Evaluation of the health level of the elderly: patient care team considerations

Avaliação do nível de saúde dos idoso: olhares da equipe de assistência ao paciente

Evaluación del estado de salud de los ancianos: miradas del grupo de asistencia al paciente

Maria Clara Duarte Monteiro[I]
ORCID: 0000-0001-8882-5389

Maria Manuela Ferreira Pereira da Silva Martins[I]
ORCID: 0000-0003-1527-9940

Soraia Dornelles Schoeller[II]
ORCID: 0000-0002-2822-4407

[I]*Universidade do Porto, Instituto de Ciências Biomédicas de Abel Salazar. Porto, Portugal.*
[III]*Universidade Federal de Santa Catarina. Florianopolis, Santa Catarina, Brazil.*

Corresponding author:
Maria Clara Duarte Monteiro
E-mail: claramonteir@gmail.com

ABSTRACT
Objective: To understand the differences of physicians, nurses, and social workers in the evaluation of the health status of the elderly. **Methods:** A cross-sectional quantitative study, using descriptive statistics. Non-probabilistic sample, consisting of 291 participants from three professional categories: 71 (24.4%) physicians, 192 (66%) nurses, and 28 (9.6%) social workers. We used a questionnaire including the variables: sociodemographic characteristics and instruments used for evaluation. **Results:** Instruments with greater utility for the evaluation of the elderly: for physicians, Mini Mental State Examination; for nurses, Braden scale; and for social workers, genogram. In the physical examination, the data most collected by physicians and nurses are the vital signs; and by social workers, the condition for performing the Activities of Daily Living. **Conclusions:** The evaluation of the elderly is based on a diversity of instruments and is an area in which health and social professionals need to share information.
Descriptors: Health Personnel; Health Level; Patient Care Team; Elderly; Nursing.

RESUMO
Objetivo: Compreender as diferenças dos médicos, enfermeiros e assistentes sociais na avaliação do nível de saúde dos idosos. **Métodos:** Estudo quantitativo transversal, com uso de estatística descritiva. Amostra não probabilística, constituída por 291 participantes provenientes de três categorias profissionais: 71 (24,4%) médicos, 192 (66%) enfermeiros e 28 (9,6%) assistentes sociais. Utilizouse questionário contemplando as variáveis: características sociodemográficas e instrumentos utilizados para avaliação. **Resultados:** Instrumentos com maior utilidade para avaliação dos idosos: para médicos, Mini Exame do Estado Mental; para enfermeiros, Escala de Braden; e para assistentes sociais, Genograma. No exame físico, os dados mais coletados pelos médicos e enfermeiros são os sinais vitais; e pelos assistentes sociais, a condição para executar as Atividades de Vida Diária. **Conclusões:** A avaliação dos idosos tem por base uma diversidade de instrumentos e apresenta-se como área em que os profissionais de saúde e sociais necessitam compartilhar informações.
Descritores: Pessoal de Saúde; Nível de Saúde; Equipe de Assistência ao Paciente; Idoso; Enfermagem.

RESUMEN
Objetivo: Comprender las diferencias de médicos, enfermeros y asistentes sociales en la evaluación del estado de salud de los ancianos. **Métodos:** Estudio cuantitativo transversal, con uso de estadística descriptiva. Muestra no probabilística, constituida por 291 participantes provenientes de tres categorías profesionales: 71 (24,4%) médicos, 192 (66%) enfermeros y 28 (9,6%) asistentes sociales. Utilizó encuesta contemplando las variables: características sociodemográficas e instrumentos utilizados para evaluación. **Resultados:** Instrumentos con mayor utilidad para evaluación de los ancianos: para médicos, Mini-Examen del Estado Mental; para enfermeros, Escala de Braden; y para asistentes sociales, Genograma. En el examen físico, los datos más recogidos por los médicos y enfermeros son los signos vitales; y por los asistentes sociales, la condición para ejecutar las Actividades de Vida Diaria. **Conclusiones:** La evaluación de los ancianos tiene por base una diversidad de instrumentos y se presenta como área en que los profesionales de salud y sociales necesitan compartir informaciones.
Descriptores: Personal de Salud; Estado de Salud; Grupo de Atención al Paciente; Anciano; Enfermería.

INTRODUCTION

Care for the elderly raises an international debate to enhance all resources to keep them active, autonomous, independent, and with quality of life. With the progressive aging of the population, health and social needs tend to become increasingly specific and complex, challenging the models of care in use, which are insufficient to achieve healthy longevity. The structured assessment of the conditions of the elderly may contribute to the early detection of risk factors that favor functional decline and condition the quality of life of this population[1], but particularly if it follows a logic of continuous monitoring of the level of health.

Several pieces of evidence have demonstrated the effectiveness of a multidimensional evaluation of the elderly, both concerning costs for the system and in health outcomes[2], anchored in different instruments or scales of specific evaluations. To this end, interdisciplinary teamwork has sought to be a possible response, constituting an integral part of health policies. Since 2006, the National Program for the health of the elderly, established in Portugal, aims to obtain gains in years of life with independence, acting on the determinants of loss of autonomy and independence[3], requiring a multidisciplinary action of health services, in close coordination with the social service of the country.

Despite the above, the health and social team has no systematized guideline to carry out a comprehensive gerontological evaluation in Primary Health Care. Such a purposeful program seems to suffer discontinuities or failures in its realization over time and in different regional contexts. In practice, it is common to observe a mismatch of professional actions as found in a study in which the process of evaluation of the elderly, carried out by physicians, nurses, and social workers of a group of Health Centers (ACeS), demonstrates information that is repeated, and the respective intervention is directed to the area of action of each professional[4].

National and international elderly health policies emphasize the need to implement interventions focused on the promotion of individual autonomy, adopting preventive measures focusing on active and healthy aging[3,5-7]. However, the literature shows discrepancies in the care model used by health professionals, verifying the mismatch between expectations and the provision of care[5,8-9] still very focused on the biomedical model, centering on the identification and treatment of acute diseases. There are difficulties in the adequacy of visits for the elderly population, and these do not differ from visits aimed at middle-aged adults[1]. Data collection is not satisfactory for a detailed analysis of their health condition[10], compromising the planning of interventions. Therefore, we recognized the need to modify the approach in health care of this population.

Several researchers have reflected on this issue, and they are consensual in the proposals for interdisciplinary assistance, among which is the Multidimensional evaluation of the elderly, which uses systematic evaluation methods based on the principle of interdisciplinary work, aiming at a long-term follow-up to the elderly[2,11]. The most studied and used dimensions in this evaluation refer to functional status, mental health, and social functioning. All these dimensions must be considered in the planning of health care to create an integrated plan to maximize health in aging.

For this, it is necessary an early diagnosis, therapeutic and guidance of support services[1], which allows the detection of unexpressed needs and health problems not perceived, because otherwise the elderly tend to hide relevant complaints, on the other hand, the professionals themselves tend to devalue them, associating them with the natural aging process. Nevertheless, it is necessary that professionals understand the logic of this process, act with a view to interdisciplinarity and overcoming the fragmentation of care, thus achieving comprehensive care and the desired quality of care[12]. It is crucial to understand that the responsibility for health promotion involves all sectors, and not only that of health, and there is a need to strengthen the articulation of health services with social services[5] to obtain gains in health and quality of life.

In short, team care needs to be rethought to articulate actions that allow the development of a new approach to the health of the elderly from the perspective of integrality, recognizing new health needs of communities and individuals, such as the aging of the population and especially the increase in longevity. The present study is based on this assumption, so we concluded that it is necessary to build paths for the promotion of the health of the elderly in the context of interdisciplinarity and sharing of actions.

In the research carried out, we found that there are few types of research on this subject, and the existing ones were not carried out in Portugal. For this reason, and because of the recognition of the importance of a multidimensional and interdisciplinary evaluation promoting an autonomous, active and healthy aging, we reinforce the relevance of this investigation.

OBJECTIVES

To analyze how the evaluation of the elderly is carried out from the perspective of physicians, nurses, and social workers; identify the most used and most effective instruments and identify the differences in their use by each profession.

METHODS

Ethical aspects

The study was authorized by the Ethics Committee of the health institutions involved, beginning in 2017. We informed the participants regarding the objectives of the investigation and the guarantee of confidentiality of the data collected, signing the informed consent.

Design

The methodological option is referred to the quantitative approach of the cross-sectional study type to meet the characteristics and objective of the study. It is an observational study in epidemiology guided by the STROBE tool (Strengthening the Reporting of Observational Studies in Epidemiology). Its purpose is not only to create an intervention program in the field of gerontogeriatrics for health and social service professionals but also to bring health gains to the elderly population in the context of active, autonomous, and healthy aging and also to

ensure that such a program has sustainable conditions without repetition of data from the same elderly by several professionals.

Data collection took place between May 2018 and March 2019. The participants received the questionnaire via mail or e-mail with the Access link in electronic support. Previously, a pre-test was conducted with 101 health and social professionals from another region, who participated as experts voluntarily to assess and identify possible problems related to the application of the questionnaire, as well as the time planned for its completion.

Population and sample

The study population consisted of physicians, nurses, and social workers who developed care for the elderly in ACeS and hospitals belonging to the National Health Service of the Northern Region of Portugal. We obtained the sample by a non-probabilistic method, for convenience, and consisted of professionals who agreed to participate in the study, in a total of 291 participants: 71 (24.4%) physicians, 192 (66%) nurses, and 28 (9.6%) social workers.

Criteria of inclusion and exclusion

The inclusion criteria were: professionals who work in the ACeS and services of Medicine, Surgery, Orthopedics, and other hospitalization services where the elderly are treated. Professionals who performed functions in oncological and psychiatric hospitals were excluded from the study because we considered it as constituting a differentiated experience in the care of the elderly.

Study protocol

We used an *ad-hoc* questionnaire survey as the data collection instrument, "Evaluation of care in interdisciplinary health care for the elderly," auto-filled, which was developed to assess the perception of a professional of the health and social care about the multi-disciplinary approach, divided into two parts, with Part I: socio-demographic characteristics of the people" and "Part II: tools used for gerontogeriatrics evaluation, where the issues arise from the categories and sub-categories identified in the study previously carried out about the "Templates used in the care for the elderly." Concerning the evaluation of the elderly performed by professionals, Part II was divided into three blocks of items, in which the questions comprise 14 instruments for the evaluation of the elderly and ten health data.

For the operationalization of the variables, we adopted the following specification: sociodemographic character variable (gender, age, education, professional category, length of service, professional experience in gerontology, continuous training in gerontology, academic training in gerontology and place of work); variable evaluation instruments of the elderly. The latter was calculated based on the Likert scales in the following components: 1) the usefulness of the scale in use (not useful, somewhat useful, useful, very useful, and critical to the patient's condition), and containing the dimensions of the Barthel, Lawton & Brody, a Mini-Mental Status Examination (MMSE), Braden Tinetti, the Mini Nutritional Assessment (MNA), Apgar score

of the Family, Genogram, Ecomap, Lifestyle Profile (LSP), the Geriatric Depression, Questionnaire for Caregiver Burden in the Informal Sector (QCBIS), Zarit, and Edmonton Frailty Scale (EFS); (2) the application of scales in clinical practice (applies, does not apply, see the interest in applying, I don't see the interest in applying it), with the dimensions of Domain, Braden, Lawton & Brody, MMSE, Tinetti, Delete, Family, Genogram, Ecomap, LSP, Geriatric Depression Scale, Informal Caregiver Burden, Zarit and EFS; and (3) the collection of physical data (never, rarely, sometimes, almost always, always) taking into account the dimensions and the weight, height, vision/hearing, swallowing, integuments, mobility/physical activity, balance/motion, nutritional status, signs of life, the condition of elimination of bowel/bladder, the assessment of the status of execution of the Activities of Daily Living (ADLs).

In this article, we intend to describe the evaluation of the elderly from the perspective of different professionals, highlighting the sociodemographic characteristics of the participants and their interdisciplinary evaluation.

Analysis of results and statistics

The data obtained were processed in the statistical program IBM-SPSS (version 25.0). The sample was described using absolute and relative frequencies for qualitative variables and mean and standard deviation for quantitative variables. The analysis of the items that constitute the questionnaire by professional category was carried out using absolute and relative frequencies. To analyze the association between the professional category and the answers to each item of the questionnaire, we used the chi-square test when its assumptions were verified (less than 20% of the cells with an expected value less than 5). For all analyses, we considered the significance level of 0.05.

RESULTS

Non-probabilistic sample, consisting of 291 participants from three professional categories: 71 (24.4%) physicians, 192 (66%) nurses, and 28 (9.6%) social workers. Female professionals predominated (80.4%) with a mean age of 42.3 years (SD = 9.6 years), most with a degree (71.8%) and almost half in gerontology (48.1%). A hundred and eighty-five participants (64.5%) had professional experience in gerontology. However, 239 (83.6%) had no continuing education in gerontology. The average length of service was 17.9 years (SD = 9.9 years), and regarding the workplace, we found that most of the participants worked in an ACeS (74.6%).

Use of the instruments for aplication in the elderly

We gathered the usefulness of the instruments into "nothing useful and little useful" and "useful, very useful and fundamental". We found that all the proposed instruments have values equal to or greater than 70% in the classification of useful, very useful and fundamental, for the total number of participants. We define the minority data in two categories (never, rarely, sometimes) and the majority data (almost always and always).

Table 1 - Sample characterization

Sociodemographic and professional data	Total n (%) 291 (100.0)	Physicians n (%) 71 (24.4)	Nurse n (%) 119 (40.9)	Social workers n (%) 28 (9.6)	p value*
Gender					**< 0.001**
Female	234 (80.4)	39 (54.9)	169 (88.0)	26 (92.9)	
Male	57 (19.6)	32 (45.1)	23 (12.0)	2 (7.1)	
Age, average (SD)	42.3 (9.6)	41.9 (13.3)	42.7 (8.0)	41.6 (7.8)	0.600
Schooling					-
Bachelor's	3 (1.0)	0 (0.0)	3 (1.6)	0 (0.0)	
Teaching Degree	209 (71.8)	34 (47.9)	152 (79.2)	23 (82.1)	
Master	78 (26.8)	36 (50.7)	37 (19.3)	5 (17.9)	
Doctorate	1 (0.3)	1 (1.4)	0 (0.0)	0 (0.0)	
Employment time, average (SD)	17.9 (9.9)	14.9 (13.0)	19.4 (8.4)	14.6 (7.6)	0.001
Professional experience in gerontology					0.002
No	102 (35.5)	37 (52.9)	57 (30.0)	8 (19.6)	
Yes	185 (64.5)	33 (47.1)	133 (70.0)	19 (70.4)	
Continuing education in gerontology					0.029
No	239 (83.6)	61 (87.1)	161 (84.7)	17 (65.4)	
Yes	47 (16.4)	9 (12.9)	29 (15.3)	9 (34.6)	
Academic background in gerontology					-
Bachelor's	7 (8.6)	1 (5.9)	6 (10.0)	0 (0.0)	
Teaching Degree	39 (48.1)	6 (35.3)	32 (53.3)	1 (25.0)	
Master	14 (17.3)	5 (29.4)	7 (11.7)	2 (50.0)	
Doctorate	1 (1.2)	0 (0.0)	1 (1.7)	0 (0.0)	
Specialization	20 (24.7)	5 (29.4)	14 (23.3)	1 (25.0)	
Workplace					0.096
ACeS	217 (74.6)	47 (66.2)	146 (76.0)	24 (85.7)	
Hospital	74 (25.4)	24 (33.8)	46 (24.0)	4 (14.3)	

SD: standard deviation; * chi-square test; * p value < 0.05.

It is seen that there is a statistically significant association between professional-grade and use in clinical practice with elderly as follows: the Lawton & Brody Index (p < 0.001), and the Tinetti Index (p < 0.001), MNA (p < 0.001), Apgar Family Score (< 0.001), Ecomap (p = 0.040), and the LSP (p < 0.001), the Geriatric Depression Scale (p < 0.001), and the QCBIS (p < 0.001), the Zarit (p = 0.001), the Edmonton Frailty Scale (p < 0.001) and MMSE (p < 0.001). Furthermore, we found that nurses presented higher percentages when compared to the other professional categories for all instruments except for the MMSE, in which physicians presented higher percentages compared to the other professional categories.

Table 2 - Distribution according to the usefulness of the instruments for application in the elderly by professional category

Evaluation instruments	Total	Physicians	Nurse	Social workers	p value*
Barthel					-
NU + LU	19 (7.2)	5 (8.2)	8 (4.4)	6 (26.1)	
U + VU + F	245 (92.8)	56 (91.8)	172 (95.6)	17 (73.9)	
Lawton & Brody					**< 0.001**
Nothing useful	42 (19.5)	9 (20.9)	21 (14.1)	12 (52.2)	
U + VU + F	173 (80.5)	34 (79.1)	128 (85.9)	11 (47.8)	
Mini Mental State Examination					**< 0.001**
NU + LU	22 (9.0)	1 (1.5)	12 (7.8)	9 (37.5)	
U + VU + F	222 (91.0)	65 (98.5)	142 (92.2)	15 (62.5)	
Braden					-
NU + LU	22 (8.7)	6 (12.8)	4 (2.2)	12 (52.2)	
U + VU + F	231 (91.3)	41 (87.2)	179 (97.8)	11 (47.8)	
Tinetti					**< 0.001**
NU + LU	46 (23.7)	11 (27.5)	22 (16.7)	13 (59.1)	
U + VU + F	148 (76.3)	29 (72.5)	110 (83.3)	9 (40.9)	
Mini Nutritional Assessment					**<0.001**
NU + LU	32 (14.4)	8 (17.0)	12 (7.9)	12 (52.2)	
U + VU + F	190 (85.6)	39 (83.0)	140 (92.1)	11 (47.8)	
Family Apgar score					**< 0.001**
NU + LU	48 (20.1)	17 (28.3)	18 (11.5)	13 (56.5)	
U + VU + F	191 (79.9)	43 (71.7)	138 (88.5)	10 (43.5)	
Genogram					0.454
NU + LU	41 (17.2)	8 (13.6)	27 (17.3)	6 (25.0)	
U + VU + F	198 (82.8)	51 (86.4)	129 (82.7)	18 (75.0)	

Table 2 (concluded)

Evaluation instruments	Total	Physicians	Nurse	Social workers	p value*
Ecomap					0.040
NU + LU	58 (25.9)	18 (38.3)	32 (20.9)	8 (33.3)	
U + VU + F	166 (74.1)	29 (61.7)	121 (79.1)	16 (66.7)	
Lifestyle profile					**< 0.001**
NU + LU	51 (26.0)	15 (36.6)	24 (18.0)	12 (54.5)	
U + VU + F	145 (74.0)	26 (63.4)	109 (82.0)	10 (45.5)	
Geriatric depression scale					**< 0.001**
NU + LU	30 (13.7)	7 (13.5)	13 (9.0)	10 (45.5)	
U + VU + F	189 (86.3)	45 (86.5)	132 (91.0)	12 (54.5)	
QCBIS					**< 0.001**
NU + LU	26 (11.0)	7 (13.0)	8 (5.1)	11 (44.0)	
U + VU + F	210 (89.0)	47 (87.0)	149 (94.9)	14 (56.0)	
Zarit					0.001
NU + LU	51 (25.4)	14 (33.3)	25 (18.2)	12 (54.5)	
U + VU + F	150 (74.6)	28 (66.7)	112 (81.8)	10 (45.5)	
Edmonton Frailty					**< 0.001**
NU + LU	30 (14.0)	7 (14.9)	11 (7.6)	12 (52.2)	
U + VU + F	185 (86.0)	40 (85.1)	134 (92.4)	11 (47.8)	

NU: nothing useful; LU: little useful; U: useful; VU: very useful; F: fundamental. * Chi-square test; * p value < 0.05

Instruments in use in the elderly

Professionals reported more frequently applying Barthel (68.9%) and Braden (59.5%). By professional category, the instruments most used in practice by physicians are Barthel (65.6%) and MMSE (60.3%); by nurses, Braden (77.1%) and Barthel (75%); and by social workers, Barthel (30.4%).

Instruments of interest to apply in the elderly

Among the instruments of highest interest for all professionals, we highlight the QCBIS (32.6%), the Edmonton Frailty Scale (29.9%), and the Geriatric Depression Scale (28.8%), and the physicians presented higher percentage values when compared to the other professional categories.

By professional category, the instruments of greatest interest to apply in the elderly are: for physicians, the QCBIS (49.1%), the Edmonton Frailty Scale (41.8%) and the Geriatric Depression Scale (39.3%); for nurses, the QCBIS (29.8%), the Edmonton Frailty Scale (29.2%) and the LSP (28.6%); and for social workers, the genogram (34.8%) and ecomap (31.8%).

We considered "strength" whenever the instrument showed a higher percentage of interest for each group. The Barthel assessment instrument ("strength" for all professionals) shows a waste of strength because there is a repetition since the professionals do not take advantage of the teamwork done previously by another professional. Weaknesses occur due to differences of opinion of interest in its use. Physicians see interest in applying the Edmonton Frailty Scale and the Geriatric Depression Scale; nurses prefer the lifestyle profile; and social workers, the genogram, and the Ecomap. We can confirm that this weakness has all the potential to become a force of teamwork.

Data on the physical evaluation of the elderly

Of all professionals, the most collected data refer to the condition for the execution of ADLs (94%), vital signs (90.8%), mobility/exercise/physical (90.8%), and balance/motion (90.1%). In the case of Physicians, the data focus on vital signs (98.6%), condition of execution of ADLs (97.1%), intestinal/bladder elimination (95.6%), balance/motion (92.8%), and mobility/physical exercise (92.8%). To nurses, the most collected was the vital signs (97,4%), the condition for the implementation of the DLAs (96,3%), mobility and exercise (95,2%), integuments (93,1%), balance/motion(93,1%), and in the disposal of the bowel/bladder (91.5 percent), while the social workers are directed to the condition of the DLAs (68,0%), balance/motion, (60,0%), and mobility exercise (52,0%). We found that there is a statistically significant association between the professional category and the collection of data on swallowing (p < 0.001), integuments (p < 0.001), mobility/physical exercise (p < 0.001), and balance/motion (p < 0.001), with nurses having higher percentages when compared to the other professional categories. There is also a statistically significant association between the professional category and the collection of data on weight/height (p < 0.001), vital signs (p < 0.001), nutritional status (p < 0.001), intestinal
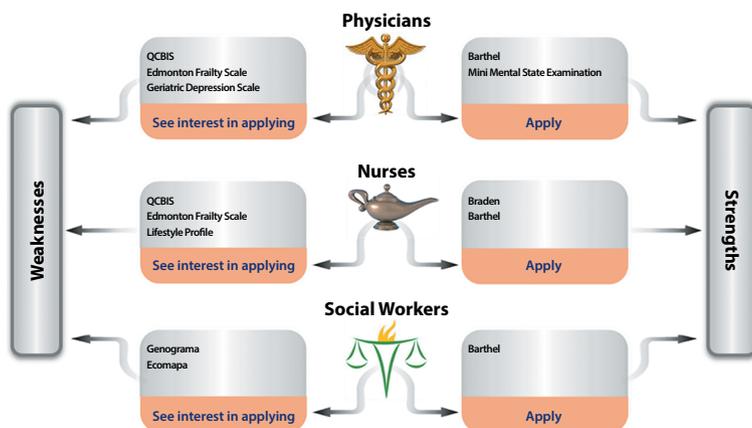
Note: QCBIS- Questionnaire for Caregiver Burden in the Informal Sector
Figure 1 - Strengths and weaknesses of health professionals' evaluation of the elderly

elimination (p < 0.001) and vision/hearing (p = 0.022), in this case, physicians have higher percentages compared to the other professional categories.

Table 3 - Distribution according to the physical examination of the elderly by professional category

Physical evaluation data	Total n (%)	Physicians n (%)	Nurse n (%)	Social workers n (%)	p value*
Weight / Height					< 0.001
N + R + S	78 (27.6)	10 (14.5)	44 (23.3)	24 (96.0)	
AA + A	205 (72.4)	59 (85.5)	145 (76.7)	1 (4.0)	
Vision / hearing					0.022
N + R + S	110 (39.4)	22 (32.8)	72 (38.5)	16 (64.0)	
AA + A	169 (60.6)	45 (67.2)	115 (61.5)	9 (36.0)	
Deglutition					< 0.001
N + R + S	72 (25.8)	22 (32.8)	33 (17.6)	17 (68.0)	
AA + A	207 (74.2)	45 (67.2)	154 (82.4)	8 (32.0)	
Integument					< 0.001
N + R + S	55 (19.7)	17 (25.8)	13 (6.9)	25 (100.0)	
AA + A	224 (80.3)	49 (74.2)	175 (93.1)	0 (0.0)	
Mobility / physical exercise					< 0.001
N + R + S	26 (9.2)	5 (7.2)	9 (4.8)	12 (48.0)	
AA + A	256 (90.8)	64 (92.8)	179 (95.2)	13 (52.0)	
Balance/motion					< 0.001
N + R + S	28 (9.9)	5 (7.2)	13 (6.9)	10 (40.0)	
AA + A	254 (90.1)	64 (92.8)	175 (93.1)	15 (60.0)	
State of nutrition					< 0.001
N + R + S	54 (19.2)	9 (13.2)	29 (15.4)	16 (64.0)	
AA + A	227 (80.8)	59 (86.8)	159 (84.6)	9 (36.0)	
Vital Signs					< 0.001
N + R + S	26 (9.2)	1 (1.4)	5 (2.6)	20 (80.0)	
AA + A	258 (90.8)	68 (98.6)	185 (97.4)	5 (20.0)	
Intestinal/bladder elimination					< 0.001
N + R + S	40 (14.2)	3 (4.4)	16 (8.5)	21 (84.0)	
AA + A	241 (85.8)	65 (95.6)	172 (91.5)	4 (16.0)	
AVDS execution capability					-
N + R + S	17 (6)	2 (2.9)	7 (3.7)	8 (32.0)	
AA + A	266 (94)	67 (97.1)	182 (96.3)	17 (68.0)	

N: never; R: rarely; AV: sometimes; AA: almost always; S: always. * Chi-square test; * p value < 0.05.

DISCUSSION

In Portugal, the rate of feminization has shown a general trend of growth over the years, fixed at 76.3%, surpassing the overall rate of Public Administration (59.9%)[7]. In this study, almost all of the sample consists of women (80.4%), with nursing staff contributing the most to this rate[7], although it is also associated with social workers (88% and 92.9%, respectively).

The average age of 42.3 years is distributed in a very similar way among physicians (41.9 years), nurses (42.7 years), and social workers (41.6 years), as in the National panorama, in which the global average ages of professionals was 44 years[13], although the distribution of the average age by the various professional groups varies between 41 and 50 years.

On the level of education, most have a bachelor's degree (71.8%), and about half of the physicians have a master's degree (50.7%), converging these results with National data in which we can see that, in the universe of careers or special health bodies (physician, nurse, among others), about 82% of these workers have an academic degree equal to or higher than a bachelor's degree[13].

Although most of the sample (64.5%) had professional experience in gerontology, only 16.4% reported continuing education

in this area. There is evidence of differences between the work processes of the medical professions (with a focus on specializations) and the social service with generalist training[14]. However, the nature of working with the elderly requires the professional to be in constant updating. Concerning academic training in gerontology, almost half (48.1%) are licensed in this area, with the professional group of nurses being the one with the highest value (53.3%), while, in the scope of the master's degree (29.4%) and postgraduate (29.4%), it is the physicians who stand out.

Despite the differences between the professionals, their options are consensual regarding the use of instruments for application in the elderly, evidenced by Barthel, for the evaluation of ADLs; Braden, for the evaluation of the risk of developing pressure ulcer; and MMSE, for cognitive evaluation. Research shows that, among the instruments most used in the various integrated programs of care for the elderly, we highlight the EASYcare (Elderly Assessment System), RAI-HC (Resident Assessment Instrument - Home Care)/RAI - CHA (Community Health Assessment), and GRACE (Geriatric Resources for Assessment and Care of Elders)[15]. The disagreement of the findings with the literature allows corroborating other authors[10] who claim that it is urgent to reformulate public policies guaranteeing a standardized evaluation system, making it a challenge to disseminate the various instruments so that they become effective in the daily lives of professionals.

As for the individual opinion of professionals, each category considers different instruments for the evaluation of the elderly, with physicians focusing on mental evaluation, nurses on physical evaluation, and social workers on social evaluation. These results agree with several authors and scholars of the Multidimensional Evaluation of the Elderly, considering the need to grant the evaluation in the four domains: clinical, functional, psychic, and socioenvironmental[2] - and can constitute interdisciplinarity an essential resource in this context. However, nurses consider a greater diversity of instruments compared to physicians and social workers, including several domains and evidencing the holistic view of the nursing discipline.

Concerning the usefulness of Barthel, a systematic review study[11] confirms this research since it was included in 90% (450) of the articles analyzed as one of the instruments of choice for

assessing the functional state of the elderly. In Spain, the most reliable instruments found to evaluate the mobility of the elderly were the Short Physical Performance Battery (SPPB) and the Minnesota Leisure Time[16], diverging from the present study, although justified by the characteristics of the sample. Barthel assesses the person's ability to perform certain basic activities of daily living (BADLs) independently, providing information based on the total score and partial scores for each activity evaluated, allowing the person to identify specific disabilities and tailor care to their needs.

The Braden scale is one of the recommended instruments for early identification of the degree of risk since, according to International evidence, about 95% of pressure ulcers are preventable[17]. It consists of six dimensions: sensory perception, moisture, activity, mobility, nutrition, friction, and sliding forces — all of which are highly sensitive to nursing care.

In practice, the use of Barthel and Braden, incorporated into the Clinical Information System (Sclínico) of public health institutions, is consensual. These results point to a medical and nursing care for the elderly particularly associated with disease/dependence situations, rather than aimed at promoting health and/or healthy aging.

The LSP and Ecomap are considered less useful instruments for the elderly by the professionals. The LSP seeks to identify lifestyle components that affect the health and well-being of the person, seeks behavioral changes and health promotion[18]. Knowing that longevity depends a lot on individual behaviors, which are influenced and modified and, with the WHO[6] defending an active and healthy lifestyle, it turns out that healthy aging is a challenge of today's societies, denoting, still, little concern for this age group in the field of health promotion. The Ecomap, representing the family unit regarding the community that surrounds it and the relations with other systems, is a valuable instrument for the understanding of family processes[19] so significant for the emotional health of the elderly[20], for spiritual well-being and the quality of life[18]. Qualitative research carried out in São Paulo (Brazil) evaluated the perception of the elderly about aging, concluding that the knowledge of the health team about the process of senescence and senility and the family and social context of the elderly is essential[21], due to the repercussions on the health of the elderly and the family itself, which differs from the present study.

Tinetti has been used to evaluate the balance and motion abnormalities. However, knowing that these aspects are among the main predisposing factors of falls in the elderly[22], we noticed that the findings diverge from the evidence, suggesting gaps in the evaluation of significant health aspects. Its use has essential contributions to the quality of life of the elderly, enabling preventive, care, and rehabilitation interventions.

In summary, the diversity of instruments in the care of the elderly by each professional group may contribute not only to reduce the weaknesses of interdisciplinary work but also to the holistic evaluation of the elderly and the determination of an integrated intervention plan, defined among physicians, nurses and social workers. With the purpose to understand how it manifests itself in the physical examination of the older practitioners, we should note that these are based on the ability, or the need for help from the old to the realization of the DLAs, which can be divided into basic (BADLs), if it is related to self-care (eating, and drinking, personal hygiene, dressing etc.), and instrumental (IADLs), required to live in the community (such as shopping, using the telephone, etc.), once the aging process is associated with an increase in the prevalence of functional impairments and chronic medical conditions.

The results reinforce the various pieces of evidence that functional capacity is one of the most identified variables in measuring instruments specifically built for the elderly[10]. Their assessment allows physicians and nurses to detect their health care needs and social workers to tailor the best support response available in the community. At the same time, we highlight the little data collected on vision/hearing, diverging these findings from International research that considered vision/hearing one of the five primary areas in evaluating care needs in the elderly[1]. In turn, decreased visual and auditory acuity are two of the main symptoms/manifestations, which may predispose to changes in balance, functional dependence, and episodes of falls[23], confirming the relevance of their integration in the physical examination. By professional category — in this case, for physicians and nurses — vital signs are highlighted, attributing its monitoring to the control of parameters related to blood pressure, heart rate, respiratory rate, and body temperature, which in the elderly may vary as a result of the vulnerability associated with aging[24].

It is observed in the literature that vital signs increasingly reflect the age and pathological changes in organic systems, for they are relevant indicators of health status, contributing to the diagnosis of acute and chronic diseases and determining their severity[25], achieving particular attention as evidenced in the findings of this study. The concern more focused on disease than on health promotion highlights the still dominant biomedical model, which diverges from practices promoting active, autonomous, and healthy aging[3,5,7].

In summary, the evaluation carried out by the multidisciplinary team is not complementary: it distances itself from a global assessment of the health of the elderly and contributes so that specific markers of the health status of the elderly are exposed, and others are repeated by more than one professional.

Study limitations

The limitation refers to the need to adapt the interdisciplinary evaluation instrument to a greater comprehension of the three professional groups since the response options related to the physical examination interfered with their real expression, as in the case of social workers. Moreover, the difficulty of accessing studies with the three professional groups made it impossible to obtain a more comprehensive comparison of results with the literature.

Contributions to the fields of Nursing, Health or Public Policy

The results of the present study provide relevant contributions to clinical nursing practice and teamwork among physicians, nurses, and social workers, highlighting weaknesses in interdisciplinary articulation, with repercussions on the health promotion of the

elderly. We hope that this research will motivate a reflection on the topic and may bring subsidies for the update of the National Program for the health of the elderly.

CONCLUSION

Given the aging and longevity of the population, the need to standardize the evaluation of the elderly has increased, considering the biopsychosocial components and the intervention of all health and social professionals. However, we must make some observations regarding the use of instruments for assessing the health of the elderly for physicians, the most helpful tools are those that focus on cognitive aspects; for nurses, those that evaluate physical aspects; and for social workers, those that contemplate social aspects, thus converging to a holistic evaluation of the elderly, without validating teamwork.

The evidence of the differentiated use of instruments among the study participants can contribute to improving the articulation of health and social care, with implications for the health promotion of the elderly. By professional category, nurses use a greater diversity of measuring instruments compared to physicians and social workers. The physical examination performed focuses mainly on the functional capacity of the elderly person, proving the focus of professionals directed to the consequences of aging, which does not favor early intervention with the purpose of preventing and maintaining the well-being of this population. There is also little concern of professionals with the identification of lifestyles and social support, essential aspects to promote longevity and active and healthy aging.

Given these results, we suggest future studies aimed at interdisciplinarity among physicians, nurses, and social workers, as an essential strategy in the evaluation of the health of the elderly.

REFERENCES

1. Balsinha MC, Gonçalves-Pereira M. A avaliação do paciente idoso em Medicina Geral e Familiar: desafios e oportunidades. Rev Port Med Geral Fam. 2014;30:196-201. https://doi.org/10.32385/rpmgf.v30i3.11364

2. Moraes EN, Pereira AMVB, Azevedo RS, Moraes FL. Avaliação multidimensional do Idoso/SAS. [Internet]. 2018[cited 2019 Oct 5]. 113p. Available from: https://www.saude.pr.gov.br/sites/default/arquivos_restritos/files/documento/2020-04/avaliacaomultiddoidoso_2018_atualiz.pdf

3. Direção-Geral da Saúde (PT). Programa Nacional para a Saúde das Pessoas Idosas [Internet]. Portugal. 2006 [cited 2019 Jul 19]. Available from: http://www.dgs.pt/directrizes-da-dgs/normas-e-circulares-normativas/circular-normativa-n-13dgcg-de-02072004.aspx

4. Vieira M. Modelos em uso na assistência a Idosos: traçado para a intervenção do Enfermeiro de Reabilitação[Dissertação] [Internet]. Porto: Escola Superior de Enfermagem do Porto; 2018[cited 2019 Oct 5]. Available from: http://hdl.handle.net/10400.26/25779

5. Direção-Geral da Saúde (PT). Plano Nacional de Saúde: Revisão e Extensão a 2020 [Internet]. Portugal. 2015 [cited 2018 Jul 19]. Available from: http://www.insa.pt/sites/INSA/Portugues/ComInf/Noticias/Documents/2015/Junho/PNS-2020.pdf

6. World Health Organization (WHO). Global strategy and action plan on ageing and health. [Internet]. 2017 [cited 2020 Jan 23]. 56 p. Available from: https://www.who.int/ageing/WHO-GSAP-2017.pdf?ua=1

7. Direção-Geral da Saúde (PT). Estratégia Nacional Para o Envelhecimento Ativo e Saudável 2017-2025[Internet]. Portugal. 2017 [cited 2018 Nov 12]. Available from: https://www.sns.gov.pt/wp-content/uploads/2017/07/ENEAS.pdf

8. Eloranta S, Arve S, Routasalo P. Multiprofissional collaboration promoting home care clients' personal resources: perspectives of older clients. Int J Older People Nurs. 2008;3(2):88-95. https://doi.org/10.1111/j.1748-3743.2007.00105.x

9. Young HM, Siegel EO, McCormick WC, Fulmer T, Harootyan LK, Dorr DA. Interdisciplinary collaboration in geriatrics: advancing health for older adults. Nurs Outlook. 2011;59(4):243-50. https://doi.org/10.1016/j.outlook.2011.05.006

10. Medeiros PA, Fortunato AR, Viscardi AA, Sperandio FF, Mazo GZ. Instrumentos desenvolvidos para o gerenciamento e cuidado de idosos em instituições de longa permanência: uma revisão sistemática. Ciênc Saúde Coletiva. 2016; 21(11):3597-610. https://doi.org/10.1590/1413-812320152111.09912015

11. Paixão Jr. CM, Reichenheim ME. Uma revisão sobre instrumentos de avaliação do estado funcional do idoso. Cad Saúde Pública. 2005;21(1):7-19. https://doi.org/10.1590/S0102-311X2005000100002

12. Manzo BF, Ribeiro HCTC, Brito MJM, Alves M. A enfermagem no processo de acreditação hospitalar: atuação e implicações no cotidiano de trabalho. Rev Latino-Am Enfermagem [Internet]. 2012 [cited 2019 Oct 5];20(1):[08 telas]. Available from: https://www.scielo.br/pdf/rlae/v20n1/pt_20.pdf

13. Ministério da Saúde (BR). Relatório social do ministério da saúde e do serviço nacional de saúde 2017. Portugal. 2017 [cited 2019 May 5]. [Available from: https://www.sns.gov.pt/wp-content/uploads/2018/06/Relatorio-Social-MS_SNS-2017-vfinal.pdf

14. Silveira RB, Silva EA. O trabalho do/a Assistente Social na Unidade de Terapia Intensiva (UTI): a (in) visibilidade de suas ações x os processos de trabalho em equipe. Texto Contexto Enferm. 2018;17(1):97-114. https://doi.org/10.15448/1677-9509.2018.1.27325

15. Stoop A, Lette M, van Gils PF, Nijpels G, Baan CA, Bruin SR. Comprehensive geriatric assessments in integrated care programs for older people living at home: A scoping review. Health Soc Care Community. 2019;27(5):1-18. https://doi.org/10.1111/hsc.12793

16. Castañeda FJR, Aznar CT, Baquero CM, Guerra JC. Sistemática descripción de los instrumentos de medida de la movilidad en personas mayores de 65 años: revisión sistemática. Rev Esp Salud Pública. 2015;89(6):545-61. https://doi.org/10.4321/S1135-57272015000600003

17. Direção-Geral da Saúde (PT). Avaliação da Cultura de Segurança do Doente nos Cuidados de Saúde Primários[Internet]. Portugal. 2015 [cited 2018 Jan 22]. Available from: http://www.dgs.pt/directrizes-da-dgs/normas-e-circulares-normativas/norma-n-0032015-de-11032015.aspx

18. Nahas MV, Barros MV, Francalacci V. O Pentáculo do Bem-estar. Base conceitual para avaliação do estilo de vida de indivíduos ou grupos. Rev Bras Ativ Fis Saúde. 2000;5(2). https://doi.org/10.12820/rbafs.v.5n2p48-59

19. Wright M, Leahey M. Enfermeiras e famílias. Guia para avaliação e intervenção na família. 5ª ed. São Paulo: ROCA; 2011. 392p.

20. Ferreira LK, Meireles JFF, Ferreira MEC. Avaliação do estilo e qualidade de vida em idosos: uma revisão de literatura. Rev Bras Geriatr Gerontol. 2018;21(5):639-51. https://doi.org/10.1590/1981-22562018021.180028

21. Horta AL, Ferreira DC, Zhao LM. Envelhecimento, estratégias de enfrentamento do idoso e repercussões na família. Rev Bras Enferm. 2010;63(4):523-8. https://doi.org/10.1590/S0034-71672010000400004

22. Rivolta MW, Aktaruzzaman M, Rizzo G, Lafortuna CL, Ferrarin M, Bovi G, et al. Evaluation of the Tinetti score and fall risk assessment via accelerometry-based movement analysis. Artif Intell Med. 2019;95:38-47. https://doi.org/10.1016/j.artmed.2018.08.005

23. Palma CS. Quedas nos idosos: do risco à prevenção [Dissertação]. Beja: Instituto Politécnico de Beja, Escola Superior de Saúde; 2012. Available from: http:// hdl.handle.net/10400.26/3975

24. Teixeira CC, Boaventura RP, Souza ACS, Paranaguá TTB, Bezerra ALQ, Bachion MM, et al. Aferição de sinais vitais: um indicador do cuidado seguro em idosos. Texto Contexto Enferm. 2015;24(4):1071-8. https://doi.org/10.1590/0104-0707201500003970014

25. Chester JG, Rudolph JL. Vital signs in older patients: age-related changes. J Am Med Dir Assoc. 2011;12(5):337-43. https://doi.org/10.1016/j.jamda.2010.04.009