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Home Care Service and Health Care Networks

Serviço de Atenção Domiciliar e as Redes de Atenção à Saúde

Servicio de Atención Domiciliar y las Redes de Atención a la Salud

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ABSTRACT

Objective: The study's aim was to determine the interrelationship of the Home Care Service in modalities 2 and 3 with the Health Care Networks in municipalities of the *Rio Grande do Sul* State. **Methods:** It is a descriptive-exploratory study with a qualitative approach, which was carried out in 6 Home Care Services over the period from October 23rd to 30th, 2015. The study has counted with the participation of 4 coordinators and 9 registered nurses. Data collection took place through a semi-structured interview. Furthermore, the Content Analysis of Bardin was used for data analysis. **Results:** The engagement of health practices, allied to Health Care Networks, represents a beneficial and innovative element, enabling the provision of continuous and dynamic assistance to the population. **Conclusion:** The functioning of the Home Care Service and the dynamics of the networks need to be organized, clarified, articulated and performed in cooperation between health services and institutions, targeting at the importance of health productive restructuring.

Descriptors: Health, Nursing care, Home care services, Nurses.

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RESUMO

Objetivo: Objetivou-se conhecer a inter-relação do Serviço de Atenção Domiciliar nas modalidades 2 e 3 com as Redes de Atenção à Saúde nos municípios do Rio Grande do Sul. **Método:** Estudo descritivo, exploratório, qualitativo, realizado em 06 Serviços de Atenção Domiciliar no período de 23 à 30 de outubro de 2015. Participaram da pesquisa 04 coordenadores e 09 enfermeiros. A coleta de dados ocorreu por meio de entrevista semiestruturada e para análise utilizou-se a Análise de Conteúdo de Bardin. **Resultados:** A articulação das práticas em saúde, aliadas às Redes de Atenção à Saúde representam um elemento benéfico e inovador, possibilitando a prestação de uma assistência contínua e dinâmica para a população. **Conclusão:** O funcionamento do Serviço de Atenção Domiciliar e a dinâmica das redes necessitam estar organizada, esclarecida, articulada e desenvolvida em cooperação entre os serviços e instituições de saúde, visando a importância na reestruturação produtiva na saúde.

Descritores: Saúde, Cuidados de enfermagem, Serviços de atenção domiciliar, Enfermeiros.

RESUMEN

Objetivo: Se objetivó conocer la interrelación del Servicio de Atención Domiciliaria en las modalidades 2 y 3 con las Redes de Atención a la Salud en los municipios de Rio Grande do Sul. **Método:** Estudio descriptivo, exploratorio, cualitativo, realizado en 06 Servicios de Atención Domiciliaria Período del 23 al 30 de octubre de 2015. Participaron en la encuesta 04 coordinadores y nueve enfermeros. La recolección de datos ocurrió por medio de una entrevista semiestructurada y para análisis se utilizó el Análisis de Contenido de Bardin. **Resultados:** La articulación de las prácticas en salud, aliadas a las Redes de Atención a la Salud, representan un elemento beneficioso e innovador, posibilitando la prestación de una asistencia continua y dinámica para la población. **Conclusión:** El funcionamiento del Servicio de Atención Domiciliaria y la dinámica de las redes necesitan estar organizada, esclarecida, articulada y desarrollada en cooperación entre los servicios e instituciones de salud, visando la importancia en la reestructuración productiva en la salud.

Descriptores: Salud, Cuidados de enfermería, Servicios de atención domiciliaria, Enfermeros.

INTRODUCTION

Considering the social, political and economic framework, experienced by the country, emerges the need to take a second look at the reform proposal in health care services, including hospital institutions. At this level, the Home Care Service (HCS) is presented as a strategy capable of contributing decisively to the internal reorganization of the health services network. Being necessary conceptual and function redefinitions to understand this modality of health care.

The HCS was instituted with the purpose of redefining Home Care (HC) within the *Sistema Único de Saúde (SUS)* [Brazilian Unified Health System]. The Ordinance No. 2527 from October 27th, 2011, revokes the Ordinance No. 2,029/11, establishing the rules for the registration of Home Care Services, formulates the qualification of health facilities in which the services will be allocated and the incentive values for its operation.[1]

The guidelines that structure the HC are present in Art. 5 of the Ordinance 2527/11 and suggest that the HC is in compliance with the guidelines of the Health Care Networks (HCN). Moreover, primary care as a care organizer and territorial action needs to be allied with the regulatory system, articulate with the other levels of health care and with the rear services and needs to be inserted in the care lines through caring clinical practices based on the user's needs.

Also, it aims to soften the fragmentation of care, keeping in accordance with the principles of *SUS*, especially in relation to the expansion of access, reception, equity, humanization, and comprehensive care. Thus, it indicates adopting the model of attention focused on the work of multiprofessional and interdisciplinary teams, encouraging the active participation of the health professionals involved, with the health of the user, family, and caregiver.

Given this context, the HCS needs to involve all participating health care services (Basic Healthcare Unit (BHU), Primary Healthcare Unit (PHU), emergency service, hospital, among others) and direct its change efforts towards the organization of health services with a focus on central to the user. This transformation from the techno-care model to the preventive model as a proposal for reordering health care services will be truly effective when adopting the interconnection between all health care services forming care networks with the user as its centrality.[2,3] Corroborating with this idea, the first element of health care networks and its reason to exist is the population.[4]

It is understood that the guidelines of HC correspond to a movement tending to encourage the organization of new structural arrangements of health care in order to meet the demands of the population, in an equitable, integrated, decentralized and humanized manner. This will make it possible to achieve smooth functioning of the Home Care Service. However, the dynamics of Health Care Networks (HCN) need to be well organized, clarified, articulated and developed in cooperation among all population health services and institutions, in view of their contribution to the reorganization of services and actions. of the public health system. The relationships arising from this process need to be jointly established in order to safeguard the right of the user, who needs to collaborate and participate in their care in order to achieve the interconnection and integration of *SUS* doctrinal, philosophical and organizational principles.

Bearing in mind the aforesaid, the objective is to know and analyze the interrelationship of the Home Care Service in modalities HC2 and HC3 with the Health Care Networks in the cities of the *Rio Grande do Sul* State that offer these types of assistance.

METHODS

Descriptive, exploratory study with a qualitative

approach, conducted in 6 Health Units that develop Home Care Services in modalities HC2 and HC3 in the municipalities of the *Rio Grande do Sul* State. Participants were 4 coordinators and 9 registered nurses, and one of the coordinators performs the role of coordinator and nurse of the team, then totaling 13 participants.

Data collection began after the proposal was approved by the Health Research Ethics Committee/FURG (CEPAS), with favorable opinion No. 148/2015, from October 23 to 30, 2015, through semi-structured interview.

To preserve anonymity, the coordinating participant was identified with the letter C, followed by two Arabic numbers, one for the municipality to which he belongs, and another for the order in which the interviews were conducted, and the letter N was assigned to the nurse participants, followed by if the same process (M1C1; M1N1).

The participant was exposed to the script with the questions, one directed to the coordinators and the other to the nurses. After each interview, the data were transcribed in full to a spreadsheet to sequence the organization for analysis and interpretation.

In order to perform the data analysis, the Bardin Content Analysis technique was used, which comprises three poles: pre-analysis; material exploration; and results processing: inference and interpretation. Such poles are judicious as to the aspects that must be observed so that they can collaborate to discover the meaning of the message contents present in the interviews.[5] The indications of each pole were carefully observed during the data analysis.

RESULTS AND DISCUSSION

The engagement of HCS HC2 and HC3 modalities, along with the HCN, represents a beneficial and innovative strategy for user service, since it is constantly evolving and changing, adapting itself to the new knowledge built along of the times until the present day comes. Integrated Services to the HCN make it possible to provide continuous and dynamic assistance to the population effectively and effectively, favoring innovations based on the context of each household, user and family assisted.

The data collected regarding this engagement gave rise to the category Engagement of the HC2 and HC3 Home Care Service with the HCN, obtaining as subcategories: the health institutions and services that the participants recognize the existence of engagement with the HCS HC2 and HC3, and the difficulties of this engagement.

Regarding the engagement of the HCS with the services/institutions that constitute the HCN, the participants have the following opinion:

[...] The engagement here of the service is only with the Hospital and Basic Health Unit (M1C1)
[...] To my knowledge the engagement is with the Hospital and Basic Health Unit (M1N1)
[...] some flows were established, mainly with BHU (M2C/N)
[...] The hospital refers to the HCS, because it is very interesting to them, it does not want to keep the cost of the user, because the user who will come to us is a user who only costs (M3C1).

In this case, some participants recognize engagement with their service, such as:

[...] User capture is much better, there are many coming from BHU and the hospital itself here. We receive the request from the hospital, we evaluate if this patient fits the criteria, then if he fits we will see the need for visits (M1E4)
[...] There is a joint. In the hospital, we have a telephone communication through WhatsApp, where they send the user [...] if some flows have been established, mainly with the BHU, but I think there is still a lot to develop, so this network is incipient with the ministry's network proposal (M2C/N)
[...] Redirecting to BHU again is more relaxed (M3N1)
[...] There is communication sometimes by telephone with other services, we get in touch [...] (M4N1)
[...] This was not good at first, so we did an activity called home care network, where we visited all these possible places of referral of users. So, we visited, explained how it worked, we left forms, it worked very well (M5C1)
[...] There is engagement, I have little working time, but I have seen that it exists (M5N3).

In contrast, the challenges highlighted by the participants are expressed through the difficulties in articulating the HCS with other health services/institutions:

[...] There are a few times when we had worked together, in this year here that I remember, only 3 calls together with BHU (M1C1)
[...] We have difficulties in connections, dialogues because most of the time communication is difficult (M1N3)
[...] We have many problems with this intermediation with BHU. I think the role is not very clear, as far as one goes and other starts, the definition of the role of each, and not even in the doorman is not very clear (M3C1)
[...] In terms of reference and counter reference, the biggest difficulty I see is when this patient has to return to the hospital because we have few beds in the hospital (M3N1)
[...] It does not work, absolutely not, said that before a social worker who was the midfield between services [...] and there are even users who do not need to be with us, could be in HC1 and BHU does not answer, and if he does not want to assist, then this responsibility is ours (M5N1)
[...] I find this a little flawed, the network does not work as it should (M5N2).

HCS is perceived as a differentiated approach to care, reducing and/or assisting in health demands, improving the quality of the service provided and overcoming the inconsistency between the service offer and the population's health needs, constituting an integrated system. based on cooperation, integration, and interconnection.[4]

Based on what was exposed by the participants, it can be understood that only the hospital and the basic health unit were identified as services that articulate with the HCS, but there are other services/health institutions that should work with the HCS, such as urgency and emergency service, emergency services or PHUs, and that do not perform this engagement, or perhaps there is a lack of knowledge on the part of professionals regarding this interaction process.

Each service participating in the composition of the HCN needs to be able to identify the appropriate user for the type of care in question. The home care notebooks advocate that user insertion strategies happen according to the services that can serve as a "gateway" to the HCS. Through previously agreed flows and protocols, the services that make up the HCN can indicate and refer the user to the HCS through standardized instruments.[6,7]

According to the Ministry of Health, these documents need to contain basic and essential information for the continuity of care to the user, such as: identification data, user's medical record, description of all consumption needs (equipment, surveys, dressings, among others). In addition to medicines to be used at home, clinical and imaging tests already performed, previous complications, among other needs because of the specificity of each user.[6]

Given the aforesaid, it is addressed the possibility of HCS being connected to the Basic Health Units (BHU), hospital and urgency/emergency institutions represent a major challenge for professionals, government, health services and, in a way, even to the user himself and his family.[6]

Among the challenges, respondents highlight the difficulty of establishing links, exercising dialogue, the insufficient number of beds for hospitalization, lack of clarification of the functions of each service and also the lack of engagement between services. In other words, the challenge ends up involving the knowledge of the criteria that should be used to insert users into HCS HC2 and HC3, as well as in other services and institutions, and the way this engagement is performed.

Similar data to this research were pointed out in studies stating that services are still dominated by fragmented systems and disorganized from a set of isolated points of health care.[4,8] As a result of this situation, it can be deduced that Within a system where there is no effective communication between the members of the network, it becomes incompatible to establish continuous, integrated and interconnected attention and quality to the user, family, and community.

Corroborating the data from this research, a study conducted in three municipalities of the state of Belo Horizonte, pointed out that the form of networking should be based on the way the sectors involved act in their responsibility, in other words, each service must have knowledge and commitment to its functions within the network, thus decimating fragmentation and providing continuity of care in an interconnected manner.[12]

When observing the speeches of the participants, it is clear that the difficulty of engagement can be triggered by the fragility/lack of knowledge given the support of the HCS with the HCN. Corroborating this idea, a study conducted in a PHU of a Brazilian region, with the local health team, shows that the lack of knowledge regarding home care modalities, their functioning and organization, as well as the way of insertion of users to it, can prevent/hinder the engagement with the HCN. In this sense, Article 4 of the Ordinance No. 963/13, emphasizes that the HCS needs to be structured in an articulated manner and integrated with the other components and the HCN, based on the action plans as established by the Ordinance No. 1,600/11.[7]

Based on what was exposed by the interviewees, there is a need for better dissemination of services, especially of the HCS in modalities HC2 and HC3, as well as how this service, the hospital, BHU, urgency and emergency, and PHUs, need to be articulated, aiming at a better understanding of the dynamics of the HCN. This engagement of HCS HC2 and HC3 is also foreseen in the Home Care Booklet, which indicates the need for the interconnection of Primary Care, Emergency Care, PHUs and hospitals.[6]

To this end, government decrees and resolutions provide support to deepen the knowledge regarding the theme of home care modalities of the SUS and guide them concerning those articulated to the HCN. Thus, HCS stands out as a "new" modality of health care, intending to ensure continuity of care and integrated into the HCN, where it is dependent on an articulated service network and an important organizational structure.[13]

Some participants point out that HCS HC2 and HC3 can articulate with other health services and institutions, and that this engagement helps to capture users. This relationship can be understood as a productive restructuring device in supplementary health. Users who are included in the service, depending on the effectiveness of this engagement to have their needs met. Similar data found by nurses from Belo Horizonte city, Minas Gerais State, in a study carried out in a Home Care Program linked to an Emergency Care Unit, point out that health services can interact in different flows, where a vertical relationship is not adequate to show.[2]

Other studies also show that, as it is HCS HC2 and HC3, besides being an articulated service, this enables the restructuring of health services, aiming at better meeting the population demand, with a view to reducing operating costs, which corresponds to the idea of HCN, which aims at

continuous assistance, both individually and collectively, at the right time and place, at appropriate costs and quality, in order to guarantee the user, at home, the set of actions and services he needs.[4,8-10]

From the data, author's weightings and legal texts about HCS used in this study, especially in the mode of HC2 and HC3, it is understood that for a proper functioning of the Home Care Service in these modalities, the practices derived from the networks of Health care needs to be better organized, planned and developed within health services and institutions, considering its importance as a device for productive restructuring in health.

In this framework, the need for interaction and interconnection of the HCS with the HCN is also highlighted. These principles are indispensable for the qualification and continuity of health care and are of great importance in overcoming care gaps, rationalizing and optimizing the available care resources.

CONCLUSIONS

The interrelationships between the Home Care Service in modalities HC2 and HC3 and the HCN were, in this study, incipient, due to the fragility of knowledge of managers about the functioning and competence of each service. Furthermore, aspects associated with the fragmentation and verticalization of the services provided raise real obstacles to the realization of networking.

It is recommended to deepen this theme so that there is a collective awareness on the subject, understanding the importance of this discussion for the benefits that it may be able to provide for the population's life. Moreover, it is noteworthy that for an engagement between HC2 and HC3 with the HCN, it is essential the legal and beneficial knowledge of the members either directly or indirectly involved in the interconnection of health services in the most diverse modalities offered to the user of *SUS* services.

REFERENCES

1. Ministério da Saúde (BR). Portaria nº 2.527, de 27 de outubro de 2011. [internet]. 2011 [citado 2014 Nov 05]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2527_27_10_2011.html.
2. Andrade AM, Brito MJM, Silva KL, Montenegro LC, Caçador BS, Freitas LFC. Organização das redes de atenção à saúde na perspectiva de profissionais da atenção domiciliar. Rev. Gaúcha Enferm. 2013; 34(1):111-7.
3. Silva KL, Sena RR, Seixas CT, Feuerwerker LMC, Mehry EE. Atenção domiciliar como mudança do modelo tecnoassistencial. Rev. Saúde Pública. 2010; 44(1):166-76.
4. Mendes EV. Redes de Atenção à Saúde. Brasilia: Organização Pan Americana de Saúde; 2011.
5. Bardin L. Análise de conteúdo. Lisboa, Portugal: Edições 70; 2011.
6. Ministério da Saúde (BR). Ministério da Saúde. Secretaria de Atenção a Saúde. Departamento de Atenção Básica. Caderno de atenção domiciliar. Brasília, DF; 2012.
7. Ministério da Saúde (BR). Portaria nº 963, de 27 de maio de 2013. Redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde (SUS). Brasília, DF; 2013. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt0963_27_05_2013.html.
8. Silva JRS. Reconfiguração do sistema único de saúde e suas relações intersetoriais no município do rio grande: contribuições do enfermeiro [tese]. Universidade Federal do Rio Grande, Rio Grande; 2013.
9. Mendes EV. As redes de atenção à saúde. Ciênc. saúde coletiva. 2010; 15(5): 2297-2305.
10. Franco TB, Mehry EE. Atenção domiciliar na saúde suplementar: dispositivo da reestruturação produtiva. Rev. Ciência & Saúde coletiva. 2008; 13(5):1511-1520.
11. Silva SF. Organização de redes regionalizadas e integradas de atenção à saúde: desafios do sistema único de saúde (Brasil). 2011; 16(6): 2753-62.
12. Brito MJM, Andrade AM, Caçador BS, Freitas LFC, Penna CMM. Atenção domiciliar na estruturação da rede de atenção à saúde: trilhando os caminhos da integralidade. 2013; 17(4): 603-10.
13. Weykamp JM, Siqueira HCH. Cuidados do enfermeiro ao usuário do sistema único de saúde no serviço de atenção domiciliar na modalidade atenção domiciliar 2 e 3 na perspectiva ecossistêmica [dissertação]. Universidade Federal do Rio Grande, Rio Grande, 2015. 132 p.

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