RESEARCH

PROFILES OF DEPENDENT HOSPITALIZED PATIENTS AND THEIR FAMILY CAREGIVERS: KNOWLEDGE AND PREPARATION FOR DOMICILIARY CARE PRACTICES*

PERFIL DE PACIENTES DEPENDENTES HOSPITALIZADOS E CUIDADORES FAMILIARES: CONHECIMENTO E PREPARO PARA AS PRÁTICAS DO CUIDADO DOMICILIAR

PERFIL DEPACIENTES DEPENDIENTES HOSPITALIZADOS Y CUIDADORES FAMILIARES: CONOCIMIENTO Y PREPARACIÓN PARA LAS PRÁCTICAS DE ATENCIÓN DOMICILIARIA

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ABSTRACT

In the context of chronic degenerative diseases and increased life expectancy, the involvement of family caregivers begins by empirically exercising care in the home. The objective of this study is to analyze the profile of patients and their family caregivers during the hospitalization of dependent patients and identify the level of knowledge of the caregiver and their needs related to the care provided to the dependent family member in use of assistive devices at home. Method: this is a descriptive study with a quantitative approach performed in an extraporte hospital in Belo Horizonte. The site was the Long-term and Palliative Care Unit. A total of 50 family caregivers participated in this study and signed the TCLE. Results: most of the patients are in the elderly group; 54% of them aged between 60 and >70 years with some disease already well-established, such as cardiovascular diseases in 54% and respiratory imbalances in 30% of the participants. The use of assistive devices was present in 36% of the participants using tracheostomies and 46% using enteric probe and dressings. Sixty percent of the caregivers stated not knowing how to provide care. Conclusion: the data from this study reinforce the importance of promoting the preparation of patients and their family members for hospital discharge and care at home, aimed at an early rehabilitation and reduction in readmissions and iatrogenic deaths.

Keywords: Frail Elderly; Caregivers; Home Nursing.

RESUMO

No contexto das doenças crônico-degenerativas e do aumento da expectativa de vida, inicia-se o envolvimento de cuidadores familiares exercendo cuidados de forma empírica no lar. O objetivo deste estudo é analisar o perfil dos pacientes e do cuidador familiar durante a hospitalização dos pacientes dependentes, como também identificar o nível de conhecimento do cuidador e suas necessidades acerca dos cuidados a serem prestados ao familiar dependente e em uso de dispositivos de assistência no domicílio. Métodos: trata-se de estudo descritivo de abordagem quantitativa realizado em hospital extraporte de Belo Horizonte. O local foi a Unidade de Cuidados Prolongados e Paliativos. Participaram do estudo 50 cuidadores familiares que assinaram o TCLE. Resultados: grande parte dos pacientes se enquadra no grupo de idosos, 54% deles na faixa etária entre 60 e 70 e >70 anos e já com alguma doença de base instalada, como as cardiovasculares, com 54%. Os desequilíbrios respiratórios alcançaram 30% de acometidos. Em relação aos dispositivos de assistência, 36% estavam em uso de traqueostomias e 46% utilizavam, respectivamente, sonda entérica e curativos. Quanto aos cuidadores, 60% disseram não saber cuidar. Conclusão: os dados deste estudo reforçam a importância de promover a preparação do paciente e dos familiares para a alta hospitalar e para o cuidado no domicílio, visando à reabilitação precoce e à diminuição de reinternações e óbitos por iatrogenias.

Palavras-chave: *Idoso Fragilizado; Cuidadores; Assistência Domiciliar*

RESUMEN

En el contexto de las enfermedades crónico-degenerativas y del aumento de la esperanza de vida comienzan a participar los cuidadores familiares ejerciendo su tarea de forma empírica en el hogar. El objetivo de este estudio es el de analizar el perfil de los pacientes y del cuidador familiar durante la hospitalización de los pacientes dependientes, como también identificar el nivel de conocimiento del cuidador, sus necesidades acerca

de los cuidados a ser prestados al familiar dependiente y en el uso de los dispositivos de asistencia en el domicilio. Se trata de un estudio descriptivo de enfoque cuantitativo, realizado en un gran hospital de Belo Horizonte. El local fue la unidad de cuidados prolongados y paliativos. Participaron del estudio 50 cuidadores familiares que firmaron el TLCE. Gran parte de los pacientes se encuadra en el grupo de ancianos, 54% de ellos están entre los 60, 70 y >70 años con alguna enfermedad de base instalada, como las cardiovasculares con 54%. Los desequilibrios respiratorios alcanzaron 30% de los afligidos. En relación a los dispositivos de asistencia 36% estaban con traqueotomía y 46% utilizaban la sonda entérica y curativa. En cuanto a los cuidadores 60% dijeron no saber cuidar. Los datos de este estudio refuerzan la importancia de promover la preparación del paciente y la familia para el alta hospitalaria y el cuidado domiciliario, con miras a la rehabilitación temprana y a la disminución de reinternación y óbito por iatrogenia.

***Palabras clave**: Anciano Fragil; Cuidadores; Atención Domiciliaria de Salud.*

INTRODUCTION

Brazil, as other developed countries, has had increasingly serious problems related to health care as a result of population ageing and chronic degenerative diseases. This problem is growing mainly due to the increased life expectancy observed during the course of the last decades as the result of improved quality of life.

The demographic dynamics in Brazil follows a measure of population growth and changes in its age structure. The process of demographic transition related to the drop in mortality and fertility rates have caused rapid variation in the age structure of the Brazilian population with a decrease in the proportion of children and young people, increase in the adult population, and considerable tendency to increase in the elderly population.[1]

With the aging of the Brazilian population and the consequent increase in the number of chronic degenerative diseases, there is an increasing demand for hospital beds for elderly patients. These patients begin to live with risk factors for chronic-degenerative diseases making complications such as stroke, fractures from falls, limitations caused by heart failure, chronic obstructive pulmonary disease, and the dependency determined by Alzheimer's more frequent.[2]

The non-fatal conditions are usually, for the most part, the generators of what can be termed disabling process, i.e. the process in which certain conditions affect the functionality of older people and, consequently, the performance of every day activities.[3] Chronic conditions cover an extremely broad category of diseases that have common aspects: they are persistent and need a certain level of permanent care requiring changes in lifestyle and health management.[4]

Thus, one can see that the number of hospitalizations among the elderly increases considerably and in proportion to the growth of chronic degenerative diseases. These chronic conditions, in the vast majority of the time, simultaneously interfere in the quality of life of older people and, when not properly accompanied, tend to cause complications and sequelae that compromise the independence and autonomy of these people.[3]

This high rate of hospitalizations and longer hospital bed occupancy raise risks of successive readmissions and high costs.[5] In this context, the involvement of informal or family caregivers happens to meet the needs of home care: tasks performed, often empirically, or even improvised because these caregivers are not properly trained for such activity.

Therefore, one must first understand who these family caregivers are and how this care is structured. The identification of the causes of chronic degenerative diseases and the means for prevention are urgent. It is necessary to identify how the process of patient care develops at home after the installation of the disease, what are the arising sequelae, and therefore, develop an improved quality of life for the sick.[6]

Domiciliary care, performed by family members of patients with cognitive and physical sequelae, is increasingly common and needed to meet the increased demands for hospital beds and risks that prolonged hospitalizations can cause in individuals affected by various diseases. In hospitals, the high incentive policy of patient early discharge imposes the challenge of preparing family members to reorganize their lives at home to take over the care for the sick in a short notice.[7]

To make the continuity of care provided by the family caregiver possible at home, the process of orientations about health, symptoms, and complications should start even during hospitalization. The program of hospital discharge can provide treatment and recovery that are more humanized and generate well-being for the patient and caregiver.[8] Actions like these can alleviate the helplessness experienced by the family of the ill, contributing to better recovery, avoiding unnecessary hospitalizations, and decreasing the spending by the public health system.

Thus, the need and importance of training and monitoring family members and caregivers done by nurses becomes evident in an attempt to promote care as a lighter activity to improve the quality of life of everyone involved. Some authors claim that this task of training caregivers to provide care related to Nursing, supervised by the professional himself, falls only on nurses.[6]

Therefore, from the several statements carried out to construct the discussion about the lack of preparation of family caregivers, the following question arises for the development of this article: who are the family caregivers who accompany the patients in the hospital environment? How will the caregiver exercise private nursing care to meet the needs of the sick in use of assistive devices at home?

Thus, it is clear that the nurse has an important role in the preparation for hospital discharge and domiciliary social assis-

tance practices and must direct them to identify the needs of patients and their families. All these practices carried out with the family caregiver may provide a more accurate form of assistance that minimizes anxieties, doubts, and possible complications that lead to readmissions.

The empowerment of the family caregiver to recognize signs of worsening clinical conditions and handle accessories and assistive devices in use leads to more tranquility and ease during the execution of care on the part of the caregiver. Thus, this training becomes a way to promote the humanization with embracement destined to the caregiver who is usually worn out by the situation.[6]

The role of the nurse in educating and training family caregivers before hospital discharge is accentuated when all the previously highlighted aspects are considered. This contributes to a reduction or exclusion of a variety of problems generated by the lack of prior knowledge about the care provided by family members who will be responsible for those patients released from hospitals and still requires the use of assistive devices for the continuity of their treatment.

Based on these considerations, this study aims to analyze the profile of family caregivers of dependent patients in use of assistive devices; the profile of caregivers will be constructed according to gender, age group, level of education, family relationship with the patient, and need for information, and to identify the level of knowledge and needs related to the care to be provided to the dependent patient in use of assistive devices at home.

METHODOLOGY

This is a descriptive study with a quantitative approach, carried out at the Long-Term and Palliative Care Unit from an extraporte hospital in Belo Horizonte, considered having the largest capacity for SUS attendance in Minas Gerais and one of the three largest in the country. The data collection was initiated after approval of the project by the Research Ethics Committee from PUC-Minas and the hospital institution, as well as with the authorization from the professional responsible for the sector involved.

The Long-Term and Palliative Care Sector is intended to improve services for chronic patients, bearers of multiple health problems, convalescents and/or in need of permanent care requiring continuous assistance and physical rehabilitation-functional for their reintegration in society. The hospitalization of patients in this sector most often occurs because of events and complications of chronic degenerative diseases, ranging from cerebrovascular events to cancer, that generate readmissions from the domicile, other sectors in the institution, and other hospital units from the Public Health System.

The subjects involved in this research participated in the study after being properly informed about the objectives and procedures and the signing of an informed consent for the completion of the relevant preparations for data collection. The data collection was performed during the permanence of the caregiver in the hospital, at times determined in accordance with their convenience and availability, and with the consent of the Coordinator of the unit. None of the initial participants was removed from the study. Participants were informed that the data and information obtained will be used only for scientific purposes and the material would be stored by the researchers.

The data collection used a semi-structured questionnaire applied to 50 bedside relatives/caregivers between May and August of 2012. The study involved family caregivers present in the unit who after hospital discharge would care for their patients at home.

The inclusion criteria were being a caregiver for a patient with: age over 60 years, affected by chronic degenerative diseases, with some degree of dependence, and in use of some assistive device such as probes, tracheostomies, urethral drains, dressings, and belonged to the group of patients treated only by SUS. The same questionnaire sought information about patient identification and their main diagnoses and complications, gender, age, length of hospitalization, clinical diagnostics, main reasons for hospitalization, complications during hospitalization, and previous illnesses.

The questionnaire also contained questions related to the profile of family caregivers such as age, gender, marital status, and educational level. Some questions sought to identify the use and knowledge about proper management of assistive devices that would be used by patients/families in the hospital environment and, possibly, at home after hospital discharge.

RESULTS AND DISCUSSION

This study brought discussions and relevant results for more in-depth discussions and decision making about the efficient work of nurses to deal with this specific area of health. The following are, therefore, these results and discussions.

Profile of the hospitalized patient

It is essential to highlight in this study that the process of aging knowingly carries many transformations, not only physical, but also physiological. These changes can also be perceived in the cognitive ability generating more dependence, decreasing autonomy, and accentuating further difficulties in the aging process. Most of the 50 approached patients were being cared during data collection and were distributed by age groups, as shown in Table 1.

Aging is a normal development process that involves neurobiological, structural, functional, and chemical changes, which affect the body together with several other factors such as environmental, socio-cultural, and the quality and style of life. Linked to diet, physical inactivity and exercises, closely interconnected, are factors that promote healthy or pathogenic aging.[9]

Table 1 - Distribution of patients according to age group

%	Variable	(n=50)
40	> 70 years	20
22	61 to 70 years	11
14	51 to 60 years	7
10	41 to 50 years	5
4	31 to 40 years	2
8	21 to 30 years	4
2	15 to 20 years	1

Source: research data (2012).

The high frequency of chronic diseases and the longevity of the Brazilian population are identified as the main causes of increases in the number of elderly with functional incapacity. The incapacity is the constraint, i. e., resulting from the lacking ability to perform an activity considered normal for a human being, which can arise as a direct consequence or as a response of the individual, to a psychological, physical, or sensory deficiency. This reflects the person's own disorders on activities and behaviors essential to daily life.[10]

Although the proportion of men is higher than women in Table 2, on health situation of the elderly, both genres show morbidities and physical disabilities at high levels. However, similar studies show that the frequency of elderly dependents to perform self-care activities is higher in females.[11] The risk factors for metabolic syndromes (SM) is shown in other studies with an average of 10% in women and 84% in men, presenting risks of coronary artery disease that leads to death, up to four times higher than in the normal patients, and three times more linked to death of any kind.[12] These considerations underline the importance to analyze the data from this study based on correlations between genre and the perceived age among the approached patients.

Table 2 - Distribution of patients according to genre

%	Variable	(n=50)
48	Female	24
52	Male	26

Source: research data (2012).

The length of hospital stay observed on the data ranged from one to three months; 22 (44%) patients remained in the hospital for up to one month, and only 10 (20%) remained more than 90 days (three months). The elderly are also the most frequent users of health services and linked to longer stays. They utilize hospital services more intensively than other age groups, involving high costs, resulting in longer duration treatments, and slower and complicated recovery.[10,13]

Despite the increased stimuli for early hospital discharge perceived at present, the data still highlights a demand for hospitalization. The survey to characterize the patient's demands, from their main diseases prior to hospitalization to the main complications generated from the stay in a hospital environment, enables the reflection about the impacts generated from the need for hospitalization (Table 3).

With regards to the basic diseases identified in the study, cardiovascular disorders were observed with the troubling percentage of 54%. Among these, one can especially cite the HAS, which reached 42% of the elderly. DM showed great prevalence, with 34%, followed by 20% with Encephalo vascular disorders. The aging is a normal development process, involving neurobiological, structural, functional, and chemical changes. Environmental and socio-cultural factors also affect the organism such as quality and lifestyle, diet, sedentary lifestyle, and other factors so intimately linked to healthy or pathogenic aging. Aging is inherent in individuals who may have intrinsic triggering factors such as diabetes (DM) and HAS, and extrinsic factors such as bad life and eating habits and dysregulated routines.[9]

As a consequence, researchers emphasize the need for periodic evaluations of the elderly to detect health problems and risk factors related to cardiovascular changes, whose main factors are related to age, gender, race, family history, high blood pressure, obesity, stress, sedentary life, use of alcohol, tobacco, and food rich in sodium and fat. Numerous aggravations emerge in this phase that can be further amplified together with a chronic disease, mostly cardiovascular diseases.[14] The permanence of disabling sequelae, imposed by those comorbidities in the elderly, such as motor, sensory limitations, and related to comprehension and expression of thoughts can drastically modify the dynamics of the elderly life making them dependent on their families for care. [15]

The main concerns related to health and longevity include the highest occurrence of chronic diseases and falls and functional incapacity causing these individuals to require, in many cases, permanent and continued care for the appropriate clinical management of their illnesses. [13]

The main diagnoses found in the hospitalized participants were separated by systems; great emphasis was observed in diseases linked to the respiratory, neurological, skeletal, and digestive systems. However, this was not verified only in relation to diseases affecting the locomotor system but also in highly prevalent systemic diseases such as heart failure, pneumonia, and dementia, which manifest themselves with the loss of function in the elderly.

The main reasons for hospitalization involved pulmonary disorders. The data reveal that 30% of the patients had problems and diagnoses related to the respiratory system. This occurrence is due to the high physiological and immunological susceptibility to infections in the elderly contributing to a reduction in the physical and biological capacity, and autonomy. In addition to the high prevalence of chronic degenerative diseases associated with aging, other clinical scenarios with different etiologies were expressed with more gravity in the elderly.

In a study by SAMU from Maceió, the survey of the epidemiological profile of elderly patients by means of collecting data from their medical records between 2011 and 2012, showed a wide range

of circulatory problems, not just restricted to hypertensive peaks, but also complications such as clinical causes, cerebrovascular accidents, syncope, acute myocardial infarction, and headaches. Other causes of the high incidence expected in the senile population are respiratory discomfort, such as dyspnea, and gastrointestinal system complications, such as constipation. Orthopedic traumas are estimated in approximately 20% of the attendances.[16]

The orthopedic trauma from falls or post-surgical complications were very characteristic in the aging process and was observed in 6% of the participants as shown in Table 3.

Fractures in the elderly are usually caused by low-energy trauma such as falls within the home and are mainly fractures of the proximal femur, distal radius, and column. These are often unique injuries in individuals who already have some systemic disease: hypertension, diabetes *mellitus*, depression, or kidney failure that would normally remain hospitalized longer when they become trauma victims. Patients of this age group, who suffer high energy trauma, usually road accidents, remain hospitalized for long periods of time and are usual carriers of some prior disease, especially hypertension. [17]

The complications during hospitalization in the interviewed patients, such as secondary diagnoses, remained in a high percentage and well aligned with their primary diagnoses.

In this study, some complications arose from the long hospital bed permanence and nutritional conditions, such as pressure lesions, which show high risks of infection, need for longer hospital stays, and increased chances of readmission caused by worsening tegumentary lesions and risks inherent to the disease. Immobility in dependent patients can bring damage to their musculoskeletal, gastrointestinal, urinary, cardiovascular, respiratory, and skin systems leading to increased limitation and hospitalization time, and weakness in respiratory and peripheral muscles, thus, impairing their functions and quality of life.[18]

Encephalo vascular diseases were shown in an expressive percentage of affected patients with complications generated during hospitalization. The permanence of the crippling sequelae imposed on those elderly patients with comorbidities such as motor and sensory limitations, and related to comprehension and expression of thoughts can modify the dynamics of the elderly life making them dependent on their families for care.[15]

The analysis of use of assistive devices is demonstrated in Figure 1 by the significantly expressive use of nasoenteric feeding probe (SNE) and tracheostomy (TQT).

The nurse, as an educator, assumes an important role in the relationship with the patient and family members who are experiencing many challenges for caring before, during, and after hospital discharge.[19]

The home care situation shows people with various conditions and limitations, bearers of TQT, gastrostomies (GTT), in a state of weakness, and often requiring palliative care because they are in a coma or clinical chronicity of diseases with complications.[3]

Table 3 - Distribution of the main basic diseases, diagnostics, and complications during hospitalization

Variable	(n=50)	%
Previous Diseases		
Previously healthy	10	20
HAS	21	42
DM	17	34
Heart Diseases	6	12
Encephalo Vascular diseases	10	20
Degenerative diseases	7	14
Respiratory tract diseases	5	10
HIV	1	2
Other	4	8
Clinical diagnostics by systems during hospitalization		
Respiratory system	15	30
Neurological system	12	24
Skeletal system	8	16
Digestive system	6	12
Cardiovascular system	1	2
Nervous system	1	2
Urinary and excretory system	2	4
Reproductive system	1	2
Immunological system	2	4
Other	2	4
Reasons that led to hospitalization		
Respiratory disorders	15	30
Gastrointestinal disorders	7	14
Cardiovascular disorders	3	6
Urinary tract infections, surgical site and others	9	18
Orthopedic trauma	3	6
Urinary tract involvement	2	4
Encephalo vascular disorders	3	6
Palliative care	2	4
Other	6	12
Major complications in hospitalization		
Cardiovascular complications	12	24
Complications and respiratory disorders	9	18
Gastrointestinal complications	6	12
Kidney complications and urinary tract	5	10
Musculoskeletal complications	2	4
Pressure ulcers	4	8
Other	5	10

Source: research data (2012).

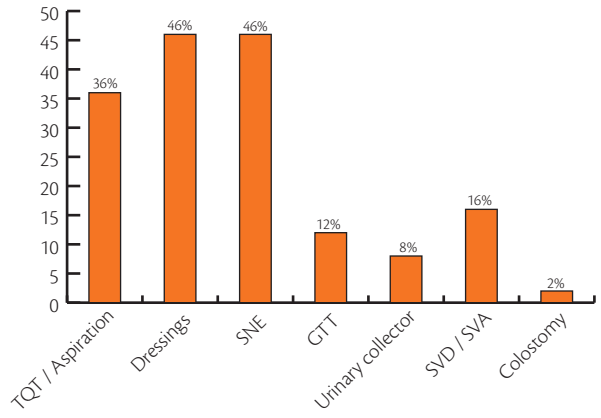

Figure 1 - Distribution of patients according to the assistive devices in use. Source: research data (2012).

This information enables a better explanation of the data that are common to those in this study, which also showed a high incidence of patients using TQT, oxygen, and bandages due to the presence of decubitus lesions. This requires planning for assisting strategies for hospital discharge programs and preparation of caregivers for providing care at home.

Some patients manifest nutritional deficiencies due to the involvement of certain diseases, requiring, in most cases, the use of a method that provides caloric intake and prevents nutritional deficit increase. Thus, one of the therapeutic interventions can be use of SNE, precisely the most expressively used device by the participants in the study, 23 (46%) of all respondents. The execution of a plan for care and guidance, individually elaborated by the team assisting the patient, in particular by the nurse, is essential to ensure continuity in the home treatment, avoiding complications and unnecessary readmissions of patients in use of these and other devices.[20]

Profile of the family caregiver

The data for the identification of profiles of family caregivers showed that 42 (84%) were females and only 8 (16%) were males. These results correspond to data reported in the literature. Historically, women carry the role of caregivers for children, parents, and family confirming this result.[21] The highest percentage of caregivers were between 31 and 40 years old, totaling 12 (24%), followed by 13 (26%) between 41 and 50 years old, and 8 (16%) between 61 and 70 years old.

Among those professions linked to healthcare, the majority is observed being performed by women, and a good example of this is Nursing. The data highlight the great importance that should be given to the age of caregivers, which is raised by other authors who say that older caregivers seem more susceptible to overload, and the young ones can experience and suffer in isolation due to the social constraints proportionate to higher possibilities for leisure and social activities in their age group.[22] The caregiver's age appears to be an important variable in the evaluation of quality of life. It was observed that the higher the patient's age, the greater the overload for the caregiver.

The predominance of primary and secondary levels of education was observed among the interviewed caregivers, with 20 (40%) in each school level, respectively. Schooling is predominantly low and this low level can contribute to the decision of becoming a caregiver because the inclusion in the formal labor market is harder for those individuals with low schooling levels.[22]

The relatedness of caregivers to patients showed that the majority of respondents were children – 24 (48%), and wives 10 (20%). These family members are active in the conduct of care; they exercise care and take all the responsibility involved. Some researchers point out that the person who primarily assumes the personal care of the incapacitated elderly are spouses, of the female gender, followed by children and parents. The physical proximity also emerges as a strong influencer in this context, which usually takes place by those living in the same environment.[10] The main caregiver arises, who generally comes from the nuclear family, becoming the person responsible for assisting the dependent patient on daily life, among other tasks.[23]

The marital status of the 50 respondents showed a significant prevalence of married individuals – 31 (62%). In families, there are usually those people who are delegated to perform certain roles, such as that of being the caregiver. However, a hierarchy is followed for the choice of caregiver that depends on factors such as: gender, age, generational factors, degree of family relationship, caregiver's place of residence, financial situation, time availability, affection between the patient and caregiver, and caregiver personality.[24]

When asked about *knowing to take care of your family member*, only 30 (60%) of caregivers reported knowing how to take care of the patient based on explanations provided during the hospital stay. Only 20 (40%) of the caregivers stated not knowing know provide care. Based on several studies, the high prevalence of caregivers without adequate preparation for care is outstanding and indicates that the task of caring for the family is linked to social accountability. Thus, this burden must be judiciously accompanied by health professionals to ensure that families are in healthy conditions to exercise the necessary care to the patient.

Professionals need to pay attention to the particularities of each caregiver/family considering that the care must be individualized, that even when based on protocols of care, it must be supported by the needs and realities of each family because this nucleus of care is loaded with emotions and characteristics resulting from cultural, social, and economic conditions.[25]

Undoubtedly, the nursing team needs to use mechanisms and instruments that can mitigate and remedy the doubts and difficulties that appear to caregivers after they take charge of the home care. The evaluation of profiles of family caregivers allows the nursing staff to group subsidies for the adoption of measures

of support to the family, helping the development of coping strategies to face the disease and the disabilities that it generates.[26]

A total of 24 (48%) caregivers stated being prepared to practice care at home, and 23 (46%) stated that they were not able to manage the dependent family member. That adds up to three (6%) individual caregivers who positioned themselves in doubt, claiming to have average knowledge about care and confidence to act as household caregivers after hospital discharge.

Often, the role of health professionals in the preparation for discharge occurs simultaneously to the hospital discharge; however, guidance for the patient must be planned by the health team since his admission to avoid information overload at the moment of leaving the hospital. Some studies have shown that caregivers/family members rarely receive clear information about the disease, guidance or support for the care, or indication of a service to enable them in providing treatment, although the patient and family education is recognized as an important component of good practices in rehabilitation.[10]

It is essential that educational modules on the provision of care at home are offered to the caregiver to mitigate these problems, with follow ups to detect how much these caregivers have, in fact, incorporated the information received.[21]

The support from the basic health services and conditions for obtaining materials for domiciliary care was received by 48 (96%) participants and only 2 (4%) did not receive it, and still needed to move to other regions to seek this support.

This information may feature a favorable scenario for building networks and partnerships facilitating home care because a representative number of people could count on the basic health attention support. However, many family caregivers say that the existing difficulties, before the process of caring, mainly comprise the lack of technical knowledge, emotional changes, physical weariness, and financial hardship.[24]

When asked about issues related to their conditions for obtaining care materials, 31 (62%) respondents stated having the conditions, and 19 (38%) stated not having the conditions due to the high cost of treatments, financial hardship, and lack of engagement and participation in programs for family health care.

CONCLUSION

We concluded, based on the data collected from 50 patients/caregivers, that a large part of the sampling is represented by elderly patients aged between 60 and > 70 years old with some underlying installed disease such as cardiovascular imbalances and diabetes.

Respiratory problems were among the main complication in the patients, often due to pneumonia, very prevalent in the elderly as discussed earlier, and factors such as those related to the physiological aging process and difficulties related to early diagnosis.

In the study, the demonstration of increased prevalence in the use of assistive devices such as TQT, SNE, and bandages due to pressure ulcers refers to the relevance of these data for improved preparation of strategies by nurses for training family caregivers to manage procedures when assisting the sick at home.

The expansion of studies in this framework is paramount to health institutions because the expenses and demands related to readmissions and extended hospital stays, often due to iatrogenic events and poor home care, are problems generated from the absence of a broad network of support to family caregivers and is one of the main reasons for exorbitant spending in health. Thus, many patients return to their homes with some assistance device, which generates the need for training those who will take charge assisting in the home environment to assure continuity of care.

In order to adopt planned measures, we see in this study the possibility to permanently diminish the many gaps identified by family caregivers related to preparation for hospital discharge. In this study, 60% of caregivers stated not knowing how to provide the care when asked about *knowing to take care of your family member*. Thus, the nurse, with the assisting team, can promote the creation of systemized assistance plans for the preparation of patient and family caregivers.

The completion of this study allowed visualizing the real need for reformulating reference and counter-reference practices in health services, as well as the empowerment of family caregivers as a safe way to obtain better results in the rehabilitation of individuals undergoing the aging process and already affected by chronic degenerative diseases. Thereby, the possibility of reducing iatrogenic events, caused by poor techniques in the home care, is verified; iatrogenic events are the main reason for a high number of readmissions.

Based on the obtained considerations and results, the need for nurses to adopt the preparation for hospital discharge into their working environment is clear, such as in the field of action to promote interventions that aim to improve the development of relations and partnerships for this caring activity. Minimizing damage from erroneous practices that are harmful to patients and caregivers themselves is an important role for nurses because they can undoubtedly decrease spending, readmissions, and overcrowding in hospitals. Above all, they can promote the reduction in the number of deaths and functional disabilities improving the quality of life of those involved in the process of rehabilitation and healing.

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