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# Taking care from the inside: reflections about home visits in the Family Health Strategy

Cuidado dentro de la casa: reflexiones sobre visitas domiciliarias en la Estrategia Salud de la Familia

Cuidado dentro de casa: reflexões sobre visitas domiciliarias na Estratégia Saúde da Família

## ABSTRACT

Home Visit (HV) is one of the options offered by the Primary Health Care, in order to provide assistance inside people's houses. Objective: To talk about the importance of HV, exploring the immersion in bonds created with patients in their homes. Methods: It is an experience report written by two Family Practice medical residents, who belong to the same Family Health Strategy team, in João Pessoa (PB). Results: Through the HV, it was possible to understand the families' dynamic, providing an equitable and integral care, specially in front of events like the COVID-19 pandemic. Conclusion: The pluralization of the social relations and the illness understanding were stimulus to learn the Family Practice principles and attributes, working as a strong tool for professionals to reframe the care.

**DESCRIPTORS:** Primary Health Care; Home Visit; Medical Residency; Family Practice; COVID-19.

## RESUMEN

La Visita Domiciliaria (VD) es una práctica de la oferta asistencial que ofrece la Atención Primaria de Salud que tiene como objetivo brindar en los hogares de las personas. Objetivo: discutir la relevancia de la VD, abordando la inmersión en lazos que se crean con las personas dentro de sus hogares. Métodos: Se trata de un informe de experiencia elaborado por residentes de Medicina Familiar y Comunitaria (MFC) de un equipo de Estrategia de Salud de la Familia, en la ciudad de João Pessoa (PB). Resultados: Mediante el VD, se logró comprender la dinámica de las familias, lo que les permitió brindar una atención de manera equitativa e integral, especialmente ante la pandemia por COVID-19. Conclusión: La pluralización de relaciones y la comprensión del enfermo fueron un estímulo para el aprendizaje de los principios y atributos del MFC, convirtiéndose en una poderosa herramienta para que los profesionales reformulen la atención.

**DESCRIPTORES:** Atención Primaria de Salud; Visita Domiciliaria; Residencia Médica; Medicina Familiar y Comunitaria; COVID-19.

## RESUMO

A Visita Domiciliar (VD) é uma prática do leque de cuidados ofertados pela Atenção Primária à Saúde que visa prestar assistência na moradia das pessoas. Objetivo: Dialogar sobre a relevância da VD, abordando a imersão em laços criados com as pessoas no seio de suas casas. Métodos: Trata-se de um relato de experiência realizado por residentes de Medicina de Família e Comunidade (MFC) de uma equipe de Estratégia de Saúde da Família, na cidade de João Pessoa (PB). Resultados: Através das VD, pôde-se entender a dinâmica das famílias, permitindo realizar o cuidado de maneira equânime e integral, principalmente diante da pandemia pelo COVID-19. Conclusão: A pluralização das relações e do entendimento do adoecer foram estímulo à aprendizagem dos princípios e atributos da MFC, tornando-se ferramenta potente para os profissionais ressignificarem o cuidar.

**DESCRIPTORIOS:** Atenção Primária à Saúde; Visita Domiciliar; Residência Médica; Medicina de Família e Comunidade; COVID-19.

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**INTRODUCTION**

**T**he Home Visit (HV) is a recognized health care practice that aims to offer care to users who cannot travel to the Family Health Unit (USF). It is an important tool, not only for the discovery of the individual in his environment, but for the potential to reframe needs in care, as well as possibilities to address environmental conditions in the process that may impact people's quality of life.<sup>1,2</sup>

With ordinance 2.527, of October 2011, Home Care (AD) gains the status of health care level focused on dehospitalization, especially for care for acute or acute chronic situations, rehabilitation and palliative care. These characteristics dialogue with the learning needs of the family and community doctor, so the home visit is so important that it is among the competencies provided for by the Competency Based Curriculum of the Brazilian Society of Family and Community Medicine.<sup>3,4</sup>

In addition to effectiveness, HVs are capable of reducing health care costs. They allow the professional to shear the disease-centered model, turning to a person-centered approach in the home environment, observing the family dynamics, the environment in which the patient is inserted and understanding how such factors interfere with their health.<sup>5</sup>

This care format was paralyzed, due

to the pandemic period of the disease caused by the new coronavirus (COVID-19), so it is necessary to restructure the home visit to minimize the chances of contamination, since, in addition to these patients being groups of risk and more susceptible to severe forms of COVID-19, professionals are listed as transmitting fomites. For this, we use Individual Protection Equipment (PPE), distance communication tools and active participation of community health agents (CHA), in order to guarantee the resolution of the HV.<sup>6</sup>

Qualitative research proved to be an option of natural choice to share our desires in discussing the relevance of the study of HV and immersion in bonds created with people in the domestic bosom, especially in the context of imposed social isolation, where the stimulus to speech and the presence of the professional proved to be a caregiver path. This pluralization of social relationships and processes of personal and family perception of illness seemed to us to be a powerful stimulus for learning the principles and attributes of Family and Community Medicine (MFC - Medicina de Família e Comunidade), and it was this report that we decided to be relevant while sharing with our peers.

**METHODS**

It is an experience report resulting

from the professional performance of a family and community medicine tutor and two residents. The work is observational, descriptive and transversal. Elaborated through a set of reflections, arising from the daily experiences lived by MFC residents, in different training processes, one in the first year of graduate school and the other in the second, linked to the same Family Health Strategy (FHS) team USF Saúde and Integrated Life, located in the city of João Pessoa (PB).

Such eSF has approximately 4000 registered users and during the sharing of the work process, it was noticed that home visits (HV) were powerful tools for territorial exploration, as they allow medical practice in different parts of it. Monthly meetings aimed at exploring knowledge and sharing experiences lived during visits from April 2019 to September 2020 were aimed at.

Thus, through dialectical hermeneutics and medical education centered on the apprentice, the visits were thought and dialogued, before and after the realization, with the tutor, aiming to help the residents to improve their relations with the patients. Qualitative research seeks to dialogue with the reality of the subjects through their stories, their biographies, their relationships, the symbolisms they hold, as well as the universe of meanings, volitions, aspirations, beliefs and creeds, ethical-moral values, of the

attitudes of the concrete subject and they handle varied techniques for the empirical work for giving substrate to the understanding of the same. The research was submitted to the CAAE ethics committee: 40858820.6.0000.5178.

## RESULTS

The VDs were carried out by the MFC residents of the same team, using a resident-centered approach as an apprentice for planning. Over the months, the most prevalent diseases in the community were already common knowledge, constituting one of the attributes of the family and community doctor, that is, they exercised an adequate clinic as a community resource. The HVs were organized according to the residents' affinities after the dialogue with the preceptorship. Comorbidities and biopsychosocial conditions were discussed in weekly meetings to make decisions about who would visit the patient, always starting from the resident himself as an autonomous subject in the process. With that, we describe here our feelings and the outcomes generated in us.

### Transformative visits

One of the most impactful visits made by us took place in the presence of the two residents, already "violating" the agreements. We face, face to face, the feeling of helplessness, hands tied before the situation. There were bureaucratic, organizational issues, and a little inherent to the patient, his experience of falling ill was demanding. We look at each other in a sense of urgency, in desperation for silent responses. How can we accurately determine each step that the patient would take in his therapeutic process when the results are not as expected and the bottleneck of the system overwhelms us?

It is common to hear reports from patients, translating that they use their medications inappropriately or that they suspend the treatment of chronic non-communicable diseases, such

as diabetes and hypertension, because they feel nothing. There is not always an understanding of their part of their treatments and the importance of medication adherence as an entity that needs to be explored by professionals. We face,

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in these contexts, outcomes that can be bad, such as that of our patient, diabetic and hypertensive elderly, in complete neglect of such situations and with alarmingly increased parameters. The prognosis, the results of bad choices, had a hint of innocence, we felt compassion

and despair, we wanted him to go to the hospital and he just didn't go, he was lucid, he didn't want to.

We reflect on actions and communication in everyday life as Residents in MFC, increasingly using strategies that allow us to give greater support to our population, the main one being longitudinality, however in the face of the concrete subject, there is something imponderable that only this relational experience is capable of translating.

### Hard realities

We made a visit that at first was focused on organic and well-known complaints, but at two different times, with and without family support. When we go far beyond the disease we are able to observe the naked reality of some elderly people in the community, who suffer from loneliness and do not have good living conditions. With this, they seek a support network with the eSF for greater comfort, trying to remedy the empty spaces left by the absence of their family members, either because they live far away or because they do not show as much proximity as they wish. With the pandemic, these symptoms intensified and the demand for home visits increased. Over the months of social detachment, we were increasingly called for psychosomatic issues and they were urgent.

We experienced the need to address palliative care and bring the reality of the patient's clinical condition to the family members, since the patient was in an advanced state of senility and his family members were unable to understand the process of natural evolution of their comorbidities. The home was an environment full of affective aspects, but with many controversies among its caregivers, always with the common denominator of fear of loss. Many feelings were explored and understood, in addition to the issues of the patient in question. Care was extended to the closest companions, there was a change in the caregiver's overview, mainly with a feeling of relief that he is giving the best

comfort to those he loves, understanding his limits.

In complex environments, there is a stronger history of problems related to mental health, we continue to face the barriers imposed by chronic conditions of a sick home, trying to help in the autonomy and active process of the patients' own therapy in people who, for a long time, they only knew what it was like to be a caregiver and self-care had already been forgotten. Often a member of the family assumed the role of primary caregiver, thus, the work that should be family, was overburdened by a single member. This usually has a great understanding of the cared individual, understanding the meaning of any change as a change in behaviors, groans and needs. Despite this, these caregivers showed common aspects of low self-esteem, guilt and renunciation.

Family influence in some cases creates pressure due to lack of support, sometimes with the judgment of relatives who point out defects in the support provided or by those who see the zeal offered as too much, generating internal anguish, which can turn into suffering and overload due they feel that others can take the same care provided by them, resulting in the appropriation of a function that should be shared. Still, it is common to hide feelings of exhaustion, but throughout family follow-up, signs of wear are noticeable.

## DISCUSSION

With an increase in the population's life expectancy and the greater coverage of PHC assistance, HVs are gaining more and more prominence, and the appropriate indication is essential to guarantee equity, prioritizing the most vulnerable. The Coelho and Savassi scale is the most used tool to do this in Brazil. Conduct centered on the individual is essential to develop the action plan, directing the goals and follow-up as needed.<sup>9</sup>

The COVID-19 pandemic imposed

changes in the work process, leading the eSF to organize themselves in response to the demand of symptomatic respiratory patients and those with other complaints. In this sense, it has become more difficult to reconcile the consultation schedule at the health unit with home visits, limiting more and more priorities.<sup>10</sup>

**It is common for family caregivers to have difficulties in self-care and not being able to seek help from a health professional, however, when looking for them, they usually bring the problems of the caregiver.**

It is in the family environment that affections and discomforts are built,

capable of influencing the therapeutic approach and the reality of people's lives. The house transmits valuable information on how to live, move around, divide spaces and respect privacy limits. It is considered a robust theme, very common to many sciences, being the practice of HV, a field of reflections and construction of new knowledge and re-framing the work process.<sup>11</sup>

The reevaluation of the home, as an environment that produces both educational and assistance health actions, allows families to be active figures in the illness process that involves them. This proposal allows an improvement in the quality of care, aiming at the family as co-responsible for health.<sup>12</sup> Thus, interventions focused on the traditional biomedical model are limited, because based on the exchange of information and prescriptions, often coercive, they are eventually destined to fail because they do not match the reality of people.<sup>13</sup>

It is common for family caregivers to have difficulties in self-care and not being able to seek help from a health professional, however, when looking for them, they usually bring the problems of the caregiver. Therefore, the HV for the person in home care also becomes an opportunity for listening and care for the actual caregiver.<sup>2</sup>

The family and community doctor is assigned the task of dealing with cultural diversity, incorporating the principles of PHC. This competence culminates as one of the characteristics experienced in the HV: a search to improve care, according to the diversity and individuality of people, reflecting the daily routine for social production of the understanding of the health-disease process. Despite these limitations, offering home care is a human approach seen as something favorable and enriching for the professional.<sup>14,15</sup>

From the visits, we aim to expand the curative perspective by implementing preventive measures, reflecting and

incorporating the knowledge acquired through longitudinality. In the search for a strong PHC role, we have communication as a tool for health education, seeking to establish joint therapeutic goals with patients. After a good doctor-patient relationship, we were able to identify the patient's active participation in caring for his illness. In this regard, communication skills are fundamental to arouse a feeling of trust, providing a more open and deep dialogue, one of its pillars being the authentic feeling of "knowing how to listen".<sup>2</sup>

Caring is guided far beyond the physical limits of the university, but in the symbiosis between theory and practice. Each patient is a complex universe, and the same disease will be expressed,

lived and felt in a completely different way between each being. Recognition of the limitations of the role of the doctor specialized in CFM reinforces the idea of decentralizing the responsibility for care around it and distributing it equitably to other professionals who are part of the FHS. In this way, all spheres of knowledge in health can and must work together for the benefit of human beings, in all their particularities.<sup>15,16</sup>

In this way, HV proposes to work on medical training focused on comprehensive care far beyond the pragmatic of the home, exploring an abstract dimension and understanding the small world of each family with their lived stories and the different versions told. Thus, there is an opening to deal

with suffering and the relationship with services.<sup>11,17</sup> The HV allows individuals to be well understood as whole and complex beings, not just defined by their pathologies.

## CONCLUSION

The benefits reaped by the performance of family and community doctors in Primary Health Care are evident, mainly in the scope of medical residency. More than going in search of those who are unable to reach the health unit, home visits are an important care tool that allows us to walk side by side in the therapeutic process and take long steps towards a good doctor-patient relationship. ■

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