



RESEARCH

THE DOMICILIARY VISIT AS A PRACTICE OF RECEPTION IN THE MEDICAL PROGRAM OF FAMILY/NITERÓI

A VISITA DOMICILIAR COMO PRÁTICA DE ACOLHIMENTO NO PROGRAMA MÉDICO DE FAMÍLIA/NITERÓI

LA VISITA DOMICILIARIA COMO PRÁCTICA DE ABRIGO EN EL PROGRAMA MÉDICO DE FAMÍLIA/NITERÓI

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ABSTRACT

Objectives: to describe as the integrant ones of a team of family doctor they carry through the practical one of the shelter during the domiciliary visit and e to identify the potentialities of the Domiciliary Visit as a device for the shelter. **Method:** a exploratory research with qualitative boarding was carried through, having been adopted as research techniques: documentary survey, participant comment and semi-structured interview with actors of the teams of the Medical Program of Family of Niterói of the following modules: Cafubá II, Engenho do Mato I, Palácio e Viradouro. **Results:** the data had been analyzed through the content analysis, of which the following categories had emerged: the potentiality of the domiciliary visit as a shelter device; planning of the domiciliary visit in the medical program of family; domiciliary visit as instrument of resignificar the practical one of the professionals. **Conclusion:** The Domiciliary Visit made possible the construction of bonds between users, familiar and professional, fact this that potencializou the Domiciliary Visit as a device for the shelter in health. **Descriptors:** Primary Health Care, Family Health, User embracement.

RESUMO

Objetivos: descrever como os integrantes de uma equipe de médico de família realizam a prática do acolhimento durante a Visita Domiciliar e identificar as potencialidades da Visita Domiciliar como um dispositivo para o acolhimento. **Método:** foi realizada uma pesquisa exploratória com abordagem qualitativa, tendo sido adotadas como técnicas de pesquisa: levantamento documental, observação participante e entrevista semi-estruturada com atores das equipes do Programa Médico de Família de Niterói dos seguintes módulos: Cafubá II, Engenho do Mato I, Palácio e Viradouro. **Resultados:** os dados foram analisados através da análise de conteúdo, da qual emergiram as seguintes categorias: a potencialidade da visita domiciliar como um dispositivo de acolhimento; planejamento da visita domiciliar no programa médico de família; visita domiciliar como instrumento de (re) significar a prática dos profissionais. **Conclusão:** a Visita Domiciliar possibilitou a construção de vínculos entre usuários, familiares e profissionais, fato este que potencializou a Visita Domiciliar como um dispositivo para o acolhimento em saúde. **Descritores:** Atenção Primária à Saúde, Saúde da Família, Acolhimento.

RESUMEN

Objetivos: para describir como los integrantes de un equipo del médico de cabecera que llevan con el práctico del abrigo durante la Visita Domiciliar e para identificar las potencialidades del Visita Domiciliar como dispositivo para el abrigo. **Método:** se realizó un estudio exploratorio de abordaje cualitativo, como las técnicas de investigación: estudio documental, observación participante y entrevistas semi-estructuradas con los actores de los equipos del Programa Salud de la Familia de Niterói los siguientes módulos: Cafubá II, Engenho do Mato I, Palacio y Viradouro. **Resultados:** Los datos fueron analizados utilizando el análisis de contenido, lo que produjo las siguientes categorías: el potencial de las visitas domiciliarias como un dispositivo de acogida; programa de planificación de las visitas domiciliarias en el Programa Salud de la Familia; las visitas domiciliarias como una herramienta para la (re) definir la práctica de la profesionales. **Conclusión:** El VD permitió la construcción de vínculos entre los usuarios, familias y profesionales, hecho que aumenta la VD como un dispositivo para la salud del huésped. **Descritores:** Atención Primaria de Salud, Salud de la Familia, Abrigo.

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INTRODUCTION

The Ministry of Health has prioritized the primary focus of their actions, the evidence constitutes the expression and strengthening of the Family Health Strategy (FHS) for all regions of the country.

In Brazil, the Primary Care (AB) is guided by the principles of universality, accessibility, comprehensiveness, equity, bond and host.

With the implementation of the Unified Health System (SUS) whose principles: universality, comprehensiveness and equity, began to invest more deeply in Primary Health Care (PHC), called AB and defined as a set of actions of individual character and collective focus on the prevention of injuries, treatment and rehabilitation and maintenance of life, and which has as its essential elements: the focus on family, universality, accessibility, coordination of care, bond and continuity, comprehensiveness, community orientation, job training.¹

The focus of attention at FHS is the family, considered in its biological context, emotional, social, cultural, political, economic, health team requires an expanded analysis of disease process. In this context of families, and, basing on the perspective of the principle of completeness, it was hoped that with the actions of the ESF, the reality in health could be modified. The proposal emphasizes that reinforces this view when, in working with families, it is a new course of professional practice, perceiving and acting with families holistically and articulate, while privileging the individual equilibrium state (health) of its members, a reality recognized during the activities in the home visits.

Given the importance of the Home Visit, which is used as a device to bond between the health professional and the user of the system and understanding it enables the professional to know R. pesq.: cuid. fundam. online 2013. abr./jun. 5(2):3698-05

the context of the life of the service user health and finding the actual conditions housing, as well as identification of family relationships, this study is justified by the need to identify how this process takes place and how the practice of the host influences the care provided to users during home visits by members of health teams belonging to the Program Family Physician of Niterói / RJ.

This study is a hook that participate research project titled: "The Home Visit device as the organization of the Family Health Strategy" developed by the Center for Study and Research in Management and Health Work / University Federal Fluminense (NUPGES / UFF). The group has operations intense and continuous research in the field of public health in the areas of Health Management, Case Management and Health Work, Language and Territory Health, <http://www.uff.br/nupges>.

This research aimed to understand the meanings that professionals of the Family Doctor Program confer Home Visit as a possible host and specific objectives, describing how members of a team of family doctors perform practice during host RV and RV identify the potential of such a device to the host.

METHODOLOGY

The research in question is a descriptive exploratory study with a qualitative approach, conducted in the city of Niterói - RJ in four health units with the Family Health Program, two are located in the downtown area of Niterói and the other two in the Oceanic region. Health facilities were chosen Engenho Mato I and II Cafubá (located in Ocean region); Palace and Viradouro (located in the downtown area of Niterói). Exploratory research aims to familiarize the subject, making it explicit and providing

enhancement idea. A qualitative approach is directed to research the meanings of human relationships, where their actions are influenced by emotions and / or feelings touched on situations experienced in daily life.

The study was conducted with health professionals team members, these being, doctors, nurses, practical nurses and community health workers. The criteria for inclusion of subjects in the study were: conduct regular home visits and voluntarily agree to participate in the research.

Data collection was conducted from May to July 2011. As research instruments were used: the documentary surveys, participant observation and semi-structured interviews with players from the teams of the Family Health Program (FMP) in Niteroi.

Thus, the participants were 13 professionals. Of these, one is a community health agent, 2 nurses, 4 and 6 medical nursing techniques. The training involved since their secondary education to higher education with graduate school. And the service time PMF ranged from eleven months to 14 years.

Subsequently, the content of the discussions was transcribed, analyzed and organized by similarity of responses - categorization. The issues related to modules PMF and the professionals involved in their theoretical processes and practices constituted a field of interdisciplinary knowledge, and interfaces with multiple cutouts, these identified during the research. Upon diagnosis with situational mapping of health facilities for family chosen for the study, which later would provide me with the approach of the team members and their work reality developed in the home visits, I opted for Content Analysis as method of data analysis, this was a technique of data analysis more appropriate to the type of investigation in question. Therefore assumes that behind the apparent lines, hides a R. pesq.: cuid. fundam. online 2013. abr./jun. 5(2):3698-05

meaning that can become evident. The term most commonly used to represent the data controller is a qualitative content analysis. However, the term means more than one technical procedure.

The construction of my discussion started from the investigation process based on the development work for the realization of the RV, through their speeches, experiences and relationships. Three categories were created for presentation of results: the potential of home visiting as a host device; planning home visit program in GP; home visits as a means of (re) define the practice of professionals.

The participation of professional health team was made by signing the consent, pursuant to Resolution No. 196/96 of the National Health Board with the number 123/CEP/HUAP. The subjects' anonymity was guaranteed during the course of the entire investigation.

After signing an informed consent, interviews were conducted with recording MP4 player, as a way of accurately reproducing the answers and record them. Subsequently, the interviews were transcribed in order not to lose the accuracy of their content.

The research subjects were named according to the interview as: E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13. Not allowing any kind of identification of the research subjects.

RESULTS AND DISCUSSION

The capability of Home Visit as a host device

In this category, the actions taken during home visits involve interaction with the community, in order to build practices and most effective strategies in the face of demands and health needs of the users, this practice needs to be developed in a participatory and co-responsible. The host has been an important principle for the organization of services, when

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articulated with other practices that seek recognition of the health needs of the population in its area of responsibility. A home visit as a host device provides the monitoring team and subsequent prioritization of risks and harms, allowing bond with its users, which facilitates monitoring and encouragement of autonomy.⁵

The Home Visit was considered a resource for the reception of users by 100% of respondents.

The interviewees attributed the Home Visit as a host device in that it allowed among others, better understand patients, their families, their home, etc.. What favored according to the same host.

"A mother who brings her child with asthma understand that because of VD already know that asthma may have been due to a moldy wall, a rug that's in the house and with that we know more or less how to accommodate this patient . "(E3)

"When you do a VD, you know the real universe he lives every day. You identify access to reach his home, the difficulties facing or not. From there you understand some whys of complaints that it brings you and that these complaints are not always due to diseases, but lack of health ... a social problem. "(E8)

In home visits realizes the need to meet the family, it is essential to be able to create links entering the home user, and this part of desire and allowed its members to agree and accept the presence of this health professional in your residence, and get involved to join its dynamic and its problems.

A home visit brings a very strong characteristic, ie, it is a space provided by the user at home, unlike the health service, which is a much more protected space for the professional. For patients and their families in general, the visit represents a differentiated care, symbolizing a commitment of staff.⁶

"The fact that we go to the house of the patient / client makes them feel important, they realize that we care about

their health because we go to their house." (E6)

"It is time for you to show your patients that cares about him and wants him to take care of yourself properly. Thus the patient feels accepted ... Whoa! the doctor cares about my treatment. "(E9)

For others, the time of the home visit made it clear that the time / date of reception strengthened the bond between them. This bond became solid when the professional needs to understand that putting in place the user to have a larger view of the health / illness to understand their needs and their family, serving them as far as possible.

Create links implies having close relations and clear, is the feeling of responsibility for the life and death of the patient within an intervention or bureaucratic responsibility nor impersonal. It is from the bond that we created that we integrate with the community and its territory, in groups, and thus become a reference for the user⁷.

"When we held the RV, we capture the best family, we become more intimate, they can speak better ... create a greater bond by seeing the conditions of the family. There is a greater acceptance among professional and patient resulting in narrowing of the relationship when we get to see the situation better. "(E4).

"I think when we realize the RV patients feel more comfortable and we feel satisfied to go home the patient perform the VDs and thus they feel more welcomed and create a bond with users." (E10)

"From the RV we have an overview of how the family lives, we create a bond." (E12)

Thus, it was possible to understand that the host during the course of the home views favored building a relationship of trust and commitment between users and professionals,

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contributing to the legitimacy of actions to improve the health of the user.

Planning Home Visit in the Family Doctor Program

The Family Medical Program (FMP) in Niterói experiences since 1992, a design model based on Family Health Strategy, through its own methodology, which differs in some points of the proposal of the Ministry of Saúde.⁸ These refer to the work process that involves the team base and a team of technical supervisors; centered care practices in the design of social production of health, referenced in the theoretical field of health surveillance, and the production of new individuals, health care and population-based practice of continuing education conducted in their own work environment and praxis oriented, associated with processes of subjectivity formed from direct contact in the social environment of the population assigned to the teams.

The focus of attention is the family, considered in its biological context, emotional, social, cultural, political, economic demands of the healthcare team an expanded analysis of the health-illness.⁹ This new concept of care refers changes in the course of professional practice, ie, the professional must understand that this care should be provided with families holistically and articulate.

Therefore, as this type of attention brings into focus the family, the home visit is structuring action care. According to the proposal of the Ministry of Health, home visits should be conducted with weekly schedule, prioritizing risk groups and situations and meeting the demands of users.¹⁰

In the FMP modules after the first contact with the population and their living conditions and health teams are organizing care to the residents of the sector under their responsibility, which consists of making regular home visits designed to

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actively seek out patients, identifying situations of risk to health and the team contact with families and outpatient care, in a modular installation located in the community (spontaneous situations or captured).

During the interviews, the registration of new residents and families; relisting, the active search for new cases and health hazards; management from medical records, requests from neighbors, relatives or requests from users themselves become a means to identify cases to be visited by the team.

"It's a neighbor who brought wink, thus we already know that the patient needs to do this to perform a search VD." (E4)

"A patient who does not care about his health, hypertensive, diabetic. So we go to his house to call, get to know what is happening." (E6)

"The cases are decided by management, mainly to find patients who abandoned treatment or do not come at scheduled visits." (E9)

"From the problems they bring me, I'll also through gravity by management that we do chronic diseases, pregnant women, children, social problems." (E12)

"The registration, for example, is a question which is only done exclusively in VD. Register or families new members coming. It is a significant demand, as will only begin to be answered after this record, so we have to accelerate, especially if the situation with a child or pregnant woman." (E13)

"The Home Visit should constitute the main axis of the work, however, some difficulties for its implementation have been identified. Among the difficulties highlight the issue of infrastructure, insufficient resources for transportation of teams, territorial conflicts, lack of time to conduct the face-to spontaneous visit to the unit, among others.

There are many situations that hinder the realization of the home visit. These are factors that are present in the day-to-day society where we live and which impede the implementation and

execution. The social, economic and political are evidenced in the statements of professionals.

"Missing time is plenty to do within the unit. It is hard to leave "(E2)

"There are few staff, equipment and support to carry out the visits." (E6)

"I believe that we should do VD to all residents of our area at least once a year. But some factors make it impossible, for example, in our area is very hardworking and when we got to the house only to find it makes it difficult and employs our work. And this happens in our industry too. "(E9)

"Access today is very complicated ... it rained a lot that week." (E11)
 "Today the field is not safe ... there is a real 'war' within the community." (E13)

We live today in health services a great paradox. On the one hand we can identify health policies designed to encourage the creation and expansion of a way to produce health, closest family and offer comprehensive care, on the other, market dynamics, requires the scrapping of this same policy, with absence professionals, lack of resources that lead to difficulties in the development work.

Home Visit as a tool to (re) define the practice of professional

The Family Health Strategy is premised shift the focus of care for a disease-centered attention on health promotion and disease prevention through a multidisciplinary team. To achieve this goal, it has the practical work of the home visit a fundamental tool for understanding the conditions that affect the lives of users.

To better understand how this reality is I directed the focus to the professional who was experiencing his actions during the course of the RV, which gave me the opportunity to understand how the study subjects develop these activities through the existing reality, conditioning factors involving work processes.

There are many reasons why health teams to the field for the visits and this is used as a tool for care users.

In Frame 1 we make explicit the reasons and the activities conducted by each member of the healthcare team.

Frame 1: Activities listed in the Home Visit for each professional category

ACS	Nurse	Doctor	Nursing technician
-Do a search for vaccines; -Director of statistics; -Director of campaigns; -Health Actions; -Visit the diabetic and hypertensive patients; -Actions of enrollment; -Scheduling appointments and examinations; -Active search; -Health education.	-Take care of more complex injury; -Evaluate the need for the presence of the doctor. -Realization of dressings; -Follow-up of patients who remained hospitalized for a long time; -Health education.	- Assessment of the State of health; -Watch cases with greater complexity; -Visit the bedridden patients; -Search of patients abandoned treatment; -Promotion and health education.	-Check pressure; -Advice as to beware of ulcers; -Administer medication; -Realization of dressings; -Active search.

With the description of the activities performed by team members, we found that in spite of Primary advocating comprehensive care and interdisciplinary actions and adopting innovative practices of care, we found that health professionals make the distinction between the PMF types of visits by each professional category, which reinforces the fragmentation of work and consequently care.

CONCLUSION

Home care is part once again in discussions on ways to provide services to the population. Recently, the Ministry of Health in October 2011 launched the decree 2527/11 Home Care setting the VD in primary care as a modality in domicílio.¹²

The RV is not new in health care, is a strategy that has been used at various times in the history of sanitary practices. The challenge for today is precisely to make this strategy is carried critically, within well-defined limits and goals for the healthcare team, under penalty of becoming an instrument of control of the target populations such assistance.

We must also be aware of the richness of the RV and its potential as innovative practice, being lost by the pressure that arises in ACS and other members of the healthcare team by lifting food for health data information systems. This is a major task for the planning of health actions, however, can not be carried out so bureaucratic.

With this study it was possible to know the meanings that professionals of the Family Doctor Program Home Visit confer host as a possibility in everyday practices.

The RV allows the construction of links between users, families and professionals, a fact that enhances the RV as a device for health care.

Home care is a type of care that arises increasingly present in our reality. The VD enhances and expands the scope of care, allowing for greater integration between the actions that happen in the home and those occurring within the health services. It is a key strategy for building a health care system really unique, comprehensive and equitable.

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