The practice of care in long-term care facilities for the elderly: a challenge for the training of professionals

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Abstract

Objective: to analyze how care is performed, understand the contributions of previous experience to professional practice in Long-Term Care Facilities for the Elderly (LTCFs), and recognize the challenges and propositions for professional training and the delivery of care in LTCFs. *Method*: an exploratory qualitative study was carried out in two stages with 33 professionals and managers of a long-term care facility in a municipality in the state of São Paulo. Analysis was performed using Collective Subject Discourse and Thematic Content Analysis (first and second stage, respectively). *Results*: It was found that, in the views of health professionals and managers, the quality of care is linked to basic needs and the training of professionals does not consider the specificities of gerontological care. They therefore reproduce a fragmented and mechanical work process. *Conclusion*: The results highlight the need to revisit courses in the area of health in order to understand their approach to training in elderly care.

Keywords: Homes for the Aged; Comprehensive Health Care; Aging Teaching; Health of the Elderly.

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INTRODUCTION

Aging is a heterogeneous, complex and natural process that continues throughout life, bringing about biological, social and psychological changes in individuals[1]. This process increases the demand for long-term care, as prolonged exposure to chronic-degenerative diseases leads to situations of vulnerability, something that permeates the lives of many Brazilian elderly persons[2].

Another factor affecting this demand is the transformations in Brazilian society. Changes to family make-up, a reduction in birth rates and a decline in intergenerational bonds have reduced the availability of family care[3].

While family care provides great benefits for the public and private spheres, and remains prevalent, the demand for long-term formal care is increasing[4]. Long-term care facilities for the elderly (LTCFs) are one option for such care. These facilities must meet the needs of this population, taking into account their life histories, preserving their independence and autonomy, and facilitating their understanding of the process of aging and institutionalization, so encouraging them to become protagonists of their own process of care[5,6].

Most Brazilian LTCFs face problems, however. They do not prioritize the hiring of professionals trained in gerontological care and possess limited resources, making it difficult for the elderly to participate in the management of their own care[7,8].

There is also a predominance of care professionals who reproduce automated techniques and consider only the physiological needs of the elderly, diminishing the importance of individual needs and ignoring the singularities of residents[9].

Considering the context of demographic transition caused by an aging population and the emerging needs of the elderly in Brazil, families are increasingly choosing LTCFs as a care option for such individuals. However, educational institutions and the LTCFs themselves have not kept up with these changes, lacking both a strategic agenda focused on the processes of aging and the production of technologies that can meet the needs of the country[10,11]. From an academic perspective, there remains little focus on elder care in the curriculum[12], while in the health services there have been problems with the implementation of the National Policy on Elderly Health[13]. An understanding of the conditions for the care of the elderly that exist in LTCFs is therefore essential, along with an identification of the challenges faced when training workers to provide care.

The objective of the present study was therefore to analyze how care is carried out, to understand how previous experience contributes to professional practice in LTCFs, to identify the challenges faced and to propose changes to professional training and how care is performed in such facilities.

METHOD

An exploratory qualitative study was carried out between October 2016 and June 2017 in a non-profit LTCF with 54 residents, in a medium-sized city in the rural part of São Paulo. The Theory of Social Representations was used as a theoretical reference in the research (TSR)[14].

The LTCF studied was intentionally chosen due to its philosophy of caring for the elderly without distinctions of any kind. All the care professionals and managers of the institution were invited to participate in the research. Of the 40 staff of the institution, 33 agreed to participate in data collection, of whom four were managers and 29 other types of care professionals. The inclusion criterion was that the individual must have worked at the LTCF for at least three months. Although all the care professionals were formally employed, the managers worked on a voluntary basis.

The first step involved individual interviews conducted by a trained researcher, namely the author of this article, which had an average duration of 15.7 minutes and consisted of the following question aimed at managers: "What do you consider as a criterion for the quality of care provided in this institution? Why?". The aim of asking about the understanding of the quality of care of the managers was to learn about their perspective on the care provided at the LTCF as volunteer workers without any prior preparation for the role, as well as identifying which issues they

value and whether there is a need to intervene in the training of professionals for the position.

The questions for the care professionals were as follows: "How do you deliver day-to-day care for the elderly? How does your previous experience contribute to your professional practice in the LTCF? What changes are required in your work and the LTCF to improve care for the elderly? Do you think that your training requires changes that could contribute to your professional practice? Give examples.".

This stage was analyzed through the Discourse of the Collective Subject (DCS) technique. The DCS is a technique for tabulating and organizing qualitative data, based on the TSR, which seeks to reconstruct Social Representations (SR), while preserving the articulation of the individual and collective dimensions[15]. The material was processed by three researchers, with evaluation and validation of the systematization of the data.

The analyzed and systematized material was then presented by the same researcher to care professionals and managers in five workshops (second stage), with an average duration of 57 minutes, in order to explore the reflections about the central ideas that emerged more deeply and to identify proposals for the challenges described.

In order to avoid placing constraints on or inhibiting participants during the reflexive processes, the workshop involving managers was carried out separately.

The second phase of this investigation involved thematic Content Analysis[16]. All material collected through the interviews and workshops was audio recorded following the consent of the participants and, after being transcribed in full, was saved for data analysis and then deleted. In order to facilitate the presentation of the collected data, the letter M was used for managers and P for care professionals, followed by an increasing numeric sequence.

The present study was approved by the Ethics Research Committee of a public university in a city in the state of São Paulo under CAAE Nº 57229316.7.0000.5413, complying with resolution 510/2016 relating to research involving human beings. It was also approved by the board of the LTCF being studied.

RESULTS

All the managers interviewed were elderly (60-75 years). The majority were female (n=3; 75%), married, had at least one university degree, had not taken a specialization or other course in the area of gerontological care and had worked at the institution for an average of 13 years (± 5.35). The mean age of the care professionals was 39.7 years (± 12.45), with women predominating among this group (n=24; 82.7%). The majority of the care professionals were married (n=17, 58.3%) and had no previous experience of caring for the elderly (n=15, 51.7%). A total of 16 (55.2%) had graduated from a technical or higher education course, while one (3.4%) was currently studying on such a course. One had graduated in the area of social care, two in the area of administration and 14 in health. Most of these professionals had not taken a specialization or other course related to elderly care (n=20, 68.9%). The average time spent working in the institution was 4.8 years (± 4.53).

Chart 1 demonstrates the divergent central ideas that were explored extensively in workshops, and are better understood.

Chart 1. Central ideas (CI) and Discourse of the Collective Subject (DCS) of care professionals about the care they provide in an LTCF in Marília, Sao Paulo, Brazil, 2016.

CI*	DCS**
Timed and systematic care	It is very busy, the day goes very quickly, it's hard. So, you have to work with a timetable in here, because otherwise you won't manage it, if you don't establish times for things, you won't be able to provide care. It isn't like a private facility, here there's bath time, coffee time, everything has a schedule. We follow the pattern of the institution. During the day it means it's quite systematic, because it has to be, I've worked during the day and when you go into one room someone in the other room is already calling you. (P1, P4, P6 to P8, P14, P15, P17 to P23, P25 to P29)
Team care	It's gratifying, you have to pay attention to everything, every detail, and we're a team here, when someone needs extra help, we're a partnership. Every shift does their job so they don't leave a mess for the next one. (P19, P24)
Longitudinal Care	I try to carry out longitudinal follow-up care more slowly, there is no established routine for re-assessment, but as often as I can I do [...] a longitudinal follow-up. (P5)
Quality basic care	You have to pay attention to everything, every detail. For example, it's very important to talk when they're having a shower, not just put them in there and leave. You have to have a different way of looking at things. It's care for hygiene. We take care so they don't run away, or hurt themselves, or fight among themselves. (P1, P4, P19, P21)

*Central idea; **Discourse of the Collective Subject.

In order to broaden this discussion during the workshops, after the validation of the central idea by the participants, the researcher asked if this form of "producing care" affected the quality of care and how it was provided. Based on this question, two contradictory categories emerged: "did not affect the quality of care" and "affected the quality of care".

The care professionals did not believe that the quality of the care was affected, as, from their perspective, they fulfilled all their proposed activities:

> "I don't think it's affected. We don't leave anything undone, even when we're busy. [...] they never miss out on their baths [...] "(P1)

> "No, I don't think it means it's mechanical. I think it has a routine, like any other place [...]" (P7)

In contrast, the contradictory "affected the quality of care" category reflected the view that care is impaired not in relation to the techniques applied, but in terms of meeting the needs of the elderly, which is part of a concept of care and assistance focused on said techniques.

> "[...] ends up becoming more mechanical. Because when you start you know that this bath is in that corridor, and you're going to spend this much time, and that bath is in that corridor, and you're going to spend this much time. It becomes mechanical. There's no way around it [...]". (P8)

The DCS relating to teamwork showed this to be a potential strength of the institution. However the workshops revealed a certain fragmentation of care, as seen in the following statements:

> "Each shift does a completely different thing, [...] most of the time they don't warn you, when you arrive, [...] we aren't aware what's happening". (P10)

Although the problem of communication appeared to a limited degree during the interviews, in the workshops it was described as a difficulty encountered by the care professionals in the daily life of the institution, and affected the provision of care. As a strategy to overcome the challenge, they proposed improving communication using visual tools, such as the creation of a manual with the purpose of standardizing the care provided to the elderly. However, they did not suggest the possibility of constructing forms of dialogue among themselves when performing daily activities.

The DCS expressed in the CI "quality basic care" involves a social representation of care associated with eating, talking and bathing, reducing the concept by disregarding important ideas such as the co-responsibility of the subject and stimuli for autonomy.

The CI related to longitudinal care reveals that the continuity of care is due to the fact that some of these elderly people have resided in the institution for more than 20 years. Although this is described as a potential strength of the care process, it does not necessarily involve the proposed implementation of integral care, as the care provided is focused on techniques and not on the people and their perceived needs, nor on the autonomy of the subject.

The perception of managers of the care provided at the LTCF is presented in Chart 2.

The CI "humanized care" introduces a collective subject who considers characteristics of humanization to be those related to the interaction between the elderly person-care professional binomial, for the "survival" of the elderly.

The CI "preparation of care professionals" refers to the effectiveness of the professionals when dealing with the problems raised, and was validated in the workshop through the following extract:

> "[...] they show it when they like an employee [...] they don't say anything, but we can see it, they say 'she takes good care of me' [...]. So it's because they must like it ... especially the ones who are more like children, they are authentic [...]. " (G2)

However, representations of care and its delivery can result in the development of dominating relationships between caregivers and care recipients. From this vertical relationship, the resolutive approach described by the managers does not always involve the contemplation of the needs of the residents. This verticalization is reinforced by the representation of the elderly person as a "child" and not someone who can make decisions about their own needs.

With the intention of obtaining a deeper understanding of the provision of care by the professionals in the LTCF, they were asked what changes they thought were required in their training, the institution and their work.

Chart 3 highlights the required changes in the work process and in the institution (LTCF).

The changes required are those associated with changes in the work process, supported by the need for family involvement to achieve quality care for the elderly. Specific training to work in the LTCF, more care professionals in the institution and improvements in the process of communication between the care professionals and management were identified as requirements. In this sense, the DCS reveals the view that increasing the number of care professionals would improve the quality of care. From this perspective, the workshops allowed the identification of a category related to "work burden", both physical and psychological:

> "[...] just a little overburdened. Because in the morning, there is a lot of going to the doctor, taking showers, we end up doing it alone [...]" (P13)

In Chart 4 the care professionals discuss their proposals for changes in training so that they can perform their professional practice better.

Chart 2. Central idea and Discourse of the Collective Subject of the managers on what they consider to be criteria for the quality of the care provided in an LTCF, Marília, Sao Paulo, Brazil, 2016.

CI*	DCS**
Humanized care	The most important quality is humanization. Here they treat the elderly in a way that makes them feel like they're at home. After all, you aren't fiddling with a plant, so if you don't like it, if you have no patience, look for another job. (M1 and M3)
Physical conditions of the elderly and the environment	Everything is always clean [...]. It's always clean, they don't smell, they're always clean. The rooms are clean, they smell of someone who's had a bath, the general area is clean, the kitchen is always spotless, the quality of the food is good and also we always follow the guidelines of the doctor responsible for the treatment of the elderly. (M2; M3 and M4)
Preparation of care professionals	The elderly are very well looked after [...] and they don't want to leave because they must like it. The staff are very attentive, they bring both problems and solutions. There are some excellent employees who wear the uniform of the institution, in return, we try to give all the staff the best working conditions to provide the best care. (M4)

*Central idea; **Discourse of the Collective Subject

Chart 3. Central Idea and Discourse of the Collective Subject of care professionals about changes required in their work and in the LTCF, Marília, Sao Paulo, Brazil, 2016.

CI*	DCS**
Doesn't believe change is required	I haven't noticed, I think I'm doing my job. I feel fulfilled, I love what I do. And things are great the way they are. At least in my area I don't think they're needed. There was a time we even thought they were, but today everything is ok and I'm content where I am. (P2, P6, P7, P8, P9, P10, P11, P12, P13, P14, P15, P16, P17, P19, P26)
Greater availability of time	I need more time actually, I can't perform all the activities I have to organize and the monitoring I do ends up being segmented at various times. I would like to have more time to talk to them, give them a little more attention, which they like, give them affection and they end up feeling it, the lack of that part of care. [...] because they're the most needy, to talk, to give them a hug. [...] because during the day the work is very mechanical, there's a lot to do [...]. (P1, P3, P5, P18, P20, P21, P22, P23 P24, P28)
More care professionals	To meet people's needs, you would need more care professionals for specific tasks. [...] I could do everything and I would have more time to sit down and talk, cut their nails, do their nails and talk to them, have fun. And it gets hard, a lot of them are bedridden. (P1, P2, P5, P7, P18, P21, P22, P23, P24, P25, P29)
Need for more training	I need to know more and I'm even looking to take other courses to see if they bring anything new, to add to our knowledge. [...] However, we have already tried to have more training, but it is not easy to understand the thinking of the paid staff. If there is no financial benefit, they don't look kindly on it. (P4, P5)
Greater participation of family of elderly person	I'd request more care from the family. It's the lack of a family that makes the work difficult. (P4, P25)
Better interprofessional communication and communication with management	Communication with both colleagues and upper management. It would improve working together. More dialogue for the betterment of the elderly themselves. (P15, P26)
New ways to stimulate the cognitive process of the elderly	I would change how we manage care, the ways of interacting, there should be other ways to stimulate the cognitive process of the inner self. But we can't do it, due to a lack of training, a lack of space, a lack of creativity, because they want to establish other routines, due to a lack of knowledgeable personnel in this area ... I would bring in someone to read, tell a story, perform theater, something, people who can get their attention, because they can't just sleep all the time. (P5, P19, P28)

*Central idea; **Discourse of collective subject.

Chart 4. Central ideas and Discourse of the Collective Subject of care professionals about changes needed in professional training, Marília, Sao Paulo, Brazil, 2016.

CI*	DCS**
Doesn't believe change is required	I don't think so, they addressed everything. First we learned through theory, then in practice, then back for more theory, I think it has to be like this anyway. (P2, P19, P29)
More time allocated to practical activities	I didn't have much of this training in internships. In theory you should see the role of the professional, but in practice you don't. So, I think there should be a bigger practical part. If the course had more of this, we would graduate having learnt more. It focuses a lot on theory and there's a difference between what you read in a book and what you get in practice at the hospital, which is so busy. (P1, P18, P21 to P24, P27)
Specific gerontological care related content	There was nothing about the elderly on my nursing course. And if you had geriatrics, there was no follow-up care, no specific elderly person to care for or to let you understand how it is. There isn't much time allocated to the subject, they do it because they have to teach that content, but it's basic care, a little psychiatry [...]. The care is described in general terms and they describe the patient as a single thing, child, adult, elderly person, but they aren't as specific as the care here. [...] There the focus isn't on the patient and here it is on the elderly person, it's different. (P1, P4, P18, P20, P22, P23, P25, P26)
Content specific to care in the LTCF	It's rare to find a university which has contact with an LTCF, because it is a different management structure from the outpatient clinic, or hospitalization, or home visits. Because you deal with the psychological aspect, with the issue of abandonment. The aspect of social fragility, at times, is preponderant in the care of the person. So you have to know how to focus on that person's needs, you control your urge to treat everything at all costs, because it's impossible. You have to manage your anxiety better [...]. So, I think if the students had longitudinal contact with this, I think it would add something [...]. Of course, the number of people who work with LTCFs is very small, so this might not be of interest to the academic director, but on the other hand, when you need it, it's a shock. You end up having to figure out what you're going to do alone. " (P3 and P5)
Availability of refresher courses and exchanges between professionals	There should always be refresher courses and updates [...] everybody could pass on a new experience. (P28)

*Central idea; **Discourse of the collective subject.

In terms of the changes required in LTCF care training, there was a need for "more practical activities" as there was a "lack of practical training", a view also expressed in the workshop. According to the DCS, the subjects did not experience practical activities in their training that allowed them to reflect on care, and the theoretical focus was their sole or main source of training. This also demonstrates that the care professionals did not receive training in either general or specific care for the elderly.

In this context, in the views of these professionals, this lack of practical experience causes difficulties when they join the labor market, which is evident in the category "professional insecurity":

> "[...]I see that those who come from a course, they're so nervous, so I try to make them feel more confident". (P6)

The central idea "Specific gerontological care related content" reveals a subject who did not study content specifically related to care for the elderly in their training, with the subject discussed superficially in broader disciplines such as adult health, medical-clinical care and other areas. This consolidates what was presented in the anchor "the theory is different from the practice" addressed in the previous question.

In the CI "Content specific to care in the LTCF", the collective subject describes how it is rare for a higher education course to feature the LTCF as a context of professional practice, or to address the specificities of this modality of care.

DISCUSSION

Both the interviews and the validation of the data in the workshop revealed that the LTCF workers consider their form of caring to be timed, fragmented and systematic. This has its roots in the industrial revolution and is related to the development of Fordist/Taylorist production models, based on division by tasks and, consequently, the automation of production. Thus, the fact that the workers identified this model, which is widely criticized but still exists, shows that there is little space for reflection on what they are producing, and that this process of care is deeply rooted in professional services and practices[17]. This is also clear when the professionals describe the need for changes in interprofessional communication and institutional management.

In contrast, in the view of the managers, care is provided in a humanized manner. They describe the patience involved, the fact that hygiene needs are met, and refer to the commitment of the professionals who perform the care, stating that problem solving occurs. For the professionals, care requires attention to detail, such as looking closely for any disorders or changes during bathing, and taking care that the elderly do not injure themselves. In the context of the National Humanization Policy, the humanization of care strengthens the accountability of all those involved in order to construct the autonomy and protagonism of the individuals and groups that permeate it[18].

It can therefore be seen that the concept of humanization and care presented by managers and professionals is not related to this policy, as the assistance-based perspective and verticalization of care perpetuates in the LTCF, assigning a passive role to the elderly, rather than the status of protagonist established by the policy. This verticalization is reinforced by the representation of the elderly person as "a child".

This infantilization presupposes a paternalistic attitude, which in the LTCF scenario is permeated by the concepts of charity and benevolence that conflict with the reference in gerontological care, which emphasizes the importance of autonomy and independence[19].

It is therefore verified in the views of both the care professionals and the managers that the manner of delivering care, has characteristics focused on the assistance-based and charitable approach, disregarding a specific and extended formation of care for the elderly person. One of the determinants that cause this care process to occur in a fragmented and unspecified manner is based on the initial training of workers. The present study reveals that this training focuses on the approach to adult health care, but disregards gerontological care and its specificities. It should also be noted that the LTCF has not been chosen as a potential learning possibility for activities carried out during undergraduate or technical-vocational education.

Literature reveals that even in higher education courses, professionals have little contact with practices of gerontological care, especially care in the context of the LTCF[12,20].

Costa et al[21] analyzed the National Curricular Guidelines (NCG) of 14 undergraduate careers in the area of health, approved between 2001 and 2004, and identified that in nursing and some other careers there are indications of advances in the practice, management and organization of care expressed in the NCG, which propose the training of critical and reflexive professionals who are ethically responsible for the processes of changes in the contexts lived. Gerontological care does not specifically appear in the NCG.

There are challenges to guide curriculum development based on best practices, taking into account the integration and articulation of the world of work and training, with interprofessional and interdisciplinary practices, seeking the creation of singular projects which are supported in social needs.

In this sense, the nonspecific form with which care for the elderly is considered in the NCG of the health professions, compromises the insertion of this content in the pedagogical plans of courses, and fails to promote new perspectives on gerontological care[22,23]. The only NCG of health courses that addresses the need to insert the undergraduate student in this setting is that of the medical course[23], published in 2014.

The NCGs of health courses are currently being reviewed, which may allow for new approaches regarding gerontological and LTCF care, as well as the teaching-learning process. It is not only a question of inserting technical care, but rather of approaching the individual from the perspective of integral care, using low, low-high and high intensity technologies. It is necessary to consider the problems arising from epidemiological and demographic transitions and to adopt active teaching-learning methods in order to construct meaning for the content learned, and for professionals to carry out their work through shared management and interprofessional practices, creating subjects in care who are able to decide upon their own needs.

Another important aspect is the view of the managers about the training of the care professionals inserted in the LTCF. When considering that the elderly require care for their hygiene, food and affection, they disregard the specific dimensions of gerontological care, failing to mention that care professionals require such dimensions. This can be attributed to a lack of specific training in management, as these individuals occupy the position voluntarily, without being professionally trained to work in the LTCF[8], but is also explained by the conception they have about the purpose of the LTCF, which is seen as being assistance-based and charitable.

In the workshops the care professionals identified gaps in their specific training for care of the elderly and proposed permanent education in health (PEH) as a strategy to overcome the difficulties encountered in professional practice, a suggestion supported by the statement: "*maybe something once a month, a quicker thing* [...]. " (P7)

It is worth noting that the way in which the teaching-learning process has been constituted in health-centered courses, centered on teachers and the transmission of content, does not favor lifelong learning. PEH can provide strategies for professionals to reflect on their practice and to seek new knowledge from the necessities they have experienced during their professional lives, and can also allow them to collectively construct new strategies and practices[24]. For Freire, teaching cannot be reduced to the transference of "knowledge", but should mean allowing the student to generate their own way of thinking, giving meaning to what is learned [25].

Although some LTCFs emphasize that they carry out sporadic training of caregivers, arguing that that more frequent training is unnecessary and citing a lack of financial and professional resources, such approaches are still focused on techniques, first aid and nutrition[26]. It is important to extend approaches to the elderly during the aging process, through expanded clinical care and the humanization of care, building new meanings for care in the LTCF through the work of care professionals and managers, in order to overcome the charitable and assistance-based vision of institutions.

There is an urgent need for the prioritization of the elderly in the elaboration of public policies directed at the quality of the services provided, through intersectoral actions that result in better-qualified care for those in the LTCF[27].

CONCLUSION

The care professionals in the LTCF described a fragmented and mechanical working process, with communication difficulties and a lack of continuity between the activities of different shifts, and stated that care is longitudinal in the sense that the elderly remain in the institution for many years.

The managers of the institution use the conditions necessary for the survival of the elderly (food, cleanliness and humanization) as a reference for the quality of care, and state that it is important for care professionals to have patience when performing their actions. However, neither care professionals nor managers consider the possibility of the elderly person as an active subject in the care process.

The training of the professionals who work in this LTCF has not contributed to changes in care for the elderly. The focus of training is still on the health of adults, with little specificity towards the elderly and little or no attention paid to the institutionalized elderly. It was also observed that these professionals, as well as not studying specific content about gerontological care, continue to learn to care in a fragmented manner, disregarding the integrality of

the subjects in the approaches performed in training scenarios, which are more frequently set in hospital-type institutions.

Another problem identified is the disarticulation of training from the world of work. In other words the teaching-learning processes and contents are not based on social health needs. Courses at a technical or higher level do not have the support of a professional strategy that contemplates changes in health care settings, in the form of integral practice, with co-responsibility and the vision of subjects as autonomous and conscious decision making individuals who can provide different perspectives to the view the care professionals have of the elderly.

There is therefore an urgent need to revise the National Curricular Guidelines and course pedagogical plans, at technical as well as undergraduate and graduate levels, expanding and sustaining professional practice in the area of health. These should contemplate the needs and demands of the process of demographic transition in Brazil, focusing on the creation of technologies that overcome these needs and that are based on the concepts of integrality of care and collective management, modifying the limiting conceptions of the health-disease process and fragmentation in the health work process.

Permanent Education in Health is a powerful strategy for reflection on professional practice, both in education and in work, constituting a space for the elaboration of propositions of change.

There is a need to broaden research in secondary and higher education institutions to better understand approaches towards the training of professionals to provide care for the elderly and the specific needs of working in a Long-Term Care Facility for the Elderly.

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