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Educational practices in health on responsibilities for the care of dependent elderly*

Práticas educativas em saúde sobre responsabilidades pelo cuidado do idoso dependente

Prácticas educativas en salud sobre responsabilidades para la atención de ancianos dependientes

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Abstract: Objective: to describe the perspectives of nurses, community health agents and family caregivers who are part of health education practices on responsibilities for the care of the dependent elderly. **Method:** qualitative, descriptive and exploratory study, conducted in 2016 with two nurses, eight community health agents and six family caregivers linked to two family health strategies, based on the development of educational practices in health. Data analysis was performed according to the technique of the triadic humanist-existential-personalist configuration. **Results:** each person involved in the care of the elderly has differentiated, singular and complementary responsibilities. For professionals, their actions developed are not being implemented in practice and/or having an expected positive effect, being influenced by cultural, value and structural issues. **Conclusion:** the responsibilities for the care of the elderly are everyone's and need to be shared among the family, health professionals, the community and the State.

Descriptors: Aged; Caregivers; Nurses, Male; Community Health Workers; Education

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Resumo: **Objetivo:** descrever as perspectivas de enfermeiros, agentes comunitários de saúde e cuidadores familiares integrantes de práticas educativas em saúde sobre responsabilidades pelo cuidado do idoso dependente. **Método**: estudo qualitativo, descritivo e exploratório, realizado em 2016 com dois enfermeiros, oito agentes comunitários de saúde e seis cuidadores familiares vinculados a duas estratégias saúde da família, a partir do desenvolvimento de práticas educativas em saúde. A análise dos dados foi feita de acordo com a técnica da configuração triádica, humanista-existencial-personalista. **Resultados**: cada envolvido no cuidado ao idoso tem responsabilidades diferenciadas, singulares e complementares. Para os profissionais, suas ações desenvolvidas não estão sendo efetivadas na prática e/ou tendo efeito positivo esperado, sendo influenciadas por questões cultural, de valores e estrutural. **Conclusão**: as responsabilidades pelo cuidado dos idosos são de todos e precisam ser compartilhadas entre a família, os profissionais da saúde, a comunidade e o Estado.
Descritores: Idoso; Cuidadores; Enfermeiros; Agentes comunitários de saúde; Educação

Resumen: **Objetivo:** describir las perspectivas de enfermeros, agentes comunitarios de salud y cuidadores familiares que forman parte de las prácticas educativas en salud sobre las responsabilidades del cuidado de los ancianos dependientes. **Método:** estudio cualitativo, descriptivo y exploratorio, realizado en 2016 con dos enfermeras, ocho agentes comunitarios de salud y seis cuidadores familiares vinculados a dos estrategias de salud familiar, a partir del desarrollo de prácticas educativas en salud. El análisis de los datos se realizó según la configuración triádica, técnica humanista-existencial-personalista. **Resultados:** cada persona involucrada en el cuidado de los ancianos tiene responsabilidades diferentes, únicas y complementarias. Para los profesionales, sus acciones no se están llevando a cabo en la práctica y / o tienen un efecto positivo esperado, siendo influenciadas por cuestiones culturales, de valores y estructurales. **Conclusión:** las responsabilidades por el cuidado de los ancianos son de todos y deben ser compartidas entre la familia, los profesionales de la salud, la comunidad y el Estado.
Descriptores: Anciano; Cuidadores; Enfermeros; Agentes Comunitarios de Salud; Educación

Introduction

In primary health care (PHC), although the model is quite advanced and proposes to serve the elderly in an integral and continuous way, in general, the practice is still unsatisfactory.[1] The National Health Policy of the Elderly Person (PNSPI, in Portuguese) explains that, in Brazil, "it is remarkable the lack of qualified professionals for the care of the elderly at all levels of care".[1:5] Thus, there is a need for training of professionals to meet this demand.[1]

The demand for professional qualification can be met from the implementation of educational practices in health (EPH). These, in turn, involve the education of users and health service professionals, which include information, guidance and technical actions. EPH occurs in the people's meeting, with different cultures and socioeconomic realities, with knowledge, representations, experiences and varied experiences, which together can (dis)build ways of

understanding and understanding health. In the meantime, the meetings involve trust and dialogues, which articulate and confront knowledge from daily experiences and scientific knowledge.[2]

Among EPH, there is Permanent Health Education (PHE) and health education, aimed at professionals and the community. Both favor the acquisition, expansion and (re)construction of knowledge, development of skills and empowerment of people for reflection and decision-making in the context in which it is to demand, as in the care of the elderly. EPH favor the emancipation of people, strengthen bonds, subsidize professional performance, guide health promotion actions, favor practices of (self)care in social, economic, cultural and political scenarios, as in contexts of the Family Health Strategy (FHS).

EPH - with the participation of users, families and the community - have been effective in acquiring and exchanging knowledge. Educational practices favor those involved autonomy in actions related to health and well-being, particularly in promotion attitudes. Among nurses, these EPH have been frequent and effective due to paradigm changes in contemporary care models.[3] Community health agents (CHA), as members of the FHS team, when developing educational practices for the community, face attitudes and values different from the people under their responsibility.[4]

There are several ways for families and society to care for the elderly. Therefore, health professionals, such as nurses and CHA, need to know the habits and customs of the people under their responsibility, so that care is performed with otherness. It is emphasized that sociocultural practices modulate family relationships, being essential that professionals consider beliefs and values as factors that influence the responsibilities for the care of the elderly performed by their children.[5]

Studies show that, among families of different nationalities, such as Lebanese, Paraguayans, Chinese, Brazilian and Chilean, there is a predominance of familial care, especially of children for their parents, followed by partners.[5-6] This is explained by the models

of intercultural relationships that take place in the social, cultural and psychological spheres, given that human behavior is formed in the context in which the person lives and relates.[5] In addition, people who live in the same household as the elderly dependent on health care are more likely to be their caregivers due to proximity and daily coexistence.

The responsibility of families in the care of the elderly is explicit in Brazilian legislation - Federal Constitution (FC),[7] Statute of the Elderly[8] and PNSPI.[1] In this context, the family caregiver, the family person who will be responsible for supporting the elderly in carrying out their activities of daily living related to physical, social, psychological and mental demands, arises when the elderly demand it. This caregiver,[9-10], in turn, presents a deficit of knowledge and skills about care for dependent elderly[9-10] and faces the lack of social support from health professionals in the FHS[8,10], such as nurses and CHA, to perform care.

Studies of this nature are justified as they seek to reduce gaps in the production of knowledge about responsibilities and EPH of nurses, CHA and family caregivers related to aging. Thus, it becomes relevant, because it contributes to the expansion of knowledge in the health field and encourages the development of other research in the gerontological area. Thus, it is expected that this investigation can support the planning of care for dependent elderly people and support those responsible for them.

The study had the following research question: what are the perspectives of nurses, CHA and family caregivers about responsibilities for the care of dependent elderly people? In view of the above, it aims to describe the perspectives of nurses, CHA and family caregivers who are part of health education practices on responsibilities for the care of the dependent elderly.

Method

This is a qualitative, descriptive and exploratory study, whose data were obtained from EPH with nurses, CHA and family caregivers of the elderly, conducted in an auditorium provided by the

Municipal Health Department of a municipality, located in the interior of the state of Bahia. This is part of a research that covered three stages (situational diagnosis, development of EPH and its evaluation) and, for this investigation, we used the data produced in the second stage of the research - development of EPH on responsibilities for the care of the elderly. Soon after that, the researchers established previous contact with the participants from the first stage - situational diagnosis.

To participate in the second stage, the inclusion criterion was to have participated in the first stage of the research. Therefore, participants who did not answer the instruments of sociodemographic characteristics that contained questions related to the responsibilities for the care of the elderly were excluded. For nurses and CHA, the inclusion criteria were: working in the FHS for at least six months, being older than 18 years; and exclusion: being on vacation, on leave or away during the data collection period. For caregivers, the inclusion criteria were: being family of the elderly with partial or total dependence, according to the Katz[11] scale, cohabiting in the same household as the elderly, over 18 years of age, be the primary caregiver, be taking care of at least six months, partially or in full and be registered in the FHS. People who were not found at home after three visits on different and scheduled days and times were excluded.

In this situational diagnosis, it was verified the lack of a course and training of nurses and CHA of the FHS and, almost unanimously (except two), guidelines for family caregivers from the perspective of aging and care for the dependent elderly. At this stage, there was also the identification of topics of interest to the participants to deepen the knowledge of gerontological aspects in EPH, as presented in Chart 1. It is emphasized that nine caregivers did not know how to inform and/or did not wish to suggest themes. The participants were thus coded to guarantee anonymity: nurses (N), CHA (A) and caregivers (C).

Chart 1 - Description of topics listed by nurses, CHA and family caregivers to expand knowledge on educational health practices. Salvador, Bahia, 2018.

Participants	Themes

N1, N2*	Aging and biopsychosocial changes. Sexual intercourse and self-esteem. Use of medication, teas and therapeutic juices and physical activity.
A1, A2, A3, A4, A5, A6, A7, A8, A9, A10†	Care for dependent/bedridden elderly. Take good care and dedicate yourself to the elderly. Patience and love in care. How caregivers should care. Personal hygiene. How to deal with the elderly. Psychological of the caregiver. Responsibility for the elderly who have no close relatives.
C1, C2, C5, C7, C9, C12, C14, C16, C17, C18‡	How to take better care of the elderly. Taking care of the elderly so as not to be bedridden. Caring for the bedridden elderly. How to take care and know if you are taking good care. How to act with the elderly and know if you need something. How to improve Alzheimer's disease. How to apply insulin to the elderly.

* Nurse, † Community Health Agent and ‡ Caregiver.

With the situational diagnosis data, the EPH were planned, based on the themes suggested during the individual interviews, plus others listed by the researchers because they consider it essential for those who care for dependent elderly people (such as health care to the binomial, (self)care, social support). Data were collected by two trained nurses, phD and doctoral student, from the development of EPH. After the participants' consent, the moments were recorded using a digital recorder.

Thirty-one eligible people were invited, by verbal and printed invitation, to participate in the EPH, that is, all participants in the first stage of the research. The selection of the participants of the first stage, which was part of this study, was due to convenience, in which the nurses and CHA informed the household that assist the dependent elderly, so the researcher would confirm at the visit with the application of Katz.

There was the participation of 16 people, two of them were nurses, eight CHA and six family caregivers, linked to the only two FHS of the urban area of the municipality. Its inclusions were intended to cover areas with different user profile (economic, social). These health units had 1,646 registered families, corresponding to about 7,266 people, and 862 elderly people were followed. Each team had 10 micro areas, a nurse, a nursing technician, a doctor, a dentist, an oral health assistant, a receptionist, 10 CHA and a general services assistant. The absence of a CHA was justified by health reasons with medical certificate and 14 caregivers due to the unavailability of people to care for the dependent elderly in the home in the absence of the primary caregiver. This stage took place in March 2016 (period from March 8th to 10th), on three consecutive days, one in the morning shift and

three in the afternoon shift. Each EPH meeting lasted an average of two hours.

Four moments of EPH were performed, three with the nurses and CHA (group 1), with a relay among them, avoiding leaving the area of activity of the FHS discovered and one with the caregivers (group 2), due to the availability of them to move from the house to participate in EPH. This division of participants into two groups was necessary, since some caregivers reported during the interviews of the first stage that they did not feel comfortable participating in EPH together with the professionals. Each nurse and caregiver participated in one day of the activities and, among the CHA, three participated in a meeting, and five in two meetings.

EPH were scheduled in advance with the participants. In the week prior to collection, they were reminded about the research. Among the professionals and caregivers, three justified their absence, for reasons of medical certificate or not having with whom to leave the elderly at home, and nine confirmed the presence and did not attend at least one day, of the four EPH meetings.

At the first moment of the meeting, for all EPH participants, the contract of coexistence occurred and, after verbal agreement, the activities continued. It gathered information about behaviors to be followed, as a way to favor the collective experience: keeping cell phone off; avoid leaving the room; punctuality; when communicating, raise the hand and enter the name; not speak at the same time as the other; respect the other person's opinion; avoid parallel conversations; keep the secrecy of everything that is talked about in the room; not to judge people, for each one has a different opinion; to say what he/she feels and/or understands, and ask, when he/she has doubts. The identification of the participants in the EPH contributed to the proximity and maintain the fidelity of authorship of the information during the transcriptions of the statements.

Then, the presentations of each person present began, from the dynamics of interaction - web technique, with the use of string and people standing and in a circle and, at the end, the

participants sat in a circle. This moment was opportune for the socialization of each member and sharing the information of who was cared, for how long and their expectations related to the activities to be developed.

The professionals participated in three days of EPH. On the first and second day, one nurse and five CHA participated, and on the third day three CHA, from different areas of the FHS. On the first day of activities, printed material was made available with questions created by the researchers, colored pens and craft paper. Then, the request was to divide into a group of three people for discussion of each other about the questions, and elaborate and write their answers on paper. The participants answered: 1) Comment on what they know about responsibilities for the care of the elderly and; 2) What are the responsibilities assumed by you in the care of the dependent elderly? It is noteworthy that these same questions were asked to the participants individually in the first stage of the research and, in group in the second stage, as a way of apprehending also collective testimonies on the theme.

The participants discussed and constructed their answers in groups (average duration of 20 minutes) and, soon after, socialized the collective constructions to the other participants. The EPH moderators wrote the oral answers of each group on wood paper, fixed on the wall, as a way of visualizing all the buildings. There were reflections, exchange of experiences, discussions and identification of convergences and divergences of responses.

Then, the EPH continued with the nurses and CHA, through the dialogued exposure technique. For the three days of educational activities, the researchers addressed and discussed topics that dealt with: I) Aging, II) Responsibilities for the care of the elderly and, III) Care for dependent elderly and social support. The exposure was based on the literature, as well as the experience and context of each person involved in the care of the elderly. The EPH allowed reflections, questions and answered doubts.

With the presence of three CHA on the third day (there were no nurses), participants of

the first and second day of EPH began from the reading and reflections of the following sentences written in paper clipping: I) Families, in some situations, take responsibility for their elderly, when there is a need for help and, II) The responsibility for aging needs to be of all. Participants were asked to comment on the understanding of the sentences and, subsequently, the researchers interspersed the answers with scientific knowledge.

With the family caregivers, after interaction dynamics (web technique) that lasted an average of 20 minutes, the researchers began contextualizations, discussions and reflections, from the dialogued exposure directed to aging, such as biopsychosocial changes, functionality, autonomy, dependence, home care, guardians and responsibilities for the care of the dependent elderly, changes in the daily life of caregivers after the assumption of care, caregiver self-care and social support.

Professionals and caregivers actively participated in EPH with comments and reports of their experiences in care. Among the caregivers, it was observed that two were concerned about the closing hours of the activity, due to the need to return home to care for the elderly. In addition, among them, there were suggestions to perform other educational moments with the theme focused on the care of the elderly bedridden at home and those with diabetes *mellitus* (DM).

The dialogues during EPH were transcribed in full, double-typed and organized in the Microsoft Office Word 2010 program for reading and comprehension. To safeguard the anonymity of the participants, the answers were identified with the letters according to the function in the social group: "N" (nurse), "A" (CHA) and "C" (caregiver), followed by numbering according to their order of performance (E1; A1, C1).

The analysis of EPH data was made using as a guide the technique of triadic, humanist-existential-personalist configuration12 according to the steps: I) Attentive reading of the manifest content of the participants, in order to apprehend its meaning within the global structure. This

happened after the organization of all statements; II) Rereading of all the material typed, with the purpose of apprehending the units of meaning, from the detailed analysis of the material. This favored the understanding of the statements and the creation of meanings within the global structure.

And, in the steps: III) Identification and classification of aspects that converged in the content of the various statements, for their overall analysis; IV) Grouping of units of meaning into subcategories and category - in this IV step, we used text enhancement with varied colors, in order to organize the units of meaning that converged; V) Descriptive presentation of the groupings; and VI) Comprehensive analysis of the significant data of the groupings and the presentation of his/her main idea.[12]

In the presentation of the groupings, there was the triangulation of the data of the dialogues and testimonies of all participants produced in the four moments of EPH (three with professionals and one with caregivers), from the identification of convergences, in subcategory I "Responsible for the care of the dependent elderly at home", and among the professionals in subcategory II "Configuration of nurses and CHA on their responsibilities in the care of dependent elderly at home". This allowed the presentation of collective groupings among the participants. Study approved with the opinion embodied: 1,388,138 and CAAE: 47661615.2.0000.5531, on January 13, 2016, by the Research Ethics Committee, being conducted according to the ethical standards required in Resolution nº 466/2012 of the National Health Council.

Results

All nurses, CHA and family caregivers were female and did not receive training and/or guidance on care for dependent elderly to develop their responsibilities to these people. As for the relatives of the caregivers, three were daughters, two wives and one sister; of these, five

cared in full for elderly with diagnoses of Parkinson's disease, Alzheimer's disease, mental retardation, hypertension, DM, prostate cancer and/or osteoporosis. The characteristics of the EPH participants are presented in Table 1.

Table 1- Characteristics of nurses, CHA and family caregivers of dependent elderly. Salvador-Ba, 2018.

Variable	Nurse	CHA	Family Caregiver
Participant (n)	2	8	6
Age (years)			
25 to 40	2	4	-
41 to 59	-	3	3
60 to 69	-	1	3
Race/Color			
White	1	-	2
Brown	1	7	4
Black	-	1	-
Marital state			
Married/Consensual union	1	6	4
Single	1	2	-
Divorced	-	-	2
Schooling	-	-	
Illiterate			1
Incomplete primary school		-	2
Complete primary school		-	2
Incomplete high school		-	1
Complete high school		6	-
Higher education	1	2	-
Specialization	1	-	-
Caring time (year)			
Up to 1	1	-	-
3	1	-	-
5 to 9	-	2	4
12	-	2	-
16 to 17	-	4	1
22		-	1

From the analysis of the dialogues of nurses, CHA and caregivers participating in EPH, a category and three empirical subcategories emerged.

Category - Perspectives of nurses, community health agents and family caregivers about responsibilities for the care of dependent elderly people at home

From this category, three subcategories emerged, describing the guardians and the responsibilities of each person in the care of the elderly. There are individual and collective responsibilities.

Subcategory I - Responsible for the care of the dependent elderly at home

Nurses, CHA and family caregivers consider as responsible for the care of the elderly, the family, society and the State, however, explain that first the family must be, and in need, assume the other responsible. They refer to the regulation of this responsibility in the Statute of the Elderly.

> *I think the responsibility of the elderly is everyone's. (A6) It is the caregiver, the CHA, the nurse, the team, the neighbor, the doctor, the social worker, the State, the friend, the most distant relative. (N2, A6, C16) The responsibility for caring for the elderly first lies with the family. (C4, A6, N2) That you really have to be committed to the elderly. It is in the Elderly Statute that it is the family's obligation to take care of their dear elderly person. (A6, N2) When the family does not take over, (A6) or when there is no family, (A1) society enters. When society is silent, that is where the State comes in. (A6)*

Subcategory II - Responsibilities of nurses and CHA for the care of the dependent elderly at home

The nurses cited as their responsibilities the performance of home visits with the CHA at least once a month, and highlighted their obligation to guide the elderly and their families. The CHA, in addition to visiting and guiding families, act in a respectful manner during the follow-up of the care provided by the caregiver to the dependent elderly at home. They cite the high demand related to the programs developed in the FHS as factors that make it difficult for nurses' home visiting.

> *Conduct home visits regularly, with professionals working at the FHS. (N1) They [CHA] are obliged to make at least one visit in the month. (N1, E2) The [professional] people's obligation is to guide. To guide the correct form of care, and not to have the practice of a bath, to give the medication. (N2) Knowing how to respect the limits as much as possible, monitor in a way that they do not feel powerless and impose limits when necessary. (A1, A2, A6, A8, A10) Clarify doubts. (A1, A2, A6, A8) The nurse is unable to cope with the demand because today he has a huge number of hypertensive, diabetic, pregnant women, prenatal, preventive and CD [growth and development childish]. Sometimes, he has to prioritize two, three agents to make the visits. (A3) He is not finding time to move from the unit, so, if we analyze the home visit, it is small, because the demand with the elderly is very high. (A3)*

The CHA explained that they cannot identify their function with families, and feel powerless in some households during visits to the elderly. At the same time, complain that their guidelines are not having a positive effect, which raises doubts about the success of their work. They reported resistance to the orientation process in relation to the habits of caregivers, except for the care with medication. The nurse expressed the need to maintain permanent guidance on the medication of the elderly.

> *We are like this, it seems that my work is being in vain. (A5) Guidance is taking, (A4, A10) both from the environment, as well as the physical, from the attention. (A10) We give guidance, but there is no return. (A10) There are houses that we feel powerless. We talk like this, what is my role here? Am I not able to identify what I brought? (A4) They [caregivers] do not ask to teach how to care, because they think they know, they have made that habit all their lives and think it is correct. (A6) In relation to medication, I am always asked for [guidance], it is so much that I explain. There is one who is disabled, dumb and deaf, every month that I go [home] it is all messed up [the medication]. It's crazy. (A10) It is to be careful with the medication of the elderly. Ah, but he is tired of knowing that he takes medicine, it doesn't matter. (N1) But he has things that are not our responsibility. I can guide, but I can't do. (A10) Then we cannot change. We want to change, but unfortunately, it is reality. Many resist. (A10)*

Subcategory III - The responsibilities of family caregivers for the care of the dependent elderly at home

The caregivers expressed that they cared fully and daily for the dependent elderly at home, considered this task a great responsibility and based the act of caring on religious and moral aspects. They revealed that the care provided is an expression of love, patience and learning acquired in the family, but they do not know some aspects of care for the elderly, and they support this care. Among them, faith, trust in God, patience, and hope are values that have expressed satisfaction in caring. The expectation is that they will take care until the death of the caregiver, or the person cared for. Another expectation is to be cared for when becoming elderly. For them, caring is difficult because they have to reconcile personal care with those of the dependent elderly and the maintenance of the house.

> *Everything about him/her [elderly] is with me. (C16) Everything is given in time, to bathe, brush your teeth, put on clothes, lunch, lunch, (C4, C9) water, tea, take it to the bathroom, exercise. (C9) We do not let anything pass. (C5) We are on the run. (C9, C16) It is taking care of the house, (C4) buying the balanced things. (C18) It is a very big responsibility. (C5) If we take care, it is for love. You have to be patient, (C4, C5, C 9, C16) to take care of the way we know, that we learn. Because we do it our way, but there are many things with the elderly that we do not understand. (C16) You have to have a lot of faith, a lot of trust in God to be able to take care, because it is not easy. (C5) It is very difficult. (C5, C9) God gives us a lot of patience, which we win. (C16) Thank God I take care of him satisfied. (C9) Take care until God calls me or him. (C9) And whatever God wants (C9, C16). I'm taking care of the way I can. (C10) You have to take care of it properly, we will also get old. (C4)*

Discussion

The sociodemographic information of the study participants showed similarities to those of others regarding the characteristics of the nurse,[13] CHA[14] and family caregivers9 were female,

with a predominance of care for the elderly being the responsibility of the woman. As well as there is a deficit and/or lack of training and/or guidance on care for the elderly.[1,10]

In this study, the use of the triadic configuration, based on the humanistic-existential-personalist theoretical framework[12], allowed the understanding of the responsibilities of the participants for the care of the dependent elderly anchored in moral, ethical, legal, deontological aspects, guidelines and regulations of the professions. As seen, in some situations, there were particularities of each participant; in others, convergences, such as who are responsible for this care at home.

In Brazil, the regulations of care for the elderly explain those responsible for their care. The FC states that "[...] older children have a duty to help and uphold parents in old age, neediness, or illness." [7:102] Although, often, this has not happened in practice.

It is described in the FC of Brazil[7] and in the Statute of the Elderly[8], that it is the duty of the family, society and the State to support the elderly, to ensure their citizenship rights and to stimulate their stay in the community with the family, with active social participation, defending their dignity and well-being and guaranteeing their right to life. Furthermore, the obligation of those responsible to ensure the elderly, with priority, the realization of the right to health, food, education, culture, leisure, citizenship, freedom, dignity and respect is explained.[8] There is an understanding among the participants of this study about who are responsible for the care of the dependent elderly, in a hierarchical way, as expressed in the Brazilian norms mentioned above, being emphasized by them, their foundation only in the statute of the elderly, which demonstrates their lack of knowledge.

Indirect caregivers, such as the family member, are fundamental people in maintaining and ensuring continuity of care for the dependent elderly at home, since they play a primary role in the administration and organization of care.[15] Caring for the elderly is complex due to changes and adaptations in the daily life of those who care and who are cared for. Assuming this

assignment, and, in most cases, almost suddenly, has caused excessive tension to caregivers.[16-17] This is because caring for the elderly is not an easy task; this activity sometimes goes beyond the desire of the family member, and circumstances and/or varied needs have influenced the decision of the assumption by the care of the dependent elderly.

A study shows that family caregivers express care as a difficult and complex task, particularly due to inexperience, unpreparedness, insecurity related to the demands of this activity, and not having support to share this responsibility at home.[18] In addition, the elderly needs uninterrupted care, such as in situations of total, functional and/or cognitive dependence, requiring from who cares for them patience, love, desire waiver, dedication, available time, self-organization, routine modifications, (re)adaptation and definition of priorities to perform this activity.

Among the reasons that lead the family to decide to care for the dependent elderly is reciprocity, the mutual obligation that involves members to take care of each other, when they need to, at different times of life, especially when the caregiver is a child.[15] This moral responsibility of family members is associated with the daily relationships built with the dependent elderly.[19] It was found in this study that, although this responsibility involves obligations and causes biopsychosocial implications, some members take care satisfied. This duty is related to values, as well as the moral and ethical aspects of these.

It is a fact that the challenges faced by the family in the care of the elderly are varied.[20] This demand has caused the family emotional and/or physical exhaustion, overload of activities and impairment of their participation in the labor market.[15,20-21] However, the waiting for improvement of the elderly promotes the continuity of this activity by these people. Hope and spirituality are positive aspects relevant to caregivers and give meaning in life, and need to be encouraged by health professionals. These are manifested in faith, affection, love, and religious beliefs.[21] Similar results were evidenced in this study, in which accountability for the elderly is

sustained in love, moral duty, and faith in God. And to take care, the person needs to be patient, given the complexity of this responsibility.

It is seen that caregivers have shown high resilience,[15] despite the lack of social support and the difficulties in achieving it. Nevertheless, they recognize the need of support[9,15] and, therefore, avoid burden and wear related to care.[10,15] This need for social support occurs because there are possibilities of compromising the health condition of caregivers related to the care of the dependent elderly.

As for formal support, it is necessary to expand home visits to the people they care for.[9] When performing home care, health education and periodic consultation with the elderly, favors the reduction of care burden and improvement of the quality of life (QoL) of caregivers.[17] It is known that the educational practice is promising, and can be performed by the members of the health team of the FHS, such as nurses and CHA. As seen in this study, EPH influenced the quality of care offered to the elderly, minimizing the insecurity and answering doubts of family members, as well as reaffirming the responsibility for health promotion actions.

PHC professionals point out what they consider necessary to care for dependent elderly.[22-23] For them, it takes interdisciplinary and multidisciplinary articulations to create a more efficient care network, to hire professionals and specialists to strengthen care in the FHS, to perform reception, training and educational practices for staff and caregivers, and home visits.[23] In addition, those from higher education, as nurses, emphasized the relevance of knowledge to ensure the resolution of demands at the local level. The CHA cited affection and listening. And all highlight the need to be patient with these people.[22] These results are similar to those of this study regarding the need to have patience to deal with the elderly.

Patience, as an attribute of the caregiver, is fundamental, especially because he/she takes care of the elderly dependent on the way they learned in daily practice, without guidance from health professionals. Nurses' duties in the PHC are the participation in the planning,

management and evaluation of the actions carried out by the CHA together with the family, as well as contribution, participation and development of permanent education activities of the nursing team and other team members, such as the CHA.[24]

There is incipience of knowledge of gerontogeriatric aspects and lack of training of professionals of the FHS from the perspective of health care for the elderly.[19,22,25-26] This lack of preparation is pointed out as gaps in the formation and/or lack of education in health services, which contributes to the care of these professionals distancing from the principles of the Unified Health System (SUS, in Portuguse) that guide the FHS. Therefore, it is necessary to invest in the permanent training of professionals, such as nurses and CHA, who are able to care for the elderly, especially dependents, as well as improve the training and guidance of family caregivers.[19,27] These results are in agreement with those evidenced in this investigation, which confirms the need to invest in the qualification of nurses, CHA and family caregivers, focused on caring for the elderly, with the purpose of improving the quality of care in this population segment.

The unpreparedness and insecurity of nurses to assist the elderly in primary health care are related to professional training, which makes it difficult to provide comprehensive care, since academic experiences were punctual and directed to the disease. Having said that, thinking about their formation from the perspective of comprehensive care for the elderly is challenging and necessary.[25] However, the expansion of knowledge in the context of aging favors the planning and implementation of actions directed to the needs and singularities of the elderly.[19] This lack of preparation related to gerontological aspects is frequent among nurses who work in the FHS and who assist elderly people also at home, as demonstrated in this study.

Home visits are performed by different health professionals and can be configured as a powerful work strategy.[28] This practice favors closer approximation of nurses and CHA with users of health services and the reality of families, as well as providing greater understanding of

the health/disease/care process of the population and contributes to the identification of their health needs.[13,28] Thus, it has been occurring insufficiently, especially due to the work overload of these professionals in the FHS related to the demands of the population of their services, which consume a significant part of the time and, consequently, influence their displacement to carry out visits.[13]

The home visit is seen by the elderly, caregivers and family members as relevant to meet their demands and, when regular, improves the well-being of those involved, the bond and the reception in the production of care.[20] In this space of care production, nurses play an essential role of health education for dependent people and their caregivers.10 In view of this, this practice should be periodic and performed by the health team of the FHS and, in particular, when there are situations of dependence in the family.

Nurses and CHA prioritize home visits scheduled for people who are housed, or who have difficulties in getting around the FHS.[13] This study's finding is similar, when the nurses see home visits to the elderly as the need to expand this type of care to these dependent people.

When entering the homes, professionals face some surprises and uncertainties.[14] The CHA have an indispensable role in the visits of families with the elderly, and they constitute mediators and a link in the integration of the community with health services.[4,14,22] However, it is necessary to verify whether the CHA home visit has served as a care strategy for the frail elderly, which consists of such occupation and whether these professionals recognize themselves as agents of this responsibility to families within the scope of the FHS.[14]

A study indicates that home visits were the main activity of CHA. However, the idealization of their competencies and the place they occupy in the team have generated a feeling of powerlessness and limitation in the face of the challenges faced in the attention of families.[4] In this context, in order to make their work in the FHS effective, it is essential to integrate them into the team, support their actions and invest in their training and continuing

education.[14,22] This favors the improvement of care for the elderly who have impaired functionality and contributes to home visits to families function as a strategy to reorient the current health care model.[14]

The CHA have an important social function when the elderly people do not have the support of family members, the family cannot or does not want to take care. In some cases, they are the only reference of care.[22,26] In addition to formal support, informal support, as well as neighbors, is fundamental in the health care of these people, since they are partners in care and, above all, in situations where the elderly do not have family support.[20]

For the elderly people and their families, nurses in the health service and at home have developed educational actions. In the nursing consultation, this professional should encourage the approximation of the elderly with care practices and consider aspects of multidimensional assessment such as the environment, the risk of falls and the family relationship.[29] In addition, guiding the elderly and/or their caregivers about healthy eating, (self)care, autonomy, lifestyle changes and socialization with people from other generations.

The nurses and CHA of this study highlighted the orientation as one of their responsibilities and a demand of caregivers. Some CHA feel powerless when performing home visits, because they do not observe changes in the daily care of families after orientations, and question their attributions with them. They believe in resistance related to the way they learned to care, in daily practice and without guidance from health professionals. Nurses recognize the importance of maintaining permanent guidance to caregivers. This impotence and the non-modification in the form of care may be related to the lack of guidance received by caregivers. Therefore, they take care without considering the specificities of the elderly.

Among the difficulties in performing care for the elderly are the lack of specific actions,[25,30] restricted actions, accessibility, insufficient development of intersectoriality and unpreparedness in professional training.[30] In the FHS, care for the elderly is not differentiated

from that of the adult, even with different biopsychosocial demands and particularities. Therefore, it is relevant to break with the single model for care to the population, which limits the care according to the needs of the system and not of the person.[26] Therefore, primary health care services need to be organized to provide comprehensive care to the elderly according to their needs.[20]

It is evident the need for training of health professionals, with the purpose of strengthening the actions of the FHS,[22,29-30] and, the PHE becomes important for the qualification in the health area of the elderly, in order to meet the needs of this population and other age groups in the aging process.[29-30] Thus, it is necessary to rethink the formation of the multidisciplinary team in undergraduate, graduate and health services to meet the demands of the transition, according to the demographic and epidemiological profile.[30] Moreover, health education should be performed for family caregivers. This evidenced demand for EPH, when implemented, can positively influence the quality of care provided to dependent elderly, empowerment, autonomy and practices of (self-care) of people.

Limitations of this study are the time interval between the meetings and the number of moments for the performance of EPH. Its expansion could favor greater support of the participants and, at the same time, varied consequences on the understanding of responsibilities for the care of the dependent elderly. For this reason, it is recommended that future research be developed in the long term with periodic educational interventions for nurses, CHA and family caregivers, considering the time and interval of EPH.

Conclusion

The findings showed that professionals linked to the FHS care for the elderly without considering the specificities of the age group, and the caregivers, as they learned in the experience with the situation, being related to the incipience of knowledge of gerontogeriatric

aspects. Therefore, there is a need to empower them, and EPH is essential - permanent health education for nurses and CHA and health education for family caregivers.

There is an understanding that the family, society and the State are responsible for the care of the elderly. Among the nurses' responsibilities is the home visit, which, in turn, is limited in view of the demands of this professional in the FHS. The CHA, when encountering the singularities of families, in some situations, question their responsibilities and their implications in people's daily lives, such as guiding families and not observing changes in care for dependent elderly people.

Among family caregivers, the assumption for the care of the elderly occurs due to the relationships built in the course of life, even though it required a lot of responsibility. Faith, trust, patience, hope and expectation to be cared for are values that express the satisfaction of caring, even when there is no sharing and it causes biopsychosocial implications.

Nursing needs to expand gerontogeriatric knowledge since graduation. And, as evidenced, nurses recognize the incipience of this knowledge to meet the demands of the elderly, as in a situation of dependence and, often, make decisions related to the health of the elderly without considering his/her specificities, which reinforces the need and relevance of educational practices in health in the context of primary health care in order to qualify care. Nurses, with this knowledge acquired, can train the members of their team as nursing technicians and CHA, as well as family caregivers who assume responsibility for the daily care of dependent elderly at home.

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