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Challenges for discharge in home care

Desafios para realização da alta na atenção domiciliar

Desafíos para realizar el alta en la atención domiciliaria

ABSTRACT

Objective: to understand the process of discharge of patients and family members assisted by home care services. **Method:** descriptive-exploratory, qualitative study, carried out with ten professionals from two Multiprofessional Home Care Teams linked to a Municipal Health Department. Data collection occurred through semi-structured interviews, audio-recorded and submitted to content analysis, thematic modality. **Results:** the interviewees reported difficulties in recognizing the appropriate moment to start planning care transition activities, the lack of a standardized flow harmful to the continuation of care by Primary Care, the use of the Singular Therapeutic Project, 1the unification of information systems and the development of protocols for the transition of safe care. **Conclusion:** the difficulties related to the execution of the discharge show the need for interventions involving the elaboration of protocols for the articulation between the services and maintenance of continuous and integral care.
Descriptors: Home Care Services; Patient Discharge; Transitional Care.

RESUMO

Objetivo: compreender o processo de realização da alta de pacientes e familiares assistidos por serviços de atenção domiciliar. **Método:** estudo descritivo-exploratório, qualitativo, realizado com dez profissionais de duas Equipes Multiprofissionais da Atenção Domiciliar vinculadas a uma Secretaria Municipal de Saúde. A coleta de dados ocorreu por meio de entrevistas semiestruturadas, áudiogravadas e submetidas à análise de conteúdo, modalidade temática. **Resultados:** os entrevistados referiram dificuldades em reconhecer o momento adequado para iniciar o planejamento das atividades de transição dos cuidados, a inexistência de um fluxo padronizado prejudicial à continuação dos cuidados pela Atenção Primária, o uso do Projeto Terapêutico Singular, a unificação dos sistemas de informação e o desenvolvimento de protocolos para a transição de cuidados seguros. **Conclusão:** as dificuldades relacionadas à execução da alta evidenciam a necessidade de intervenções que envolvam a elaboração de protocolos para a articulação entre os serviços e manutenção do cuidado continuado e integral.
Descritores: Serviços de Assistência Domiciliar; Alta do Paciente; Cuidado Transicional.

RESUMEN

Objetivo: comprender el proceso de alta de pacientes y familiares asistidos por programas del Servicio de Atención domiciliar.**Objetivo**: comprender el proceso de alta de pacientes y familiares asistidos por servicios de atención domiciliaria. Método Estudio cualitativo, descriptivo-exploratorio, realizado con diez profesionales de dos Equipos Multiprofesionales de Atención Domiciliaria vinculados a una Secretaría Municipal de Salud. La recolección de datos ocurrió a través de entrevistas semiestructuradas, grabadas en audio y sometidas a análisis de contenido, modalidad temática. **Resultados:** los entrevistados mencionaron dificultades para reconocer el momento adecuado para iniciar la planificación de las actividades de transición asistencial, la falta de un flujo estandarizado perjudicial para la continuación de la atención por la Atención Primaria, la utilización del Proyecto Terapéutico Singular, la unificación de los sistemas de información y el desarrollo de protocolos para la transición segura de la atención. **Conclusión:** las dificultades relacionadas con el alta muestran la necesidad de intervenciones que envuelvan la elaboración de protocolos para la articulación entre los servicios y el mantenimiento de la atención continua e integral.
Descriptores: Servicios de Atención de Salud a Domicilio; Alta del Paciente; Cuidado de Transición.

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INTRODUCTION

The global aging process, characterized by accelerated changes in the demographic configuration and associated with the change in the morbidity and mortality scenario due to the prevalence of Chronic Noncommunicable Diseases (CNCD), required the development of policies to promote long-term care. Due to the aging and illness process, the scenario of the sectors that provide health care suffers socioeconomic and biological impact, especially with the dense occupation of hospital beds and the costs spent for this, requiring new forms of care for human beings[1].

One of the modalities of care transversal to the Health Care Network (HCN) and that allowed to mitigate these impacts is Home Care (HC). Standardized through the Best at Home Program, its vehicles are the Multiprofessional Home Care Team (MHCT) and the Multiprofessional Support Team (MST) integrated into the Primary Health Care (PHC) teams. This modality is presented as a form of viable solution by proposing a new configuration of care that allows the continuity of care and the reduction of hospital costs [2-3].

The organization of HC services occurs through the recognition of the flow of services offered by the HCN and includes the inclusion of individuals, according to eligibility criteria defined in regulations for the different modalities, in the planning of care by multidisciplinary teams, as well as the resources necessary for home care[2]. Thus, under the responsibility of PHC are individuals of the HC1 modality, characterized by clinical stability and the need for less complex interventions, in addition to requiring less frequent care. The individuals assisted by the HC2 and HC3 modalities, whose severity of the clinical condition requires home care more frequently and with the support of high technological density equipment, are the responsibility of the MHCT or MST[2-3].

The division into modalities contributes to the management of care, in order to share the care with the different points of the network. It is noteworthy that the discharge of individuals of the HC2 and HC3 modalities attended by HC services, occur, among other criteria, after the stabilization of the clinical condition and the preparation of the caregiver/family member to take care[3]. Thus, users are counter-referenced to PHC, since they belong to the territory covered and, thus, remain under the responsibility of the Family Health Strategy teams according to the area assigned[4-5].

Although the eligibility and discharge criteria for users are defined, difficulties are perceived for the continuity of care after the discharge of HC services for PHC. This is because there is difficulty in coordinating, given the wide demand for work to which they are submitted, the failures in the devices for the transfer of information from the user care process to other points of the network and the challenges in the performance itself between the devices that integrate the HCN, a reflection of a training centered on biomedical knowledge[1,2,6]. In addition, often the referral and counter-referral occur only at the time of admission and discharge, and there is no effective communication in the follow-up[7].

Several studies show gaps in the articulation of HC services with the other points of the HCN[1-2,4,6-7]. This situation can be justified as an impact caused by the lack of standardized and regulated flows that direct the continuity of care. In this context, the construction of administrative flows that allow the maintenance of effective communication between the levels of the network is necessary for the care of users after discharge by the teams of HC services, ensuring the longitudinality, integrality and continuity of home care[1].

Given this context, the following question arises: “How does discharge occur by HC services?”. In order to answer it, the present study aimed to understand the process of discharge of patients and family members assisted by HC services.

METHODS

This is a descriptive-exploratory research of a qualitative nature, which is linked to the Research Project “Home care for adults and the elderly in the perception of health professionals, patients and caregivers”.

The study took place in Campo Grande, capital of the state of Mato Grosso do Sul/Brazil, with professionals from the MHCT allocated to the Municipal Health Secretariat (SESAU). Professionals from two teams participated in the interviews. Among the inclusion criteria were considered: health professionals with technical level and higher, belonging and working in the MHCT of the SESAU, with a minimum activity of one month. In addition, the following exclusion criteria were used: absence from work during the period of data collection due to leave, vacation and unavailability after three contact attempts.

An initial approach was established with the coordination of the teams, by telephone, with the purpose of inviting them to participate in the research. Then, a schedule of interviews with 13 professionals was made available, of which three were excluded from the study due to refusal of the collaboration invitation. After accepting the invitation, the interviews were conducted individually, following a semi-structured instrument, which was elaborated by the researchers, in order to collect sociodemographic information from the participants and about the process of discharge of patients and caregivers assisted by HC services from the perspective of the professionals. The interviews took place according to the availability of time of the participants, previously organized and scheduled at the place of service, in order not to interfere in the work routine.

The information was collected during the month of September 2020 by researchers from the scientific work team, under the guidance of professors experienced researchers in qualitative research. The face-to-face meeting for the interview was carried out following all COVID-19 prevention recommendations, such as the use of a mask by all those present and a distance of two meters between them. The interviews were audio-recorded, with mean duration of 15 minutes, and referred to the characterization of the professionals interviewed and the guiding question: "How does the discharge by the Home Care service occur?" In addition, questions were asked to define and describe the use of instruments in the construction and planning of discharge by MHCT.

After data collection, the interviews were transcribed in full and the information obtained was submitted to Content Analysis, thematic modality, following the phases of pre-analysis, exploration of the material, treatment and inference of the results[8]. The first moment of the pre-analysis was composed of data organization and floating reading; in sequence, the material was explored in detail through exhaustive reading. Then, during the coding stage, the data were cut and aggregated into recording units according to the theme for the elaboration of the unit of signification. Finally, from the thematic analysis and development of the core of meaning, it was possible to organize the thematic categories, shown in Figure 1.

Figure 1 – Thematic Categories and Nuclei of Meaning

Thematic categories	Core of Meaning
Home Discharge Process.	Discharge process in HC.
	Criteria for discharge in HC.
	Use of directive flowchart for discharge.
	Preparation of the patient/family/ caregiver in the elaboration of the discharge.
Influential aspects in the effectiveness of discharge by HC services.	Factors that hinder the discharge process.
	Participation of other Network component points in the construction of the discharge.

Source: The authors, 2021

The study received authorization from the Municipal Health Department and the Regional Hospital, and was submitted to and approved by the Human Research Ethics Committee of the Federal University of Mato Grosso do Sul (CEP/UFMS), opinion 3.226.138, in compliance with Resolution 466/2012, of the National Health Council (NHC), which regulates research with human beings in the country. All participants signed the Informed Consent Form and were kept in anonymity through the representation of the names expressed by the letter P alluding to "Professional", followed by the Arabic number referring to the order of the interview.

RESULTS AND DISCUSSION

Characterization of subjects

Ten health professionals working in two MHCT/SESAU participated in the study, two nurses, three nursing technicians, one physician, one social worker, one speech therapist and two physical therapists. Nine of them were women and their age ranged from 27 to 55 years (mean 33.2 years). The period of activity in the service ranged from four to 24 months (mean of 12.8 months).

Home Discharge Process

The category covers the elements involved in the home discharge process, which is scheduled and discussed as a team during the preparation of the Singular Therapeutic Project (STP). The participants highlighted the

discharge modalities and the disconnection criteria used for the preparation and involvement of the individuals responsible for patient care.

It was observed in the interviews that the home discharge occurs with the stabilization of the illness presented by the patient, followed by the referral and transfer of care to another level of care. However, there are setbacks in relation to the operationalization of the procedures, documents for the execution of discharge and continuity of care by the other service points of the HCN, due to the turnover of professionals in the service and the lack of a standardized flow for the scheduling of discharge. "We provide care to them until they stabilize the condition, refer them to another unit, or to the health center or to a specialized center, physiotherapy, something like that that they need, never the patient leaves helpless [...] the STP is where we discuss the patient's case, his evolution (P2)". "We deliver a form stating that we are discharging [...] I think we could improve our work process, make a discharge report even with everything that happened (P3)". "We make some agreements at the meetings [...] each team discharges as it thinks it should be, and sometimes passes a report to the coordination, sometimes it does not pass [...] so all this is still being sought (use of standardized flowchart); we have read the ordinances, there is still a great turnover in the sector of people who work, new people come in and each one wants to do it in a way [...] P4".

It is noteworthy that the turnover of professionals is a factor that can negatively influence the organization of the service routine, the establishment of flows and even the lack of health history and therapeutic conducts adopted[1]. In addition, the lack of information and the difficulty of access to the guidelines and treatments prescribed to patients, when referred to specialized services, make up some of the failures of insufficient communication and misunderstanding between the different points of the HCN[1,6].

In this sense, the dialogue between the different points of the network is a potential for the continuation of care and effectiveness of the home discharge process. Likewise, communication failures between the levels of complexity involved in care, contribute to the increase in the rate of early readmissions, lack of control of health conditions and constancy of fragmentation, in addition, these indicators directly interfere with the quality of the service provided and the care transition system[9].

In a study on the coordination of care, although PHC is defined as an ordering factor of the health system, the communication difficulties evidenced by the lack of counter-referral with descriptions and use of inefficient tools for integration of services were identified as influential factors in the organization of care. In addition, during the details of the construction of the discharge documents, inconsistencies were identified among the team members and lack of information considered appropriate to characterize an adequate report[6].

Among the termination criteria, the professionals pointed out the administrative discharge, due to clinical improvement and death. We discharged the woman for change, she moved from the neighborhood and went to a region that was not covered by the Home Care Service [...] (P1) "We do some types of discharges, such as administrative, at the request of the patient, when he no longer wants to receive care from the Home Care Service or when he fails to meet the service's criteria, such as having a caregiver. When the patient is actually discharged due to improvement or discharge due to death (P4)". "When the patient recovers, when the patient no longer has a device, when it is classified as HC1 [...]. When he is able to go to the basic unit with walker, with wheelchair (P8)".

It should be noted that the aspects that define discharge also consider the patient's living conditions, availability of caregivers, follow-up of the therapeutic conduct suggested by the team, stabilization of the health condition and/or worsening[3]. In this sense, the descriptions of the eligibility, exclusion and discharge criteria are essential for care coordination and to facilitate the direction of the patient within the HCN. Thus, it is possible to offer the patient quality care in a timely manner due to the level of complexity that is most appropriate to the demands of the health user.

In addition, the ability to travel to the health unit closest to the patient's residence and death were also mentioned as criteria for discharge. However, it was observed in a study carried out in 2015 that, although the specifications for inclusion, exclusion and discharge from the program are defined, HC teams and coordinators extend or do not execute the discharge. This may be influenced by the difficulty of communication and participation of other points of the HCN

during the care and preparation of the discharge planning. Therefore, due to uncertainties about the continuity of care, users considered HC1, for example, are kept in care by the HC service, in order to avoid the discontinuity of care and complications of the health condition[3].

The professionals emphasized that during the meetings for the development of the STP, the discussion of the discharge process begins. However, the definition of the appropriate moment for its execution is hampered by the singularities and severity of the condition presented by each user. "There are patients that we program the discharge; we usually make STP of our patients here, we define this and when we get close, we check if this discharge will really be possible. If the patient did not exacerbate, there was no other complication, we performed this discharge. Only there are few patients who experience this, this discharge schedule, because we receive many patients in palliative care, these do not have a discharge schedule. Patient HC1 that is acute, something like that, we schedule the discharge, yes, we refer this patient to a specialized service [...] (P6) " We have the STP, which is the meeting where we weekly discuss the fate of each patient; we discuss the improvements, we make an action plan, what we are going to do with the patient and within this meeting we decide; all of us who form the team give the opinion and decide (P9)".

The discharge process was referred to as the transfer of care offered by the HC service to another point of care, which is directed according to the clinical picture presented by the user. Thus, the stability and improvement of the health condition are highlighted for the beginning of the discussions and activities aimed at the discharge process during the elaboration of the STP[3]. However, in line with a study conducted with nurses in Portugal, some professionals also showed difficulty in recognizing the most appropriate time to start the discharge program[10].

In a study with HC services in the state of Paraná, the use of STP demonstrated great potential to improve care by allowing the planning of conducts, meeting individual needs and promoting the autonomy of the user and responsible caregivers. However, although the benefits provided by the use of this tool are recognized, it has not been used by all HC services[11].

According to a study carried out in Paraíba, the lack of responsibility for the development of a STP together and articulated with the other care levels was considered as an obstacle and negative factor to the reference and counter-referral of users[12]. Therefore, with the implementation of the tool for the planning of care and discharge activities, as a shared model with the different points of care of the HCN, it would be possible to favor the continuity of care.

Thus, with the use of the STP, the transition from care to home can be favored through the use of nursing care protocols that direct the educational activities of caregivers responsible for users[13].

With a view to the quality of the discharge process, the participants highlighted the importance of preparing both the user and the caregiver, and how the ability to perform the care activities reflects in the team's decision to discharge. "We try to give this discharge with prior guidance, already warning the patients that soon they will receive discharge. We make documents, drawings, glue on the wall so they can understand and when they cannot get all this to receive effective care at home, sometimes the team even stops giving discharge for now. Because it is something that also impacts our discharge decision or not when the caregiver can do some care or when he cannot. The patient, if he is able to do it, we train the patient too; then both are visualized. P4. "[...] the caregiver himself is already guided several times until this discharge, we advise a lot. Before we had a meeting of caregivers to answer questions, to give training, for us to see if the caregiver was really interested in learning [...]. During this period when we stay at the patient's house, we try to capture the difficulties he has and he watches us do it with the patient [...] (P9)" "As soon as the patient is admitted into MHCT, we are already preparing the family for discharge. We had the caregivers' workshops regularly, during these workshops we talked about all the processes; we also talked about discharge (P10)".

Studies highlight the importance of training those involved in care for the success of transition actions, associated with a set of activities of coordination and continuity of care. Among them, the realization of a care program, communication, adequate use of medications, support networks, availability of a multidisciplinary team, monitoring and follow-up[13-14].

However, when asked about the participation of users and caregivers in the planning of discharge, they reported difficulties in inserting users in the process, despite recognizing them as important

figures during care. “Our patients generally do not have much participation in this discharge process, because they are well bedridden, many non-responsive. The caregiver does not participate because he is disoriented; people are very ignorant about how the network works; they do not know who receives the care, where the patient goes; that is, they do not understand the process very well (P5)”.

Since the discharge plan must be constructed in order to meet the needs of the users, this plan must also consider and assess the skills and weaknesses of the health users and the caregivers responsible for maintaining self-care. Thus, among the purposes of preparing those involved for discharge is the empowerment and development of independence, making them responsible for care actions [15-16].

However, despite evidencing the benefits obtained from the involvement of the patients, caregivers and family members in the discharge process, the reports of the participants show difficulties in inserting them in the elaboration of the actions, in consonance with a narrative review that highlights the statements of caregivers not involved in decision-making[9]. Several studies highlight the dissatisfaction of health users and responsible caregivers about the failure of communication with the professionals who provide care during the planning of discharge and transition of care[9,17-18].

Therefore, it is necessary to provide support to responsible caregivers. For this, the involvement of the family and users during the preparation of the discharge plan enables a safer transition process, prevents complications by clarifying the difficulties and aspirations. In addition, telephone monitoring is also presented as an alternative to help in the evolution of the users and offer support to recent doubts after discharge[17].

The construction and discharge process should be developed individually, aimed at meeting the demands and particularities of each user and responsible caregiver. The guidelines should cover all issues and difficulties, appropriate to the sociocultural aspects and taken up again. In addition, it is important to educate about the possibilities of complications and direction of care in emergency situations[18].

Influential aspects in the discharge of HC services

In this category, it was possible to recognize some aspects that interfere in the process of elaboration and planning of discharge. In addition, in the discourse of some professionals, strategies that could facilitate and improve communication and care sharing between the levels of the HCN are identified.

Among the aspects that hinder the execution of the discharge, the professionals highlighted the acceptance of the caregivers in relation to the disconnection of the users, the difficulty of contact with the health unit responsible for the users and the sharing of care to ensure continuity in the PHC. “When patients need only one professional, we have a lot of difficulty in discharge. They do not accept discharge, they want us to continue attending [...] when it is administrative discharge it is more difficult. There are some who have resistance and others who don’t; they welcome discharge (P3). “What makes the discharge more difficult are the health units. Often, to take on the patients, only through a lawsuit due to this lack of counter-referral [...] there are some patients that we even stay with them, even if they are HC1, because if they are not attended to, they will get worse. (P6)”. “Lack of family knowledge, they think the Home Care Service is home care, that the patient has to stay with us [...] they have a lot of difficulty getting things in the basic unit [...]. And this is what makes it difficult the information (P7)”. “What makes our discharge process difficult is the lack of professionals within the PHC. Sometimes we don’t have nurses or sometimes in the area where the patient is, it is not the Family Health Unit, there are no visits, there is no monitoring of this patient who needs to be monitored at least once a month; it is a risk [...] (P10)”.

It is noteworthy that the transition of care should cover all those involved in patient care, including the family, team professionals and responsible caregivers. In this sense, nurses must act as mediators between the PHC and the health users, in order to guarantee them the necessary inputs to meet their demands and the continuation of care[15].

However, caregivers, sometimes due to the new duties and responsibilities of care imposed by home care, feel distressed and not prepared to perform this function. In particular, due to the lack of knowledge of the procedures that will be necessary at home, changes in family routine, economic issues and anxieties about the continuity of care at other levels[17]. These

factors generate a dependence of users and caregivers assisted by the HC service, in addition to contributing to resistance in relation to the assistance provided by the other modalities and service points of the HCN[1].

In a study conducted in the state of Minas Gerais, it was evidenced through the speeches of health users the difficulties faced in accessing PHC services and the emergency network. Thus, it was claimed as an advantage the link to HC for entry and obtaining assistance at levels of high complexity, such as emergency care units and hospitals[19].

Another national study pointed out that the support of the basic health unit is limited to the supply of inputs. However, it is essential that the person ordering care is responsible for monitoring and home care, in order to supervise users and caregivers, offering the necessary support and plan actions for the evolution of the health condition[20]. Therefore, it is necessary to recognize PHC as an essential device for the success of home care management.

In addition, users elected for HC also refer to the convenience and ease of performing laboratory tests, exempting them from responsibilities and costs with locomotion. The comfort and privacy offered by the home environment, added to the decreased chances of hospital contamination are also listed as advantages of being inserted in the home care program[19].

In addition to the difficulties of access to primary care units, some users live in regions that are not covered by the Family Health Strategy, preventing the users elected as HC1 from being monitored at home. Moreover, due to communication failures with the other points of the HCN, evidenced by the vulnerability existing during the referral of the health users and the discontinuity of their care, many cases are maintained even without the need for home care[2-3]. Thus, it is important to highlight the continuous analysis of the criteria for discharge, according to the individualities of each user.

Regarding the planning and execution of the discharge, it was possible to notice in the speech of the professionals the lack of efficient communication and the lack of participation of other service points of the HCN in the construction of the discharge of the users in care by the HC service. “The Home Care Service is an independent sector, we are not added to any other, that is why there is no participation from another point of the HCN in the planning of discharge. It makes it a little difficult, because if it had (communication with the HCN points of attention) it was already much easier to refer. We refer the patient to the basic unit, but we do not have the feedback if this patient is being treated or not. It would be good if we were connected to other sectors and this communication, even to be discussing the patient’s case better (P1)”. “The Home Care Service and Basic Care could not be disconnected, from the moment the Home Care Service admits, they (Basic Care) leave the patients, they no longer serve, which is a fragility that we are trying to rescue. Some patients I attend in partnership with Basic Care; it is a very big gain, I have two or three that we get this effective contact, and others we try, but unfortunately there is this impasse. But at the time of discharge we need to make this referral for them [...] (P4)”. “We only refer to someone (participation of another point of HCN in the planning of discharge). Until there is a certain interaction with some units, but in fact when we take on the patient, there are many units that want to exempt themselves from care and that is not what it should be, it is a shared care (P5)”. “Today I understand that the greatest difficulty for us to have a more effective link with the primary care is professional turnover [...] our management of the Home Care Service is trying everything to achieve the management of the Primary Care, but sometimes it is so much program (P10)”.

The continuity of care is perceived by the users as a cohesive action capable of meeting their health demands and derives from the combination of some components. These include accessibility to the service, interpersonal skills, information sharing among professionals, coordination of care, integration of services and use of an individual-centered care approach[21].

A Brazilian study highlights the influence on the dynamics of home care, when it comes to the unavailability of financial and structural resources, family support and the lack of experience and/or preparation of caregivers. In this context, PHC proves to be essential and facilitating in the transition and preparation of the caregivers. In addition, the team of professionals also needs a situational diagnosis regarding the vulnerabilities and potentialities of the family context that will be inserted in the care, since from this the planning of care becomes more effective. Together, the effectiveness in the

continuity of home care is evident when training actions are carried out with the caregiver for hospital discharge[22].

With regard to hospital discharge, the continuity of care offered by the points of care that make up the HCN can be favored by a process of transition of care efficiently performed[15]. The maintenance and continuation of care occur when the service provided is complemented by different components of the health network in a timely manner[23].

Determined by a series of activities that coordinate the continuation of care, as well as the sharing and transfer of care between different levels of complexity, the elaboration of transitional care during the hospitalization period is recommended[16]. Thus, it is possible to prevent the discontinuity of care through the planning of discharge by ensuring access through the coordination of care, articulation of PHC and other components of the HCN and improvement of counter-referral[21].

Among the essential strategies that contribute to the discharge of HC services, there is the planning of discharge aimed at educating caregivers and promoting user self-care in advance. In addition, the complete communication of information with PHC teams for the sharing of health history and adopted conducts facilitate the continuity of care, reducing readmissions, complications and costs with treatments[24].

HC is a complementary care modality to other health care points of the HCN, therefore, it must maintain a flow of communication with the other levels of care, in order to meet the needs of users and promote continuity of care[1,4]. For this to be possible, it is necessary to adopt an organizational model. The training, planning and decision-making must be carried out in partnership with the other elements of the HCN through an information system that enables clinical assessment, standardization of protocols, longitudinality and feedback[23].

Finally, some strategies were suggested to improve the discharge process and the communication of HC services with the other service points that make up the HCN. “Improving shared care, suddenly make some shared visit to align care, make a shared STP [...] (P5) “The unification of medical records would already be a way that would help a lot in this counter-referral of this patient, so that later he receives a discharge and a proper follow-up (P6)”.

Studies have pointed out several strategies to facilitate the sharing of information between hospital and PHC professionals. The availability of the discharge plan in a computerized platform, added to the aspects of the clinical history, complications and implemented therapy, facilitate the continuity of care and prevent complications of the health condition and case management[10,15-16,21].

FINAL CONSIDERATIONS

In this study, we observed the difficulties related to the discharge to the home, as they show the current challenges that permeate the health sectors. It also allowed the understanding of the importance of the discharge process carried out by the HC services and the identification of elements that directly imply the success and planning of the discharge.

The programming of the transition of care has great potential to improve the process, execution of discharge and effectiveness in the continuity of home care. It is noteworthy the implementation of training actions carried out with the caregivers for hospital discharge. In addition, the use of tools such as the STP can collaborate to identify the most appropriate time to start the activity and the recognition of the needs of each user and caregivers. For this, it is necessary to educate users and caregivers about the importance of co-responsibility in the elaboration and monitoring of the STP for their effective participation. In addition, they favor the continuation of care, promote better flow and services provided by levels of care, longitudinality, comprehensiveness and cost reduction with early readmissions.

The study was limited to the participation of only two MHCT with peculiar characteristics of a region, and did not contemplate the perspectives of users and caregivers who went through the discharge process.

It is expected that the results of this study may support the actions of planning discharge by the teams of the HC services, especially by pointing out modifiable factors that interfere in the continuation of care and sharing of responsibilities between the levels of assistance of the HCN. Permanent education actions among nurses of different levels of care can contribute to increase the understanding of the importance of communication between professionals working in different points of the HCN as a way to build

shared, longitudinal and integral care. Finally, when analyzing the practices described by the research, it will be possible to develop new flows and protocols that guide the transition of care and allow greater participation of users and caregivers during decision-making.

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