Sociodemographic and clinical profile of users assisted in home care

Perfil sociodemográfico e clínico de usuários assistidos na atenção domiciliar

Victor Fernando Alves Neves[1] ⓘD
Thaís Marques Moura[2] ⓘD
Gleide Regina de Sousa Almeida Oliveira[3] ⓘD
Gilmara Ribeiro Santos Rodrigues[4] ⓘD

[1,4]Escola Bahiana de Medicina e Saúde Pública (Salvador). Bahia, Brazil. victor_nevesba@hotmail.com, gilmararodrigues@bahiana.edu.br
[2]Corresponding author. Escola Bahiana de Medicina e Saúde Pública (Salvador). Bahia, Brazil. thaismoura16.1@bahiana.edu.br
[3]SOS Vida (Salvador). Bahia, Brazil. gleideenf@gmail.com

ABSTRACT | OBJECTIVE: To describe the sociodemographic and clinical profile of users admitted to a home care service. **METHOD:** Cross-sectional descriptive and retrospective research using secondary data, carried out in November 2018 in a private Home Care unit. The sample consisted of 110 medical records by simple random sampling. Data were formed using descriptive statistics. **RESULTS:** Of the home care users, 54.5% were male, over 60 years old (72.8%), retired (61%), with complete high school (45.5%) and Catholics (74.6 %). The main diagnosis of stroke (35%) with home care plan, type of management (43%) and use of intravenous therapy (51.8%); 60% not similar cutaneous; 42.7% received clinical discharge; 30.9% were transferred to the hospital and 23.7% died. **CONCLUSION:** The predominant profile of the user identified in the survey is male, aged over 60 years, retired, Catholic and with complete high school. Home care requires specific care due to the great diversity and multiplicity of requirements and needs according to the profile of each user and family assisted at home.

DESCRIPTORS: Home Care. Health Profile. Descriptive Epidemiology.

RESUMO | OBJETIVO: Descrever o perfil sociodemográfico e clínico dos usuários admitidos em um serviço de assistência domiciliar. **MÉTODO:** Pesquisa transversal descritiva e retrospectiva com a utilização de dados secundários, realizada no mês de novembro de 2018, em uma unidade privada de Assistência Domiciliar. A amostra foi composta por 110 prontuários por amostragem aleatória simples. Os dados foram analisados por meio da estatística descritiva. **RESULTADOS:** Dos usuários da assistência domiciliar, 54,5% eram do sexo masculino, acima de 60 anos (72,8%), aposentados (61%), com ensino médio completo (45,5%) e católicos (74,6%). O principal diagnóstico foi acidente vascular encefálico (35%) com plano de atendimento domiciliar tipo gerenciamento (43%) e uso de terapêutica venosa (51,8%); 60% não apresentaram lesões cutâneas; 42,7% receberam alta clínica; 30,9% foram transferidos para o hospital e 23,7% foram a óbito. **CONCLUSÃO:** O perfil predominante do usuário identificado na pesquisa é do sexo masculino, com idade acima de 60 anos, aposentado, católico e com ensino médio completo. O atendimento domiciliar requer especificidades no cuidado pela grande diversidade e multiplicidade de exigência e necessidades de acordo com o perfil de cada usuário e família assistidos em domicílio.

DESCRITORES: Assistência Domiciliar. Perfil de Saúde. Epidemiologia Descritiva.

Introduction

With the decrease in general beds in hospital units and the need for turnover of ICU beds, a new health model emerged that is in the process of ascending in Brazil, called Home Care (HC). This model of assistance emerges to support the various changes that the Brazilian population has been undergoing in recent years, such as: inversion of the age pyramid, consequently, an increase in the number of chronic patients; patients in palliative care; higher hospital costs; integration and humanization of the multidisciplinary team with the patient and the family.[1]

There are different modalities of HC according to the Resolution of the Collegiate Board (RCB) of N 11/2006, which establishes the Home Care Programs are provided according to the complexity of care to be provided to the individual: Home Hospitalization and Home Care. After revisions of the set of laws and regulations that guided the HC in Brazil, the National Household Care Policy (NHCP) was instituted, by Ordinance N 2029.[2]

Thus, HC is a health care with unique specificities, which encompasses the performance of different professional categories in the health field, opening a new space in the labor market in both the public and private domains. And it requires that professionals be trained to manage quality and humanized care for their patients and family members.[3]

The care of the individual in the home environment requires the nurse and her team peculiar skills to provide care based on the expanded clinic and conflict management, valuing interpersonal relationships in order not to transgress the subjectivity of the assisted.[3]

The nurse as a care manager must have a vast scientific technical knowledge on the subject, initiative, and autonomy in the face of certain exposed situations. Knowledge about the patient's profile is necessary, also to provide consistent data to improve the planning of the health care process of these patients.[3-4] Regarding the nursing category, these data can help to design nursing actions, to be performed with patients in AD, in addition to contributing to home health services, to help improve the care provided to the individual in home care, minimizing, among others, the rates of re-hospitalizations.

However, there are few studies addressing home health care. In view of the above, the profile of patients assisted in home care is delimited as the object of study. The present study becomes relevant because it allows identifying the profile of individuals who have the possibility of being admitted to home care, contributing to the dehospitalization, release of hospital beds and quality of life of the individual. The characterization of these patients may facilitate the elaboration of hospital discharge strategies and the management of home care to be provided specifically for each patient and family members.

To this end, the socio-demographic and clinical profile of patients assisted in home care is questioned? And to answer this question, the objective is: to describe the sociodemographic and clinical profile of patients admitted to home care.

Method

This is a retrospective, descriptive cross-sectional study based on data from primary sources, and electronic medical records. This article comes from a Course Completion Paper entitled Sociodemographic and Clinical Profile of Assisted Patients in Home Care.

The survey was conducted in November 2018, in a private home care unit in the city of Salvador - BA, Brazil. This institution was chosen because it is the pioneer in the State of Bahia to provide home care to people with chronic illnesses who need assistance from health professionals at home. The service is a reference, with an average of 30 monthly hospitalizations, admits patients with chronic diseases and stable clinical conditions, and can continue treatment at home in more than 19 cities in the State of Bahia-Brazil.

After the approval of the administrator of the research field and the approval of the research ethics committee, the principal researcher had access to the Medical Accounts Sector, where he accessed the medical records, in the company's digital system, of patients who were no longer in care and/or treatment during the period of data collection. The research was approved by the Ethics Committee of the Bahian Foundation for the Development of Sciences - FUNDECI, Salvador, BA, under the number of opinion 3,005,939 and CAAE 99850418.6.0000.5544. The privacy of patients has been preserved, and their names are not identified and assured that the information will only be disclosed anonymously with a scientific nature.

The selected medical records were submitted to adequacy analysis, to verify whether these documents met the inclusion and exclusion criteria, as well as the proposed objective. An investigation was conducted through the collection and analysis of information contained in an electronic document (medical records), which had not yet been treated scientifically or analytically. From 570 medical records available in the research field file, simple random sampling was performed, and the sample was calculated in Winpepi (PEPI-for-Windows) of 230 medical records. The sampling error of 5% and a 95% confidence level were considered.

The documental corpus of the research was composed of medical records of patients who met the following inclusion criteria: adults and elderly, of both sexes, who underwent hospitalization and were admitted to AD from 2017 to July 2018, with medical records that had relevance, sufficiency, completeness, representativeness, and homogeneity. Of the 230 medical records that met the proposed inclusion criteria, 120 medical records were excluded because patients were still in-home care and would not have access to obtain the signature of the terms of free and informed consent. Thus, the sample eligible for this study was composed of 110 medical records, with 95% confidence, and a margin of error of 6 to 7%, resulting in a sample n of 105 medical records.

A form was elaborated for data collection that contained the following variables: gender, age group, education, spirituality/religion, profession, unit of origin, the reason for hospitalization, diagnosis, home care plan, care by professional category, therapeutic support, presence of skin lesions and clinical evolution. The data were then tabulated in a spreadsheet and after analysis, they were presented at absolute and relative frequencies.

Results

Table 1 presents the results referring to sociodemographic characteristics, in which the elderly profile of the population and median level of education may be related to the fact that the field of study has a private administrative/financial character is evident.

Variables	N	%
Gender		
Female	50	45.5
Male	60	54.5
Age group		
25-30	1	0.9
31-40	12	10.9
41-50	4	3.6
51-60	13	11.8
>60	80	72.8
Profession		
Retired	67	61.0
Autonomous	15	13.6
Housekeeper	16	14.5
Other	12	10.9
Schooling		
Incomplete elementary school	24	22.0
Complete elementary school	10	9.0
Incomplete high school	3	2.7
Complete high school	50	45.5
Incomplete graduate school	3	2.7
Complete graduate school	20	18.1
Spirituality/religion		
Catholic	82	74.6
Evangelic	16	14.5
Spiritist	7	6.4
Atheist	5	4.5

Source: Own authors. Search data.

Regarding the most common diseases, the most prevalent were stroke (35.5%), of these, 30.9% had Systemic Arterial Hypertension, and 21.8% had Diabetes Mellitus. Neoplasia also stood out with 30%, urinary tract infection at 18.1%, and dementia (16.3%). It is emphasized that the same patient may have been diagnosed with more than one medical diagnosis.

Regarding the type of Home Care Plan (HCP) (Figure 1), management was highlighted with 43% followed by 24-hour Home Stay (HS) with 24%. What draws attention is that of the total number of patients assisted in the home care program, 94% were transferred from a hospital unit and 31% were admitted from their own homes.
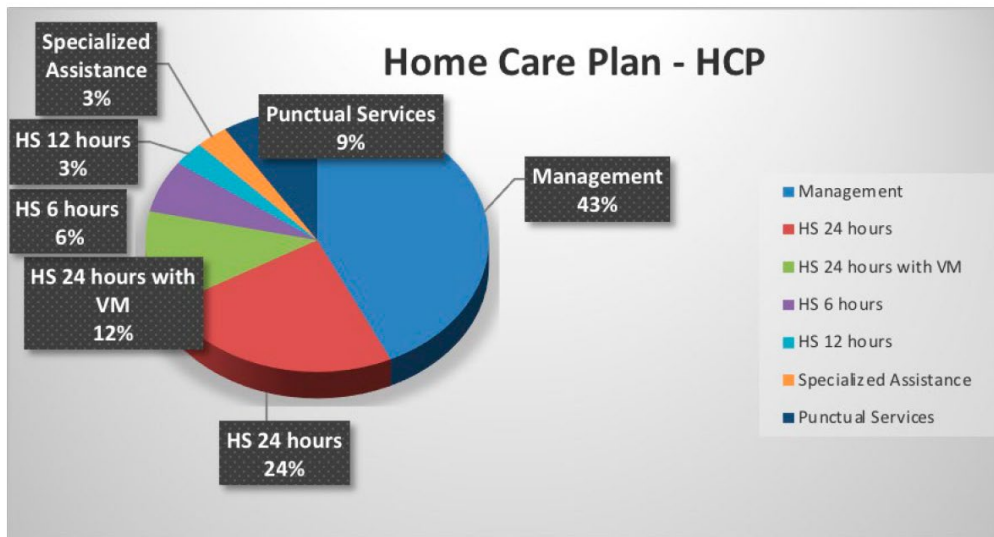
Source: Own authors. Search data.

In relation to the visits/care of the multidisciplinary team, the patients received the medical visit in greater supply, being 24% since the doctor is the professional responsible for prescribing medications. Therefore, the nurse's visit, 22.5%, for the same being responsible for the management of care, supervision of the nursing technicians' team, 21.8% and for the prescription of the treatment of skin lesions (Table 2).

Table 2. Distribution of home visits by professional. Salvador, BA, 2017-2018. (N=412)

Variable	N	%
Doctor	98	24.0
Nurse	93	22.5
Nursing technician	90	21.8
Motor/Respiratory/Neurological Physiotherapist	79	19.1
Speech therapy	32	7.8
Nutritionist	16	3.8
Occupational Therapist	2	0.5
Psychologist	2	0.5

Source: Own authors. Search data.

Related to the therapeutic supports received by patients in home care, it was observed that the devices and predominant procedure was drug infusion therapy, 51.8%. Most patients 83.7% breathed in room air and 17.3% did not have invasive procedures (Table 3).

Table 3. Therapeutic support of patients attended at home. Salvador, BA, 2017-2018. (N=110)

Variables	N	%
Venous support		
Peripheral Insertion Central Catheter - (PICC)	29	26.4
Port a Cath	4	3.6
Hypopoderclise	4	3.6
Peripheral venous catheter	20	18.2
No venous support	53	48.2
Urinary device		
Permanent bladder probe	8	7.2
Intermittent bladder probe	2	1.8
No urinary device	100	91
Airway aspiration		
Superior	1	0.9
Lower	10	9.1
Use of tracheostomy	13	11.8
No invasive procedure	19	17.3
Ventilatory Support		
No ventilatory support	96	87.3
Oxygen	9	8.2
Intermittent mechanical ventilation	1	0.9
Continuous mechanical ventilation	4	3.6
Feeding route		
Oral	75	68.1
Gastrostomy	24	22.0
Total parenteral nutrition	1	0.9
Enteral or gastric tube	10	9.0

Source: Own authors. Search data.

When considering the clinical evolution of patients, 110 patients investigated were discharged from home care. Being 42.7% by clinical discharge, 30.9% by transfer to some hospital service, 2.7% by administrative discharge and 23.7% by death.

Discussion

The sociodemographic and health conditions of patients linked to home care are important because of the potential to determine their care profile. The predominant profile of the patient identified in the research was male, aged over 60, retired, Catholic, and with complete high school education.

The findings of this study are part of Brondani et al.[4], which indicated in their study the mean age of 58 and most males. An analogous result was found in the characterization of a home care and palliative care program in the city of Pelotas, Rio Grande do Sul, Brazil.[5] It is important to know which type of sex predominates in-home care because there are gender differences in presentation, evolution, and the way diseases are addressed.

The vast profile of patients is justified by the process of inversion of the age pyramid that the country is experiencing, resulting from technological-care advances that increase the life expectancy of these patients, making them more susceptible to the development of comorbidities.[5-6] The high frequency of chronic diseases in the elderly population is closely related to lifestyle, neurobiological, functional, and chemical alterations, and these factors are determinants for healthy or pathogenic aging.[6,8-9]

Senescence can be mitigated with actions that promote health and help maintain the functional capacity of the elderly, and in this context[9], home care programs are one of the alternatives to this demand.[4] Most studies on home care show that the predominant patients are long-distance but differ in relation to gender. Studies on home care showed the predominance of people between 61 and 80, and females[6-8], corroborating another that presented related results, revealing that most individuals were female with an average value of 676.

The association of the long age group with the type of profession justifies the fact that 61% are retired, as well as in a study conducted in Rio de Janeiro in which the majority were elderly, and the variable "monthly income of the patient" had a statistically significant association with the presence or absence of welfare benefit (p<0.001).[10] It is worth noting that although the patients in focus are mostly long-distance, other age groups have also been assisted in AD services. This reveals the variety of profiles, conditions, and passive situations of home care.[7]

Of the patients in home care, 74.6% declared themselves Catholic, however, when observing IBGE data on the religiosity of the population, there was a decrease in the number of Catholics. Keeping in mind the relationship between history-culture and religion is important to understand society as a whole[8] and to provide care based on evidence, values, culture, and beliefs, mainly because it is care provided within the territory (home) of the patient himself.

The indications for follow-up and/or treatment in AD are usually: clinically stable clinical conditions that require completing treatment under medical and nursing supervision; clinical conditions that require training of the patient or caregiver in the face of new conditions; end of injectable therapy; performing complex dressings; chronic diseases with a history of frequent readmission; prolonged or recurrent infectious processes; the need for life support devices; and palliative care.

The services of AD serve patients, mostly elderly people in the process of illness secondary to chronic diseases, bedridden, partially or totally dependent on self-care.[11,13] According to the literature, among the predominant causes of AD are chronic heart failure; SAH; diabetes; cerebrovascular diseases (Ischemic and Hemorrhagic Stroke); oncological diseases; tuberculosis; chronic obstructive pulmonary disease (COPD); dementia; traumas; chronic illnesses; wounds and skin lesions; diagnosis of HIV/AIDS; palliative care and psychosocial problems.[4-5,7,9,14] The multi-professional home care team provides palliative care to patients and family members in various contexts, respecting the autonomy of patients and family in the very environment in which they live[4,9,11,14], especially when the service has a specialized oncology sector.

Patients in AD have as characteristic not to present a single condition, but the interaction of several diseases that act concomitantly in the body, thus presenting more than one medical diagnosis. The work process of nurses, in this scenario, consists of guiding and supervising the work of the nursing team and performing procedures of greater complexity, as well as performing health education and support to family caregivers.[2]

In relation to the diagnoses identified, stroke and systemic arterial hypertension (SAH) were highlighted because they were related to the profile of elderly patients seen at home. It is noteworthy that cerebrovascular diseases, especially stroke are the second leading cause of morbidity and mortality in the world, predominant in adults and the elderly, stroke leads the ranking of hospitalizations and mortality with the highest incidence in females.[4,6,9-10,12-13]

According to the World Health Organization (WHO), 15 million people a year have a VES. Of these, five million progress to death due to the event, and survivors in most cases have sequelae that trigger physical and mental limitations, bringing the need for prolonged care.[10] Among the factors correlated with the right, SAH has a high prevalence, constituting a relevant public health problem, due to the high mortality rate. SAH is characterized by a multifactorial pathology and is associated with the aggravation of cardiovascular diseases such as veal, consequently, because disabling diseases are considered the first cause of extended periods of hospitalizations, technological dependence, and deaths.[4,6,12-13]

The third cause of homestay was neoplasms representing 30% of the diagnoses. The diagnosis of neoplasia stands out in other studies, being one of the most serious and debilitating pathologies in the world, whose chemotherapy treatment leads the patient to intense side effects and physical weakness.

Thus, the existence of an environment with cancer within the family causes an impact and generates the need for adaptations that aim to meet the needs of the patient.

There were also patients who were admitted to home hospitalization (HH) for the diagnosis of urinary tract infections for venous antibiotic therapy (18.2%), which is quite common in the elderly. It is important to emphasize that HS should contribute to the reduction of the level of cross-infections, a risk very associated with long stays in hospitals.

The HS requires specificities in care due to the great diversity and multiplicity of requirements and needs according to the profile of each patient and family assisted at home. The assistance offered in HS is organized in three modalities: HS1, HS2, and HS3. The definition of the care modality is related to technological density, health needs, periodicity of visits, the intensity of multidisciplinary care, and the use of equipment. The eligibility and inclusion criteria for one of them may be clinical and administrative, standardized by Ordinance n. 825/2016.[14] Thus, the demand for the HS is in different dimensions, such as the prevention of injuries, recovery, and health promotion[4-5,7,9], which determines the type of home care plan (HCP).

The patient's admission to HS should follow strict eligibility criteria, such as full-time caregiver; risk-free home, and impediment of the patient to move to the accredited network, aiming to ensure a safe and quality assistance throughout the process, from admission to discharge. Those whose health status is stable are considered eligible for HS1, allowing care to be performed at home by caregivers, under the responsibility of monthly follow-up by PHC. For HS2, those patients with acute or chronic acute diseases, with the need for intensified and sequential care, minimally weekly, by a multidisciplinary team, are elected, and, if they require equipment and procedures of greater complexity, these are attended in the modality of HS3.[14]

In this context, HCP is provided according to the complexity of care to be provided to the individual and can be classified as Home Care (HC) and Home Care (HS). Home care is a set of actions performed at home, characterized by patient care with greater complexity and the need for nursing technician services in the 12- or 24-hour regimens. Equipment may be required to maintain treatment. And home care is aimed at patients in need of punctual nursing care, such as dressings and administration of injectable drugs and other procedures performed by the nurse or nursing technician.

In the service searched, the type of HCP can be classified into Management, HS 6 hours, HS 12 hours, HS 24 hours, and HS 24 hours with Mechanical Ventilation; Punctual Services and Specialized Assistance (these being the smallest quantitative care plan). Management, 24-hour HS, and 24-hour HS with Mechanical Ventilation are the types of plans that predominate in relation to patients assisted in this home care service, separated by care modalities.

Most of the care refers to Management and is related to the medical and nurse visits and involves intermittent procedures, such as medication administration, dressings, the passage of bladder catheter or probes, physiotherapy, among others.

The visits can be performed by several or by a single category of the multidisciplinary team. The health team of the field under study is composed of the following professionals: doctor, nurse, nursing technician, physiotherapist, nutritionist, psychologist, occupational therapist, social worker, and pharmacist. The number of professionals who provide care to the patient is related to the type of home care plan.

Concerning the visits/care of the multidisciplinary team, the patients received the medical and nurse visits. · It should be emphasized that the nurse is responsible for the management of care, provision of private care of the nurse, supervision of procedures performed by nursing technicians and auxiliaries, and guidance to patients and/or family members.

When considering the therapeutic supports in use by patients in home care, it was observed that the most used devices and procedures were related to venous drug therapy, via a peripherally inserted central catheter (PICC), peripheral venous catheter, and Port a Cath and hypopoderclise. Port a Cath is widely used in patients in cancer treatment and hypopoderclise in patients in palliative care.

A study conducted on the profile of patients and caregivers assisted by the home care service in the State of Rio de Janeiro showed that regarding the "classification in HS", this variable demonstrated a statistically significant association with the "degree of dependence", where patients classified as HS2 have greater dependence for self-care.[10]

Regarding the clinical and functional conditions of patients assisted at home, during the data collection period, a higher frequency of patients breathed in room air, and small percentages used the aid of continuous mechanical ventilation and intermittent mechanical ventilation, in contrast to the fact that in 24-hour HS with Mechanical Ventilation, it usually includes the highest number of patients hospitalized in home care. It is noteworthy that of the 11.8% of the patients who were tracheostomized, the majority (9.1%) needed lower airway aspiration.

Skin lesions are a factor widely discussed in the literature and predominant in patients hospitalized with HS. Studies show that 85.2% of home patients are bedridden, with a predominance of bed-restricted patients.[5,7,9,13,15] However, only 25.5% of the patients surveyed presented pressure injury and 14.5% presented other types of skin lesions.

The percentage of 42.7% of patients who received a clinical discharge from home care is highlighted because they responded to the treatment proposed in the request for home care. One point that should be evidenced is the frequency of patients who were transferred to hospital health units due to some type of complication (30.9%) and death (23.7%), which may be related to the profile of elderly patients in chronic illness. Considering that in this study 2.7% of patients had administrative discharge related to bureaucratic and administrative aspects with health plans, it is worth reflecting that even being a small percentage, the study shows that conflicts between consumers and health plans can lead the patient to interrupt hospitalization in HS, and sometimes with damage to the health care of the same.

This research presented as a limitation the impossibility of having access to patients at home so that we could obtain the signature of the term free of consent and we could perform the interview technique to deepen the inherent and singular aspects of each patient.

Knowing the profile of patients in home care is relevant for the proper planning of human and material resources and the direction of individualized care. However, although relevant for a population with the same characteristics of the service surveyed, the findings cannot be generalized to all home care services.

Conclusion

The predominant profile of the patient identified in the research is male, aged over 60, retired, Catholic, and with complete high school education. The research contributed to characterizing the profile of patients assisted in Home Care, management type, venous drug therapy, diagnosed with a stroke and systemic arterial hypertension. Accompanied by the doctor and nurse.

The current research becomes relevant because it allows identifying the profile of patients who have the possibility of being admitted to home care, contributing to the dehospitalization, the release of hospital beds, and the quality of life of the individual. The characterization of these patients may facilitate the elaboration of home care strategies and the management of home care to be provided specifically for each patient and family.

Authors' contributions

Rodrigues GRS, Neves VFA participated in the design of the project, design, search, and statistical analysis of the research data, interpretation of the results, and writing of the article. Rodrigues GRS, Oliveira GRSA, and Moura TM participated in the writing of the article and critical review of the relevant intellectual content. Oliveira GRSA, Moura TM, and Rodrigues GRS participated in the last version of the scientific article to be published.

Competing interests

No financial, legal, or political conflict involving third parties (government, companies, and private foundations, etc.) has been declared for any aspect of the work submitted (including, but not limited to grants and financing, participation in the advisory board, study design, manuscript preparation, statistical analysis, etc.).

References

1. Silva KL, Silva YC, Lage EG, Paiva PA, Dias OV. Why is it better at home? service users' and caregivers' perception of home care. Cogitare Enferm. 2017;22(4):1-9. http://dx.doi.org/10.5380/ce.v22i4.49660

2. Portaria nº 2029, de 24 de agosto de 2011 (Brasil). Institui a Atenção Domiciliar no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União, Brasília, DF, 25 ago. 2011. Seção 1, p. 91. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2029_24_08_2011.html

3. Andrade AM, Silva KL, Seixas CT, Braga PP. Nursing practice in home care: an integrative literature review. Rev. Bras. Enferm. 2017;(1):210-9. http://dx.doi.org/10.1590/0034-7167-2016-0214

4. Nery BLS, Favilla FAT, Albuquerque APA, Salomon ALR. Characteristics of home care services. Rev enferm UFPE on line. 2018;12(5):1422-9. https://doi.org/10.5205/1981-8963-v12i5a230604p1422-1429-2018

5. Olario PS, Moreira MC, Moreira IB, Martins JCA, Souza AT. Deinstitutionalization in palliative care: profile of users of a unit in Rio de Janeiro/Brazil. Cogitare Enferm. 2018;(23)2:e53787. http://dx.doi.org/10.5380/ce.v23i2.53787

6. Johann DA, Cechinel C, Carvalhal TFT, Benatto MC, Silva GP, Lara JA. Home care in the national health system: profile of assisted patient. Semina. 2020;41(1):83-94. http://dx.doi.org/10.5433/1679-0367.2020v41n1p83

7. Nunes EM, Frias RS. Perfil Sociodemográfico, Epidemiológico e do Atendimento Fisioterápico dos Pacientes de uma Clínica Escola de Fisioterapia que Funciona no Espaço de uma Unidade Básica de Saúde Particular de Foz do Iguaçu, PR. Revista Pleiade [Internet]. 2017;11(22):46-55. Available from: https://pleiade.uniamerica.br/index.php/pleiade/article/view/347

8. Zandavalli RB, Silveira JBS, Bueno RM, Santos DT, Castro Filho ED, Mosqueiro BP. Spirituality and resilience in home care. Rev Bras Med Fam Comunidade. 2020;15(42):2213. https://doi.org/10.5712/rbmfc15(42)2213

9. Braga PP, Sena RR, Seixas CT, Castro EAB, Andrade AM, Silva YC. Supply and demand in home health care. Ciênc. saúde coletiva. 2017;21(3):903-12. http://dx.doi.org/10.1590/1413-81232015213.11382015

10. Neves ACOJ, Seixas CT, Andrade AM, Castro EAB. Home care: care profile of a service linked to a teaching hospital. Physis. 2019;29(2):e290214. http://dx.doi.org/10.1590/S0103-73312019290214

11. Neves ACOJ, Castro EAB, Costa SRD. Needs for at-home nursing care after discharge from hospital in the sus context. Cogitare Enferm. 2016;21(4):1-10. http://dx.doi.org/10.5380/ce.v21i4.47708

12. Canuto MAO, Nogueira LT, Araújo TME. Health-related quality of life after stroke. Acta Paul Enferm. 2016;29(3):245-52. http://dx.doi.org/10.1590/1982-0194201600035

13. Carnaúba CMD, Silva TDA, Viana JF, Alves JBN, Andrade NL, Trindade Filho EM. Clinical and epidemiological characterization of patients receiving home care in the city of Maceió, in the state of Alagoas, Brazil. Rev. bras. geriatr. gerontol. 2017;20(3):352-62. http://dx.doi.org/10.1590/1981-22562017020.160163

14. Portaria nº 825, de 25 de abril de 2016 (Brasil). Redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde (SUS) e atualiza as equipes habilitadas. [Internet]. Diário Oficial da União, Brasília, DF, 26 abr. 2016. Seção 1, p. 33-38. Available from: https://www.in.gov.br/materia/-/asset_publisher/Kujrw0TZC2Mb/content/id/22685962/do1-2016-04-26-portaria-n-825-de-25-de-abril-de-2016-22685827

15. Atty ATM, Tomazelli JG. Palliative care in home care for cancer patients in Brazil. Saúde debate. 2018;42(116):225-36. http://dx.doi.org/10.1590/0103-1104201811618