



LECTURE

Post-discharge care preparation begins in day one of admission

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Abstract

Cerebrovascular disorders are the main cause of functional disability in people, and an exponential increase of people with disability in the next few years is foreseeable.

The Portuguese General Directorate of Health recommends that in an intervention in a patient with stroke there are four preponderant factors: the severity of the stroke, early and intensive rehabilitation, the expectations of rehabilitation on the part of the patient/family and the family support. It is regarding three of these factors that the Neurology nursing team advocates an efficient and effective intervention where family involvement is indispensable to achieve care objectives. This involvement can have several moments: initial evaluation, complementary evaluation, intervention and resolution.

In the initial evaluation, the following is carried out: collection of general information about the patient and the family, presentation of the service and a direct telephone contact is provided aiming to create confidence and show availability.

In the complementary evaluation, we intend to understand the perception the family has about the clinical state, the future family changes related to the disease process, the features of the family core and identification of strengths and weaknesses. At this stage, we also explain what the patient and the family can expect from nurses and nursing care. We propose that the family accompanies the patient in an extended period of visit with the objective of minimizing the impact of the disease and allowing a partnership of care.

In the following phase, we discuss the intervention plan during and after the hospitalization, planning a house visit and aid in the request of support products with the objective of promoting greater autonomy of the patient and reducing the burden of the caregiver. The possibilities for continuity of care are also discussed. We prefer that the final destination is the patient's home, who can, however, first be discharged to another service/institution or integrated into the National Integrated Care Network.

The resolution phase arises as an evaluation of the structured education that was given to the patient and or/caregivers throughout the process (life activities, anticoagulation, modifiable risk factors, among others), trying to understand the indicators of mastery.

After hospital discharge, the patient/family stays in contact with us whenever doubts or anxiety arise. When there is worsening of the clinical state or the need for further diagnostic investigation, the patient may have direct admission in the service.

We think it is an effective and rewarding intervention for everyone involved in the process by increasing professional satisfaction and decreasing the impact of the disease by transmitting security and trust in care and contributing to a safe continuity of care.

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