NEEDS OF THE FAMILY CAREGIVER OF THE PERSON WITH STROKE IN THE TRANSITION FROM THE HOSPITAL TO THE COMMUNITY

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After experiencing a stroke, a person should have some temporary or definitive consequences, which cause functional disability and dependency in self-care. This makes it impossible to satisfy the basic human needs autonomously and independently (Faria, 2014).

During the transition process from the hospital to the community, these people are dependent on a caregiver in a complex situational transition and are also in need of nursing therapeutic support for a healthier transition (Araújo, 2015).

This integrative literature review aimed to identify the needs of the family caregiver during the transition from the hospital to the community. The research based on the question: "What are the care needs of the family caregiver in the transition from Hospital to the community, to the person with stroke?" was effected in the EBSCO, B-ON, Science Direct and SCOPUS databases, within the temporal line 2013 – 2017. The bibliographical sample consisted of 13 articles, which met the inclusion criteria. The results of the primary studies were subject to thematic analysis-categorial and emerged the following category: the self-care needs, psycho-socio-emotional needs and requirements in the provision of home care.

The non-abolition of self-care requirements causes major impact on informal caregivers in their social life (tiredness and distress) and dissatisfaction in the access and quality of health services available. This situation is worrying, because low levels of social support are associated with anxiety, depression and irritability of the caregiver, increasing the risk of burnout, generating negative impacts on their life, impairing the situational transition, and consequently the provided care.

The results pointed out that early individualized education promotes improvements in the knowledge of caregivers. It is important that caregivers demonstrate and practice the care to enhance the acquisition and mastery, increasing the empowerment, decreasing the overload, enabling a better quality of life and mental health, with consequent improvement of the satisfaction with the care provided. The informal caregiver’s action will be better as sooner as the nursing intervention, perfecting his skills in the performance of the new role and the possibility of solving problems that arise, lowering hospital readmissions.

We concluded that caregivers must be prepared to face the new relationship with stroke relatives, and the transition to that role often occurs after the hospitalization. Thus, the nursing team’s performance can not only be achieved through technical activities, but also through the training of the caregiver, adopting a differentiating posture in order to provide early care during the hospitalization, so that the family members feel more supported in the situational transition and that this happens healthily.

**Keywords:** Nursing; Stroke; Elderly; Integrative review; Discharge; Continuity of care.
References
