise de conteúdo. Resultados: a atenção domiciliar proporciona benefícios ao cuidado, como o conforto do lar, vínculos afetivos e apoio dos profissionais de saúde. A inexperiência nos cuidados diretos no domicílio, a escassez de recursos materiais e financeiros e a ausência de integração entre os serviços foram descritos como desafios para o cuidado. As ações de capacitação do cuidador para a alta hospitalar implicam na continuidade do cuidado e aperfeiçoamento das habilidades necessárias. Considerações finais: os

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resultados demonstraram a importância da compreensão das potencialidades e os desafios para as famílias cuidar do idoso no domicilio.

Descritores: Cuidador. Assistência Domiciliar. Enfermagem. Idoso.

Objetivo: conocer las experiencias que impregnan la estancia hospitalaria domiciliar de los ancianos desde la perspectiva de la familia. Método: estudio exploratorio con abordaje cualitativo, desarrollado con diez cuidadores familiares de ancianos inscritos en un Servicio de Atención Domiciliaria. Los datos fueron recolectados de abril a junio de 2019, a través de entrevistas individuales semiestructuradas y sometidos a análisis de contenido. Resultados: la atención domiciliaria aporta beneficios a la atención, como la comodidad desde el hogar, los vínculos afectivos y el apoyo de los profesionales de la salud. La inexperiencia en la atención directa en el hogar, la escasez de recursos materiales y financieros y la falta de integración entre los servicios se describieron como desafíos para la atención. Las acciones de formación del cuidador para el alta hospitalaria implican la continuidad del cuidado y la mejora de las habilidades necesarias. Consideraciones finales: los resultados demostraron la importancia de comprender las potencialidades y desafíos de las familias para cuidar a los ancianos en el hogar.

Descriptores: Cuidador. Cuidado en el Hogar. Enfermería. Viejo.

Introduction

Aging is a natural process that implies age-related gradual, physical and mental changes. However, aging is not synonymous with getting sick, and this condition is influenced by genetic factors, as well as by risk behaviors adopted throughout life[1].

Although developed countries are pioneers in the population increase in the number of elderly, the demographic transition has also occurred markedly in developing countries[2]. Estimates for 2050 show that the world population will have two billion people aged 60 years or more, and Brazil will be the sixth country in the world with the largest number of people in this age group[3].

In turn, the epidemiological transition has been reflected in the disease profile, especially by the prevalence of chronic conditions. Thus, there is greater use of health services requiring hospitalization, and a high time of occupation of beds demanded by the elderly population, compared to other age groups. In this scenario, there are countless challenges to society, especially the health sector, which requires planning strategic actions that favor aging with quality of life[4-5].

In this case, the *Programa Melhor em Casa* emerged as a strategy to promote dehospitalization and guarantee the user the continuity of home care[6]. Home Care (HC), a health care modality organized in a model of care for patients under stable clinical condition who will remain dependent on care with the use of medical devices or not, for treatment, rehabilitation and prevention of injuries, as well as to provide support to their families and those who need HC in home care[7].

In this context, the permanence of an individual in the home environment, under conditions of illness with dependence, can change the family dynamics, implying the need for the whole group to reorganize to meet care needs. Although the aspects that permeate the act of "caring" may reflect positively in the strengthening of relationships, attention should be paid to the ambiguous feelings that may arise with the routine and weaken the family bond beyond the care provided[8].

The practice of care emits reflexes that vary from one subject to another due to the differences existing both between those who care and among those who receive care. Thus, care actions do not materialize in a single or homogeneous way, and their repercussions enable unprecedented experience[9]. Moreover, care is mostly assumed by a caregiver, family or not. Although the management and expression of care are intrinsic to each individual and

expressed in various ways according to culture, the role of the caregiver is commonly attributed to a family member referred to as the primary caregiver, who performs and is responsible for the greater demand for direct care[10].

However, the care process, most often assumed by a family member, can be permeated by constant challenges with the potential to reflect negatively on its execution, such as role reversal, overload, caregivers with fragile health, in addition to feelings of insecurity and sadness that permeate care. These impacts can be evidenced in gradual biopsychosocial exhaustion, ineffective care and reduced quality of life of those involved[9-11].

Thus, it is believed that, by also caring for the family caregiver, it is possible to provide better patient care, better quality of the whole family group. Thus, attention is given to the importance of studies that explore the process of dehospitalization and home hospitalization from the perspective of the family member who experiences and performs care, with a view to knowing their needs and supporting the planning of care actions in HC.

From this perspective, the question is: How does the family caregiver experience home hospitalization? To answer this question, the present study aims to know the experience that permeates the home stay of the elderly from the family perspective.

Method

Descriptive study with qualitative approach, linked to the Research Project "Home Care for Adults and the Elderly in the Perception of Health Professionals, Patients and Caregivers". The Consolidated Criteria for Reporting Qualitative Research (COREQ, in Portuguese) guidelines guide the study methodology description.

The study participants were family caregivers of the elderly registered at the Home Care Service (HCS) of a public hospital in Mato Grosso do Sul. It is a service with high turnover of admissions and discharges, being mostly pediatric, palliative and elderly patients. The service has two care teams accredited by the Ministry of Health (MH) in the "*Programa Melhor em Casa*", composed of nurses, physiotherapists, doctors and nursing technicians, distributed in the South and West districts, which geographically comprise four urban regions of the city. It also has a support team composed of social worker and occupational therapist.

The study participants were family caregivers of elderly people in home care, accompanied by multidisciplinary teams of coverage of two health districts assisted by HCS, in the modalities HC2 and HC3, since these patients demand a higher frequency of care, health resources and continuous follow-up. The districts were selected by convenience in relation to proximity to the University.

The main family caregiver was defined as the one who was registered in the HCS. The identification of family caregivers occurred after receiving a list requested from the service containing the records of the elderly under follow-up.

Initially, with the support of HCS professionals, the study was dissected stating that the head researcher would make telephone contact to present the objectives of the study and the invitation to participate. After the acceptance to participate in the research, the home visit was scheduled.

For the selection of participants, an intentional sample was considered, with the following inclusion criteria: family members in the role of primary caregiver of the elderly in home care for at least three months, aged 18 years or older. Those who were not located by telephone contact to schedule the interview after three attempts on alternate days and times were excluded, and those who, during the research development, the elderly assisted could die.

Of the 19 elderly in home care registered in the service, 13 family caregivers participated in the study. Data were collected by the main researcher, who had no link with the institution or with the participants, through a single semi-structured and audio-recorded interview with the family caregiver. The data collection

instrument consisted of a form to characterize the caregiver and the elderly, in order to obtain the sociodemographic and clinical variables, and the following guiding question: Talk about the process of home care and the care performed. In addition, support questions were raised to explore and deepen the information related to the objective of the study.

Initially, this instrument was submitted to a pilot test with the first caregiver interviewed, with the objective of validating the understanding and its need for adequacy, especially the adequacy of the guiding question with the objective of the study. However, the instrument proved to be adequate and did not change. Data were collected from April to June 2019, and the interviews lasted an average of 50 minutes.

After the full transcription, the material obtained was submitted to content analysis, thematic modality. Thus, three stages were followed: pre-analysis, exploration of the material and treatment of the results. The sequence consisted of floating reading, with the pre-exploration of all the material obtained and apprehension by the researcher of general aspects and meanings. Then, the units of record were identified, annotated by the significant expressions, and, later, the categorization of the statements according to their similarities and differences[12]. The statements were identified by the letter I (Interviewee), followed by the number indicative of the order of the interviews, bond and age (I7, bond, age).

After approval by the Health Department, the project was submitted for consideration by the Human Research Ethics Committee, Universidade Federal de Mato Grosso do Sul (CEP/UFMS), Certificate of Presentation of Ethical Appreciation (CAAE) n. 02623818.4.0000.0021, and approved by Opinion n. 3.226.138.

Results

Of the 13 interviews conducted, 3 had audio recording problems identified at the time of their transcription. Thus, ten family caregivers participated in the study, six of whom were female, five were married, three were single and two divorced, and the age ranged from 36 to 60 years (mean 46 years). Regarding the level of education, five had incomplete elementary school, two had complete high school and three had incomplete high school. Regarding the degree of kinship of the relatives, nine were children and one husband. All declared to follow a religion. Regarding the existence of health problems, four reported having Systemic Arterial Hypertension (SAH), two of which were concomitant with depression disorder.

Benefits of home care: "it seems that her recovery is faster"

The home care modality, from the perspective of caregivers, provided important implications, such as the positive influence of the home environment (the comfort of the home) and the presence of the family in the elderly's recovery.

> *Compared to the hospital, it is much better because today she can do the little things she did before, not as much as before, with some limitations, but she feels comfortable here. This is her place.* (I1, daughter, 42 years old).

> *Many positive points, living with the family, being inside her house. When she was there* [hospital]*, her psychological if she did not left there was worse. She said, "If they did not discharge me, it is because I am worse." When she got home, the other day was something else, living with the family, if she is in a treatment of this, the coexistence with the family is the best thing she has.* (I6, daughter, 48 years old).

Family caregivers also expressed the feeling of satisfaction in the quality of care offered to the elderly, associated with the possibility of having the support of other family members and in the support received from the HCS. Moreover, in the home environment, as a consequence of the care process, the feeling of satisfaction arises in seeing the elderly well cared for:

> *We do enough to keep her quality of life. I like that, I feel grateful that she stays with us regardless of the way she is or not, she is always there. When she gets the view from the doctor, she is always well hydrated, blushing, so I understand that they cannot go back, but we can keep the best quality of life for her, so for us it is gratifying to see her well.* (I8, son, 42 years old).

> *We took a hard stop because when she came from there my mother was not weighing even 40 kilos, was very skinny, with time we were adapting, we caught a person who came out of the coma, weakened, almost died and*

today is here firm and strong, for us this is much more gratifying. To deal with her today is easy, at first we had no idea, I told my wife myself, as we will do with mom when she comes home, I myself had no idea and today we are here. (I8, son, 42 years old).

Moreover, the division of responsibilities among family members was highlighted as a positive resource for home care:

When I took on this role of caretaker, it was me and my daughter who also lives here although my brothers help me a lot, are very active, are here every day, there is one who lives here with me, if I need to leave they help me. (I6, daughter, 48 years old).

Only positive, have the professionals here, physiotherapist comes once a week, as well as the clinician, the speech therapist. They pass me security, I say that a caregiver without them does nothing, they are always following up and guiding. If she gets to feel sick during the weekend I already know where to go: UPA [Emergency Care Unit]*, and if it is a holiday, same thing! Other than that, I can call them and if they are near, they already comes, or they already guide me by phone or schedule a visit.* (I3, daughter, 60 years old).

In particular, in situations of instability of the clinical picture at home, the participants highlighted the relevance of the training received from the HCS team to perform the techniques by family caregivers.

She got sick, gave what they call a stopper in the trachea, but as HCS had already guided me as to what to do, I was doing the procedures. It was not a good situation, it was right at the beginning when she was at home. (I2, daughter, 40 years old).

When I felt insecure about some procedure I resorted to the HCS because they were the ones who taught me, from there that came here. We had a lesson in that [inhale]. (I1, daughter, 42 years old).

Challenges for the care of the elderly in home care: "Wow! And now?"

In this category, there are challenges for family care for the old person in home care, especially in relation to insecurity in performing procedures and the identification of factors that may limit the care provided.

Some participants reported that the inexperience before the new care demands to be carried out by them at home generated feelings, such as fear and insecurity.

It was scary! Feeling of fear. Because then, back at the hospital she had all the assistance, then there were hours when I kept looking, "Oh, my God! I am going to have to inhale my mother", I kept thinking! [...]. (I2, daughter, 40 years old).

The worst procedure was inhaling. I felt sorry. Because I do not like to see her in pain. There were days when she was in pain, but now she is on morphine, so she is not in pain anymore. The feeling of pain is very sad, you see feeling pain. (I5, daughter, 51 years old).

Moreover, difficulties in monitoring and interpreting information were also highlighted:

When she just arrived, it was troubling. In the first 20 days a group of students came from the college with the professor and told us to buy an oximeter and see her saturation at night while sleeping. We saw it and gave 67 saturation while I sleep. She [the professional] *said – "No way! She is going to die in her sleep!" Then it was another scare, because for us it was normal.* (I7, son, 57 years old).

However, it was observed that the time of care and the experience brought safety in the execution of the different care demands.

I used to wake up early at first at night and go there and see if she was breathing, I just happened to wake up and be afraid to open her room. Before I slept with her, today I sleep in a separate room. It scared me, I trusted the HCS, but I knew they would not be here every day. But today I have more confidence, feel calmer to deal with it, with illness, it is not easy, but I feel more confidence. (I6, daughter, 48 years old).

Today I feel good to carry out the care, but in the first week I had no confidence [...] *I had difficulty, even with her, because she had no coordination at all. So I was afraid to drop her at night, today I already have greater understanding.* (I3, daughter, 60 years old).

The interviewees also highlighted factors that limit the performance of care in the home context, such as the unavailability of material resources, the need for adaptations in the home environment, sometimes unfeasible due to the scarcity of financial resources, and the absence of integration between the HCS team and the Basic Health Unit (BHU).

Do not miss dressing things, food and medicine, things like that, if I go look at the health center, sometimes they have, sometimes they do not. (I3, daughter, 60 years old).

If I had conditions, I would have made a bathroom in her room with more space. She uses my bedroom bathroom, but it is small. The house is not adapted for her so what we manage to do and improve, we do, in this sense for her. (I7, son, 57 years old).

What now? We had to have all the structure for her here, like an ICU [Intensive Therapy Center] *indoors* [...]. (I1, daughter, 42 years old).

The UPA and HCS communicate, but not the unit [BHU]*, they know because the health agent made*

the registration, then came the nurse and made an assessment, so they know of her existence, but they do not come. (I8, son, 42 years old).

Discussion

The data of this study allowed describing the experience of family caregivers of elderly people in hospitalization and the role of HCS in this process. Health care, in view of the repercussions of the demographic and epidemiological transition, has sought to adapt to meet the needs of the elderly population at all levels of the Health Care Network (HCN)[1]. In this sense, the modality of HC proposes the care continuity in the home comfort, accompanied by caregivers, together with the guarantee of holistic and humanized care by the multidisciplinary team of the HCS[13].

Concerning the general profile found among the family caregivers of the present study, it is possible to perceive the predominance of child caregivers with low schooling. Culturally, women have their image associated with the gift of caring[14]. However, studies do not cancel that this inversion of roles (children caring for parents) and the presence of ambiguous feelings can impact the relationship of the loved ones, the health of those who care and the quality of those who receive care[14-15].

Although positive feelings were identified in the present study regarding the execution of home care, when assuming responsibility for care, sometimes harmful reflexes may arise to the caregiver's already fragile health, resulting from overload when present[15]. Thus, we highlight the need for care and follow-up in relation to the health of family caregivers, due to pre-existing comorbidities presented by the participants, especially those related to psychic problems.

The positive influence of the home environment for the recovery of the elderly, highlighted in this investigation, corroborates findings of two other studies with family caregivers, which also indicated home hospitalization and the care process established in the home comfort and in the presence of family ties as a favorable factor to the rehabilitation process and increased well-being of the elderly, as well as in improving the patient's clinical picture[5,16]. Similarly, a study conducted with family caregivers, the elderly and health professionals on the perception of home care emphasized the significant improvement in the health conditions of the elderly person in home care[11].

Regarding the family caregiver, there was satisfaction of seeing the elderly well cared for at home. This result is in line with findings from a study that explored the experience of caregivers of elderly people with chronic disease in the state of Osun, Nigeria, who pointed out the feeling of pride in caring for. The same study also highlighted that, although there are challenges inherent to the practice of home care, the participants highlighted happiness and satisfaction with the process[17].

Participants considered the division of responsibility with other family members as a positive resource in home care. They reported support/assistance in daily dynamics, whether direct or indirect, for basic care, such as bathing and feeding, and that this sharing provided more time to meet other personal demands with reduced overload.

The caregiver is an essential figure to guarantee care continuity. Nevertheless, the possibility of dividing responsibilities among other family members is not excluded in order to avoid overload[17]. Thus, family union and the possibility of sharing care are influential in the process of adaptation to the new routine and in the quality of life of those responsible for care[16]. Nonetheless, this division of responsibility among other family members and support to the primary caregiver is still small in most cases, which implies isolated care and caregiver burden[17].

Therefore, we highlight the need for health professionals to provide subsidies to involve different family members in care, through actions that support and transmit safety to family members and patients in cases of clinical instability and routine follow-up, for example. The bond with the family is a precursor to other

actions, such as the implementation of a care plan and the instrumentalization of caregivers[5].

It should be emphasized that the difficulties related to the execution of the care faced by the caregiver could sometimes have been mitigated even with the hospitalized family member, since, during this period of hospitalization, the caregiver, under the supervision of professionals, can develop skills and abilities that would imply in reducing insecurity and anxiety when alone at home[16].

The importance of the elderly and the family being inserted in the HC program was pointed out by the family caregivers of the present study, especially regarding the bond and support offered by the HCS team, which, in many cases, exceed routine care. It was emphasized the return given by the team members in emergency cases outside the working hours and the willingness to clarify doubts, especially when the elderly arrive at home.

From the perspective of the family members of this research, safety is established by monitoring and clarifying what they do not know, which facilitates the adaptation to their new role and the execution of care. A study conducted in Portugal on the experience of family caregivers in transition to home care highlighted the practice of guidance still in the hospital environment and the previous interaction with professionals seeking to learn the care process as factors that facilitate this process[18].

In this sense, access to HCS should include the training offered for daily management and care before the clinical instability of the elderly at home, with a view to enabling the caregiver and the family greater tranquility before adversities. Contact with the HCS team should represent the guarantee of follow-up and obtaining precise guidance, which reduces the need to resort to emergency units due to the clinical acute picture of the patient[19].

Attention is given to the consistency of knowledge, competence and technical ability of the caregiver to provide care in the home environment. Thus, the importance of the training developed by professionals and the provision of practical instructions for the performance of home care are, above all, of great relevance for the effectiveness of this process[17].

Therefore, given the efficiency of the care modality, the competencies and skills of the service professionals are emphasized to identify positive and negative aspects experienced by caregivers. Such actions will enable the planning of actions to be agreed with the caregiver, which will build on the singularities of the family, validate the potentialities and reduce the difficulties experienced.

Therefore, patients and families accompanied by HCS, after hospital discharge, recognize the benefits of recovery at home, but arouse reflection on the importance of the support offered by the service for satisfactory achievements regarding care adaptation and continuity. Thus, health professionals should pay attention to the monitoring and systematization of care to be performed by family caregivers at home, through strategies aimed at reducing psychological impacts and initial management difficulties, and enabling a more pleasant transition to the home environment.

Home care encompasses aspects that influence the family routine and the responsibilities attributed to the caregiver. In this sense, the importance of recognizing the difficulties that permeate this care modality by health professionals is highlighted, especially in the context of the care of the elderly dependents on HC. A study conducted with seven caregivers of dependent elderly assisted by the Home Care Program of a University Hospital of São Paulo pointed out, as a challenge of the new reality, the reorganization of the family and the reversal of roles by family members[14].

Thus, the care process in this scenario is marked by weaknesses, especially in relation to the fear of family members/caregivers to provide care, often with insufficient resources and limitations in the execution and understanding of the procedures necessary for care[20].

Although the role of mediating dehospitalization, the provision of training and recommendations to the caregiver is

attributed to the health service, the participants referred to the difficulties experienced and the limitations faced by home care, with emphasis on insecurity in performing invasive procedures at home. A study that explored the experience of 15 family caregivers of the elderly in Thailand demonstrated that the obstacles of home care are in the caregiver's inexperience, especially in the presence of worsening of the elderly clinic, which consists of difficulties in the early identification of warning signs, in the execution of correct techniques and in the lack of monitoring devices[21].

In this scenario, once the clinical changes and the correct management are identified, there is a direct impact on the maintenance of life and anatomophysiological preservation of the elderly, aspects that should be considered by HCS professionals, together with family caregivers, regarding the planning of care and adaptation to the new routine. Thus, it is important to identify the need for guidance to the caregiver before emergency situations, because it is understood that the greater the knowledge, the caregiver will have more security to offer safe care, which avoids hospitalizations of the elderly assisted[22].

In short, it is noteworthy that, in most cases, even after discharge from HCS, the elderly remain dependent, which reinforces the importance of preparing this family for the promotion of care and prevention of injuries, in order to facilitate rehabilitation, inclusion, autonomy and independence of the elderly. This suggests the need for those involved in care to develop strategies aimed at consolidating a safer, problem-solving and permanent practice.

Home hospitalization also implies concern about the conditions that go beyond the knowledge and practices exercised for care in the home environment, as mentioned by the participants of this study, such as the daily difficulties experienced before the need for adaptations in the residence, for more practicality in the care performance, comfort and safety provided to the elderly, but which are sometimes hindered by the scarcity of financial resources. A study conducted in Minas Gerais with 15 caregivers showed that the participants mentioned the importance of the materials and the adaptation of the environment, but as a distant reality for some families, which result in limited and uncertain care[23].

Thus, the caregiver establishes new ways of serving the family member daily, and that the relationships, partly weakened, the overload, the viability of resources and the existence of physical barriers and access are configured as aspects that perpetuate in this care modality.

Furthermore, the caregivers' statements aroused reflection regarding the counter-reference between the Services of the HCN, which sometimes does not occur. This fact influences the follow-up and comprehensive care of the elderly and their families. A study conducted in Rio Grande do Sul, with HCS nurses, sought to know the articulation of the HC service with the care networks, and demonstrated the positive impacts on the construction of continuous care, in the presence of integration of services[24].

Therefore, health teams are required to work in the complexity of the home territory, in the multiplicity of family dynamics, and to contemplate the values and knowledge of this family in care.

In view of this perspective, the importance of this care modality in response to demographic, epidemiological, social and cultural changes in the health context in Brazil is unquestionable. Even before the challenges related to the care implementation, consolidation and qualification, the benefits include greater well-being for the elderly and their families, the strengthening of affective bonds, greater autonomy of the family, and reduced burden on the public health system are increasingly highlighted.

Therefore, the particularities of care in HC need to be explored in all its dimensions, reaching users and caregivers in full, since, sometimes, this modality does not fit the care of the HCN, which encourages to reflect on strategies for producing policies and management ordering to identify the real needs of this context. The current scenario proposes and invites all those involved in the home care modality to foster,

reflect, reinvent and create new possibilities in health in a comprehensive and interventionist way[25].

The data obtained in this study, even if compared with others in the literature, are limited to a local reality, with a specific sample of caregivers with their own characteristics. Furthermore, the scarcity of studies regarding the initial challenges in the caregivers' perception, especially in emergency situations at home, restricted a more in-depth discussion, thus requiring more research to foster this and other challenges that permeate home care.

Final considerations

The participants emphasized the benefits provided by the HD, such as the comfort of the home, affective bonds and support of the service professionals, seen as satisfactory for the elderly's recovery, in addition to the feeling of satisfaction of the caregiver. The unavailability of financial, structural resources, family support and the inexperience mentioned by the caregivers in this study, configure as challenges in the dynamics of care at home.

Although the importance of HCS is highlighted, attention is given to the performance of team professionals as facilitators in this transition phase and the preparation of the caregiver through more frequent orientations and visits, in order to reduce the initial impacts and provide autonomy and safety for the performance of care at home.

The findings of this study demonstrate the importance of the health team understanding vulnerabilities and potentialities in the family context, so that they are explored and inserted in the care plan, since it was evidenced that the training actions offered to the caregiver for hospital discharge imply the quality and continuity of care, and in the improvement of the necessary skills at home.

Above all, more studies should propose effective interventions in the home context, including caregivers and the elderly and the challenges faced, in order to reduce unnecessary hospitalizations and consolidate safe care at home.

Collaborations:

1 – conception, design, analysis and interpretation of data: Sara Ingrid de Rezende Ferreira and Elen Ferraz Teston;

2 – writing of the article and relevant critical review of the intellectual content: Sara Ingrid de Rezende Ferreira, Elen Ferraz Teston, Gleice Kelli Santana de Andrade and Bianca Cristina Ciccone Giacon-Arruda;

3 – final approval of the version to be published: Sara Ingrid de Rezende Ferreira, Elen Ferraz Teston, Gleice Kelli Santana de Andrade, Bianca Cristina Ciccone Giacon-Arruda, Daniela Miyuki Sato and Rodrigo Guimarães dos Santos Almeida.

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