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Active ageing: social representations of health professionals in Elderly Health Reference Units*

Envelhecimento ativo: representações sociais dos profissionais de saúde das Unidades de Referência à Saúde do Idoso

Envejecimiento activo: representaciones sociales de profesionales de la salud en las Unidades de Referencia para la Salud de los Ancianos

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ABSTRACT

Objective: To identify social representations of health professionals providing elderly care in seven Elderly Health Reference Units in São Paulo city regarding health necessities, their role in care and promotion of active ageing. **Method:** Qualitative research, based on directives from the document "Active ageing: a policy framework" by the World Health Organization. The Discourse of the Collective Subject is employed to systematize social representations, whose central ideas were categorized using the QualiQuantiSoft® program. Four reference situations were elaborated and the one related to iatrogenesis and elder vulnerability was selected. **Results:** Twenty-nine professionals took part in this study (sixteen physicians, seven nutritionists and six nurses). Seven categories emerged from the central ideas, with higher frequency for medical conduct disagreement on referring the patient to the Basic Health Unit and the polypharmacy issue. **Conclusion:** Discourse by professionals point out the necessity of creating care that overcomes the fragmentation of the work process.

DESCRIPTORS

Aging; Aged; Public Policies; Health Personnel; Health Services for the Aged.

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INTRODUCTION

Discussing the promotion of elderly health means thinking Health Promotion as a viable path for public policy making. What space is that of Elderly Health Reference Units (URSIs – *Unidades de Referência à Saúde do Idoso*), where active ageing and health promotion are conjoined, and which conceptions sustain it?

Active ageing, developed by The World Health Organization (WHO)'s Department of Ageing and Life Course, is a health policy that offers information and supports the design of action plans aimed at promoting healthy and active ageing in the care network[1].

The WHO adopted the term "active ageing" to mean the process of achieving continuous opportunities in their three pillars: health, participation, and safety, centered in improving quality of life as people age. In the document "Active ageing: a policy framework"[1], the health pillar presents the following directives: "1.1 Prevent and reduce the burden of excess disabilities, chronic disease and premature mortality; 1.2 Reduce risk factors associated with major diseases and increase factors that protect health throughout the life course; 1.3. Develop a continuum of affordable, accessible, high quality and age-friendly health and social services that address the needs and rights of women and men as they age; 1.4. Provide training and education to caregivers".

Despite advancements achieved by this document, needs regarding implementation of its pillars persist. Particularly, the recent social and economic crisis has impacted social policies and public institutions, which suffered substantial cuts. That did not allow for a compensation of the reduction in family income, loss of social security and instability in pensions of many citizens, including the elderly. This setting reinforces the importance of building plans that integrate the principles of active ageing[2].

Health professionals involved in caring for the elderly population, according to the health policies, must develop integral and interdisciplinary care based on expanded clinic. Nonetheless, there is evidence that such approach is being implemented with restrictions due to insufficient professional education and the way the work process is organized in the health area. Health education for primary care is still provided in a fragmentary and specialized manner, based on a biological model, even with all the developments achieved[3].

The URSIs are health services specializing in caring for the elderly in their coverage area. As a part of the secondary attention level, they develop preventive actions, health promotion and protection, and educational actions, maintaining an interdisciplinary and intersectoral profile, observing what is more broadly established by the National Health Promotion Policy (*Política Nacional de Promoção à Saúde*)[4].

The attributions of professionals working at URSIs are evaluating all aspects of the patient's complaints, such as the psychosocial and comorbidities, as well as understanding the current phase of the elder's ageing process (robust, pre-fragile or fragile) to determine a subsequent conduct.

To evaluate the interpretation of elderly care by URSI professionals, one opted for employing the Social Representation Theory. Employing a structural approach, it accounts for the cognitive process and, consequently, while encompassing theory and work methods, it abides by the impact and influence of social factors and language choice over the characterization, interaction and evaluation of these representations[5].

In this approach, understanding the care process is believed to be possible by drawing the interviewee's subjectivity to their social representations on work in the health area and ageing in the contemporary society. Thus, this study had as its goal identifying social representations of professionals caring for the elderly in the seven URSIs in São Paulo city regarding their health needs, as well as their role in the care and promotion of active ageing.

METHOD

Study type

Qualitative, cross-sectional and descriptive-based study.

Population

The study participants were physicians, nutritionists, and nurses caring directly for the elderly in the URSIs. The study was conducted in all seven unities of São Paulo's Municipal Health Office. They are distributed in territories of Regional Health Coordinating Departments (CRS – *Coordenadorias Regionais de Saúde*) and Administrative Districts (AD) as follows: Center-west (one in Sé), North (one in Tremembé and one in Vila Guilherme), Southeast (one in Mooca and one in Ipiranga), South (one in Cidade Ademar and one in Santo Amaro). These services were selected due to being unities specializing in elderly care in their coverage areas.

The investigated group was assembled in accordance to the following criteria: being a nurse, physician or nutritionist, and providing service directly to the population, regardless of speciality.

Initially, this research would include an interview with all health professionals working at the URSIs. Nonetheless, due to the high number of interviews and time constraints, only nurses, physicians and nutritionists were chosen among the professional categories.

Data collection

Data collection took place from September to November 2015. Research participants engaged in a semi-structured interview whose design included data on personal and professional profile (age, gender, profession, position, time of employment and workplace) and four reference situations regarding the elderly health needs and the role of care and Active ageing promotion.

These situations were assembled from information obtained by an URSI health professional and by the person

responsible for the Technical Area of Elderly Health in the Basic Attention Coordinating Sector. The professionals' experience enabled contact with these services' reality and reflection on the concept of health promotion in its daily practice.

For this article, the reference situation presented below was selected, considering that it approached the dimensions of needs and elderly care in the basic health care network, of the contradictions in the work process and of vulnerability in the ageing process in society. The development of the situation was based on the document "Active ageing: a policy framework", in the perspective of directive 1.3, regarding iatrogenesis prevention in the care process.

"Mr. Isac, eighty-seven years old, suffers from hypertension, diabetes, dyslipidemia, generalized pain, impaired hearing and postural instability. He goes to the geriatric appointment alone, where he complains of intestinal constipation. Mr. Isac takes six medications to treat the comorbidities. As a routine procedure, the physician has demanded laboratory exams and prescribed three additional medications (laxative, analgesic and muscle relaxant), due to the patient's complaint. Since it was an independent patient and aggravations had been compensated, the physician considered there was no need to keep this patient in the URSI and has forwarded him to the original Basic Health Unit (UBS – Unidade Básica de Saúde). If you were the physician, would you proceed likewise or not? Why?"

A portable recorder was utilized in data collection for interview conduction and recording. The material was transcribed in the QualiQuantiSoft® program, version 1.3c.

Data treatment and analysis

The method adopted for processing the discourse content was Discourse of the Collective Subject (DCS), which is founded on identifying social representations of health professionals. This technique consists of selecting Key Expressions (KE) from each individual answer. The KE are the most significant interview excerpts. They correspond to Central Ideas (CI), which synthesize the collective discourse manifesting in the KE. Each KE set with the same or complementary meaning will subsequently integrate the DCS. Therefore, the DSC is a discourse encompassing the KE which have the same CI category[6-7].

The individual discourses were methodologically treated in the QualiQuantiSoft® program. It organizes qualitative data, such as opinion polls and social representation research, presented as discourse. In this tool, the qualitative dimension manifests through DCS, whereas the quantitative emerges in the frequency of discourses with the same CI or a similar one. Therefore, after all the interviews have been typed and transcribed, this program facilitates classification in CI categories and discourse elaboration, as well as the production of quantitative reports, which produces the percentage of individuals contributing with their KE in relation to the CI[8].

Special care by the researcher is highlighted as necessary to select interview excerpts with the most relevance to a certain theme, as well as establishing delimitations and correcting mistakes and inadequacies in these discourses. Nonetheless, it is essential that researchers preserve fidelity to the discourse's meaning, not introducing their interpretation or opinion. Therefore, the program will be able to run classification tasks based on factual elements extracted directly from the subjects' interviews[8].

Finally, the produced DCS were analyzed according to an articulation related to the United Nations principles for the elderly regarding the health pillar described in the project "Active ageing: a policy framework"[1].

Ethical aspects

The study was evaluated and approved by Universidade São Judas Tadeu's Ethics Committee in Opinion number 1.220.070/2015 and by São Paulo's Municipal Health Office in Opinion number 1.221.399/2015. Norms and directives for conducting research involving human beings were followed, abiding by the determinations provided in resolution 466/12, by the National Health Council. During conduction, professionals' secrecy and anonymity were ensured, as well as the privacy and freedom of participating or not in the research and abandoning it at any time, using the Informed Consent Form. The interviewees were identified by the generic term "Ursi" followed by numbers in data collection order, e.g., Ursi01, Ursi02 and so on.

RESULTS

From the thirty-one invited professionals who corresponded to the defined criteria, two refused participation.

According to Table 1, among the twenty-nine participants, sixteen (55.2%) were physicians, seven (24.1%) were nutritionists and six (20.7%) were nurses. These percentages reflect the distribution of professionals in the selected sample, with higher proportion of female professionals (79.3%), in their forties or older (62.1%). Regarding work experience at URSIs, one to five years was observed to be predominant.

Table 1 – Characterization of health professionals interviewed in the URSIs per gender, age, profession and work experience – São Paulo, SP, Brazil, 2015.

Variable	N	%
Total of professionals	29	100.0
Gender		
Female	23	79.3
Male	6	20.7
Age		
< 40	11	37.9
≥ 40	18	62.1
Profession		
Physician	16	55.2
Nurse	6	20.7
Nutritionist	7	24.1

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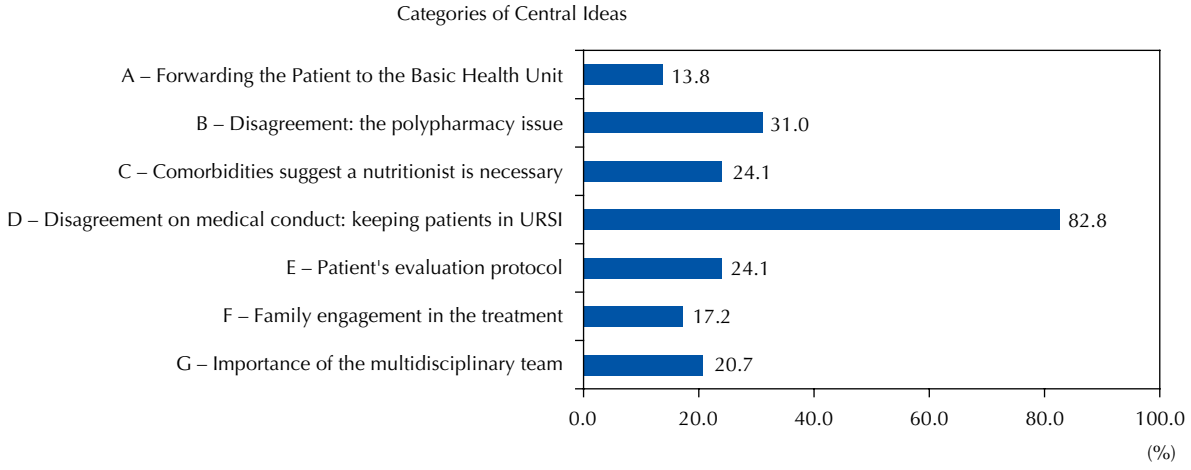
Variable	N	%
Time in URSI		
< 1 years	8	27.6
1-5 years	14	48.3
> 5 years	7	24.1

From the selected reference situation, sixty-two CI emerged from the interviews with health professionals. They were grouped in the following categories: A – Forwarding the Patient to the Basic Health Unit; B – Disagreement: the polypharmacy issue; C – Comorbidities suggest a nutritionist is necessary; D – Disagreement on medical conduct: keeping patients in URSI; E – Patient's evaluation protocol; F – Family engagement in the treatment; G – Importance of the multidisciplinary team. Based on the consolidated CI categories, seven DCS were developed.

Figure 1 presents the distribution of answers from the twenty-nine subjects by discourse CI category. Taking into account that each professional's discourse may be included in more than one category, the highest frequencies are identified in categories D (82.8%, i.e., 24 out of 29 professionals), B (31%, i.e., 9 out of 29 professionals), C and E (24.1%, i.e., 7 out of 29 professionals).



Note: (n=29).

Figure 1 – Distribution of the percentage of professionals by categories of Central Ideas identified in their discourses – São Paulo, SP, Brazil, 2015.

Central Idea Category A – Forwarding patients to the Basic Health Unit

DCS 1: *Departing from the presuppositions that this geriatrician has examined the patient and that he has seen a nutritionist, an otolaryngologist, a physiotherapist and a falls group, and that he is stable, he would go to a UBS, because here, in the URSI, basically, patients with cognitive disorders are prioritized, patients who suffer repeated falls. Therefore, if the patient is fully compensated in his condition, then yes, he must be forwarded to his original Basic Unit, because this is the URSI's proposal (Ursi 01, Ursi03, Ursi 05 and Ursi19).*

This DCS contemplates directive 1.1 regarding prevention goals and efficient treatment by humanized screening services and less costly and more efficient therapeutic processes. Some of the objectives laid out by directive 1.3. were also identified in the DCS. This directive establishes the need for the development of a high-quality, accessible social and health service, suitable for the third age, specifically concerning continuum of care throughout the life course, based on promoting health and disease prevention, as well as the right to fair and equal access to services and coordinated ethical care systems.

Figure 2 summarizes the correspondence between reference situation, KE and CI emerging from the semi-structured interview, data analysis and treatment regarding the A category, its DCS and relation with what is advocated by the Reference Document, used to analyze social representations by URSI professionals. The other CI and DCS categories followed the same line of analysis.

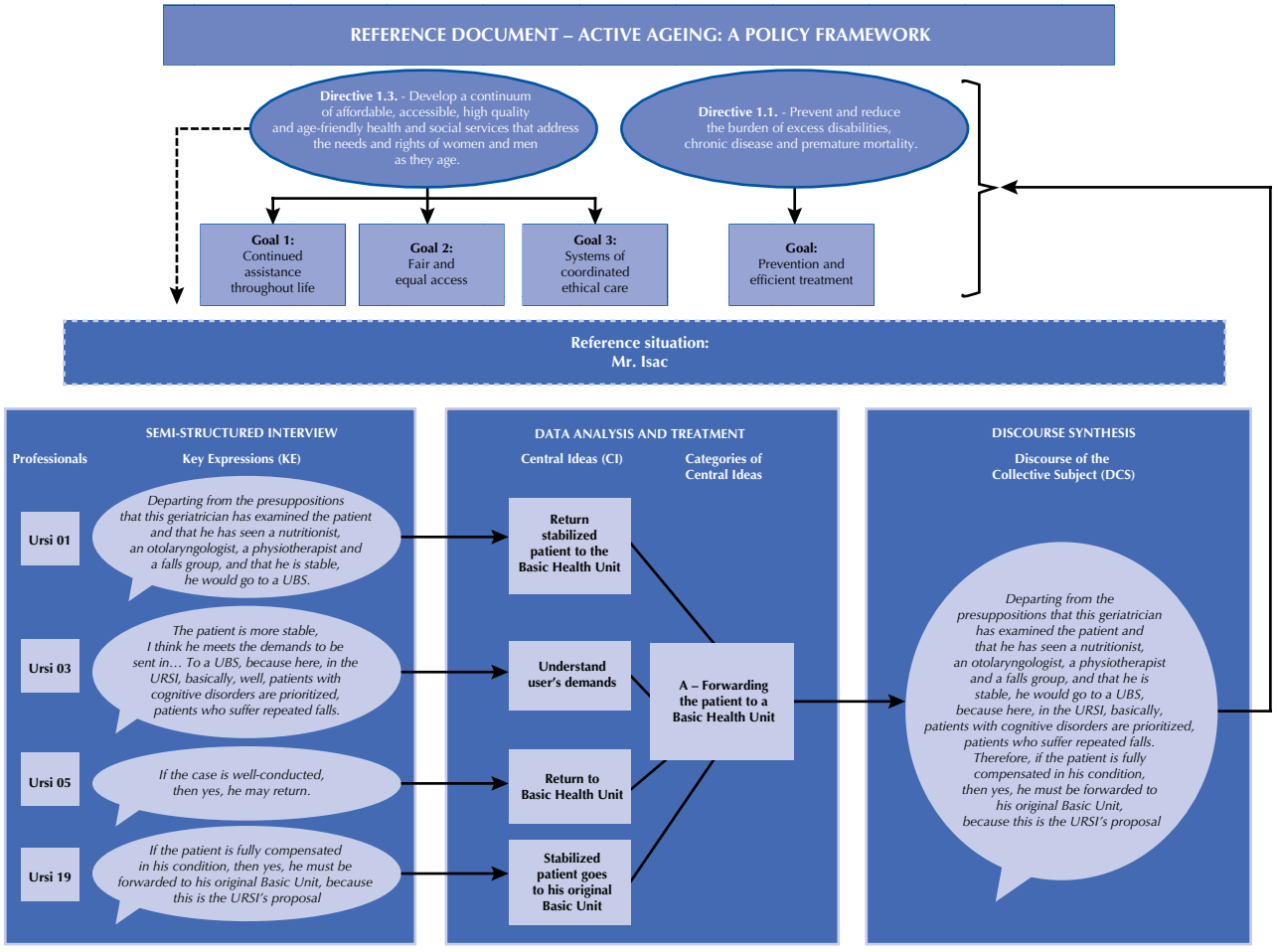


Figure 2 – Schematic representation of the Discourse of the Collective Subject construction departing from the semi-structured interview and its relations with directives and goals in the document "Active ageing: a policy framework".

Central Idea Category B – Disagreement: the polypharmacy issue

DCS 2: *If he were a patient under my care, before anything else, I would try to reduce this medication. I would follow him for some consults, trying to reduce the list of medications he uses – from the polypharmacy. He takes six medications already and the geriatrician has introduced three more, including muscle relaxants, what, by the way, may increase drowsiness, as well as fall risk. Therefore, reviewing medication already in use – if they are truly necessary – and avoiding to the utmost adding more medication to his prescription. He comes to appointments alone, but he is eligible to being cared for at URSI exactly to control these variables and avoid iatrogenesis; also avoiding that medication adds up, preventing hence these events, including polypharmacy (Ursi 02, Ursi03, Ursi05, Ursi11, Ursi15, Ursi17, Ursi22, Ursi23 and Ursi24).*

In the DCS above, the following contents can be observed: that of directive 1.2, which suggests reducing risk factors associated to the main diseases and increasing protection factors, concerning the goal of reducing improper medication prescription by health professionals; and directive 1.3, which led to the reference situation in the goal of preventing iatrogenesis.

Central Idea Category C – Comorbidities suggest a nutritionist is necessary

DCS 3: *I would forward Mr. Isac to a nutritionist for a dietary re-education, since he has arterial hypertension, diabetes and dyslipidemia. It is important to perform a nutritional evaluation for a better dietary orientation, isn't it? Basically, increasing fibers and checking how much liquid he drinks. Orient more laxative, natural food, right? With fibers and everything else, I would not use a laxative (...). (Ursi03, Ursi05, Ursi06, Ursi12, Ursi13, Ursi14 and Ursi18).*

This DCS, other than observing directive 1.1, which proposes preventing and reducing the amount of excess disabilities, chronic diseases and early mortality, specifically for the goal of prevention and efficient treatment, deals with directive 1.2 regarding the goals nutrition and healthy diet, with the objective of ensuring nutrition that is proper to each age during the whole life.

Central Idea category D – Disagreement on medical conduct: keeping patients in URSI

DCS 4: *This patient has a strong recommendation to stay at least for a while in URSI, until all these questions are better solved. Even though he has some independence, the aggravations are enough to keep him in URSI. Many medications, postural instability, hearing deficit, unaccompanied. He is hypertense, diabetic, dyslipidemic, has generalized pain and intestinal constipation. So, he is a patient who has multimorbidities, isn't he? And not only because of multimorbidities, but also because of polypharmacy, such a patient has a true recommendation of maintaining follow-up in the URSI. So, I wouldn't send him to the UBS at all! (Ursi02, Ursi04, Ursi06, Ursi07, Ursi08, Ursi09, Ursi10, Ursi11, Ursi13, Ursi14, Ursi15, Ursi16, Ursi17, Ursi18, Ursi20, Ursi21, Ursi22, Ursi23, Ursi24, Ursi25, Ursi26, Ursi27, Ursi28 and Ursi29).*

DCS 4 endorses directive 1.1 regarding the goal of prevention and efficient treatment, as well as directive 1.3 in the goals of continuum of care throughout the life course and fair and equal access, directives related also to DCS 1.

Central Idea Category E – Patient's evaluation protocol

DCS 5: *We are working here with a material, a model, which has been developed very recently, especially regarding these older, unstable patients. A questionnaire, named AMPI, is applied, to verify in which degree of elder he is at – healthy elder, pre-fragile or fragile elder. If it really is on the record that this patient, even with a chronic disease, has some degree of independence, he may eventually return to his original Unit. He has no need of staying in an URSI and, when a new geriatric evaluation is demanded, he'll return to the geriatrician, so it's not the case that he'll leave and never come back (Ursi01, Ursi03, Ursi05, Ursi08, Ursi09, Ursi22 and Ursi27).*

In this DCS, the directives observed were 1.1, regarding the goal prevention and effective treatments, and 1.3, on the goals continuum of care throughout the life course, fair and equal access to healthcare services and ethical and coordinated systems of care.

Central Idea Category F – Family engagement in the treatment

DCS 6: *First, I would ask him to come with a companion to the appointments, to reduce the risk of this patient while walking in the streets unaccompanied. Sometimes orienting a care plan to a relative, or to someone, and then explain why he is being forwarded to the UBS. Because, generally, elders think they are a burden in their son's life, and they don't want their son to come, interrupt their job to accompany them. Nonetheless, in such a circumstance, the family would have to accompany him (Ursi08, Ursi18, Ursi21, Ursi24 and Ursi26).*

In this DCS, the following directives were highlighted: 1.1, regarding the goal improving quality of life for people with com chronic diseases and disabilities, favoring their continuous independence and interdependence and community support for relatives; and 1.4, which advocates training and education to caregivers in the goal informal caregivers.

Central Idea Category G – Importance of the multidisciplinary team

DCS 7: *Staying in URSI, he would have access to multidisciplinary care, wouldn't he?*(...) *So, he might be forwarded to a nutritionist, a psychologist; he needs a social worker, needs an occupational therapist, he could be forwarded to a physiotherapist, to help with these generalized pains. As for the hearing deficit, he could be forwarded to a phonoaudiologist, couldn't he? And also because we know that URSI, as a São Paulo model, has a multidisciplinary team, whereas the UBS doesn't (Ursi07, Ursi13, Ursi16, Ursi18, Ursi26 and Ursi28).*

In DCS 7, contents from the directive 1.2 are highlighted. It advocates reduction of risk factors associated to the main diseases and the increase of protection factors, such as stimulating physical activities, ensuring healthy diets and the development of autonomy and cognitive skills, improving psychological well-being; as well as directive 1.3, regarding goal continuum of care throughout the life course, based on the promotion of health and disease prevention.

As CI categories were outlined and DCS were produced, their analysis was carried according to and in articulation with the directives and goals of the research's reference document (Chart 1).

Chart 1 – Categories of Central Ideas, Discourse of the Collective Subject and its relations with the directives and goals in the reference document – São Paulo, SP, Brazil, 2015.

Central Idea (CI) Category	Discourse of the Collective Subject (DCS)	Directive	Goal
A – Forwarding the Patient to the Basic Health Unit	DCS 1	1.1	Prevention and efficient treatment
		1.3	Continuum of care throughout life course Fair and equal access Systems of coordinated ethical care
B – Disagreement: the polypharmacy issue	DCS 2	1.2	Medications
		1.3	Iatrogenesis

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C – Comorbidities suggest a nutritionist is necessary	DCS 3	1.1	Prevention and efficient treatment
		1.2	Nutrition Healthy food
D – Disagreement on medical conduct: keeping patients in URSI	DCS 4	1.1	Prevention and efficient treatment
		1.3	Continuum of care throughout life course Fair and equal access
E – Patient's evaluation protocol	DCS 5	1.1	Prevention and efficient treatment
		1.3	Continuum of care throughout life course Fair and equal access Systems of coordinated ethical care
F – Family engagement in the treatment	DCS 6	1.1	Quality of life
		1.4	Informal caregivers
G – Importance of the multidisciplinary team	DCS 7	1.2	Physical exercise Nutrition Healthy food Psychological factors
		1.3	Continuum of care throughout life course

DISCUSSION

The elderly do not constitute a homogeneous group and diversity among individuals is usually increased with age[1]. Such population, nonetheless, presents well-established singularities: greater prevalence of chronic diseases, which lead to more costs; bigger frailties and reduced availability of social and financial resources, both individually and socially[9].

Due to these characteristics, most functioning care models regarding the elderly focus disease only, proliferating appointments with experts, non-shared information, prescription of numerous potentially inappropriate drugs and risk for improper drug interaction. Consequently, iatrogenesis is highly prevalent in this population[9-10].

Recent studies question this model, suggesting "that attention must be organized in an integrated manner, and care must be coordinated along care pathways, following a network rationale"[11].

The social representations of subjects in this research, articulated in the DCS, clarify all these contradictions routinely lived in URSIs.

Lack of consensus among health professionals is observed as to the care models revealed in DCS 1 and DCS 4. From all interviewees, twenty-four would keep this patient in the URSI *('This patient has a strong recommendation to stay at least for a while in URSI...')*, and four would forward him to the original UBS *('...Therefore, if the patient is fully compensated in his condition, then yes, he must be forwarded to his original Basic Unit…')*.

Studies based on "evidence show that the model of elderly health care, to be efficient, must encompass activities organized in hierarchical flow, and that, even if they are carried independently, they must interact"[12]. Basic Care, as proposed in the National Policy of Basic Care (PNAB – *Política Nacional de Atenção Básica*), constitutes the first contact of users with the care network and "is characterized by developing a set of collective and individual actions that include health promotion and protection, harm prevention, diagnosis, treatment, rehabilitation, and health maintenance"[13].

To ensure longitudinality of care, the Health Care Networks (HCN) strategy is increasingly highlighted. It aims to integrate actions and health services based on continuous, integral and humanized care, enabling better outcomes for SUS regarding access, equity, clinical and sanitary efficiency and economic efficiency[14].

It is essential to understand that integral health care cannot be reduced to a single service or health system. The dimension of integrality is established by juncture of a solidarity network and intersectoral policies, services and professionals[15].

Forwarding the patient to the original UBS or maintaining him in URSI led to doubts on the practical conduct of health professionals. Maybe this impasse shows that, although the importance of multidisciplinary work is recognized, as in DCS 7 *('Staying in URSI, he would have access to multidisciplinary care...')*, this strategy is still little strengthened and far from interdisciplinary. Additionally, in DCS 5, professionals are observed not to fully employ the understanding of the validity of protocols regulating the work process, the flow of forwarding and attributions of each assistance level: *('We are working here with a material, a model which has been developed very recently (...) a questionnaire, named AMPI...')*. The clinical protocols, the Therapeutic Directives and the Basic Care Brochure are important tools for supporting this care management, and they require special attention and knowledge from professionals. The usage of these instruments tends to minimize the variability of information and conducts among the health team, establishing limits of action and cooperation between diverse professionals[16]. A study conducted with ICU professionals, related to palliative care, has also evidenced different views

of care efficiency in patient recovery, difficulty in interdisciplinary collaboration and absence of assistance protocols, what complicates decision-making regarding care[17]. In Mr. Isac's case, it is clear the importance of a process of permanent education and training on abiding by preestablished protocols for the care offered in URSI. Understanding each case's demands becomes essential for a proper conduct by the URSI's multidisciplinary team.

The polypharmacy issue emerges as another aspect of the care model, centered on the disease, that reveals professionals' concern – according to DCS 2 *('If he were a patient under my care, before anything else, I would try to reduce this medication. I would follow him for some consults, trying to reduce the list of medications he uses – from the polypharmacy...')*. Polypharmacy is related to a relevant share of iatrogenesis, leading to side effects and adverse reactions in the elderly, compromising their functionality[18-19]. A qualitative study carried with users registered in Family Health Units in the state of Bahia shows the same questioning by workers regarding the prescriptive-curative character of medical appointments, which do not always provide listening and knowledge of health needs, emphasizing biomedical aspects by valuing medicine prescription[20].

Along with this DCS, and taking into account the patient's complaint, health professionals have identified the importance of nutritional intervention as a positive factor in the treatment, avoiding, hence, the introduction of more medication and its consequences to elderly health, according to DCS 3 *('... It is important to perform a nutritional evaluation for a better dietary orientation, isn't it? Basically, increasing fibers and checking how much liquid he drinks. Orient more laxative, natural food, right? With fibers and everything else, I would not use a laxative...')*. There is consensus that nutrition plays an important role in the ageing process and in the etiology of age-related diseases, as well as in the functional decline in occurrence of disabilities; therefore, the evaluation and nutritional monitoring of the elder are necessary for proper care and planning of actions for health promotion[21]. Another aspect raised by DCS 3 was the importance of liquid ingestion. If it is neglected or forgotten by the elder, there is dehydration risk. These may be due to various causes, such as diabetes, dementia or ageing itself, which reduces the mechanisms of thirst regulation[22-23].

DCS 6 highlights the importance of familial involvement in elderly care (*'First, I would ask him to come with a companion to the appointments, to reduce the risk of this patient while walking in the streets unaccompanied. Sometimes orienting a care plan to a relative, or to someone, and then explain why he is coming to the UBS'*). Elderly-related health policies advocate that older people and their caregivers need to be involved in planning and implementation of activities to broaden their knowledge on active ageing and its care[1], corroborating the DCS. The chronic disease in this situation does not equal uselessness or dependency, and family plays a crucial role in these circumstances, since it can reinforce in the elderly self-care, offering exercise of their autonomy[24].

In the previously referred discourse, it is also highlighted the resistance by patients unwilling to hinder their relative's routine *('... elders think they are a burden in their son's life, and they don't want their son to come, interrupt their job to accompany them')*. Currently, the elder are much more prone to ageing well than becoming dependent. Old age is no longer associated to disease or loss of control over one's own life. Particularly, the elderly want their wishes to be considered, as well as being able to make decisions affecting their autonomy and their quality of life, even when faced by chronic diseases[25].

Trying to rescue an elder's family relations and understanding his life environment and who his support network is are factors that may contribute to attention in following the case and to treatment adhesion.

The adoption of the model with focus on health promotion and HCN strengthening would include "at least two crucial elements for elderly health care: the reduction of iatrogenesis and the organization of the care flow. The directives and clinical protocols are also essential in constructing the therapeutic project"[11], "a driving force behind the flowing of care path, which establishes the assistance proceeding in accordance with demands"[12].

As limitation of this study, one points the fact that not all the URSI's staff was interviewed. Other professionals could have provided different emphasis to elderly care and needs in the search for active ageing. This study is also limited by the non-inclusion in DCS of articulation with other sectors, such as social workers, people with disabilities and even a comprehension of cultural and socioeconomic reasons involving the elderly and their family in their environment. Nonetheless, the fact that the research was conducted in the totality of URSIs in São Paulo is indicated as a potentiality.

The study is envisioned to continue, including all health professionals involved in the process, as well as service managers and other actors in this network, such as representatives of users in managing councils in the unit. Learning the perceptions of the elderly cared for in the URSIs and their relatives would also be an important approach for a new research, which would enable integration of the biopsychosocial and spiritual dimensions of ageing.

Due to this study's findings, one suggests the elaboration of permanent education plans to URSI professionals, ranging from clinical protocols and reference and counter-reference flows, as a form of reflection and review of care practices based on the National Health Promotion Policy, on the Basic Care Brochures – Aging and Elderly Health, on Health Care Networks, among others.

CONCLUSION

As a return to this study's main objective, professionals were verified to base their actions on elderly health needs, as in DCS analysis, contents dealing with the four document directives on active ageing were identified.

Regarding their role in care and promotion of Active Ageing, the DCS point towards building multidisciplinary care, with practices based on expanded clinic.

Thus, this research stimulates reflection on the care network regarding measures to be taken to improve quality of care and promoting Active Ageing to the population which was the study's object.

RESUMO

Objetivo: Identificar as representações sociais de profissionais de saúde que atendem idosos nas sete Unidades de Referência à Saúde do Idoso no município de São Paulo quanto às necessidades em saúde, seu papel no cuidado e na promoção do envelhecimento ativo. **Método:** Pesquisa qualitativa, fundamentada nas diretrizes do documento "Envelhecimento ativo: uma política de saúde" da Organização Mundial da Saúde. Utilizou-se o Discurso do Sujeito Coletivo para sistematizar as representações sociais, cujas ideias centrais foram categorizadas utilizando-se o *software* QualiQuantiSoft®. Foram elaboradas quatro situações referência e selecionou-se aquela relacionada à questão da iatrogênese e vulnerabilidade do idoso. **Resultados:** Participaram do estudo 29 profissionais (16 médicos, 7 nutricionistas e 6 enfermeiros). Dos discursos dos entrevistados, emergiram sete categorias de ideias centrais, com maior frequência para discordância da conduta médica quanto ao encaminhamento do paciente à Unidade Básica de Saúde e o problema da polifarmácia. **Conclusão:** Os discursos dos profissionais apontam a necessidade da construção de um cuidado que supere a fragmentação do processo de trabalho.

DESCRITORES

Envelhecimento; Idoso; Políticas Públicas; Profissional de Saúde; Serviços de Saúde para Idosos.

RESUMEN

Objetivo: Identificar las representaciones sociales de los profesionales de la salud que atienden a los ancianos en las siete Unidades de Referencia para la Salud de los Ancianos en la ciudad de São Paulo con respecto a las necesidades de salud, su papel en la atención y promoción del envejecimiento activo. **Método:** Estudio cualitativo, basado en las directrices del documento "Envejecimiento activo: un marco político" de la Organización Mundial de la Salud. El Discurso del Sujeto Colectivo se utilizó para sistematizar las representaciones sociales, cuyas ideas centrales se clasificaron utilizando el *software* QualiQuantiSoft®. Se elaboraron cuatro situaciones de referencia y se seleccionó la relacionada con el tema de iatrogénesis y vulnerabilidad de los ancianos. **Resultados:** Veintinueve profesionales (16 médicos, 7 nutricionistas y 6 enfermeros) participaron en el estudio. De los discursos de los entrevistados, surgieron siete categorías de ideas centrales, con mayor frecuencia para el desacuerdo de la conducta médica con respecto a la derivación del paciente a la Unidad Básica de Salud y el problema de la polifarmacia. **Conclusión:** Los discursos de los profesionales apuntan a la necesidad de crear una atención que supere la fragmentación del proceso de trabajo.

DESCRIPTORES

Envejecimiento; Anciano; Políticas Públicas; Personal de Salud; Servicios de Salud para Ancianos.

REFERENCES

1. Organização Mundial de Saúde. Envelhecimento ativo: uma política de saúde [Internet]. Brasília: OPAS; 2005 [citado 2018 jun. 10]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/envelhecimento_ativo.pdf
2. Kalache A. Vested rights, active aging and resiliance: the importance of such concepts throughout life [editorial]. Rev Bras Geriatr Gerontol [Internet]. 2017 [cited 2018 Nov 02];20(2):159-60. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1809-98232017000200159&lng=pt
3. Carnut L. Cuidado, integralidade e atenção primária: articulação essencial para refletir sobre o setor saúde no Brasil. Saúde Debate [Internet]. 2017 [citado 2018 nov. 3];41(115):1177-86. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-11042017000401177&lng=pt&tlng=pt
4. São Paulo (Cidade). Secretaria Municipal de Saúde; Coordenação de Atenção Básica. Documento norteador: Unidade de Referência à Saúde do Idoso URSI [Internet]. São Paulo: PMSP; 2016 [citado 2018 nov. 2]. Disponível em: https://www.prefeitura.sp.gov.br/cidade/secretarias/upload/saude/DOCUMENTONORTEADOR%20URSIversaofinal09012017.pdf
5. Marková I. The making of the theory of social representations. Cad Pesq [Internet]. 2017 [cited 2018 Nov 2];47(163):358-75. Available from: http://www.scielo.br/scielo.php?pid=S0100-15742017000100358&script=sci_arttext&tlng=en
6. Lefèvre F, Lefèvre AMC. Pesquisa de representação social: um enfoque qualiquantitativo: a metodologia do discurso do sujeito coletivo. Brasília: Líber Livro; 2010.
7. Morais VS, Chaves APL. Perception of municipal health managers regarding environmental health: Cerrado Araguaia Tocantins intermunicipal health consortium. Saude Soc. [Internet] 2016 [cited 2018 Nov 2];25(2):349-60. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902016000200349&lng=en&nrm=iso&tlng=en
8. Nicolau KW, Escalda PMF, Furlan PG. Método do Discurso do Sujeito Coletivo e usabilidade dos softwares Qualiquantisoft e DSCsoft na pesquisa qualiquantitativa em saúde. Fronteiras J Soc Technol Envirom Sci [Internet]. 2015[citado 2018 dez. 5];4(3). Disponível em: http://periodicos.unievangelica.edu.br/index.php/fronteiras/article/view/1413
9. Veras RP, Oliveira M. Aging in Brazil: the building of a healthcare model. Ciênc Saúde Coletiva [Internet]. 2018 [cited 2018 Dec 20];23(6):1929-36. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232018000601929&script=sci_arttext&tlng=en
10. Novaes PH, Cruz DT, Lucchetti ALG, Leite ICG, Lucchetti, G. The "iatrogenic triad": polypharmacy, drug–drug interactions, and potentially inappropriate medications in older adults. Int J Clin Pharm. 2017;39(4):818-25. DOI: http://dx.doi.org/10.1007/s11096-017-0470-2
11. Veras R. Care pathway for the elderly: detailing the model. Rev Bras Geriatr Gerontol [Internet]. 2016 [cited 2019 May 20];19(6):887-905. Available from: http://www.scielo.br/pdf/rbgg/v19n6/1809-9823-rbgg-19-06-00887.pdf
12. Oliveira MR, Veras RP, Cordeiro HA, Pasinato MT. A mudança de modelo assistencial de cuidado ao idoso na Saúde Suplementar: identificação de seus pontos-chave e obstáculos para implementação. Physis [Internet]. 2016 [citado 2019 May 22];26(4):1383-94. Disponível em: http://www.scielo.br/pdf/physis/v26n4/1809-4481-physis-26-04-01383.pdf
13. Bara VMF, Paz EPA, Guimarães RM, Silva BF, Gama BBM, Moratelli L. Diagnóstico de utilização do instrumento de avaliação da atenção primária à saúde - PCATool-Brasil versão adulto - para população idosa. Cad Saúde Colet [Internet]. 2015 [citado 2019 nov. 5]; 23(3):330-5. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-462X2015000300330&lng=pt

14. Brasil. Ministério da Saúde. Portaria n. 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília; 2017 [citado 2018 nov. 4]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/ prt2436_22_09_2017.html

15. Silva PFA, Baptista TWF. A Política Nacional de Promoção da Saúde: texto e contexto de uma política. Saúde Debate [Internet]. 2015 [citado 2018 dez. 16];39(n.esp):91-104. Disponível em: http://www.scielo.br/scielo.php?pid=S0103-11042015000500091&script=sci_abstract&tlng=pt

16. Conselho Regional de Enfermagem de São Paulo. Guia para construção de protocolos assistenciais de enfermagem [Internet]. São Paulo: COREN; 2017 [citado 2018 nov. 2]. Disponível em: https://portal.coren-sp.gov.br/sites/default/files/Protocolo-web.pdf

17. Gulini JEHMB, Nascimento ERP, Moritz RD, Rosa LM, Silveira NR, Vargas MAO. Intensive care unit team perception of palliative care: the discourse of the collective subject. Rev Esc Enferm USP. 2017;51:e03221. DOI: http://dx.doi.org/10.1590/S1980-220X20160 41703221

18. Manso MEG, Biffi ECA, Gerardi TJ. Prescrição inadequada de medicamentos a idosos portadores de doenças crônicas em um plano de saúde no município de São Paulo, Brasil. Rev Bras Geriatr Gerontol [Internet]. 2015 [citado 2018 nov. 2]:18(1):151-64. Disponível em: http://www.scielo.br/scielo.php?pid=S1809-98232015000100151&script=sci_abstract&tlng= pt

19. Manso MEG, Osti AV, Borrozino NF, Maresti LTP. Avaliação multidimensional do idoso: resultados em um grupo de indivíduos vinculados a uma operadora de planos de saúde. Kairós Gerontol [Internet]. 2018 [citado 2018 nov. 2];21(1):191-211. Disponível em: https://revistas.pucsp.br/kairos/article/view/38758/26308

20. Santos FPA, Acioli S, Machado JC , Souza MS, Rodrigues VP, Couto TA. Care practices of the Family Health Strategy team. J Nurs UFPE on line [Internet]. 2018 [cited 15 Dec 2018];12(1):36-43. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/ article/view/230589/25842

21. Tavares EL, Santos DM, Ferreira AA, Menezes MFG. Nutritional assessment for the elderly: modern challenges. Rev Bras Geriatr Gerontol [Internet]. 2015 [cited 2017 Dec 17];18(3):643-50. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1809-98232015000300643&lng=en&nrm=iso&tlng=en

22. Hooper L. Why, oh why, are so many older adults not drinking enough fluid? J Acad Nutr Diet. 2016;116(5):774-8. DOI: 10.1016/j.jand.2016.01.006

23. Hooper L, Bunn D, Jimoh FO, Fairweather-Tait SJ. Water-loss dehydration and aging. Mech Ageing Dev. 2014;136/137:50-8. DOI: 10.1016/j.mad.2013.11.009

24. Rocha LS, Beuter M, Neves ET, Leite MT, Brondani CM, Perlini NMOG. Self-care of elderly cancer patients undergoing outpatient treatment. Texto Contexto Enferm [Internet]. 2014 [cited 2018 Nov 2];23(1):29-37. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072014000100029

25. Couto R. Independência e autonomia de velhos que moram sozinhos. Memorialidades [Internet]. 2014 [citado 2018 nov. 2];10(19):119-26. Disponível em: http://periodicos.uesc.br/index.php/memorialidades/article/view/18