

Family caregiver in the home care assistance

Cuidador-e-familiar na vivência da internação domiciliar

Anna Maria de Oliveira Salimena¹ • Juliana Bernado Nazareth² • Andyara Pinto Coelho Paiva³
• Thais Vasconcelos Amorim⁴

RESUMO

Objetivo: Desvelar significados e sentidos do cuidador familiar na vivência da internação domiciliar. **Método:** Investigação exploratória qualitativa, fundamentada na fenomenologia e no referencial teórico, metodológico e filosófico de Martin Heidegger. Constituíram-se cenário as residências das famílias cadastradas no Departamento de Internação Domiciliar localizado na Zona da Mata, no interior de Minas Gerais, e que atende exclusivamente pela rede pública de saúde do Sistema Único de Saúde, sendo participantes 13 cuidadores familiares com entrevista aberta. **Resultados:** Dos depoimentos, emergiram então as estruturas essenciais que construíram as Unidades de Significados. O modo de ser -aí-cuidador-e-familiar-de-paciente-em-internação-domiciliar é desvelado pelo cuidador familiar lançado na *facticidade* e permanece no modo da *ocupação* ao desempenhar suas atividades. A relação do cuidador-familiar com o Departamento de Internação Domiciliar deixa-se dominar pela *cotidianidade* mostrando-se como ser da *impropriedade* ao se descon siderar como ser de possibilidades. Desvela o ser-no-mundo presente nas relações interpessoais harmoniosas com os profissionais de saúde ao exercer um *cuidado inautêntico*. **Conclusão:** Conhecer os sentidos que os cuidadores familiares atribuem ao seu fazer possibilitará que gestores de saúde e membros da equipe multiprofissional de saúde de internação domiciliar possam repensar as intervenções mais direcionadas de acordo com necessidades singulares de cada paciente e cuidador familiar.

Palavras-chave: Serviços de assistência domiciliar; Enfermagem; Cuidadores; Fenomenologia.

ABSTRACT

The objective was to unveil the meanings of the family caregiver in the experience of home care assistance using qualitative research, based on Martin Heidegger's phenomenology and theoretical-philosophical-methodological reference. The research setting was the residence of families registered at the Department of Home Care Assistance located in Zona da Mata, countryside of Minas Gerais, serving exclusively the public health network of the Unified Health System. The participants were 13 family caregivers with an open interview. Essential structures supporting the Units of Signification emerged from the interviews. The mode of being-there-family-and-caregiver-of-patient-in-home-care-assistance is unveiled by the family caregiver thrown into the *facticity* and remains in the mode of *occupation* while performing the activities. The relationship of the family caregiver with the Department of Home Care Assistance is controlled by everyday lives, showing itself the dimension of impropriety when the being of possibilities is disregarded. It reveals the being-in-the-world found in interpersonal relationships in harmony with health professionals when they practice inauthentic care. Knowing the senses that family caregivers assign to their work would provide health managers and members of the multiprofessional health team in home care assistance an opportunity to rethink about the most appropriate interventions according to specific needs of each patient and family caregiver.

Keywords: Home care services; Nursing; Caregivers; Phenomenology.

NOTA

¹Nurse. Doctor. Professor of the Stricto Sensu Postgraduate Program Master's Degree in Nursing, Faculty of Nursing, Federal University of Juiz de Fora. MG e-mail: annasalimena@terra.com.br. Corresponding author.

²Nurse. Master's student in Stricto Sensu Postgraduate Program Master's Degree in Nursing at the Faculty of Nursing, Federal University of Juiz de Fora. MG e-mail: jujubnjf@yahoo.com.br

³Nurse. Doctor. Professor of the Faculty of Nursing at the Federal University of Juiz de Fora. MG e-mail: luandyjf@yahoo.com.br

⁴Nurse. Doctor. Professor of the Faculty of Nursing at the Federal University of Juiz de Fora. MG e-mail: thaisamorim80@gmail.com



INTRODUCTION

In recent years, significant changes in the demographic, epidemiological, social and cultural aspects have been taking place in our country, leading to increasing longevity, the inversion of the age pyramid, and the chronification of diseases with new and important challenges resulting from population aging⁽¹⁾.

Population aging and the limitations that this can bring to the individual, either by the appearance of chronic non-communicable diseases and their consequences or by cognitive and functional losses in the advancing age, have been demanding home care and changes in the daily lives of many families⁽²⁾.

Actions for better quality of care, for comprehensive care, assurance of continuity of care and high cost of hospital care demonstrate the need for new strategies for health care. Among these, the Home Hospitalization deserves to be highlighted, since its main objectives are early dehospitalization, the reduction of readmissions and a more humanized treatment process⁽³⁾.

The model of hospital-centered health is better adapted to the treatment of diseases with fast resolution, which does not account for the current demand resulting from chronic degenerative diseases. Thus, it is believed that it is necessary to have alternative forms of attention that consider this problem⁽³⁾.

Studies published in the national literature⁽⁴⁾ show that the home can present itself as a potential space for changes in the care process in the sense of completeness, since it favors the widening of the look and deinstitutionalized action, going beyond the specifically technical issues, allowing the clinical practice is reinvented and recognizing the person in his multiple relationships.

People receive what the system considers best, but without glimpsing what is most meaningful to the individual. Thus, it is necessary to evaluate, detect the difficulties and deficiencies of health programs implemented, to carry out effective and directed questions with a focus on what can be improved, aiming to provide more resources in the right direction for the correction of failures or to serve as a model for the creation of new programs within the health system.

Home care enhances the recovery of the doctrinal principles of the Unified Health System (SUS) (integrality, universality and equity) and must be assumed as a person-centered practice as a co-responsible person in the health-disease process⁽⁵⁾. In this context, home hospitalization emerges as a modality of care to meet the current needs of permanent care, both in terminal patients and chronic patients, avoiding unnecessary hospitalizations⁽⁶⁾.

Home care is a generic term that represents several health care modalities developed at home: home visit, care and home stay. Portaria n° 2.527 brings important

elements such as Modality of Attention Substitutive or Complementary; Health promotion, prevention, treatment and rehabilitation actions; Continuity of care; Integration to Health Care Networks⁽⁷⁾.

It is worth mentioning that one of the central axes of Home Care (AD) is “dehospitalization” in order to provide speed in the process of hospital discharge with continued care at home; to minimize clinical interurrences from the systematic care maintenance of the home care teams; to reduce the risks of hospital infections for a long time of patients in the hospital environment, especially the elderly; provide needed emotional support to severely or terminally ill and family members; to institute the role of the caregiver who can be a relative, a neighbor or any person with an emotional attachment to the patient and who is responsible for the care of health professionals and proposes autonomy for the patient in care outside the hospital⁽⁵⁾.

It should be noted Law 8080 that included through the Law 10.424/2002 the Subsystem of Attention and Home Hospitalization. This mode of care can only be performed by medical indication with express agreement of the patient and his/her family. Home care can not be imposed, since the context of family relationships is always more dynamic than the actions developed by the professionals compromising the therapeutic efficacy proposed. It is recommended that every family is aware of the process of caring for the person assisted by committing themselves to the team in carrying out the activities to be carried out⁽⁵⁾.

The AD care process is directly linked to aspects related to the family structure, the home infrastructure and the structure offered by the services for this assistance. Thus, it can be said that AD does not only represent a continuity of the hospital care procedure in the wide aspect of human health coverage.

Caring for health is an activity that requires knowledge, requires skills and abilities, and the family caregiver needs to adapt and coexist with changes in the life of patients who are hospitalized at home⁽⁸⁾. The person who provides the care directly in a continuous and / or regular manner may or may not be someone in the family. It should be guided by the health team in the procedures to be performed daily in the home, being the attributions agreed between team, family and caregiver thus democratizing, knowledge and responsibility⁽⁵⁾.

The caregiver figure usually arises from family relationships almost always weakened by the presence of the disease and requires great arrangements in the intrafamilial organization and dynamics to correspond to the needs of the dependent person⁽⁹⁾. The task of caring is complex, permeated by diverse and contradictory feelings, and often given to individuals who are not prepared

for such action⁽⁵⁾. Limitations of knowledge, emotional involvement and performance of new roles in the home context are frequent difficulties experienced by caregivers⁽¹⁰⁾.

Caregiver, most of the time, is neither planned nor chosen and the way it evolves depends on the characteristic of the illness, the abilities of the caregiver and the position of the caregiver within the family. Generally the form of family care follows a configuration prior to the onset of illness or the availability of people to care for. It is emphasized that not all people have a family relationship strengthened by affection, so that caring can be revealed as an obligation, and regardless of the degree of kinship, this function can be seen as a designation that has been established throughout the life⁽¹¹⁾.

Listening to caregivers, valuing their way of caring, understanding the meanings of this activity and understanding how care is performed makes it necessary for caregivers to carry out interventions in a comprehensive way⁽¹²⁾.

The caregiver has physical, emotional and socio-economic overload which can contribute to the appearance or aggravation of diseases. Thus, the overload generated by the caring process, besides presenting a multidimensional concept, suffers the diversity of influences associated with the patient and the caregiver himself⁽¹³⁾. Family caregivers are exposed to high levels of fatigue and depression so health care providers need to be aware of the potential impact of caregiving to assess caregiver needs⁽¹⁴⁾.

It is essential to diagnose the needs of caregivers when thinking about the integral care of the family caregiver, which also requires taking into account that, in identifying them, there are some difficulties to be faced such as the recognition of veiled needs, the variability of needs along the care process, related to the task of care and related to the care of self.

Caregivers have needs related to the task of care, which requires the caregiver to plan as their routine is altered as needs related to self care, since the time required for care causes reduction of leisure, family and the friends beyond affect the private life. Therefore, they should be encouraged to express the impact and challenges they face when playing the role of carer⁽¹⁴⁾.

In the last two decades, the nursing team has undergone important transformations in their day-to-day care with the insertion of the family in the caring process in order to perceive care not only the client but the client-family, bringing to the fore the need for new instruments to take care of these new characteristics of care practice and the demand for a better quality of care, through integral and continuous care, strengthening anti-hegemonic practices and the formation of new strate-

gies for health care.

Nurses play an important role in the provision of care when the family caregiver demonstrates a lack of knowledge that may compromise the care of the dependent family member⁽¹⁵⁾. Communication is imperative in care, a valuable resource in the practice of nursing which, if properly applied, contributes to a true relationship, in which nurses provide caregivers and patients with support, comfort, information and feelings of trust and self-esteem⁽¹⁶⁾.

In this context, it is important to emphasize the importance of the nurse's role in health education actions, and it is essential that there be a partnership among professionals from different areas of knowledge, in which complementarity of care occurs⁽¹⁷⁾. The nurse as part of the health team can offer caregivers subsidies for the instrumentalization of care and guide their adaptation in the home context⁽¹⁸⁾.

In this sense, home care was taken as the object of study, and as a guiding question as is the family caregiver's experience in home hospitalization, with the purpose of unveiling meanings and meanings of the family caregiver in the experience of home hospitalization.

METHOD

An exploratory study of a qualitative nature based on the theoretical, philosophical and methodological framework of Martin Heidegger, in which human subjectivity was sought, especially the ontological dimension⁽¹⁹⁾. Thus, the movement towards the meaning of the experience attributed by the family caregivers during hospitalization was carried out.

The scenario of this study was the residences of families enrolled in the Department of Home Care (DID) of the city of Juiz de Fora, Minas Gerais, and that exclusively serves the Public Health Network, the Unified Health System (SUS).

The study participants were composed of thirteen non-professional family caregivers. The inclusion criteria were domiciles registered in the Department of Home Care (DID), with family caregivers older than 18 years. We took into account the concept of family that allowed to encompass the greatest possible number of variations found in practice as ties of consanguinity, kinship or mating, only living in the same house, necessarily having an emotional bond, compromised, identifying each other and in the group to which they belong⁽²⁰⁾. Family caregivers under the age of 18 years and caregivers without psycho-emotional conditions were excluded to give testimony.

We used the records of the patients enrolled in the DID in order to collect information regarding the address and telephone number for later contact and scheduling

the interviews according to the availability of the family caregivers. The closure of the meetings was delimited when the content of the statements did not point out new information and those obtained had relevance to investigate the object and to meet the proposed objectives. The criterion of rigor that is imposed in conducting the interview as a technique of data production in this approach is the phenomenological attitude that consists in respecting the singularity of being, its historicity and experiences, availability for the phenomenological time lived in the encounter and the revived in its memories, aroused feelings and behaviors.

The meetings were scheduled with families in their residences according to their availability, using the open interview technique. The interviews were individually collected in an environment where privacy was sought, from October 2015 to March 2016. The testimonies were recorded in a digital recorder and later transcribed. The following guiding questions were used for the interview: How is it for you to take care of your family member at home? Have you received any guidance to experience this moment? How is your relationship with the professionals who provide Home Care?

The analysis was based on Heidegger's⁽¹⁹⁾ phenomenological framework, after attentive readings to highlight the essential structures and subsequent construction of the Units of Meaning that expressed the life of the caregiver of these families.

The research project was sent to Plataforma Brasil CAAE 49451515.0.0000.5147 for evaluation by the Committee of Ethics in Research with Human Beings of the Federal University of Juiz de Fora. The survey was started after approval on October 1, 2015 under opinion nº 1,254,415/2015.

RESULTS

Age ranged from 25 to 74 years. Of the thirteen family caregivers interviewed, 4 are single, 3 are divorced and 6 are married. Of the degree of kinship with the patient, 2 are grandchildren, 1 nephew, 2 wives, 7 daughters and 1 child. Caregivers' years of schooling ranged from higher to incomplete primary education. Of the 13 family caregivers, only 2 had professional activities, the rest being retired or unemployed. The years of inclusion in the program ranged from 1 to 10 years.

Through the gestures, the smile and the eyes of the interviewees we sought to access the experience establishing from the first contact a relationship based on empathy through the reduction of assumptions. The meeting allowed an opening to listening going beyond the apparent to reach the expression of meanings. Thus, family caregivers faced with hospitalization meant that: They received care instructions and guidelines; Have a

good relationship and even friendship with the team; It is difficult to deal with everything, have to have courage and patience, have moments of sadness, revolt and desire to disappear. Lacks family support and needs medicine and psychologist to put up with.

They receive care instructions and guidelines

The deponents revealed that they received instructions and care guidelines from the in-home care staff, seeing things and learning from them. They described how they receive attention during the visits, that the professionals arrive and are in no hurry to leave, that they receive some materials for the accomplishment of the dressings. They evaluate the evolution of the wounds together with the team, as expressed in the cuts:

"The attending physician came, several nurses, and they explained step by step what would have to be done with him. What procedures would we have to take." (E1)

"The DID people came in the first few days, gave the information to turn around, move their legs. Care of glove, be careful not to let go because if you let go you have to run with her to the hospital." (E4)

"There is a lot of guidance from the DID staff, the medical staff, the nurses look and explain. Anything different they send the medicine to me, it brings healing. They help." (E5)

"When the team came to come here I went to see things and learning how to do a right dressing, food, nutritionists helped me and I was learning. The directions I had from the nurse to turning up in bed was very good. From the sheet not folded to not hurt." (E6)

"We learned what we did not know. He had never seen an eschar in his life, he did not know how to take care of it, he was losing his fear. Came the DID guided, the Nurse came guiding, debriding, spoke in the highest goodwill, guides the use of ointments. Call them and they'll guide you around!" (E8)

"They give me a lot of support when he gets sick. A wound that infected I called the doctor, she came, explained straight that can not put ointment that the ointment erodes. Every time I call them they come." (E9)

"I contacted the DID that came and gave instructions, showed me how it was, position to turn, to get out of bed. And the DID guided me so well in the wound, it helped me a lot. Vinha would put her hand in the dough, do the dressing, teach me a lot ... the side that had to turn every 3 hours at least." (E10)

"Although they can not do the dressing every day, the doctor looks at the dressing and talks you will do so, she made one for me to see how it does. And if I had not learned, I believe she would have done two, three, until I learned." (E11)

Have a good relationship and even friendship with the team

They reported having a good relationship and even friendship with the team and presented as meaning of this relationship: kind, caring, friendship, affection and team. They emphasize that home hospitalization was one of the best things that could have happened and that, if they did not have this kind of assistance, their families would be hospitalized for many of the times, but when they became caregivers, their lives changed, they had difficulties and most of the time they do not receive support and help from family members. They spoke of the need to have to adapt to the new routine of care as perceived in their lines:

"She always had a good relationship with them, every time I stayed at home and saw them coming, they treated her very well, they helped." (E1)

"We treat them very well and they too, thank God. They are welcome as they do good to help us." (E2)

"Good, they are very kind, caring people, not in a hurry to leave." (E3)

"We ended up forming a real friendship." (E4)

"Below God, they who are giving assistance to us." (E5)

"I have a good relationship with all of them. End up making friendship." (E6)

"They are very good, we even create a friendship. We even create a link. The mother makes coffee for them and everything to be able to please, because they have good will. Neither in the hospital we were so well attended." (E8)

"Very good, they are very polite, they all have a lot of affection with me, they are kind people." (E9)

"All very good. It's a very good program, lots of assistance, I like them too much." (E10)

"I was not waiting, my intention was to ask the hospital bed there came this gift together and they are good people, very attentive." (E12)

"I have a good relationship with them, but I also argue. What I think is not good, I wonder. I realize that I have a good relationship with the DID nurses, I form a team with them. Who really helps is nursing." (E13)

It is difficult to handle everything and lack family support

In the cuts of the testimonies it is observed that in relation to the care, there are at the same time feelings of love, sacrifice, courage, patience, dedication, surrender and privation. They highlighted some of the difficulties encountered by the caregiver that involves the need to change their lives, start to live the life of the patient during hospitalization at home.

The emotional and financial part is compromised by having to quit their jobs and, most of the time, only with

the source of income of the patients in home hospitalization. They explained the need for the program to look beyond the need for medical care, and to prioritize the needs of the family as a whole.

They recognized that they needed help in coping with the difficulties of being a caregiver and meant that such help would be through referral to psychologists, but in most cases they were not able to get through the door that should be in the system. primary care units and that the home care program does not offer psychologist assistance to patients or caregivers. Those who have resources resort to private help with professionals who charge a symbolic value, and those who do not have the possibility of help and assistance are left without receiving this care.

"On the first day I started to feel sick but then I went to see how he (a nurse) did. I've been taking care of it and it's going to be okay. He's too heavy to turn, there's no one day to help him sit down. I sit him alone, but it's difficult. Now I'm taking a strong 150mg serraline drug so it's already a tranquilizer. Then you can deal with the situation. If you need a friendly word, a person who talks ... because sometimes you have everything in your head, then you do not." (E05)

"Dealing with people in bed is sacrifice, it depends on you for everything, to brush a tooth, it's up to you to change, to wash, to wash dirty clothes. You have to have a lot of courage and love, because if you do not you do not do it then it's very difficult." (E6)

"It's very difficult because you have to have a lot of care, patience and the dedication of people's lives. I can not work today, and his salary is not giving. Sincerely (tears) there is a day that makes you want to disappear, drop everything because the situation becomes more difficult every day. My attention to him is 24 hours. The doctor was explicit with me, who could not give me referral, prescribed an antidepressant remedy." (E07)

"I am sad, there is the prejudice, the neglect within the family that left me, the uncles, the false friends. Christmas, New Year, three of us alone, it hurts us a lot." (E9)

"I had moments of revulsion, to think so-and-so could have done, my sister could have done. Today I am not like that anymore, I do what I can, what is within my reach. Love does not charge, I just have to thank God, ask for strength because it is not easy. We are human beings, we are wrong (tears) ... It is not easy ... (tears)." (E10)

"It is difficult to see her mother in a debilitated, dependent situation. The DID sent me a referral to the psychologist, who paid after making an evaluation, a symbolic value. Thank God I was able to improve a lot, accept this situation. (Tears) ... is difficult Today my experience is this, I live nowadays both by my psychologist, by the team that we know that is supported." (E11)

“The big problem of the caregiver is that he has to deal with the disease, deal with the surroundings, deal with money. You take responsibility for caring and you have the financial side, you stop working and I never liked being a housewife. Before, I worked, studied, took a course all of a sudden, inside a house, with a child, living my mother’s life. You become a family collector, it’s not easy ... cling to the faith, after a few years everyone goes to therapy. I had a very strong depression. I gathered my brothers, it was he who helped me. I went to the psychologist and psychiatrist and I got up.”(E13)

The deponents revealed that they received instructions and care guidelines from the in-home care staff, seeing things and learning from them. They described how they receive attention during the visits, that the professionals arrive and are in no hurry to leave, that they receive some materials for the accomplishment of the dressings. They evaluate the evolution of wounds together with the team.

They reported having a good relationship and even friendship with the team and presented as meaning of this relationship: kind, caring, friendship, affection and team. They emphasize that home hospitalization was one of the best things that could have happened and that if they did not have this type of care they would have their families hospitalized for many of the times, but that when they became caregivers their lives changed, they went through difficulties and in most sometimes they do not receive support and help from family members. They spoke of the need to have to adapt to the new routine of care.

In regard to care there are at the same time feelings of love, sacrifice, courage, patience, dedication, surrender and deprivation. They highlighted some of the difficulties encountered by the caregiver that involves the need to change their lives, start to live the life of the patient during hospitalization at home.

The emotional and financial part is compromised by having to quit their jobs and, most of the time, only with the source of income of the patients in home hospitalization. They explained the need for the program to look beyond the need for medical care and to prioritize the needs of the family as a whole.

In this first moment, the senses remain veiled and to reach the interpretation of the understood meanings it becomes essential to conquer a guiding thread through the intersection of the units of meaning that results in the concept of being and leads to the second methodical moment, the interpretative or hermeneutics. It seeks to understand the meanings the possibility of unveiling the senses of the being-there-caregiver-family in the face of home hospitalization.

DISCUSSION

Like this study based on the theoretical/methodological/philosophical reference of Heidegger ⁽¹⁹⁾ the whole discussion will be developed following the methodology proposed by the thought of this philosopher. Therefore, after the first methodical moment, vague and medium comprehension, it was possible to point out the meanings expressed by being-care-and-family-of-patient-in-home-hospitalization, evidencing the understanding of what they showed the facts and in the second moment, in the interpretative understanding, to unveil the veiled meaning in these family caregivers.

Thus, the concept of being that emerges from the experience of family caregivers in face of home hospitalization indicates a daily life in which they receive care instructions and guidelines; have a good relationship and even friendship with the team; it is difficult to deal with everything, it has to have courage and patience, it has moments of sadness, revolt and desire to disappear; lack of family support and needs medicine and psychologist to endure. Thus, the concept begins to express the movement that is the movement of being-there-care-and-family-of-patient-in-home-hospitalization, announcing possibilities to singular modes of being in the daily life, starting from the entity that was expressed, endowed with an ontic/ontological movement, from the interpretative understanding.

Participants, upon revealing that they receive care instructions and guidelines, show themselves in the facticity of being a family caregiver. In facticity they have the existential which is the cure, which is to be-cared for with and with the other. This facticity was not chosen by them, it happened, it was determined, and therefore they become being-in-the-world-of-care-of-the-family.

In the public world, the Department of Homecare (DID), which is approaching by facticity, becomes also the surrounding world, which is the family member who is sick; which is what surrounds this familiar caregiver of the caregiver’s own world.

These approximations between the public and the surrounding world, in this world, itself establishes significant relationships that occur from the occupation with the patient, both for the relative and for the DID and not from the being. They are in a relation of occupation that Heidegger calls preoccupation of the occupations (instruments, utensils, techniques, procedures). Relationships are not from being, but from the condition of illness and from the need of the family caregiver to qualify. It was thus revealed that the caretaker-family remains in the mode of occupation while performing its activities.

The being-there-caregiver-and-family is veiled (the caregiver that needs to be empowered and the patient entity that needs to be assisted by the DID). In this man-

uality (occupation) he is together (together with the procedures) and shows himself as being-to-care.

In this facticity, the family caregiver enters into relationship with the DID and in this relation of being-there-with it is revealed that in the life of the carer-family-being it is allowed to dominate by the daily life, showing itself as being of the impropriety to the disregard as being of possibilities..

The meaning of the talk is revealed in the reproduction of the technical language that is not the caregiver, but the health professionals when they reproduce the given guidelines. Thus, they are in the middle understanding that is dominated by the talk. They only repeat in the speeches what is said by everyone and for all, not showing new conceptual interpretations.

Ambiguity is revealed when family caregivers of patients in home care think they understood the breadth of care to the family member when they did not do so, meaning that they find it difficult to care for. They think they did not understand, when deep down they have done so much that they continue to care according to the instructions and guidelines transmitted by the DID.

The curiosity is revealed when the family caregivers occupy themselves in seeing and not in understanding what was being seen. Thus, they de-fell into the world (which is driven by talk, ambiguity and curiosity). The being-caregiver-and-family of a patient in home hospitalization is shown in an impersonal and inauthentic way, being in the manner of all the impropriety mode here unveiled for a comfort in daily life.

They revealed that it is difficult to deal with everything (lack of support from the family), but they still do, they have no alternative, being in some experiences in the decadence linked to the presence and to be launched. Sometimes the health team also, in the impropriety of everyday life, has an improper understanding of the limit of care of this caregiver.

In being-with-others, they have a good relationship with the professionals of the hospitalization health team. Being-in-the-world is present in interpersonal relationships that are harmonious when the deponents reveal closeness and the building of bonds.

Health professionals showed an inauthentic care towards caregivers, remaining in the mode of occupation, not committing themselves to being-with the caregivers in a mode of dis- position, going beyond the technical care.

Caregivers have revealed that they have a difficult routine having to adapt to life with limitations and deprivation. Being-in-itself care is deficient, because when caring for patients who are hospitalized at home, they are busy and do not have time to care for themselves. They perceive themselves taking care of the hospitalized relatives more than of themselves.

Being-there-with is understood in a relationship of

professional nursing care with being cared for. As being-in-the-world, the being-there-caregiver-and-family-of-home-in-home-patients feels limited, leaves their choices, their desires, dreams and their dependency on the patient.

They expressed feeling overwhelmed because they do not have with whom to divide the innumerable activities, they do not receive support from the family members, occurring more and more the decrease of the social life of the caregiver due to the assumed function that is always dependent on being-care.

The caregiver of patients hospitalized at home revealed that they need medicine and psychological care to be able to cope. When the deponents reveal that they go to the nearest place of their homes to ask for help, to ask the doctor to give him a medicine to “help withstand” and thus to free himself from anguish, from suffering, they are thrown into the facticity of being a caregiver-and-family-of-patient in a home stay.

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FINAL CONSIDERATIONS

By unveiling the senses of the caregiver-and-family being in the experience of home hospitalization, it is expected that this study will contribute to an understanding of the daily life of these caregivers and to a better implementation of the Home Care Programs. We sought to enter into the existential dimension considering that qualified care is an essential condition of effective service delivery and consequently the execution of a health program with higher quality.

It is announced as urgent the inclusion of professionals as psychologists as new members of the multiprofessional health team to assist family caregivers of patients hospitalized at home with the beginning of a Health Program that perceives and values the singularities and needs of each individual -caring by valuing them as being-unique and at the same time as a whole and respectively with their different needs. It is important that caregivers do not feel alone in the caring process because they are essential as sources of support for the patient and information for the health team.

Therefore, it is worth highlighting the need for other studies in other scenarios to deepen the theme, as well as discussions that may help the planning of care practices focused on home care, above all, regarding the family relations existing in this process..

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