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Dimensions assigned to Long Term Care Facilities by managers and health professionals: interfaces and contradictions

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Abstract

Objective: to analyze the dimensions assigned to long term care facilities for the elderly (LTCFs) by managers and health professionals. *Method:* a descriptive-exploratory study with a qualitative approach was conducted in the metropolitan area of Belo Horizonte, through ten focus groups with 51 managers and health professionals. Analysis was based on the content of the interviews. *Results:* considering the most common themes, three empirical categories emerged that explained the consensuses and contradictions present in the empirical material: a) the LTCF and the perpetuation of the asylum space; b) the LTCF as a space for health treatment c) a home: convergences and contradictions in the LTCF. Initially, findings relating to the political definition of the LTCF directly linked to social organs are evidenced. In the second category, LTCFs are described negatively, perpetuating the stigma of the term "asylum" which still reverberates in their daily lives. As a treatment space, LTCFs are considered health facilities due to the services offered and the presence of health professionals on a daily basis. In the third analysis, they are recognized as a home, based on current legislation that describes the LTCF as a collective, residential area. *Conclusion:* it is important to discuss the different attributes given to the LTCF to create resolutive actions in the care of the institutionalized elderly. The importance of thinking about the rights to health of the elderly and the need to understand how they inhabit this space is also emphasized.

Keywords: Aging. Elderly. Home for the Aged.

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INTRODUCTION

Rapid demographic transition has resulted in a need for the expansion of long-term care for the elderly population. Such care is characterized as a set of actions, usually provided over a sustained period, in the home or in the community, with the purpose of guaranteeing the continuity of a life with quality[1-3]. In this context, Long-Term Care Facilities for the Elderly (LTCFs) are an important structure of non-family care for the elderly.

In Brazil, however, there is a lack of consensus about the definition of a LTCF, with different nomenclatures and concepts applied. According to the National Health Surveillance Agency (ANVISA), LTCFs are governmental or non-governmental institutions that are residential in character, aimed at the collective residence of persons aged 60 or over, with or without family support[4].

For the National Council of Social Care (CNAS)[5], LTCFs are highly complex services for elderly persons who cannot live with their families and those who are homeless or suffer abandonment, violence or neglect. Other agencies associate LTCFs with health facilities because of the similarity of the services offered therein[6].

Faced with the significant increase in numbers of LTCFs and the constant demand for care structures, the guarantee of comprehensive care for institutionalized elderly persons should be based on politic directionality, which itself is mixed, involving social and health policies. Some countries already have well-structured and organized policies that consider the premise of institutionalization as an integral part of health planning and management[7-9].

Achieving this reality remains a challenge in Brazil, however. The management and inclusion of these services in the agenda of health priorities is urgently required to guarantee the principles and guidelines that govern the Brazilian Unified Health System.

The formulation of public policies and consequently the care offered to the elderly is based on the understanding that the various actors involved have of the role of LTCFs and the relevance of these institutions in the health and social network. It is believed that the meanings and dimensions attributed by administrators, coordinators and the formulators of public policies have repercussions in the establishing of priorities and the various forms of the care model offered to the elderly. Dimensions, in this case, are understood as the multiple meanings and signifiers attributed to LTCFs, the understanding of which are fundamental from a political and care perspective and help to guide practices of care.

The present study therefore aims to analyze the dimensions attributed to LTCFs by municipal administrators and LTCF professionals in the Metropolitan Region of Belo Horizonte, Minas Gerais.

METHOD

A descriptive-exploratory study with a qualitative approach was performed, based on the "Quality of Life of the Institutionalized Elderly: Aspects of Health Promotion" survey carried out in the Metropolitan Region of Belo Horizonte (MRBH) between 2014 and 2017. Data collection was performed through interviews with a semi-structured script with 51 public municipal and state health service administrators from the RMBH on the political directionality of care for the elderly, in addition to 62 professionals from 52 LTCFs, who participated in ten focus groups, with the aim of identifying their perceptions on the promotion of health for institutionalized elderly persons and the actions carried out.

The interviews were codified as follows: I for scripted interviews conducted with public administrators and FG for focus groups with professionals and managers from the LTCFs, each followed by a sequentially assigned number.

The present study was approved by the Research Ethics Committee of the Pontifícia Universidade Católica de Minas Gerais (CAAE: 31471114.4.0000.5137), and all the participants signed a Free and Informed Consent Form (FICF).

To analyze the data, the steps of the content analysis technique proposed by Bardin[10] were followed. This consisted of the organization of the empirical material, the transcription of the discourse and the exhaustive reading of the same, with the aim

of grasping the central ideas that the participants tried to transmit, as well as the relevant contents. After the central ideas were established, a vertical and horizontal reading of the text was carried out, and themes emerged through the approximation of similar ideas. The Hermeneutic-Dialectic approach was adopted as a reference for analysis, seeking to identify the social practices of individuals in terms of their consensuses and contradictions, considering the reality they experienced and conditioned in terms of historicity, taking as a starting point the maintenance and extension of intersubjectivity of a possible intention as the guiding nucleus of action[11].

RESULTS AND DISCUSSION

From the grouping of recurrent themes, three different dimensions emerged which explained the consensuses and contradictions present in the empirical material: a) LTCFs and the perpetuation of the asylum space, b) LTCFs as a treatment space, and c) a home: convergences and contradictions in LTCFs.

LTCFs and the perpetuation of the asylum space

The term asylum is no longer used due to its pejorative association as a place where needy elderly persons and those without family support are welcomed by philanthropists.

Despite the established change in nomenclature from asylum nomenclature to Long-Term Care Facility for the Elderly, suggested by the Brazilian Society of Geriatrics and Gerontology, the analysis of the discourses of the subjects indicates that even after the change of name, a strong "inheritance" of asylum remains, thus perpetuating the stigma:

> "[...] I call it this because most of the time everyone here calls it a rest home for the elderly... asylum, or put in an asylum is very critical". (FG8).

> "[...] At the time of the transition, leaving the bosom of the family for an institution is a negative milestone, most of the time, for those we care for. People still see LTCFs as asylums" (FG8).

> "[...] I don't live there, the collective home is theirs, so they're the ones who need to speak, to say that this space is not an asylum, I always say that, it's not an asylum, it's not a dumping ground for the elderly, you don't come here to die but to live, so I always emphasize this to them." (FG10).

To minimize the hurt caused to the elderly and their families by the name "asylum", other synonyms have appeared as denominations for these places: rest home and old people's home, for example. However, it is argued that the place occupied by the LTCF in the social imagination goes far beyond the names attributed to the place[12].

Studies of the elderly have indicated that abandonment can be one of the reasons that result in the elderly living in LTCFs[13,14], in tandem with the way in which the family and the institution conduct themselves and the institutionalization is handled. This, therefore, contributes to the strengthening of stigma, meaning the institution must dismantle this negative stereotype and become a place where the rights of the elderly are guaranteed by the State, the family, the community and the staff. Nevertheless, although several studies have been carried out with the lay population or the elderly themselves as subjects, it was expected that a new resignification would have been created for this phenomenon by the professionals involved in the services or even those directly involved in the creation of policies.

However, at the heart of the findings of this study is the fact that scientific knowledge does not seem to be the only area that defines meanings in relation to the construction and implementation of policies aimed at the elderly. This is because professionals, whether working in management or care, form part of social groups, and therefore share representations about health, illness, institutions, users and how they should act. In addition, they have values, habits and customs that influence their managerial and care practices, giving meaning to them. These meanings and dimensions, in turn, are located in the imaginary register and persist in their professional experiences[15].

> "The model is still an asylum model, which comes from the culture of asylums and the abandoned elderly person. Those who deal with families in

> LTCFs understand that it can be an escape route, as it is very common for a relative to say "I'm here because I have no other alternatives, you are my last option, I have nothing else". (FG 3).

> "[...] There remain other serious prejudices related to the family and in relation to cultural values. So that's the big issue. I think when you search the internet or social networks, the first word that comes up is asylum. No one knows what the LTCF is, the size of the place. Even the institutions themselves have this problem." (FG 3).

The above discourse reveals how the family itself sees the LTCF. In general, when the family opts for institutionalization, it has already sought other alternatives, often without resolving its needs. The teams are still focused on medical knowledge, and preconceived values justify their practical approach. The institutionalization of the elderly is considered as a last resort by Brazilian legislation; it does not state, however, what the other options are.

However, it is worth remembering that there are a few discordant voices that not only attribute a new nomenclature to these physical spaces, but reconstruct them through a new vision, as exemplified in the following statements:

> "[...] There is still a great cultural challenge about what an LTCF really is, what are the true activities and functions of the space, especially thinking about the promotion of health and quality of life. And I also think that putting this in practice is the great challenge, thinking of the LTCF as a place of care, but also a welcoming space for the elderly, for professionals, and the family and all who are directly or indirectly connected with this service" (FG3).

> "[...] People still see LTCFs as asylums, until a given moment where they are in and begin to experience the space, which allows it to be "re-signified". Then the LTCF becomes somewhere they are grateful for having come to." (FG4).

It is important to emphasize that the re-signification and construction of new dimensions (perceiving in a new way and giving a new meaning to what has already been formatted in our system of values and beliefs) of a given object is a slow and progressive process. It is important, therefore, that professionals, who are at the forefront of policy-making and/or coordinating care for the elderly, are open to the construction of new meanings, as these changes involve ways of thinking and acting that are culturally incorporated and cannot be transformed quickly.

Recognizing the LTCF as an option for long-term care is to enable a new vision, new care practices and to re-signify this space through legislation, the general community, professionals, family and the elderly.

LTCFs as treatment spaces

LTCFs are commonly associated with health care facilities because of the services they offer, which "meet the demand for health care" as a consequence of the profile of elderly people admitted, most of whom have chronic or incapacitating health problems. When institutionalized, the elderly arrive with a certain autonomy, but with the advancement of age and the deterioration of their health conditions, or even through inadequately provided care, this autonomy can be compromised[6], requiring increased care and health service coverage. In terms of inspection, Health Surveillance, through Directorial Board Resolution (RDC) nº 283 of 2005, ensures that the LTCF are evaluated as health services, with criteria pertinent to the hospital context, which suggests the need for a broad review of this legislation.

Regarding the provision of resources, at a national policy level LTCFs are part of the network of social care services[6]. LTCFs should be considered as hybrid structures so that financing can be provided not only for social care but also for health, as many of the professionals working in these institutions are from the area of health, suggesting a need for systematic health care.

A correlation with health services was revealed in the present study. Possibly, the history of these institutions plays an important role in the emergence of this dimension, as institutionalization began through Christian charity, through shelters and the *Santa Casa de Misericórdia* homes, with a purely care-based outlook[6].

It is worth noting that LTCFs linked to the Catholic, Pentecostal or Spiritist Church are common in the municipal regions mapped in the study, as in smaller regions, philanthropic LTCFs are fundamental for the care of elderly persons requiring institutionalization.

For those interviewed, the LTCF is comparable to a health service, usually a clinic, where the elderly receive care and treatment:

> "[...] I work in a group of health establishments. Today health surveillance employs a university-educated inspector who is qualified in these three areas ... the third group, which is mine, is made up of eight inspectors working with health care services: clinics and health care establishments, which include the LTCFs, clinics, consultancies, hospitals, radiodiagnosis, the therapeutic community, and so on." (I2).

> "[...] When you live in an institution you are deprived of everything, there's a time to eat, a time to take a shower, a time to cut your nails, a time for everything, your life is regimented." (FG6).

The institutionalized elderly, as well having access to housing and food, receive health care. This area, which involves a vast number of professionals, removes the informality of a home and, in many cases, makes the institution resemble a hospital environment. For LTCFs to maintain the characteristics of home care, health teams require organization, respect and action planning, involving the elderly in decisions that are pertinent to them.

Exemplifying the dimension of a treatment space, the institution clearly ceases to be a home that welcomes the individuals and becomes a space of procedures and health interventions, according to some reports:

> "[...] Today I'd say there is a big problem in LTCFs ... which is the hospitalization of care. [...] it's the same dynamics as a hospital, isn't it? It's time for breakfast, time to take a shower [...]. As I already said: it's their home, they have to feel at home and instead they feel eternally hospitalized" (I2).

For participants, LTCFs remain associated with health care facilities, although the sole paragraph of art. 4 of the National Immunization Program (PNI) prohibits the permanence of people with diseases that require medical or nursing care in LTCFs[6]. In contrast to the PNI, RDC 2834 describes degrees of dependency for the elderly and the need for a caregiver according to the profile of each resident, as well as indicators of quality of care, monitoring, and evaluation of the functioning of institutions similar to those used in hospitals, such as the prevalence of pressure ulcers[4].

These two opposing views point to a lack of defined policy, even in relation to the population of the LTCFs, resulting in contradictions regarding the permanence or not of elderly people who need health care in a continuous or long-term manner. If not in the ILPI, what are the other care structures capable of providing long-term care for elderly persons for whom the family cannot provide support? Should these elderly people be hospitalized? These are fundamental issues to be discussed at a policy level due to population aging and the lack of prioritization of national long-term care policy.

Finally, this paradox may be explained, according to Camarano and Barbosa[6], by the fact that LTCFs arose because of the needs of the entire community, and not the implementation by the state of a long-term care policy, which results in practices with a focus that goes beyond care.

> "[...] On the other hand, the logic is quite perverse as we say there are problems with the institutions, but we don't have much of a model, especially a standardized model, of where we want to be. So, I say that... okay, it needs to be better, but based on what, huh? We don't have much to go on, and that's a hindrance. In terms of political gameplaying, especially regarding budgets, even guaranteeing what is set out in a law, or a guideline, would be something. We fight to improve the service, but these minimums aren't predicted very clearly, so it becomes much more difficult." (I1).

A home: convergences and contradictions in LTCFs

The recognition of the institution as a home where family bonds are created between residents and professionals, based on the coexistence and bond established was also observed in the reports of professionals and managers.

> "[...] What I like about the institution I work for is it doesn't look like an institution, it looks like a house, a home, and we do our best to keep it that way, to feel at home and have freedom." (FG4).

> "Look, the affinity we have is like a family, we treat each other like family." (FG7).

In some discourses it was possible to infer that, although it is important to think about the individuality of the elderly, the routine imposed by the institution ends up creating pre-established schedules for meals, baths and showers and other activities. The lack of flexibility, need for authorization and justifications imposed on the elderly by the institution were recognized by the participants. However, the reports show the effort and commitment towards the construction of a space that resembles a home:

> "We are fighting against standardization because everything is based on a schedule, everything has its place, everything ... so, for me everything is aimed at massification. And it's not just my opinion as a psychologist but also that of my colleagues who are also health professionals, everyone contributes to it depending on their outlook, depending or not depending on the outlook, depending on their willingness to optimize an individual's quality of life." (FG7).

> "Obviously the institution will be the home of the elderly and will welcome them and try to promote activities without imposing on them, to relax the imposition by professionals of a schedule with a time for everything, a time for workshop, times to worship, times for baths or showers ... it's difficult, but this is a model of safe care." (FG9).

Routine is necessary for the proper functioning of any institution, but when these routines are ingrained or have little flexibility, they are no longer the common practices of a home. The discourse of the professionals suggests the need for a constant effort on the part of the team to configure the LTCF as a home for the elderly. This contradiction puts the space occupied by the elderly and their own autonomy at risk. An LTCF should not look like an old people's home; it should be the elderly person's home with their personal objects, their routine, their beliefs and their way of living respected and assured.

Through institutionalization, the desire of the elderly person becomes that of the institution, that is, their daily lives associate directly with the planning and organization of the LTCF. Thus, the elderly, who are unable to counter the effects of institutionalization, comply with all the demands without questioning[12].

To solve problems through health surveillance inspections and at the same time maintain a family-like environment, as well as empowering the elderly, one institution created an alternative kitchen for workshops and other activities, with an accessible space that the elderly persons could use when they wished, which had a positive impact on the individuals:

> "[...] The kitchen is really the heart of the LTCF, but the elderly persons can't use it ... but we have created a parallel kitchen in our LTCF. We have wood stoves, just to make snacks, gather everyone from occupational therapy and they will use the time this way, this time, this moment, that they have." (FG9).

Reports such as those presented above reinforce the attempt of professionals and managers to provide adequate conditions for the institutionalized elderly to recognize the LTCF environment as a space of intimacy and freedom resembling their own homes. These attempts illustrate the breaking of the LTCF paradigm as a space of exclusion and of limitations, signaling new conceptions and practices in this context.

Among the range of professionals working in the LTCFs and the range of activities that are offered by them, a desire to "eliminate" the idle time of the elderly was reported by some respondents. This range of activities, in many LTCFs, was denominated as a "menu" of activities, a nomenclature attributed by the study participants, which includes various activities, either based on the diversity of the professionals or the demands and needs of the elderly.

> "What happens is we have a weekly schedule which takes up half of the recreation area, in addition to the therapeutic activities with these health professionals, we have other activities there such as music." (FG2).

> "Just to provide them or reduce the period of idleness, because if you stop thinking about them, like I said, they are restricted to their environment ... and if you don't insist they won't participate" (FG1).

It is questionable, however, whether these elderly people are given the option of choosing or to not participate in the proposed activities if they so wish. In this sense, the dimension of the LTCF in its entirety must be constructed in a harmonious manner, respecting the desires and choices of the elderly as well as promoting the life that pulsates in this context with quality.

Gandini et al.[16] affirm that it is not enough for the LTCF to meet the rules of safe construction, sanitation, hygiene and accessibility. It must also provide an environment that incldues social and affective aspects for elderly persons who need it. A home is a space that takes into account the preferences of those who reside in it, evidenced by the availability of objects, activities and the relationships established[17].

CONCLUSION

The present study showed that professionals and managers attribute several dimensions to LTCFs, characterizing this as a difficult and extremely challenging field for those who work or live in it.

It is necessary to discuss the different attributes given to LTCFs, from the singular dimension, with the intention of carrying out pertinent and resolutive actions for the process of care for the institutionalized elderly, including the living conditions and choices of such individuals, to the structural dimension of social and health policies in an intersectoral construction.

The real and coherent consensus is also important because of the need to think about a long-term care policy with suitable funding for the complexity of this care, which therefore requires intersectorality, co-financing, and the belief by the State, society and professionals that LTCFs are spaces of life choices, and not just protective measures. To achieve this, a social commitment to the demands of aging that must be made as part of a collective cause and the apparatus of the city, that is transversal to different policies and no longer exists as a segregated space with one-off and isolated actions.

It is essential to think about the right to health, equity and integrality of these elderly people, and the need to understand the relation of how the elderly inhabit these spaces, so that they are places of inclusion and social and family recovery.

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