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Understanding of professionals about the process of hospital discharge of children dependent on technologies

Compreensão de profissionais sobre o processo de alta hospitalar de crianças dependentes de tecnologias

Comprensión de los profesionales sobre el proceso de alta hospitalaria de niños dependientes de tecnologías

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ABSTRACT

Objective: to understand the process of hospital discharge of technology-dependent children by professionals from pediatric and neonatal units. **Method:** descriptive study with technology-dependent child care professionals at a University Hospital between July and September 2020. The data obtained was exported to the Iramuteq software and interpreted in light of content analysis theory. The study is approved by the Research Ethics Committee. **Results:** the word cloud contextualized and provided support for the identification of two categories: Understanding the need for teamwork to plan hospital discharge and perception of the need to implement tools such as protocols and flows to guide preparation for discharge and continuity of care. **Conclusion:** professionals report that hospital discharge is carried out according to the care routine and still follows a medical-centric model.

Descriptors: Child, Hospitalized; Patient Discharge; Patient Care Team; Nursing; Technology Addiction.

RESUMO

Objetivo: compreender o processo de alta hospitalar de crianças dependentes de tecnologias por profissionais de unidades pediátricas e neonatais. **Método**: estudo descritivo com os profissionais da assistência à criança dependente de tecnologias de um Hospital Universitário entre julho e setembro de 2020. Os dados foram obtidos foram exportados para o *software Iramuteq* e interpretados à luz da teoria de análise de conteúdo. O estudo possui aprovação pelo Comitê de Ética e Pesquisa. **Resultados**: a nuvem de palavras contextualizou e forneceu subsídios para a identificação de duas categorias: Compreensão da necessidade de trabalho em equipe para planejamento de alta hospitalar e percepção da necessidade de implementação de ferramentas como protocolos e fluxos para o direcionamento do preparo para alta e continuidade do cuidado. **Conclusão**: os profissionais referem que a alta hospitalar é realizada conforme a rotina assistencial e ainda segue um modelo medicalocêntrico.

Descritores: Criança Hospitalizada; Alta Hospitalar; Equipe de Assistência ao Paciente; Enfermagem; Dependência de Tecnologia.

RESUMEN

Objetivo: comprender el proceso de alta hospitalaria de niños dependientes de tecnología por parte de profesionales de unidades de pediatría y neonatología. **Método:** estudio descriptivo con los profesionales de cuidado al niño que depende de tecnologías en un Hospital Universitario, entre julio y septiembre de 2020. Los datos obtenidos se exportaron al software *Iramuteq* y se interpretaron a la luz de la teoría del análisis de contenido. El estudio es aprobado por el Comité de Ética en Investigación. **Resultados:** la nube de palabras contextualizó y trajo subsidios para la identificación de dos categorías: comprensión de la necesidad de trabajo en equipo para planificar el alta hospitalaria y percepción de la necesidad de implementar herramientas como protocolos y flujos para orientar la preparación para el alta y la continuidad de la atención. **Conclusión:** los profesionales refieren que el alta hospitalaria se realiza según la rutina asistencial y sigue un modelo médico centrado.

Descriptores: Niño Hospitalizado; Alta del Paciente; Grupo de Atención al Paciente; Enfermería; Adicción a la Tecnología.

INTRODUCTION

Public health policies aim at guaranteeing basic rights to the population, taking into account the diversity and complexity inherent to the care required for sustaining life and quality of life[1]. In this scenario, the objective is to ensure the children's and adolescents' rights to actions to promote, prevent and restore health[2], including Technology-Dependent Children (TDC), that is, those who have complex health conditions due to their dependence on an assistance technology that is essential for sustaining life[3].

Dependence on life-sustaining technologies leads to changes in children's daily health and social life, which require complex, continuous and temporary or permanent assistance[4]. The need for complex care oftentimes demands long hospitalization periods, causing anxiety and fear in the TDC-family dyad[5].

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To this end, it is up to health professionals to understand the weaknesses of the TDC-family dyad and to act to effectively collaborate in recovery, thus making it possible for the patients to return home as soon as possible in a safe way and providing care effectively to avoid further hospitalization periods[6].

The hospital discharge process is a fundamental period during hospitalization, as it is through the guidelines provided by clinical professionals that the TDC-family dyad acquires the knowledge and autonomy necessary for home care. Therefore, multiprofessional teams become fundamental in the hospital discharge of TDC[7-8].

In this context, the guidelines provided by the multiprofessional team need to be theoretically aligned, and it is indispensable to use tools such as health education to guarantee the improvement of technical-scientific knowledge to support preparation for hospital discharge[9-10]. Therefore, this study seeks to understand the hospital discharge process fir technology-dependent children by professionals from pediatric and neonatal units.

METHOD

This is a descriptive study with a qualitative approach, carried out from the professionals' point of view, effective members of the team or multiprofessional and medical residency who work in the care of TDC at the pediatric clinic and the pediatric and neonatal Intensive Care Unit (ICU) of a University Hospital, in a Brazilian municipality between July and September 2020. To guarantee quality in scientific writing of this study, the *Consolidated Criteria for Reporting Qualitative Studies* (COREQ) was used to report the findings in a scientific model[11].

To choose the aforementioned target population, non-probability convenience sampling was used, applying the "snowball" strategy, which consisted in approaching "seed" participants, that is, people who had the basic characteristics needed to make up the target population and agreed to voluntarily participate and contribute to the research. Thus, the "seed" participants were free to nominate other potential participants for the study[12].

Data collection was divided into two phases (A and B) to cover exploration of the object under study. Phase A consisted in approaching possible participants in the study ("seed" participants) via email, which included the following: presentation of the study covering the objectives, method, risks and benefits; the Free and Informed Consent Form (FICF); a sample characterization questionnaire to investigate data on age, gender and professional activity; a space to indicate other possible participants in the study; and an invitation to take part in an interview, which made it possible to report the availability for the interview date and time. Thus, despite only approaching 10 "seed" participants, a total of 20 participants was reached in phase A of the study.

Phase B, consisting of an individual, recorded interview carried out remotely via the "Google Meet" platform and according to each participant's availability, used the following triggering questions: "Are the actions that take place in the clinic, regarding preparation for discharge, drawn up as a team?", "Which professionals take part and how do they happen?", and "How are these situations handled?". In this stage there were five sample losses among the participants; therefore, only 15 finished the interviews.

Regarding the analysis, although this was a qualitative study, the data referring to phase A, which included the sample characterization, were tabulated in *Microsoft Excel* 2010 and exported to the *Statistical Package for Social Sciences* (SPSS) to generate absolute and relative frequencies. The data for phase B were organized in the *Phyton* language to be analyzed by *Iramuteq* via the R software[13]. Thus, the results were analyzed using the interviewees' answers in the form of a word cloud (Figure 1) generated from the text *corpus* by the *Iramuteq* software and, therefore, interpreted in the light of the Content Analysis theory[12], highlighting the main and most relevant points for the research, presenting the main testimonies.

During the text *corpus* analysis, words were not lemmatized to guarantee that colloquial language remained while the word cloud was created; therefore, the lexical analysis was carried out on words that were repeated at least three times, belonging to the following classes: adjectives; supplementary adjectives; adverbs; unrecognized forms; unusual words; indefinite, personal and possessive pronouns; and verbs. Also in this context, in order to guarantee the participants' anonymity during composition of the text *corpus*, the excerpts from the interviews were identified by the letter "P" followed by ordinal numbering, making it possible to code the reports as "P1", "P2", "P3" and so on[13].

Finally, it should be pointed out that participation was voluntary and offered minimal risks (generally related to embarrassment at being asked about professional practices), but it is believed that these risks were minimized by the anonymity guarantee, an individualized approach, and the researchers' professional attitude.

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In addition, the research was assessed and approved by the Research Ethics Committee (*Comitê de Ética e Pesquisa*, CEP).

RESULTS AND DISCUSSION

According to the findings of this study regarding phase A, there was predominance of females (19/95%) among the participants, with ages between 27 and 50 years old and a mean of 39. As for professional aspects, there was predominance of nurses (5/25%), followed by nursing technicians (4/20%). Regarding the specialization degree of the professionals interviewed, and considering it as a multiple choice, 14 had some *lato sensu* specialization (70%), four had an MSc degree (20%), three had training (15%), two were PhDs (10%) and two only had some undergraduate degree (10%).

Regarding the professional setting, 11 worked in the pediatric clinic (55%), five in the neonatal or pediatric ICU (25%) and four in the multiprofessional or medical residency (20%); the last one worked in both units. As for institutional links, 12 were linked to the Brazilian Hospital Services Company (*Empresa Brasileira de Serviços Hospitalares*, EBSERH) (60%), three came from multiprofessional residencies (15%), four were linked to the Single Legal Regime (*Regime Jurídico Único*, RJU) (20%) and one came from a medical residency (5%). It should be noted that the interviews lasted a mean of 27 minutes.

Concerning the findings about phase B, that is, what corresponds to the semi-structured interviews using trigger questions, the Figure below shows the illustration of the text *corpus* that graphically portrays the answers given by the professionals interviewed, highlighting the size of the words that correspond to the repetition degree in the *corpus* analyzed (Figure 1).

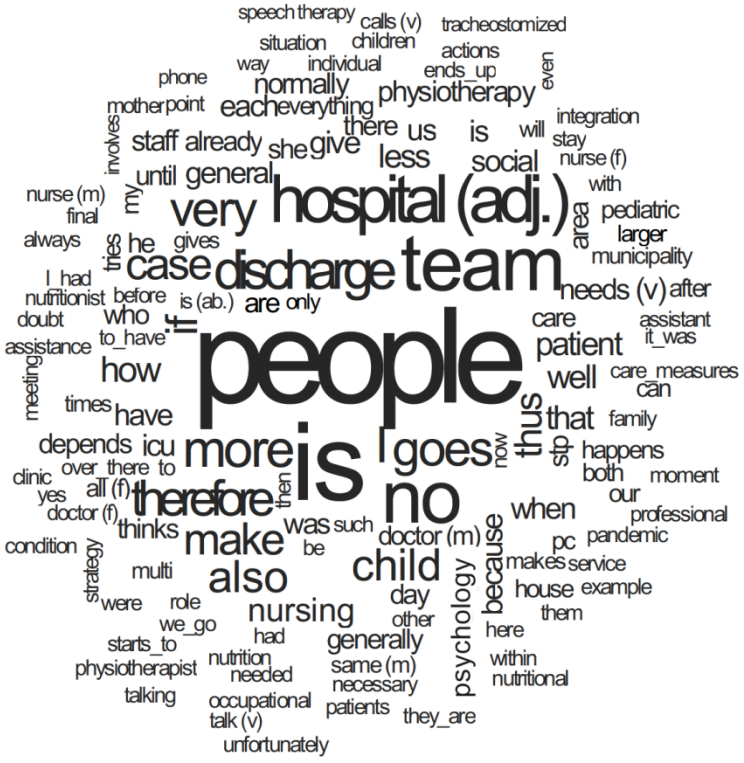

Figure 1: Word cloud generated from the text *corpus*. João Pessoa, PB, Brazil, 2022.

As for the analysis of the text *corpus*, illustrated by the word cloud, it can be seen that, when preceded by the article "the"(*a*), the noun "people" (*gente*) incorporates the noun phrase "the people" (*a gente*), which corresponds to a personal pronoun in the expression of colloquial language. Despite this, this terminology is not officially part of the Portuguese language in its cultured form[18]. This explains why it is so widely used by the professionals interviewed, since the terms were interpreted as they were expressed by the interviewees.

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The words “team” (*equipe*), “discharge” (*alta*), “hospital” (*hospitalar*) and “child” (*criança*), which stratify the object under study and identify the similarity between the discourses.

Based on the interviews, two categories to be addressed were identified: I - Understanding the need for teamwork in hospital discharge planning; and II - Perception of the need to implement tools such as protocols and flows to guide discharge preparation and care continuity.

Figure 2 presents data related to the category Understanding the need for teamwork for hospital discharge planning.

Understanding the need for teamwork in hospital discharge planning	
INTERVIEWEES	**ANSWERS**
P1	*“The dynamics are as follows: the doctor visits, informs the family that he's going to discharge the patient, the nurse tells us (the nursing technicians responsible for the dyad), we prepare, and the physiotherapist is also involved at the time of discharge and then the patient is discharged from the hospital. Usually, we don't accompany him to the ward, because it's the stretcher-bearer and the nurse who go with the patient”.*
P2	*“(...) usually, our multi-team doesn't meet in order to, for example, discharge a child from the hospital and the mother needs to be instructed”.*
P3	*“This collaboration will depend a lot on the characteristics of the care provided (...)”.*
P4	*“If necessary, the municipality of origin is called in to make this discharge possible, to tie the knots, to leave the patients in the municipality's network, so that they don't get lost and are hospitalized again”.*
P5	*“Teamwork depends a lot on the case. When the case is more complex, we're able to work better as a team (...), it all depends on the case, but we're able to do multiprofessional work. (...) There was a case now (...), we held a meeting with the staff, even people from the municipality, with the staff from the FHP, CREAS, CRAS, who are going to continue this work”.*
P6	*“Because patients are many times discharged and returns to a municipality where there's no specialty center, no rehabilitation space (...) they'll always have to return to the municipality in their metropolitan region with greater resources. (...) It's very rare for municipalities to give us feedback so that we can see if what was planned, what was pointed out, is being carried out”.*
P7	*“Most of the time, we try to make this integration happen. It's not easy, it doesn't happen all the time, but we do try. As it's the doctor, nurse and physio who are there every day, there's more integration, but we also try to bring in the psychologist, social worker, nutritionist, pharmacist, when necessary, so that the patient can be discharged from the ICU as safely as possible so that they don't return”.*
P8	*“Yes, always as a team, it has to be the medical team with the nursing team, who are usually the ones who do this kind of care, along with the physiotherapy and occupational therapy staff (...)”.*
P9	*“(...) in many cases (discharge), meetings aren't necessary to define actions, but it was always discussed, even in the hallway”.*
P10	*“But I see that we're really lacking in this respect, when it comes to preparing this hospital discharge with the multi-team, which is precisely our multi-residency that should be working hard on this but, unfortunately, most of the time it's really individual”.*
P11	*“In general, it's usually the doctor who gives the final word, even though we talk to the team beforehand, he's the one who gives the news, in this case (...)”.*
P12	*“We usually do STP. We did this a lot during the pandemic. We carry out the STP and try to pinpoint the biggest weaknesses (...)”.*
P13	*“There have been a few cases in which we've called in the municipalities so that the municipal health teams can take in these children, these families when they return home, but we can't do this standardized discharge because there's variability of cases”.*
P14	*“The actions are usually defined in agreement with the multiprofessional team that cares for the child”.*
P15	*“It's carried out on a multiprofessional basis, with each area assessing the condition for hospital discharge”.*

Figure 2: Clippings from the testimonies that cover the understanding of the importance of teamwork for hospital discharge planning (n = 15). João Pessoa, PB, Brazil, 2022.

Through the statements illustrated in Chart 1 (P1, P2, P3, P5 and P7), difficulties are identified in implementing joint activities that favor discharge planning and that make its success unfeasible due to mismatches between the multiprofessional team members, which results in gaps in care continuity[15,19]. Also in this context, the literature explains what was stated by two professionals (P1 and P11) by pointing out that the weaknesses are due to assistance that is sometimes medical-centered, which weakens care integrality[20].

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Considering the statements made by the professionals under study, it was identified that the multidisciplinary team's work in this context depends on the complexity degree presented by each patient's clinical condition. Complexity is related to functional and frailty domains and to technologies and equipment for sustaining children's life, who are referred to as Technology-Dependent Children (TDC)[21].

A study carried out in the Brazilian South region showed the fragility of the discharge process in the clinical and surgical care of children and adolescents; these challenges are caused by the fact that the hospital discharge process is linked to mechanized verbalized guidelines focused only on pathology and bureaucratic aspects[7]. Effective communication between professionals and family members is essential for a safe dehospitalization process based on health education[20], which is in line with the testimonies presented in Chart 1 (P10 and P14) and in Chart 2 (P2 and P3).

For TDC, the home-return process is characterized by various obstacles that refer to their clinical stability during the hospitalization period and that, with proper support, they are able to continue care at their homes. For these children, discharge reduces the risks inherent to the hospital environment, comforts them and allows them to return to their social cycle, and these reflections are necessary to discuss new health care models[22].

In this context, the multiprofessional team needs to plan for hospital discharge, focusing on the TDC-family dyad, and family participation is fundamental for maintaining and promoting health[23]; in other words, guidelines enable families to learn and transform their realities, minimizing the readmission risk[7], as shown by the professionals in Chart 1 (P5, P7, P9 and P15).

In addition, the service professionals showed that they understood the importance of collaborating with other health services belonging to the Health Care Network (HCN), which are responsible for the continuity of post-discharge care, as shown in Chart 1 (P5). Some studies have shown that family members of TDC require the HCN support to provide effective care continuity during this process[24-25].

However, despite the obvious need for a link between care levels to promote follow-up and counter-referrals, there are weaknesses related to communication in the HCN. A number of studies show that the HCN is considered to be weak and disconnected, and that care is directed to specialized centers[24-25], which is reinforced in the testimony given by professional 6 in Chart 2. Therefore, it becomes indispensable to provide permanent education for the professionals and to carry out health education activities for the TDC-family dyad, both of which are essential for successful discharge preparation.

Figure 3 presents data related to the category Perception of the need to implement tools such as protocols and flows to guide preparation for discharge and continuity of care.

Perception of the need to implement tools such as protocols and flows to guide discharge preparation and care continuity	
INTERVIEWEES	**ANSWERS**
P1	*"As we have a lot of chronic patients, we usually give them certain notice, I mean days so that we can prepare the patient and the family (...) but there was a time when discharge was kind of a necessity for an exchange. A less serious patient would go down (to the ward) so that a more serious one could go up (to the ICU) (...) unfortunately, it's a bit of a rush, there's no routine".*
P2	*"(...) This intra-unit communication work process is still very flawed in the hospital unit as a whole. Because it was loose for a long time, the line of care is still not closed, and it's not understood by all parties".*
P3	*"(...) on a day-to-day basis, depending on each child's needs, the teams put together parts of the team that can collaborate more specifically to follow this strategy for discharging children and adolescents".*
P4	*"Another thing that I think could be different is to standardize the flow, when you know that the patient is going to be discharged, already anticipate it, and already look for those professionals who are important, so as to establish a flow for that discharge".*
P8	*"I think that it could be standardized (...) And it should be something that, when the need arises, prepares for discharge already, kind of, made the admission to the service, already opened a protocol, to gradually prepare the family. (...) because how are you going to discharge a child who needs special care without having instructed the family?".*
P13	*"(...) We haven't yet reached the stage where we have a tool, but if we did, it would certainly help a lot".*

Figure 3: Clippings from the testimonies that cover the perception about the need to implement tools such as protocols and flows to guide preparation for discharge and care continuity (n = 6). João Pessoa, PB, Brazil, 2022.

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In line with the weakening in terms of care continuity, the absence of institutional protocols or guiding flows that make it possible to plan the preparation for hospital discharge can be seen in the testimonies included in Chart 2 (P4, P8 and P13). Thus, the importance of collaboration among the team members to move away from the medical-centered model in favor of devising health education and care promotion strategies is believed to favor the teaching-learning process and empower those involved to provide care outside the hospital environment[15].

In this context, it is clear that the discharge guidelines should be based on a guiding tool that ensures a systematic and safe process. Furthermore, the need to implement protocols and care flows is also a reality in other Brazilian states, where researchers see the creation of organizational mechanisms and tools that recognize the needs of TDC and enable care continuity in an orderly, systematized and safe way as a positive step[20].

However, the statements by the professionals in Charts 1 (P2, P7, P9 and P11) and 2 (P1, P2, P3, P8 and P13) show that care is provided in a non-systematic way, with gaps that compromise its effectiveness in its entirety, as each professional acts according to their sensitivity and empathy, depending on individual factors that sometimes do not favor integration and effective communication among professionals[15].

In addition, discharge planning should not only instrumentalize the family as a guarantee of autonomy for the dyad, but devise actions that enable care continuity by the HCN through a successful return of the children and their family to their social environment[15,25].

Study limitations

This study has some limitations. In the first place, it may lack generalizability to a national population because it was conducted in a single institution within a single city. Secondly, the practice standards probably differ across institutions, and there is significant variability in how discharge is made among the Brazilian states and regions. However, future studies can bridge these gaps more accurately using prospective strategies. In addition, it can be seen that there are interrelated factors that affect the family's readiness for discharge.

CONCLUSION

The multiprofessional team interventions in planning for hospital discharge are carried out according to the care routine and still follow a medical-centered model. In addition, even though 70% of the professionals are specialized and fully understand the importance of planning and guidelines for hospital discharge, there is lack of institutional tools to ensure that actions are planned and carried out with the TDC-family dyad.

Among the testimonies, the weakness of the HCN was identified concerning the counter-referral of TDC, as articulation is difficult among services and municipalities, which undermines the care continuity to be offered to children and their families.

It is evidenced that, by having tools such as a care flow or protocol to guide actions directed at the TDC-family dyad, the objective is to guarantee comprehensive assistance and care continuity, directing discharge in stages and guiding both guidelines and communication among professionals and sectors, keeping the focus on the TDC and their family so that they both acquire the skills and abilities to return home.

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Conceptualization, ARCAD and EAGP; methodology, WCM; software, WCM; validation, WCM and KLS; formal analysis, ARCAD, YTR and MGLB; investigation, YTR and MGLB; resources, ARCAD and YTR; data curation, ARCAD, YTR and WCM; manuscript writing, ARCAD and YTR; manuscript review and editing, WCM; visualization, KLS and EAGP; supervision, EAGP; project administration, ARCAD and EAGP; financial aquisition, ARCAD and EAGP. All authors have read and agreed to the published version of the manuscript.