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Older adult care: permanent education practices of the Family Health Support Center*

Atenção ao idoso: práticas de educação permanente do Núcleo de Apoio à Saúde da Família

Atención a la persona mayor: prácticas de educación permanente del Núcleo de Apoyo a la Salud de la Familia

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ABSTRACT

Objective: To unveil the Permanent Education in Health practices developed by the Family Health Support Center in the care provided to older adults. **Method:** A qualitative and exploratory-descriptive study developed in a municipality in the state of Paraná with professionals from the Family Health Support Center. Data were obtained by the Focus Group technique and submitted to the Descending Hierarchical Classification using IRaMuTeQ® software. The implemented theoretical-analytical references were the National Policy of Permanent Education in Healthcare and the Dialogical Theory. **Results:** Forty-six (46) professionals participated. Five classes emerged which revealed that the practices of permanent education in care provided to older adults occur during the moments of discussion of cases, in collaborative care planning (*matriciamento*), in the home visits, in the operative groups and in the daily life of the informal work. **Conclusion:** The permanent education practices developed by the professionals in the care provided to older adults occur at different moments of professional performance and are permeated by the practice.

DESCRIPTORS

Aged; Primary Health Care; Education, Continuing; Primary Care Nursing; Health Personnel.

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INTRODUCTION

The Brazilian Unified Health System (*SUS – Sistema Único de Saúde*) has several competences and among them the ordering of training in the health area stands out, which was conceived in the year 1988 from the Brazilian Federal Constitution[1]. Thus, health education issues are intrinsic to the SUS.

In order to observe and implement this attribution, the Ministry of Health has developed several strategies and policies aimed at adequately training and qualifying health workers to the health needs of the population and to the development of SUS, with emphasis on the National Policy on Permanent Education in Health[2].

Permanent Education in Health (PEH) was conceived as a relevant policy, and is based on meaningful learning and the possibility of transforming professional practices and the organization of work itself[2]. PEH provides a reflexive practice, mediated by the capacity for reflection and the need for transforming the processes generated at work. Their assumptions prioritize the daily problems of health services and teams, seeking the transformation of practices, relationships between subjects and understanding of health work in an attempt to overcome the logic of skills, improvements and updates[2-5].

Regarding Primary Health Care (PHC), effective PEH is desirable, especially in the practices of the Family Health Strategy (FHS), which proposes a reorganization of PHC and the consolidation of SUS principles. In this scenario, the important performance of health professionals who provide comprehensive care to individuals and families in all phases of human development is highlighted, and due to the magnitude of population aging and their respective management, care for older adults whose care requires specificities[6], is fertile ground for PEH.

Thus, it is stated that care for older adults should be provided in a comprehensive way, necessarily involving multi-professional care. For this guideline, the technical-pedagogical support offered by the Family Health Support Center (*NASF – Núcleo de Apoio à Saúde da Família*) through the matrix support to the FHS is adequate[6-7]. Thus, the NASF teams constitute a strategic device to improve the quality of healthcare for older adults through sharing knowledge and expanding the clinical resolution capacity of the FHS teams[7]; a practice consistent with the principles of the PEH by favoring knowledge and doing through the work context, and in line with the current foundations of permanent training of workers for transforming care practices.

It should be emphasized that the biomedical care model is still predominant in the care for older adults in PHC, favoring curative actions to the detriment of preserving the overall functionality of older adults, possibly due to the incipient gerontogeriatric training of the professional. This reality can be transformed by the PEH in search of knowledge and practices which are in line with active and healthy aging[5,8].

In this direction, the confrontations experienced by health professionals in care provided to older adults, especially regarding excessive demand[5,8] coupled with the lack of preparation in aging management in PHC clarify the need for PEH in order to minimize the challenges that exist in the daily life of PHC and to redefine practices in the care of older adults[2,6]. This scenario is undoubtedly a field of intervention of the NASF team for its multidisciplinary and pedagogical character with the FHS teams[7].

In this sense, this study outlined the following question: What are the PEH practices developed in the interaction between the NASF professionals and the FHS teams in the care provided to older adults? Knowing the eminently educational and collaborative role of the NASF with the FHS, the objective was to unveil PEH practices developed by the NASF in care of older adults.

METHOD

Study design

This was a qualitative exploratory-descriptive field study with an analytical and interpretive character developed in a municipality located in the north-central region of the state of Paraná, Brazil.

Population

The target audience of the study were 53 health professionals, members of nine NASF teams in the municipality.

In order to be included and participate in the study, NASF professionals had to be registered in the National Registry System of Health Establishments of the researched municipality, have work experience in the year 2016, and be exercising their functions in the NASF during the data collection period. Exclusion criteria were selected professionals who were temporarily or permanently removed from their functions and who belonged to the NASF teams which were part of the pilot test for the adequacy of the data collection instrument.

All NASF eligible professionals were invited to join the study through a scheduled meeting, and thus 46 professionals participated in the study.

Data collection

Data collection took place from February to April 2017 using the Focus Group (FG) technique[9], which is configured as a group discussion in which the participants interact with each other and discuss different points of view on a specific phenomenon, developing a wide debate and enabling the participants to reflect, in this case, on the PEH practices developed by them with the FHS regarding the health of older adults.

Thus, a FG was performed per team, totaling nine FG, however only eight were considered in the present study due to the need to exclude the pilot group. The FGs were performed in the meeting rooms of the Basic Health Units (BHU), a workplace reference of health professionals, through a prior appointment, with good acoustics and luminosity, where the participants were arranged in a circle format, guaranteeing an adequate environment which is favorable to dialogue[9]. There was an average of 5.75 participants per FG with an average duration of 49 minutes. They were conducted by a moderator, the researcher herself, who had the assistance of a reporter and observer.

The instrument for data collection was a road map developed by the researchers and composed of sociodemographic and professional research questions to characterize the participants and for triggering questions which subsidized the discussions in the FG. These were related to PEH practices developed by the NASF professionals regarding older adult health. This road map was previously approved by expert judges in the area and by the previously mentioned FG-pilot in order to maintain methodological rigor in the study and to avoid biases.

It should be emphasized that the criteria established in the *CO*nsolidated criteria for *RE*porting *Q*ualitative research (COREQ) were used in this study as a support tool for methods of qualitative studies[10].

Data analysis and processing

The data regarding the characterization of the participants were organized in the Microsoft Excel 2010® computer program and analyzed using simple descriptive statistics. FG discussions were recorded in audio, transcribed in their entirety by the researchers and submitted to lexicographic analysis using the *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* – IRaMuTeQ® software for the data organization, processing and analysis[11].

The manifesto of PEH practices performed by the NASF with the FHS in care provided to older adults was organized in a single file, called the corpus. Each FG characterized a text, and the set of these texts referring to PEH practices constituted the corpus of analysis of this study.

We used the Descending Hierarchical Classification (DHC) in order to analyze the corpus, a mechanism which composes the application and which scales the Elementary Context Units (ECU), classified according to the higher frequency vocabularies and chi-squared values in the class in order to understand the most significant words for qualitatively analyzing the data[11].

Thus, the software identified and reformatted the text units using the corpus in ECU to perform the lexical analysis. The ECUs which were obtained in the DHC presented similar vocabulary to each other and different from the ECUs of other classes[11]. After the design of the ECU, the classes were defined and the relationship between these classes was presented through a DHC dendogram. We then selected words which had $p < 0.005$ to compose the classes, indicating a significant association. It should be noted that the data processing time using IRaMuTeQ® software lasted 16 seconds.

This study used the National Policy of Permanent Education in Health[2] and Freire's Dialogical Theory[12-13] as theoretical-analytical references for discussing the findings, which refers to the transformation of knowledge and practices permeated by dialogue, especially considering the close relationship between these theoretical references and the NASF attributions[7].

Ethical aspects

All ethical and legal provisions established by Resolution 466/2012 of the National Health Council[14] were respected. In order to ensure anonymity of the participants, their reports were identified by the acronym "FG", referring to the term "Focus Group", followed by Arabic numerals which corresponded to the order of FG performance. The study is part of a more comprehensive study and has ethical appreciation from the Standing Committee on Ethics in Research with Human Beings of the State University of the municipality under study, in which it obtained the favorable opinion number 1.948.003/2017.

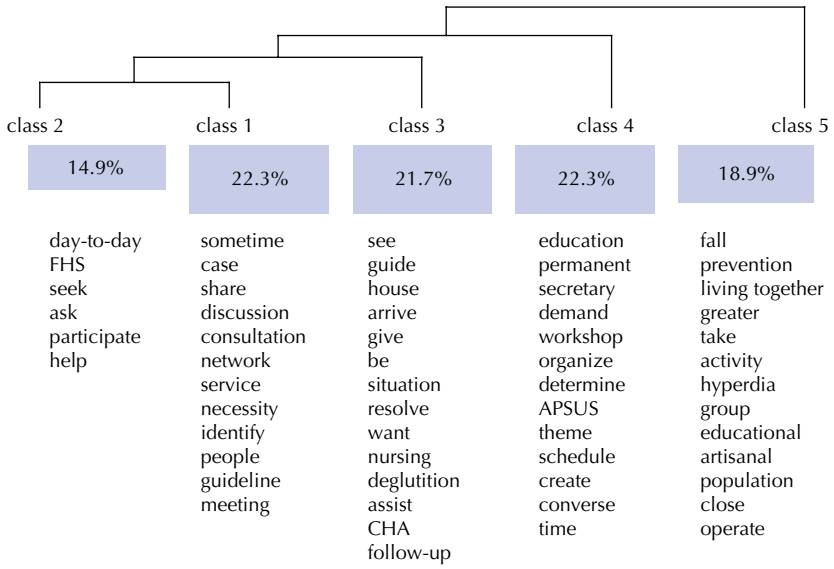
RESULTS

Forty-six (46) health professionals participated in the study, 17.4% who were nutritionists, 17.4% psychologists, 13% physical educators, 13% social workers, 13% speech therapists, 11% physiotherapists, 8.7% pharmacists and 6.5% occupational therapists. Regarding gender, females predominated (84.7%), and the age ranged from 24 to 61 years, with a mean of 34.8 years. The time since graduation ranged from 3 to 41 years (mean of 10.4 years), and the working time in the NASF in the studied municipality ranged from 6 months to 8 years (average of 3 years and 8 months).

The analysis of the FG corpus with NASF professionals denoted 6,272 occurrences of words, distributed into 1,132 reduced forms, which are considered equivalent words with common roots which have the same meaning, but differ in gender, number or the fact that they are nouns, adjectives or adverbs.

The DHC subdivided the corpus into 175 ECUs, and its totality (100%) was considered relevant and analyzed by the program, demonstrating excellent consistency of the analyzed content and then being used to construct the five classes from the content partitions (Figure 1).

Two axes were identified: the first one comprises class 5, with 33 of the 175 ECUs (18.9% of the data analyzed), and the second axis corresponds to the subgrouping of classes 1, 2, 3 and 4, containing the other 142 analyzed ECUs (81.1%), as shown by the dendrogram in Figure 1.



Organized by IRaMuTeQ® software.

Figure 1 – Dendrogram: PEH practices developed by the *NASF* with the FHS in care provided to older adults in a north-central municipality of the state of Paraná – Brazil, 2017.

Class 1 is among the two classes that presented the highest number of ECU (22.3%). This class revealed that PEH in the practice of NASF professionals is characterized by learning moments which develop during the discussion of older adult cases. These discussion moments of cases mainly occur during team meetings and in shared consultations, as observed in the following ECU:

We have shared consultation with other professionals, and this is a time when we learn a lot. (...) During our discussion of cases, in 1 hour we learned several things, discussing the case of an older adult. We give suggestions to each other in these moments (FG1).

We do a lot of discussion of older adult cases, especially during team meetings. There are many specific cases of older people that we need to support (FG4).

When the teams call us to help and participate in a specific case, sharing some situation that the FHS team cannot solve alone, then together we construct new ways and learn how to care for older adults (FG8).

Class 4 (ECU= 22.3%) demonstrates the formalized and orderly PEH within the municipal management, mainly by the corroborative care planning (*matriciamento*) provided by workshops on the health topic of older adults. NASF professionals take the matrix support as a moment of PEH and consider it as part of their work.

The thematic workshops in which NASF professionals acted as facilitators and multipliers of knowledge along with other professionals in providing care for older adults were moments described by the participants, although specific and sporadic. Regarding corroborative care planning and workshops, they reported:

We do permanent education on care for older adults when it is requested, when they call us on the desk or somewhere else: they give us knowledge and determine that we will be multipliers. So we come back to the BHU and pass on what we learned to FHS teams (FG2).

I remember the last time I gave a workshop on older people's health myself at APSUS, where we talked about old-age care. There were several discussions, but it was a workshop organized by the State, and we only had to pass on (FG4).

NASF was also a facilitator in APSUS. When the secretariat promotes these events with a scheduled time, we go, we have the training, and we act as facilitators: we pass on the learning to the professionals to promote changes in the work process later, in the case, in older adult patient care (FG6).

Class 3 (ECU= 21.7%) points to the moments of educational practices within the scope of the PEH provided by means of concrete care situations, such as the Home Visit (HV), considered by the study participants as one of the main moments for developing PEH in the health of older adults.

The HVs are mainly performed for the older adult clientele and happen in partnership between NASF and FHS professionals, with emphasis on the Community Health Agent (CHA), which incorporates the guidance provided by the support team, especially for caregivers and relatives of older adults, transforming knowledge and practices in this area.

I believe that PEH occurs in the older adult HV, because we evaluate the older adult patient and the CHA and also another professional is usually accompanying us, so they learn parts of the other training, to be able to also guide in another HV (FG1).

The HVs are a permanent education tool (...) Because when I go to a residence and advise the caregivers on some issues of difficulties in aging, the FHS team is with me, and they are reflecting on what I am talking about. CHAs look at situa-

tions differently after my intervention with the older adult when they are together, I think it is a moment of permanent education (FG3).

We call a CHA to schedule a HV for the older adult. This CHA empowers and is empowered themself to disseminate new information and act in a more qualified way in the care of older adults (FG6).

Class 5 (ECU= 18.9%) clarifies PEH practices developed during educational groups focused on health promotion and disease prevention, with emphasis on physical activity groups, a group of people with chronic conditions registered in the Health System Registration and follow-up of patients with Hypertension and/or Diabetes mellitus, popularly known as *HIPERDIA*, a group of older adult caregivers, handicraft work, among others.

NASF professionals provide guidance to the older adult population during group activities. By participating in these educational moments, FHS professionals educate themselves on various health issues, sharing knowledge and practices, so relevant that they begin to incorporate this learning into their practices, as the reports:

We developed the caregiver group for older adults, and many CHA participated. After these meetings, the FHS's look changed, especially when it came to identifying a caregiver who needed care (FG1).

It also occurs in the groups (...) when we give an orientation in the groups directed to older adults on prevention of falls or on another specific subject. It is a moment of permanent education as well, since the team is together (FG4).

The nurse participated in an orientation in which I performed for a hyperdia group. One day I arrived at the BHU and was going through the hall, and I heard her speaking exactly what I had said the other day. So she was passing on the information just like I said (FG5).

Finally, the ECU in **Class 2** (14.9%) predominantly revealed that the PEH occurs in the daily lives of professionals incorporated in the work process and in the daily life of the teams, and is mainly characterized by the dialogue among health professionals in an informal way. From the demand, the FHS professionals look for the NASF to dialogue and to clarify questions, favoring an exchange of knowledge and practices in the care provided to older adults:

Often departs from a demand, which is happening a lot. A specific demand in care for older adults, or when too many cases are appearing. (...) Most of the time this happens informally (FG3).

I think that this happens in the day-to-day routine, in the exchange between a professional and another who is attending the same older adult patient. We pay attention when we are together in an intervention with another professional, we observe how that professional will act and we begin to add some of those characteristics in our practice (FG4).

But this happens all the time, in the day-to-day routine. Yesterday I did a telephone interview. (...) It is daily. Their quest is daily. And this is permanent education, and it happens all the time (FG6).

I do this work day by day, it's a constant exchange. We sit with the nurse and we have an open door for them and the teams. We sit a lot with the CHA, because they bring forward the cases of the older adults and want help, and this is done day-to-day, there is no day scheduled. I'm there, they show up, they ask me if they can talk to me. Sure! Let's talk! It's on a daily basis! It's straightforward, if you mess up in the hallway (...) Teams then come to us to discuss cases and ask for guidance, to ask which strategies we will use to better serve that older adult patient (FG8).

DISCUSSION

In general, the investigated reality indicates that the PEH in care for older adults develops in the interaction between the NASF and FHS, privileging everyday situations by the horizontal dialogue. These moments enable action-reflection-action[12] and favor the autonomy and accountability of health teams in an emancipatory way through practice-mediated learning[2]. Teams seek shared solutions from diagnosing situations, and this movement allows access to new knowledge, indissolubly linked to changes in action and in the real context of practices in providing healthcare for older adults[2-3], concretizing praxis.

Such evidence implies pointing out the role of the nursing professional with the team in care of older adults in PHC, since they are a member of the minimum FHS team, and therefore collaborative for the action-reflection-action process to transform care for older adults.

It can be inferred that through the reflective and participative experience of the professional practice in the context under study, the reality of the service exposes its needs and problems with stimulus for exchanging experiences. As a result, practices are recreated from the critical thinking and conscious action generated by this process[2,12], which enables new care to be provided to older adults. In this way, the moments shared among health professionals[15] stand out as a real possibility of PEH in the care of older adults.

In more specific aspects, case discussions (class 1) revealed moments of PEH in the care of older adults through the dialogue between NASF and FHS and triggered dialogue spaces for teaching and learning such as meetings, shared consultations, planning and articulation of health actions, requiring professional nurses who were fit to this practice. Thus, these discussions allowed a space for reflection, learning, exchange of knowledge and improvement in practice, bringing benefits to the service and mainly to the older adult user[16], who is well known to be devoid of more qualified actions[5,8].

PEH is a deliberate educational intervention whose axis is the critical discussion of concrete practices which involve all professionals involved[2] and is based on the dialogical approach in essence[17]. For this reason, the discussion of older adult cases evidenced in class 1 is a practice that challenges praxis by anchoring itself in action-reflection-action[12,16].

The municipal management initiatives, presented in class 4, are related to adherence to an educational practice that is inseparable from the care practice related to the "Primary Health Care Qualification Program – APSUS", whose objective was to organize the actions and services of PHC in the state of Paraná – Brazil. Concerning the health of older adults, APSUS attempted to foster changes in the care practices for older adults in 2014, starting with a workshop aimed at equipping PHC professionals to work in the care planning for older adults based on risk stratification, as well as to increase its resolution potential in relation to this population[18].

Due to their group learning proposal shared and based on the reality of the work processes of those involved, the APSUS workshops provided reflection and collective construction of knowledge and practices in the context of care for older adults, permeated by praxis and dialogue. This organization explains the PEH as a guiding thread and as a transforming action of knowledge and practices in health[2].

The collaborative care planning achieved by these thematic workshops was considered a consistent practice with PEH, mainly because of its resolution capacity for care[15,19] of older adults. Despite the sporadic accomplishment, the thematic workshops on the care of older adults mobilize the teams for an approach to dialogue, facilitating reflections on the care practices provided to the older adult population and implementing the dialogical education that transforms care[2,20].

HVs to older adults, described in class 3, provided the FHS professionals, and especially the CHA, knowledge building along with NASF professionals. The actions and orientations of NASF professionals in home care instrumentalize the CHA to carry out their work, allowing an exchange of knowledge and interprofessional learning, pointing to the HV as one of the means to put PEH into practice in the care of older adults in the daily lives of professionals[21].

It should be clarified that the CHA, mainly coordinated by the nurse, is the link between service and the population[3], and has essential information about the users to guide care. The exchanges of knowledge permeated by the HVs to the families of older adults among different professionals enable a constructed and contextualized learning of the reality[2,22] and favor awareness of a real situation in search of its transformation[2,12-13,23].

Overcoming practices and knowledge required critical insertion of professionals in the reality to act on it from the involvement between the subjects, permeated by dialogue and autonomy[13], and made possible by the care for older adults in the actions triggered by the HV. Knowledge and experience are shared among professionals, who not only learn from each other but also educate one another in a reciprocal way, contextualizing PEH[22] in the care for older adults.

From a collective care perspective, the educational and intervention groups with the older adult population were described by professionals (class 5) as timely moments for PEH. The activities developed in the groups, according to them, enable PEH to allow NASF and FHS health professionals to work together, building and strengthening teamwork, harmonizing actions together, and reinforcing shared commitments with care quality of older adults[19-20,24], thus materializing teaching and learning by real practice.

Considering that educational processes should be problematizing[12,19], the inclusion of NASF and FHS professionals in the education and intervention groups with older adults facilitates a dialogic relationship[20,24] and concretizes PEH in the care of the older adult, making their own work an essential condition for learning[25], as we find in the present context.

Regarding this, the importance given by the study participants to the nursing professional figure is mentioned as being a transformation agent of practices (class 5 and class 2). As a multiplying agent of shared knowledge during the PEH strategies mentioned above, nurses find strategies which enhance care for older adults, and by conducting the work processes of these teams, recreate the practice itself in allowing action-reflection-action[12- 13,23]. Thus, it is possible to highlight the role of the nurse in transforming care practices to the older adult in PHC.

In this study, group activities contribute to the learning that is permeated by the NASF and FHS professionals, because new perspectives of the work process are identified in organizing and executing the actions agreed upon in the health of older adults[19], thus enabling new practices. In this sense, the groups are teaching-learning spaces which favor reflection and awareness by those involved[26].

Regarding NASF's work process and its relation to the timely construction of dialogic spaces which enable the teaching-learning process of the team, class 2 is the one that best clarifies the dialogical potential of daily professional relations for an exchange of experiences[2], and consequently learning. It should be emphasized that health professionals see possibilities for PEH in the care of older adults framed by the work context itself. It is through daily demand that the health professionals of this study seem to assume the awareness of their inconclusiveness as unfinished beings, and become connected to the world in order to dialogue with others and thus maintain desires, longings, and the will to learn something new, seeking education which is constantly renewed in praxis[12-13], and thus increasing the possibilities of caring for older adults.

PEH moments in care for older adults described by the study participants go beyond shared team meetings and consultations (class 1), and also include informal exchanges provided by the informal dialogue in the BHU and through contact via technologies (class 2)[20]. It was considered that all educational action, when understood in its multiple facets, occurs at definite and formal moments (class 1), as well as at occasional and informal moments (class 2)[27]. In this sense, the informal dialogue between the NASF and FHS was considered a tool for learning which facilitated

the interaction between them and extended the possibilities of care, enabling knowledge and action transformations in the health of older adults.

The fact that perceptions about the subject from the FHS professionals, also implicated in the PEH, were not covered is a limitation of this study. The participation of professionals in the FHS teams would undoubtedly add new perspectives and views on NASF's PEH practices on the health of older adults.

CONCLUSION

This study has enabled the unveiling of PEH practices developed by NASF professionals about the health of older adults together with FHS professionals. The health professionals who are part of the NASF team develop PEH together with the FHS professionals in the care of older adults, especially during discussion moments of older adult health cases through the matrix support triggered by the initiative of the state and municipal management through HVs during the performance in the health education groups and in the daily work, in an informal way.

Therefore, it increases advances in the clinical-care and technical-pedagogical role of the NASF, especially at the current opportune time for this topic since the new reformulated basic care policy, the reconfigured role of the teams and an implemented PEH program. Thus, it enabled highlighting the PEH spaces in the daily lives of PHC professionals, and will certainly serve as reference to drive the work processes of these teams and to reinforce the relevant collaborative role of the nurse in this new political and ideological scenario of PHC and PEH.

It is worth noting that the use of a free software for organizing the qualitative data was a differential for this evidence and could serve as an option for use in other studies with the same approach.

It is emphasized that the context in which the study participants are inserted influenced their practices and perceptions about PEH in the care for older adults, so that the presented results are limited to the reality in focus, and therefore may not reflect the reality of other municipalities of Brazil.

It is therefore suggested that new studies be carried out in other contexts and scenarios, including the perception of FHS professionals about the researched phenomenon.

RESUMO

Objetivo: Desvelar as práticas de Educação Permanente em Saúde desenvolvidas pelo Núcleo de Apoio à Saúde da Família na atenção ao idoso. **Método:** Estudo qualitativo e exploratório-descritivo, desenvolvido em um município do estado do Paraná, com profissionais do Núcleo de Apoio à Saúde da Família. Os dados foram obtidos pela técnica de Grupo Focal e submetidos à Classificação Hierárquica Descendente utilizando o *software* IRaMuTeQ®. Os referenciais teórico-analíticos foram a Política Nacional de Educação Permanente em Saúde e a Teoria Dialógica. **Resultados:** Participaram 46 profissionais. Surgiram cinco classes que permitiram desvelar que as práticas de educação permanente na atenção ao idoso ocorrem durante os momentos de discussão de casos, no matriciamento, nas visitas domiciliares, nos grupos operativos e no cotidiano do trabalho de modo informal. **Conclusão:** As práticas de educação permanente desenvolvidas pelos profissionais na atenção ao idoso ocorrem em distintos momentos da atuação profissional e são permeadas pela prática.

DESCRITORES

Idoso; Atenção Primária à Saúde; Educação Continuada; Enfermagem de Atenção Primária; Pessoal de Saúde.

RESUMEN

Objetivo: Desvelar las prácticas de Educación Permanente en Salud desarrolladas por el Núcleo de Apoyo a la Salud de la Familia en la atención a la persona mayor. **Método:** Estudio cualitativo y exploratorio descriptivo, desarrollado en un municipio del Estado de Paraná, con profesionales del Núcleo de Apoyo a la Salud de la Familia. Los datos fueron obtenidos por la técnica de Grupo Focal y sometidos a la Clasificación Jerárquica Descendiente utilizando el *software* IRaMuTeQ. Los marcos de referencia teóricos analíticos fueron la Política Nacional de Educación Permanente en Salud y la Teoría Dialógica. **Resultados:** Participaron 46 profesionales. Surgieron cinco clases que permitieron desvelar que las prácticas de educación permanente en la atención a la persona mayor ocurren durante los momentos de discusión de casos, en el matriciamiento, las visitas domiciliarias, los grupos operativos y el cotidiano del trabajo de modo informal. **Conclusión:** Las prácticas de educación permanente desarrolladas por los profesionales en la atención a la persona mayor ocurren en distintos momentos de la actuación profesional y traen consigo la práctica.

DESCRIPTORES

Anciano; Atención Primaria de Salud; Educación Continua; Enfermería de Atención Primaria; Personal de Salud.

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