

The family living the child recovery process after hospital discharge

A família vivenciando o processo de recuperação da criança pós-alta hospitalar
La familia que vive el proceso de recuperación de niños después del alta hospitalaria

Júlia Peres Pinto¹, Myriam Aparecida Mandetta¹, Circéa Amalia Ribeiro¹

¹ Universidade Federal de São Paulo, Paulista Nursing School,
Postgraduate Program in Health Sciences. São Paulo, São Paulo, Brazil.

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ABSTRACT

Objective: to understand the meaning attributed by the family to its experience in the recovery process of a child affected by an acute disease after discharge, and to develop a theoretical model of this experience. Symbolic interactionism was adopted as a theoretical reference, and grounded theory was adopted as a methodological reference. **Method:** data were collected through interviews and participant observation with 11 families, totaling 15 interviews. A theoretical model consisting of two interactive phenomena was formulated from the analysis: *Mobilizing to restore functional balance* and *Suffering from the possibility of a child's readmission*. **Results:** the family remains alert to identify early changes in the child's health, in an attempt to avoid rehospitalization. **Conclusion:** the effects of the disease and hospitalization continue to manifest in family functioning, causing suffering even after the child's discharge and recovery.

Key words: Family; Child; Convalescence; Nursing; Patient Discharge.

RESUMO

Objetivo: compreender o significado atribuído pela família à sua vivência no processo de recuperação da criança acometida por doença aguda, após a alta hospitalar e elaborar um modelo teórico a respeito dessa experiência. O Interacionismo Simbólico foi adotado como referencial teórico e a Grounded Theory como metodológico. **Método:** os dados foram coletados por meio de entrevista e observação participante com 11 famílias, totalizando 15 entrevistas. A análise levou à formulação de um Modelo Teórico composto por dois fenômenos interativos: *Mobilizando-se para resgatar o equilíbrio de seu funcionamento* e *Sofrendo com a possibilidade de reintegrar a criança*. **Resultados:** estes revelaram que a família mantém-se em alerta para identificar precocemente alterações de saúde da criança na tentativa de evitar uma reinternação. **Conclusão:** os efeitos da doença e hospitalização continuam a manifestar-se no funcionamento familiar, gerando sofrimento mesmo após a alta e a recuperação da criança.

Descritores: Família; Criança; Convalescença; Enfermagem; Alta do Paciente.

RESUMEN

Objetivo: comprender el significado atribuido por la familia de su experiencia en la recuperación de los niños afectados por el proceso de la enfermedad aguda, después de la descarga y desarrollar un modelo teórico sobre la experiencia. El Interaccionismo Simbólico fue adoptado como un teórico y la Teoría Fundamentada como metodológico. **Método:** los datos fueron recolectados a través de entrevistas y observación participante con 11 familias, con un total de 15 entrevistas. El análisis dio lugar a la formulación de un modelo teórico consta de dos fenómenos interactivos: *Mobilización para restaurar el balance de su funcionamiento* y *Sufriendo con la posibilidad de reinternar el niño*. **Resultados:** éstos revelaron que la familias e mantiene en alerta para la identificación temprana de la salud el niño en un intento de evitar un reingreso. **Conclusión:** Los efectos de la enfermedad y la hospitalización aún se manifiesta en el funcionamiento familiar, que produce sufrimiento, incluso después de la descarga y la recuperación del niño.

Palabras clave: Familia; Niño; Convalecencia; Enfermería; Alta del Paciente.

CORRESPONDING AUTHOR Julia Peres Pinto E-mail: rj.sampaio@gmail.com

INTRODUCTION

In recent decades, early hospital discharge has been a consolidated trend around the world, on the grounds of decreased hospital costs, technological advances in the health care field, and hospitalization-related risks. In pediatrics, early hospital discharge is also supported, given the argument that reducing the length of stay minimizes the harmful effects of child separation from his/her family⁽¹⁾.

Nevertheless, children remain vulnerable after hospital discharge⁽²⁻³⁾, requiring follow-up health care interventions to ensure comprehensive care⁽²⁾. A systematic review showed that the risk of morbidity and mortality of these children is significant in developing countries during the months following hospital discharge⁽³⁾.

The convalescing child returns home and his/her family should continue participating in the care scenario, since the continuity of care and recovery become their responsibility⁽¹⁾. In this context, the family must be understood as a constant unit of child care, and also a focus of professional care in all health care levels, as proposed by the Family-Centered Care model⁽⁴⁻⁵⁾.

There is also evidence that hospital discharge does not determine the end of the family's experience of child hospitalization, even when the disease is curable⁽⁶⁾. In the family unit, there are consequences to family functioning after discharge, such as impairment of family cohesion, reduced ability to make changes⁽⁷⁾, and alterations in routine because of the new child's needs⁽⁸⁾.

At the individual level, there are reports of physiological and behavioral changes, both in the child and the parents, such as eating disorders, apathy, aggressiveness, separation anxiety and insomnia⁽⁸⁻⁹⁾.

When parents do not feel safe taking care of their child, or confident about his/her recovery, they become anxious about decreased hospital stay and early discharge⁽⁷⁾. Parents' perception regarding their child's health at discharge has been associated with the risk of a subsequent unplanned readmission⁽¹⁰⁾. A sense of isolation is mentioned by parents who express the need for follow-up after child discharge⁽¹¹⁾.

These studies expand understanding of this theme, but they do not explain the family's interaction with hospitalization, an event marked by suffering and functional disruption⁽¹²⁾, which causes the family to modify its relationship, assign new meanings to the child's illness, and redefine its needs and plans after discharge. In addition, the family experience after child discharge has been investigated in studies focusing on children with chronic diseases, leaving a knowledge gap when the cause of hospitalization is an acute illness with a curative perspective⁽⁶⁾.

In Brazil, although there is a movement in defense of a family-centered care approach, disease-focused treatment and care remains incipient in hospital practices⁽⁴⁻⁵⁾. Nurses themselves recognize that there are limitations in their follow-up performance after discharge, evidencing a weakness in comprehensive care when the child returns home⁽²⁾. In this sense, they compromise family-centered care, which aims to promote family well-being and restore its control⁽⁴⁾.

In view of the Brazilian care culture and the currently proposed structuring of health care services with a focus on

family health, we question the nature of the family experience after child discharge, outlining a study with the following *objectives*: to understand the meaning attributed by the family to its experience in the post-discharge recovery process of a child affected by an acute disease with a good prognosis, and to develop a theoretical model of this family experience.

METHOD

This qualitative study used *symbolic interactionism* as a theoretical reference and *Grounded Theory* as a methodological reference. Symbolic interactionism is a reference for the analysis of human interactions that focus on the nature of the interaction and the dynamics of social activities that occur between people⁽¹³⁾. Grounded theory is a method to investigate basic social processes, proposing a theory that explains human interactions in the social scenario⁽¹⁴⁻¹⁶⁾.

Eleven families met the inclusion criterion and participated in the study. The inclusion criterion was having experienced an unexpected hospitalization of a child due to an acute illness which held the potential for recovery; all members were invited to participate in the interview. All family members that agreed to participate were older than 18 years and signed the Terms of Free and Informed Consent, after research project approval was received from the Ethics Committee of the Federal University of São Paulo, Process No. 0005/07.

A family can be studied based on data obtained from a single member, so long as the researcher articulates the individual to the family unit conceptually and analytically⁽¹⁷⁾. Therefore, 15 members were interviewed - eleven mothers, three fathers and one brother - in individual meetings or in collective interviews with up to three members, according to the family choice, marked in the text as F1-M (family 1, interview with the mother), F1-F (family 1, interview with the father), F1-B (Family 1, interview with brother), continuing to F11.

Data collection was performed using unstructured interviews and participant observation, from January of 2008 to July of 2009. Interviews were recorded, and lasted 40 to 90 minutes. They were preceded by the development of a genogram and eco-map⁽¹⁸⁾ which helped with conducting the interviews, which began with the guiding question: "*How is your family experiencing the recovery process of the child (child's name) after hospital discharge?*"

Because the families were not in an institution, the interviews were performed in locations based on their preferences: four at their homes; four in the children's daycare centers; and, three at the mothers' workplaces.

The number of participating families was determined by theoretical sampling, a process through which the researcher collects, analyzes and encodes data, deciding which will be collected next and where to find them, seeking to generate the theory. This dynamic process is finished when theoretical saturation is reached, namely, when no more data are needed for the development of new categories or theoretical insights. The goal is to point to events that indicate categories and not people, because the interest is to collect data on what people do in terms of action-interaction⁽¹⁵⁾.

Box 1 - Family and child characteristics at the time of interview

Sample Group	Family composition	Age of child when hospitalized	Previous experience of hospitalization	Hospital type	Reason for hospitalization	Participant's relationship with the child	Time since discharge
1 st	Father, Mother, 1 child	14 months	No	Private	Urinary tract infection	Mother	10 months
	Father, Mother, 1 child	5 months	No	Private	Bronchiolitis	Mother	4 months
2 nd	Father, Mother, twins	9 months	No	Public	Bronchiolitis	Mother and Father	1 month
	Father, Mother, 3 children	36 months	Yes	Public	Bronchospasm	Mother	2 months
	Father, Mother, 2 children	11 months	No	Public	Bronchiolitis	Mother	2 months
	Father, Mother, 3 children	19 months	Yes	Private	Varicella	Mother	3 months
3 rd	Father, Mother, 1 child	5 months	Yes	Private	Bronchiolitis	Mother and Father	2 months
	Father, Mother, 2 children	17 months	Yes	Private	Vomiting and diarrhea	Mother	3 months
4 th	Father, Mother, 4 children	14 months	No	Public	Meningitis	Mother	10 years
	Father, Mother, 3 children	5 years	No	Private	Hives	Mother, Father and Brother	12 years
	Mother, 2 children	9 years	Yes	Public	Vomiting and Petechiae	Mother	5 years

Thus, during the analysis process, the emerging concepts generated hypotheses and questions that originated four sample groups^(15,19), shown in Box 1, with the family characteristics.

According to the assumptions of grounded theory, the choice of the two families that comprised the *first sample group* exclusively met the inclusion criteria. Data analysis revealed that, after child discharge, they felt overwhelmed and alone, even with extended family support and the private health care system. These data led to the questioning and exploring of the following hypothesis: *What is the experience of families who depend on the public service and have another kind of composition?*, which led to the *second sample group* of three families who used the public health care system.

Data analysis suggested that *interaction with more than one hospital could change the meaning attributed by the family to the experience of the child's recovery process*, a hypothesis that led to the configuration of the third sample group, consisting of three families who experienced more than one hospitalization of their members. The *fourth sample group*, consisting of three families with children who were hospitalized a minimum of five years prior to interview, was formulated based on the following hypothesis: *Can one hospitalization interaction permeate the family trajectory for a long time, even when the hospitalized child has fully recovered?*

Data were analyzed after literal transcription of each interview and concurrent research observations, following the grounded theory steps⁽¹⁵⁾: substantive coding, which includes open coding and selective coding; theoretical coding; identification of the central category, which includes all the other categories; and, formulation of a theoretical model that is representative of the experience.

Open coding is the stage of the analytical process when data obtained from interviews and observations are examined line by line, and cut into units of analysis, giving rise to the codes that were developed as data were grouped into categories by

similarity of meaning. Selective coding started when the central category began to emerge, which enabled grouping of all the theoretical elements and defining the explanation of the behavioral pattern, according to the differences found in experience. In theoretical coding, substantive codes were integrated until the central category was identified, which enabled weaving of the fragmented story and evaluating whether theoretical saturation had been reached, therefore ceasing data collection⁽¹⁵⁾.

A theoretical model was formulated to represent the meaning attributed by the family to its experience in the recovery process of a post-discharge child affected by an acute disease with a good prognosis, which was validated⁽¹⁴⁾ with four families that experienced the same situation.

RESULTS

The conceptual categories extracted from the comparative data analysis consisted of two interactive phenomena: *Mobilizing to restore functional balance* and *Suffering from the possibility of a child's readmission* the first category reveals how the family struggles to reorganize after the impact of hospitalization, triggering its resources to ensure the child's recovery. The second category expresses the family suffering from the possibility of a disease recurrence that can require a new hospitalization, which even continues along the trajectory a long time after discharge and full recovery of the child. The interaction between the two phenomena led to the identification of the central category and the construction of the theoretical model: **SEEKING PREVENTION OF CHILD REHOSPITALIZATION TO AVOID SUFFERING**, shown in Figure 1.

Next, the conceptual narrative of the theoretical model will be presented, with the categories highlighted in *italics*, illustrated with excerpts from the *empirical data* that was extracted from the statements of the interviewed family members.

After returning home, the family will *Resume control of child care* and interact with the impact of illness and hospitalization.

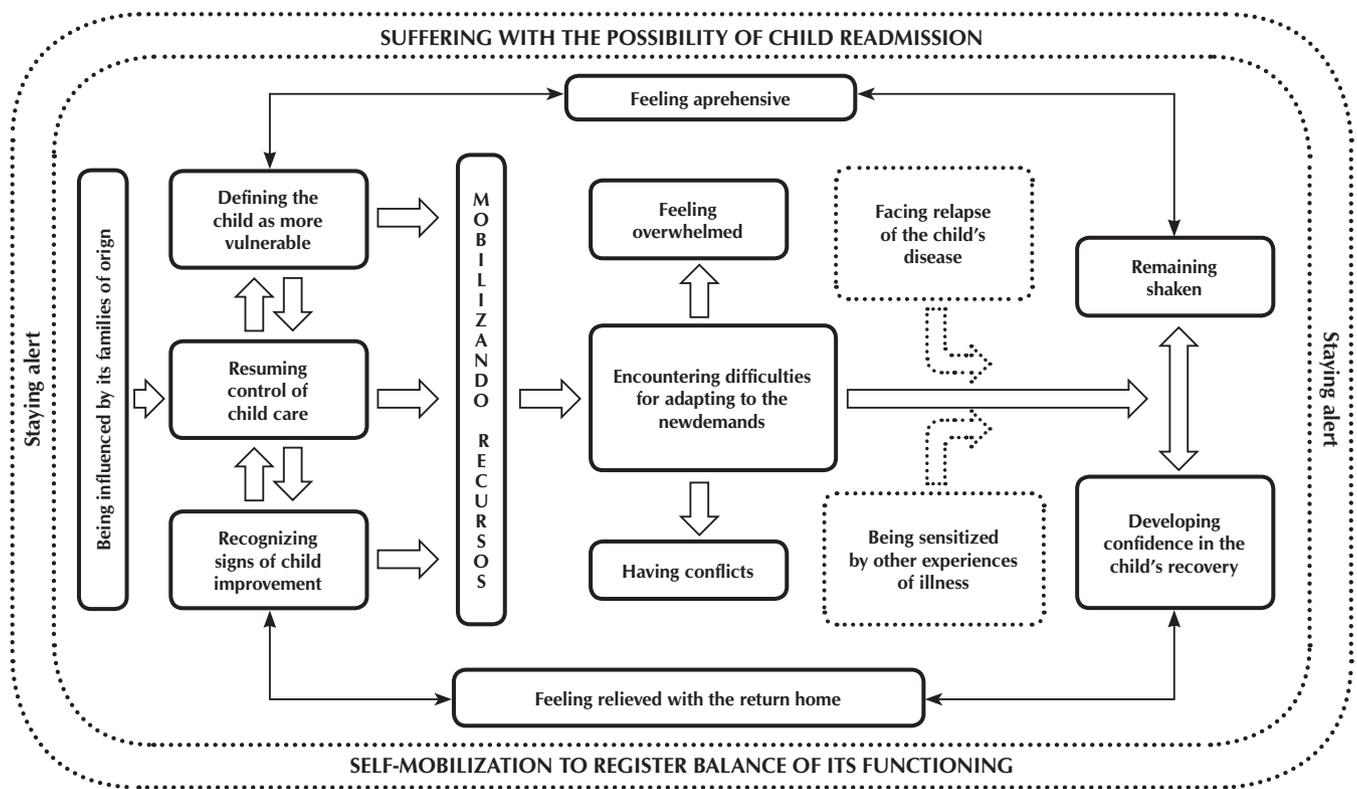


Figure 1 - Theoretical Model "Seeking Prevention of Child Rehospitalization to Avoid Suffering"

Continuing care means prioritizing the child and recognizing that there is an obligation for continuing treatment, taking responsibility and making decisions without the direct support of health care professionals.

During this period, all attention is focused on her. If there is another problem, you end up ignoring it and turn all attention on her [...]. (F2-M)

I give one (medication) at bedtime, another before coming to day care, and when we get home. (F4-M)

However, because the family at home is far from the hospital, they make decisions about child care, *Being influenced by their families of origin*. Through interaction with significant people in their families, they incorporate new child care demands, acting under the influence of the reference group and approaching its cultural context.

[...] my mom tells me not to leave her without socks on even when it's hot, to put on a cap when it's cold so she doesn't get chilled. I also took care of my brothers and I know it! (F5-M)

She (grandmother) advises him (father); we removed the carpet from the home because she told us to. (F7-M)

When resuming its role as the primary child caregiver in their environment, the family becomes more vigilant about the child's health by *Defining the child as more vulnerable*. Therefore, family members act by intensifying child care and believing that the child's safety is under a constant threat of disease and hospitalization.

She (Da) is the most fragile, then comes my mother, my father, "De" and me. (F10-B)

For him (the father), O (convalescent child) is always so fragile. He is actually always afraid. (F6-M)

On the other hand, the constant interaction with the defining attributes of the child's recovery leads the family to direct its actions, demonstrating that family members are *Recognizing the signs of child improvement*, both organic and behavioral. In this sense, in addition to finding that the signs of the disease are regressing, parents also realize that the child is calmer and is playing, which favors the restoration of his balance.

They had no more crisis after they left the hospital. Only the cough was a still little issue. (F3-M)

And you know, I thought he would become frightened, afraid of the doctor, but he gets all excited, and he himself says, let's go to the doctor? He gets all happy! (F4-M)

In addition, the family feels more relaxed to restructure its routine according to the perceived needs in the family environment, realizing that the child is recovering, *Feeling relieved about return home*, because this fact gathers family together again, and parents can rest while resuming their activities.

When I came home (from work), it was a relief (seeing the child at home), I couldn't wait to get home [...]. (F2-M)

After her return, not only she, but also I was really tired, I guess

[...] for two weeks, I slept with her most of the afternoon. She was relaxing, she knew she was at home [...]. (F1-M)

However, the experiences from the disease and the need for hospitalization modify parents' behavior regarding the child's signs of illness, which are perceived as having the potential to result in something more severe, even years later. Thereby, by *Remaining alert*, parents remain ready and vigilant at all times at the slightest sign of child illness, regardless of time since discharge, even though the child is already a teenager. They also start watching the surrounding environment closely to identify unhealthy conditions, acting quickly when they observe illness signs. It is a constant effort to prevent a new hospitalization.

When he has a headache, I jump. I check it, I see about it, I put him to sleep in my bed to this day! (F9-M)

I don't know whether they didn't medicate her, whether they didn't give her medication on time here in day care [...]. Also when I arrived here I saw her standing on the ground. (F5-M)

[...] So when she worsens a little bit, I run to avoid hospitalization. (F2-M)

In addition, when the family realizes that interaction with the disease and child hospitalization changed the behavioral pattern of its members, or when family members interact with signs of the disease, they realize how they continue *Feeling apprehensive*. Fear threatens the balance of family functioning and generates suffering, even after discharge. At first, the family recognizes that there is a possibility of recurrence of the child's disease, and changes in his functioning can be definitive if the physical or mental effects on its members become permanent.

I was already worried and afraid of a new hospitalization. It was very difficult for her, she suffered a lot. (F7-M)

I too am concerned. When she breathes a little deeper, we get scared. (F7-F)

Then, I took him to the doctor and told him the whole pneumonia story and asked for an prescription. I always do this, I am terrified that he might have any lung issue again (after 5 years). (F11-M)

Even years later, and recognizing that the child who is already a teenager and more independent, has recovered from the disease, the family remains concerned. To alleviate its suffering and restore its functional balance, the family seeks to align its actions, mobilizing resources to take care of the child. Although dealing with increased demands, the family counts on internal and external resources to meet them. These resources become new learning and support established between its members, relatives and friends, with work colleagues and other institutions that flex their rules, so that parents have time to devote to their new needs.

When it's time for medication, they (other children) get the medicine for me to give him, they remind me sometimes: Mom, isn't it time to give O's medication? (F6-M)

[...] I had my husband's support, which gave me safety to look after her. (F8-M)

Whenever I need to leave, I leave him with my mother (grandmother). (F4-M)

The possibility of a leave reassures me, I can stay home with them. (F9-M)

However, along the child's recovery process, the family continues *Facing difficulties adjusting to the new demands*, such as those related to: the ability to provide home care for the child, the ability to understand the situation, the ability to provide child care and material and human resources to manage the child's recovery process at home.

[...] Yesterday I brought her to daycare, she (convalescent child) was normal, excited, and then she looks ill?! [...]. The (medication) I found was 50 bucks a box. And they (convalescent twins) have to take four. I said, my God! (F3-M)

It wasn't good to stop working! I earn according to my production, you have to work to earn. (F5-M)

He (father) does not recognize (when his daughter is tired), he looks at me and asks me, he's more trouble than me. (F2-M)

Considering the whole situation, the interaction of each family member with him/herself and the situation can make him/her assign different meanings to the child's disease and hospitalization. The difficulty of putting oneself in another's shoes can misalign actions, accentuating suffering of the family that starts to experience the stage of *Having conflicts* with each other and with the support network.

I argue with him! (F10-M)

She wanted me to get angry. (F10-F)

I wanted him to share, I wish he had the same perception as mine, but he is like this all the time. (F10-M)

He (father) says that day care makes her sick. I don't think that she would have anything if she stayed home. He thinks we should take her out of day care and I should stop working. (F5-M)

Although feeling relieved about returning home, the limited emotional or social resources and the conflicts that arise make the family trajectory permeated by fatigue: *Feeling overwhelmed*. In this context, a difference between the role of women and men in the family should be noted. The mother is the primary caregiver, taking direct care of the child, even if it means postponing the resumption of some of her activities.

It's only the two of us (father and mother) to take care of her. We have no help. (F7-M)

I find a way, I take care of them and the house. I gave the medication and come to day care to give her inhalation treatments (F5-M)

I plan on going back to work, but I don't want to leave (the daughters) unattended with anyone and suffer the consequences. (F3-M)

The meaning attributed to the disease after interacting with hospitalization results in great suffering. Thereby, the difficulties are accentuated when, *Facing relapse of the child's disease*, the family realizes what was feared, the possibility of facing readmission. The interruption of the recovery process triggers a new thought process, redirects its actions, causing the family to mobilize some resources again and modifying its routine

She left the hospital well, but then the chest was getting too congested [...]. I talked to the doctor, she took an Xray and told me to leave her home and gave me a leave. (F5-M)

At the time you are helpless ... You do not know if the child will improve or deteriorate, and when you get a discharge, his daughter gets worse! I was a little shaken that day. (F2-M)

The family defines that the child's readmission must be prevented, triggering its resources to meet its needs. However, family members might act due to *Being touched by other disease experiences*. Thereby, the impact of a previous hospitalization experience is present in the family history, and it may be more relevant than the experience related to the current recovery process.

(Chickenpox) recovery was good, thank God! And he (O), had no (respiratory) crisis (F6-M)

How is O's recovery to your family? (Researcher) He was hospitalized four or five months ago for eight days (the mother reports hospitalization for bronchiolitis and not for the chickenpox, which is the last hospitalization). Then he had a respiratory crisis due to shortness of breath, tiredness. (F6-M)

Was the last time he was admitted due to chicken pox? (Researcher) It's been about three months since he has no (respiratory) crisis. (F6-M)

When was the last time he was hospitalized? (Researcher) About three weeks ago for chickenpox. (F6-F)

Although the family realizes that there is a possibility of readmission, they also check for the child's signs of improvement. Thereby, over time, they begin *Developing confidence in the child's recovery* and start to adapt to additional care, recognize their potential, resume regular child care, plan new activities, and resume routine functioning.

[...] I saw an improvement after the seventh day, she was well and she really was ready to return to daycare. (F2-M)

Now, I can even go out. They are very calm with their father. (F3-M)

However, if on the one hand, the family regains its self-confidence, on the other hand, its members show how traumatized they were because of the suffering caused by the child's disease and hospitalization. Thereby, *Remaining shaken*, the family

continues to act promptly as if the signs of disease, especially those similar to the child's symptoms at the time of hospitalization, could cause a readmission, evidencing how they still experience the impact of the disease and hospitalization after discharge.

Nobody touches her kiki (genitalia) to this day, even me. She is traumatized and cries when it has to be clean. (F8-M)

Even to be weighed she cries [...]. Even when it's just an appointment for examination, it's a lot of work. (F5-M)

To the hospital, never! I hope I will never return! (F3-M)

As a consequence, in every new disease experience, the memories can be clear for the family, reviving the suffering experienced as a result of illness and hospitalization, generating fear about a worsening condition, a new hospitalization and child loss. This fact is an indication that the hospitalization experience makes the family vulnerable even after discharge of a child with a potentially curable acute disease, and this is still present in family life as an event capable of permanently changing its behavior. The child's disease, although potentially having a good prognosis, is receives new meaning after hospitalization, prompting the family members to consider the possibility of the loss of the child, causing them to mobilize to prevent readmission and thus avoid more suffering.

DISCUSSION

The definitions constructed by families that had a child hospitalized for a potentially curable acute disease, as described in the theoretical model, reveal that the unforeseen child hospitalization, even for a disease with a good prognosis, in addition to causing family suffering during hospitalization, can continue causing pain and affecting its dynamics after discharge, for an indefinite time.

Understanding suffering as any pain, discomfort or physical, emotional or spiritual distress⁽²⁰⁾ which occurs as an experience that threatens the physical, social and emotional integrity of persons and their families⁽²¹⁾, it was unveiled that after discharge, although lessened, family suffering still exists because of the perceived threat to the child's health and life, and the possibility of a new hospitalization. Thus, suffering makes the family members feel vulnerable, both in the hospital and at home after discharge, even with the resolution of the disease.

During hospitalization, the elements that trigger this feeling are the accumulation of demands, unpreparedness to act, and previous experiences^(8,22); there are also present in the family experience after discharge. At home, caring for the convalescent children and resuming activities overburdens the family members and reveals their unpreparedness to act in several situations. Family members feel vulnerable to damage, not due to the disease severity, but because they define the child as more vulnerable to illness, and the family unit as vulnerable to separation.

Although regaining confidence in the ability to control their functioning, the family members still live with signs of the disease and uncertainty about the child's recovery. The fear of exposure to damage caused by the disease after the child's

discharge is also one of the characteristics that defines family vulnerability to the hospitalization of one of its children⁽²³⁾.

Anguish and fear that accompany suffering can be accentuated as a result of difficulties experienced by the family⁽²¹⁾, which was also observed in this study. Every time the family members feet alone, they interacted with family conflicts, with the possibility of disease recurrence or family breakdown. In accordance with another study that investigated the family experience after discharge⁽⁷⁾, the results of this study show that family members realize that there is a decrease in their ability to make the necessary changes to meet the new demands, making it difficult to resume control of their functioning.

In addition to the fear and sense of loss and disability, feelings of sadness and abandonment are expressions of family suffering⁽²¹⁾, which were also present in the experience regarding the child's recovery process. When they perceive themselves divided between the needs of caring for the convalescent child and other needs, the family members felt unable to provide the necessary resources for the child's recovery.

Struggling to rescue autonomy is one of the consequences of feeling vulnerable in a situation of disease and hospitalization of one of its children⁽²³⁾, an action that is similar to the one held by the family members with the child in the recovery process after discharge, when they make efforts to prevent child readmission, make their demands and maintain family integrity.

In this sense, the strategies adopted by the family in this study, such as the ability to access the network of relationships for support, sharing child care, trying to understand what is happening, were also described in the context of hospitalization for an acute disease⁽¹²⁾, and in the family experience regarding the severe⁽²⁰⁾ or chronic condition of the child⁽²⁴⁾.

In the context of an acute disease, the disease itself and hospitalization of the child are not experiences that were planned by the family, and they begin with little or no possibility of control. Hospital discharge, although it should be planned with the family in general, is actually planned according to the health facility needs and determined by professionals, when they judge that the child is already in a position to continue the recovery process at home.

Supported by the results of this study, we can state that health care professionals cannot consider their work finished by taking into account only the child's recovery or discharge, while the family is struggling to maintain its balance due to the impact of hospitalization and the need to continue caring for the child at home. Therefore, interventions should be guided

by the family-centered care approach, because both in vulnerability and suffering there is a growth opportunity for the family^(18,23), as long as it is supported by professionals.

Strategies to implement this care model, in addition to strengthening the family, would decrease the use of emergency health care services and the number of readmissions. Even if the family did not have control of the transition triggered by the child's disease and hospitalization, health care professionals can help members to prepare for greater control and participation at discharge and the transition to home, where they will have the power to decide how to resume the care of the convalescent child, since, as pointed out in the literature, they still need the support of primary health care for better recovery⁽²⁾.

We agree that supporting and engaging in the child hospital discharge process is one of the dimensions of nursing care, whether in hospital or in primary care through the Family Health Strategy team, in order to promote the continuity of hospital care at home, ensuring integration between levels of care⁽²⁾. The findings also support the need for combined intersectoral actions aimed at promoting, protecting and recovering health, aimed at the principle of comprehensive care.

Future research should focus both on creating tools to help define groups of children most likely to benefit from post-discharge interventions, and also in the formal evaluation of the effectiveness of these interventions in reducing morbidity and mortality in the first months after hospital discharge⁽³⁾, thereby favoring the restoration of family balance.

FINAL CONSIDERATIONS

The theoretical model constructed in this study can contribute to the practice of several professionals, employed as a research and evaluation guide, facilitating identification of situations that represent family strengths and needs or those situations that generate vulnerability, encouraging adaptive responses during the transition from the hospital tutelage to autonomy at home.

Considering that the family experience can be different and that, according to the grounded theory assumptions, a theoretical model can be modified or expanded, performing research involving other types of families, other causes of hospitalization, other age groups, and members exercising other roles as family providers can broaden the understanding of how families interact with the process of one of its members recovering after hospital discharge, as this study was limited to investigating the post-discharge period of a child with acute disease that had a good prognosis.

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