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Caring for institutionalized elderly: representations of managers and professionals

Cuidando de idosos institucionalizados: representações de gestores e profissionais

Cuidando de ancianos institucionalizados: representaciones de gestores y profesionales

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Abstract

Objective: Analyze the social representations of professionals and managers of long-term care institution for the elderly about the care and the influence of this conception in the practice of caring. **Method:** This is a qualitative research carried out with twenty-nine professionals and four managers of a long-term institution for the elderly in a city in the interior of São Paulo. The data, collected in two phases through individual interviews and workshops, were analyzed through the techniques of the Collective Subject Discourse and Content Analysis in the thematic modality. **Results:** About their representations about care, three main ideas were identified for managers: "giving affection"; "Supply basic needs"; and "look broadened." For the professionals, the main ideas were "to help and to give affection"; "Supply needs"; and "extended care". It also identified that the representations of the elderly influence the care practice. **Final considerations and implications for the practice:** The maintenance of the caregiving vision of the care process and the charitable model of producing health in these institutions are reflections of the representations of the elderly. Thus, it is necessary to review the social roles of the elderly, recognizing them as protagonists of their care process aiming at a better quality of care for this population.

Keywords: Homes for the Aged; Comprehensive Health Care; Health Facility Administrators; Health Personnel.

Resumo

Objetivo: Analisar as representações sociais dos profissionais e gestores de instituição de longa permanência para idosos sobre o cuidado e a influência dessa concepção na prática do cuidar. **Método:** Trata-se de uma pesquisa de abordagem qualitativa realizada com vinte e nove profissionais e quatro gestores de uma Instituição de Longa permanência para idosos de um município do interior de São Paulo. Os dados, coletados em duas fases por meio de entrevistas individuais e oficinas, foram analisados pelas técnicas do Discurso do Sujeito Coletivo e Análise de Conteúdo, na modalidade temática. **Resultados:** Acerca de suas representações sobre o cuidado, identificaram-se três ideias centrais para os gestores: "dar afeto"; "suprir necessidades básicas"; e "ter olhar ampliado". Dos profissionais, as ideias centrais foram "ajudar e dar afeto"; "suprir necessidades"; e "cuidado ampliado". Identificou-se, ainda, que as representações dos idosos influenciam a prática do cuidado. **Considerações finais e implicações para a prática:** A manutenção da visão assistencialista do processo de cuidado e o modelo caritativo de se produzir saúde nessas instituições são reflexos das representações do idoso. Assim, faz-se necessário rever os papéis sociais dos idosos, reconhecendo-os como protagonistas de seu processo de cuidado, visando à melhor qualidade na assistência dessa população.

Palavras-chave: Instituição de Longa Permanência para Idosos; Assistência Integral à Saúde; Administradores de Instituições de Saúde; Pessoal de Saúde.

Resumen

Objetivo: Analizar las representaciones sociales de los profesionales y gestores de una Institución de Larga Permanencia para ancianos sobre el cuidado y la influencia de esta concepción en la práctica del cuidar. **Método:** Se trata de una investigación de abordaje cualitativo, realizada con veintinueve profesionales y cuatro gestores de una Institución de Larga permanencia para ancianos de un municipio del interior de San Pablo. Los datos, recolectados en dos etapas por medio de entrevistas individuales y talleres, se analizaron a través de las técnicas del Discurso del Sujeto Colectivo y Análisis de Contenido en la modalidad temática. **Resultados:** Respecto a sus representaciones sobre el cuidado, se identificaron tres ideas centrales para los gestores: "dar afecto", "suplir necesidades básicas", y "tener una mirada amplia". En los profesionales, las ideas centrales fueron: "ayudar y dar afecto", "suplir necesidades", y "cuidado amplio". Además, se pudo observar que las representaciones de los ancianos influencian la práctica del cuidado. **Consideraciones finales e implicaciones para la práctica:** El mantenimiento de la visión asistencialista del proceso de cuidado y el modelo caritativo de producir salud en estas instituciones son reflejos de las representaciones del anciano. Así, es necesario revisar los roles sociales de los ancianos, reconociéndolos como protagonistas de su proceso de cuidado, buscando mejorar la calidad en la asistencia de esta población.

Palabras clave: Hogares para Ancianos; Atención Integral de la Salud; Administradores de Instituciones de la Salud; Personal de la Salud.

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INTRODUCTION

The process of population aging is a phenomenon that brings with it multiple consequences, thus becoming a worldwide challenge of this century. Disseminated in different regions of the world, it is advancing even more rapidly in countries with less economic development such as Brazil with several significant economic, social and health effects.[1]

Care is part of the essence of the human being and is translated from a relational movement. Whether it is the relation of the person to his own self or to another and for the other, it is he who gives individuals the condition of humanity. It is worth mentioning that because of this condition, care is completed by the other, that is, both the caregiver and the one being cared are co-responsible throughout the process. It is composed not only of actions, but also of behaviors and attitudes.[2]

In addition to techniques and tasks, care is built on the values and beliefs of professionals, who, inserted in a given context, express them in the production of care.[2] Thus, both the biomedical model supported by the Cartesian paradigm and the integrality of the care are expressed supported by the conceptions of health-disease, organization and management for the care, education and context in which they are/were inserted.

Faced with the complexities that permeate the human being, the insufficiency of the practice of care, based on automated actions and centered on biological aspects and medical conduct, becomes evident. The movement of rupture and rejection to the biomedical model, and consequently to the Cartesian paradigm, becomes necessary, pleading relationships between the binomial care-giver and the one being cared being closer, (re) signifying thinking/doing care in the sense of completeness.[3,4]

In order to meet the emerging needs of the new population configuration, health professionals should to consider the various dimensions of the lives of older people and their families throughout their history, helping them to develop and/or restore self-care in the best way possible. Thus, in addition to dealing with the situation of illnesses, losses and disabilities, this professional should encourage and empower the elderly to maintain their condition of fullness by investing in necessary actions towards an active and healthy aging and with quality of life.[3,5]

However, the economic and social impacts of the process of accelerated population aging in the country, the scarcity of specialized services to assist the population, the lack of preparation and capacity of families to deal with the changes in the senescence process, the growth rates of the elderly at older ages and aging alone have exponentially increased the demand for formal long-term care.[1,6] Among the different services that offer this kind of care is the long-term care institutions for the elderly (LTCIE).

These institutions, intended for the collective housing of elderly people, with or without family support, must act in a condition of freedom, dignity and citizenship with a view to maintaining the autonomy, independence and social conviviality of its residents.[7] Unfortunately, the context of precariousness of many LTCIE in the country and, consequently, the predominance of professionals with no specific training in care to this population compromise the quality of care.[8]

Thus, faced with this context and the changes in the supply of family care with the exponential increase in the demand for care offered by these institutions, the following questions are identified: What is the care concept of LTCIE professionals and managers? How does the vision of professionals and managers influence the provision of care in these institutions? The objective of this study was to analyze the social representations of professionals and managers of long-term care institutions for the elderly (LTCIE) about the care and influence of this conception in the practice of caring.

METHOD

This is an exploratory research, with a qualitative approach carried out in two stages with professionals and managers of an LTCIE of a medium-sized municipality in the interior of São Paulo. This research is part of the master's thesis entitled "Care in a long-term institution for the elderly: the training of professionals". According to the institution's own information, the selected LTCIE assists 54 elderly people, and according to the geriatric doctor of the institution, 16 independent, 22 with grade I dependency, 12 grade II dependents and 4 grade III dependents.

All the managers and professionals hired by the institution were included in the sample, totaling forty participants, being, respectively, five and thirty-five. The professional categories of the research were nurse, doctor, social worker, clerk, supervisor of general services, general services, cooker, nursing assistant and caregiver.

The criterion of inclusion was to be working at LTCIE, with employment or voluntary status, for at least three months. The data collection took place in two phases, in days and times agreed according to availability of the institution, and were sometimes rescheduled due to intercurrences in the institution.

The first phase, carried out through semi-structured interviews with professionals and managers between October and December 2016, included sociodemographic data and the questioning about the conceptualization of care. Data on sociodemographic characterization are related to age, gender, marital status, technical or higher education, presence of course or specialization in the area of care for the elderly, time in the institution and previous experience with the elderly. These were presented as single frequency. The analysis of the question was carried out using the analysis technique of the collective subject discourse (CSD).

The CSD is a technique of tabulation and organization of qualitative data that seeks to reconstruct a Social Representation (SR), preserving the articulation of the individual and collective dimensions.[9] Thus, it was organized the following steps: 1) analysis of the question with the extraction of the total content of the answers to the analyzed question; 2) extraction of the Keywords (KW) of each testimony; 3) Identification of the Central

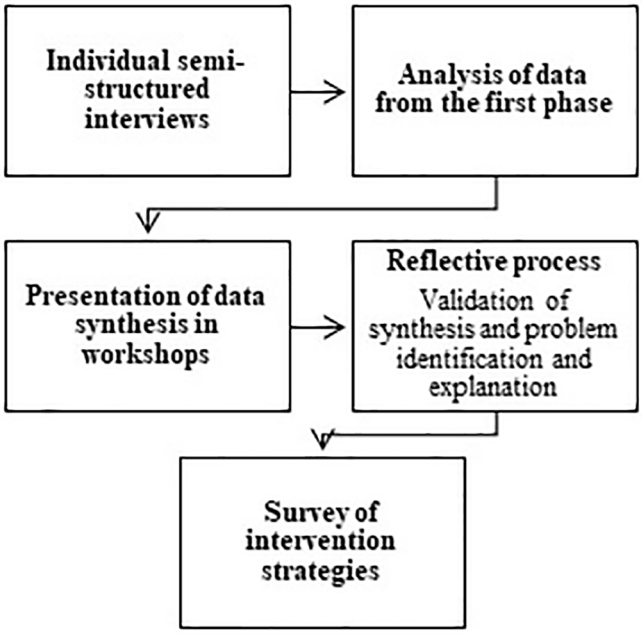
Ideas (CI) and Anchors (AC) present in each KW; 4) grouping the KW of the same CI/AC; and 5) construction of the CSD. For the construction of the CSD, each grouping, carried out in the fourth step of the process, was sequenced through the introduction of connectives, ensuring cohesion of discourse and eliminating particularisms and repetition of words or expressions, thus forming, testimonial-synthesis, in the first-person singular.[9]

After the analysis, the second phase began, between May and June of 2017, in which three workshops were held, one with the managers and two with the other professionals, considering their work shift. These workshops took place with the purpose of deepening the reflections about care and proposing intervention strategies for identified problems. From the reading of the synthesis of the data, the main problems raised were analyzed in order to deepen the core of the argument, allowing the participant to refute or validate what was presented to him and to propose intervention strategies. In order to avoid constraints and inhibition of the participants during the reflexive processes, the workshop with the managers occurred separately.

The interviews and workshops were recorded in audio, after the consent of the professionals, transcribed in their entirety and after the data analysis of the two phases, were disregarded. Figure 1 represents the data collection process performed.

In the second phase, Content Analysis was used in the thematic modality. This technique can be characterized by a set of methodological strategies applied to different discourses, starting from a superficial decoding of a written material in order to reach deeper levels, confronting the signifiers with their meanings and articulating what was explicitly expressed with the factors that influence it.[10]

Figure 1. Flow of data collection in the two phases of the research.
Source: authors own construction.



Thus, the analysis was organized into three chronological poles: a) pre-analysis: organization of the material collected in the workshops; b) exploitation of the material: use of classificatory operations to reach the core of understanding of the workshops; c) treatment of results obtained and interpretation: construction of an interpretive synthesis through dialogue with the objectives and assumptions of the research as well as with the theoretical basis adopted.[10]

The analysis of the materials produced in both phases was based on the Theory of Social Representations (TSR). The choice of TSR as a theoretical reference was due to the possibility of deeply understanding the conception of care of LTCIE professionals and managers, since, considering a social representation (SR) as a system of values, images, languages, ideas and practices common to a group, theory studies the collective empirical knowledge, considering it as a source of legitimate knowledge with the capacity to promote social transformations.[11]

The project that gave rise to this research was approved by the Research Ethics Committee of a municipality medical college linked to the National Committee for Research Ethics under opinion No. 1,662,805, pursuant to resolution 466/2012 and appreciated by the board of the studied LTCIE.[12] Professionals and managers, who voluntarily participated in the research, previously signed a Free and Informed Consent Form (LTCIE).

For the presentation of the results, the managers were coded by G and the professionals by P, inserting after it ascending numerical sequence (G1...G4; P1...P29).

RESULTS

Two pilot interviews were conducted that did not make up the final research material. One professional was on medical leave, one manager left the institution during data collection, two professionals chose not to participate in the research and one professional did not fit the inclusion criteria, resulting in 33 participants, four managers and 29 professionals.

Of the managers interviewed, all were elderly (60-75 years), with a majority of females, married, with at least one higher education course (only one with health training) and no specialization or course in the area of gerontological care, acting in the institution for 13 years, on average, on a voluntary basis. For professionals, the average age was 39.7 years. The majority of females, married, without previous experience with the elderly, having attended or still attend technical or higher education and without course or specialization related to the care of the elderly, with an average performance of 4 years and 9 months in the institution.

The presentation of the results will be done in an articulated way between the first and second phases, through the answers issued by the managers and, later, by the professionals.

Responses from managers to the question "What is care for you?" allowed to elaborate three central ideas. They are: giving affection, meeting basic needs and having an enlarged look.

The CSD of the central idea "to give affection" was:

> *It is the way the person treats the elderly, is to treat in the best way possible. It is to have affection, patience, love, attention and dedication with them, because caring is dedicating oneself. (G1; G3 and G4)*

The central idea "meeting basic needs" was represented by the following CSD:

> *Care for me is when they are always clean, well-fed, neat, with the clean room, tidy, the bathroom clean, the food well-made. When they can not eat with their own hands, be careful to give food in the mouth. It is each one doing well in his area, because by performing your service well, you are taking good care of their lives. (G1 and G2)*

The other central idea "to have enlarged look" emerges in the following CSD:

> *It is to have a different look at the elderly who is already a weakened person, a person who has already been abandoned. They are needy, they need everything, they have nothing, then the little you give, they are already happy, it is to pay attention to them, it is to fight with the family to come visit, this is all part of care. (G3)*

However, although the discourse points to an enlarged view, the reflection during the workshop allowed us to understand that this view is in a welfare perspective of health:

> *Yes, that is to be careful, to pay attention to these things, that they have nothing, and the really little that you give is everything to them.* (G2)

In the workshop, the idea of care as "emotional support" was also deepened, considering the psychological manifestations and the importance of listening and valuing the voice of the institutionalized elderly:

> *[...] because it's not just because of depression that we pay attention. I was talking about the elderly X now. So, listen to them ... they have those stories [...] much more listen to them when they need it, they want to tell[...].* (G1)
>
> *[...] he just wants to get your attention, just want to tell [...].* (G2)

The category "informality of care", which appears in the workshop, brings an informal care representation, in which the work process has characteristics similar to the family care:

> *[...] physical need. Care of ... so ... physically, now the affective part, which is the affection, the patience ... this is it right here[...].* (G2)
>
> *[...] they say that we are their family, the family they do not have. Because he is always with them and the family is not.* (G2)
>
> *[...] of affection, that 'pay attention to me' because they do things like 'pay attention, I'm here'.* (G1)

The analysis of the answers of the professionals to the same question led to the identification of three central ideas, close to those presented by managers: "act of helping and giving affection", "meet needs" and "care for basic needs with quality".

The CSD of the central idea "act of helping and giving affection" was:

> *Care for me is to help, you do something for another person, dedicate yourself, treat in a fair way and do what you do best. It is you take care of him since he enters into an entity. You won't be able to do everything for them, but the little that you do for each one already is important, is a contribution. It is to treat with tenderness, with affection, to protect, to love and to give attention. The greatest care is our love with them. Not everyone has a family, so their family ends up being us. Those who are going to work with such a profession must have love for what they do. (P1- P4, P6, P8, P10- P16, P18 -P28)*

This central idea is evident in the workshops with greater intensity, which is consolidated by the core of meaning "work for love":

> *[...] and I think that an important speech that appears is 'liking', if you do not like it ... because for money you do not stay. You may be needing, but if it's just for money, and you do not identify with it, do not have love, you can not stay.* (P7)

Another conception found is associated with the central idea "to meet needs":

> *Care is a good morning, a good afternoon, is to listen to complaints, to pay attention, listen to their problems, they are very needy. To care is to serve the patient's need, is to serve a person who is dependent, from bathing, changing, dressing, giving assistance, participating in their lives, keeping them clean, giving food, from a glass of water to putting a slipper on the foot. They are very sad. From time to time, then, you sit, talk, exchange, laugh, relax. A touch I make in him with affection, a simple touch,*

may be the only touch he'll have all day, it'll be my only contact with him, the only chance he'll play and smile. (P1, P4, P7, P8, P10 - P16, P18, P19, P21- P28)

The CSD means that the care is to contemplate the basic needs of the individual, as well as "giving attention", "caring", seeking to meet the affective needs of the elderly.

As in the discourse of managers, the research also identified the central idea "Care for basic needs with quality" with the following CSD:

Care is to contemplate need. Not only the need that the person understands that he has, or does he feel, but also that he has no idea that he needs. So, when you can contemplate this, you providing care. I do not see care just like bathing, hygiene, these things. Care is to be careful with everything, with the cleaning, with the hygiene, is to take care of, in various forms and the whole time and to like what you do. Keep an eye, even if it's not our part. Care covers various areas, sentimental, physical, conversation, pedagogical, everything. It encompasses everything from a conversation, listening to the elderly, to a bath, evaluating the whole body, if it's looking like anything, any complaints from them. It is more than techniques, much more. We are taking care of a human being, not a little robot in which you will put a device. (P1, P4, P5, P9, P11, P17, P19, P20, P22, P23, P27- P29)

The reflection on the results of this question during the workshops with the professionals gave rise to the core of meaning "LTCIE as a deposit for the elderly".

Here it became a den for old people and not a shelter as it should be. The family should be more participatory. There was a case of us saying that we were going to use the judge, the prosecutor, because the elderly was very depressed and the son simply abandoned [...]. (P19)

[...] I was even talking to professional X today. Yesterday arrived a bag of medicine, there we went to look, everything expired. What do these people think out there? That we use expired medicine. Sometimes they call, "Hey, come get it, there's banana, there's apple". When the drives arrive, he does not bring any because they're all rotten". (P7)

DISCUSSION

The analysis of the interviews of managers allowed the identification of argumentative cores that express their views about the conceptualization of care. Attributing care to feelings, such as "love", "tenderness", "attention", and "dedication", shows that they are tied to the philanthropic condition of the institution. Thus, as reaffirmed by the workshop, this informality in the practice of care compromises its quality with a direct impact on the autonomy and independence of the residents.[13]

From the data, we can see that the managers present a "common sense" vision about how to approach care for the elderly, demonstrating that they only need tenderness, affection, since they are in LTCIE to receive care, however, do not recognize the complexity and specificities of the health of the elderly.

In Brazil, there is no need for managers of philanthropic institutions to have qualified training to play this role, according to the researched institution. By having the philanthropic character, for the most part, only identifies the "willingness" to donate their time in favor of the management of inputs, to organize the professionals to do the care.[8,14] It was also identified that they do not consider that this care carried out by the professionals needs training aimed to the specific needs of these elderly people, although they have an expanded degree of actions that require their own knowledge, skills and attitudes for this age group.

In a study conducted in Rio Grande do Sul, it was identified that one of the challenges encountered by managers of these institutions and that interferes with the maintenance of qualified professionals for gerontological care is the lack of resources. Thus, managers often, instead of carrying out activities related to the administrative issues of the institution, use their available time to raise other sources of financial resources, finding it difficult to comply with what determines the legislation.[8,14]

Similar to what was found in interviews with managers, the concept of care to professionals is also related to the philanthropic character of the institution, reinforcing the concepts of benevolence, charity and love. Thus, the social representation of care related not only to the historical inheritance of the insertion of the institutions in the country, but also to the changes in the conceptions of care and the work process in health itself.[13]

The National Policy of the Elderly (PNI), promulgated by Law No. 8,842 in January of 1994, establishes the objective of preserving the social rights of the elderly, promoting their autonomy, integration and participation in society, thus guaranteeing the exercise of their citizenship.[15] However, the perpetuation of care from the assistance perspective, common in the assistance to the elderly in the setting of the long-term care institution for the elderly with the infantilization of their residents and the construction of the work process in the logic of informal care, greatly jeopardizes this exercise.[16]

The infantilization of this part of the population, which presupposes a paternalistic attitude, is permeated by the concepts of charity and benevolence that goes against gerontological care. In this sense, infantilization, although usually originated in the erroneous conception of pleasing the elderly, consists of a form of social violence, since it does not recognize its social rights foreseen in the PNI.[15,16]

Physical care, as a representation of care as conditions of cleaning the elderly and the environment, as well as food, disregards many elements that are contained in the production of life, proving to be a problem in health work.[17] From this perspective, integrality in care is compromised when the practice is focused on some of these elements.

In the same sense, the fragmented care expressed by managers with the performance of each professional "doing their job well," reinforces the work process outside the logic of integral care. By attributing to care the condition of contemplating the basic needs of the elderly, professionals focus their eyes and their action on the biological body of the residents. In this way, the professional practice is centered in procedures and not in the other.[17]

The professionals of the institution associate these needs with the suppression of the affective needs of the elderly. However, although it can identify a conceptual advance in the path of integral care, it is possible to see the SR of the care still rooted in concepts of informal and family care.[13]

This care, in the context of the LTCIE, which refers to meeting the needs is also associated with compliance with norms and institutional rules. The normalization of the routines of the elderly compromises the exercise of their individuality. Thus, although residing in institutions may represent the possibility of survival for the elderly, this experience limits the social and family participation of these individuals, preventing them from controlling their own lives.[18]

Such disruption in the lives of the elderly makes them often unmotivated, being common to find depressive moods, feelings of loneliness and lack of perspective, causing their social isolation. The lack of recognition of the elderly as the protagonist of the care process and, often, the devaluation of the determinants of institutionalization corroborate the distance from the integral practices of health care. This represents one of the main obstacles to adaptation in the process of institutionalization, leading to the re-signification of its social role.[18,19]

The expanded view, as a necessity raised by the managers for the work with the elderly population, highlights the importance of seeing the elderly in its entirety in order to contemplate the different faces of care. However, the deepening of the workshop confirms the assistant approach of the conception of care, retaking philanthropic and benevolence characteristics, part of the charitable historical heritage of this setting assistencial.[13,20]

For professionals, the inclusion of health needs in the care process, conforming to a broad format to build health, contemplates different dimensions. Contemplating the health needs of an individual means much more than meeting the demands for medical appointments and procedures, covering several other elements. For Cecílio, these needs comprise four main dimensions. The "good living conditions" dimension refers to environmental issues such as adequate housing and good food, as well as their social condition in family relations and with society as a citizen and the economic condition, among others, so that they can live and decide on your life. "Consumption of technologies to improve and prolong life" is related to access to medicines and other therapeutic resources and health services.[21]

The "bond" is tied to the relationships of trust between the individual "care", the professionals and the staff. The fourth dimension "autonomy in the way of walking the life", refers to the condition of protagonism of the subject, making it co-responsible for his plan of care.[21]

Thus, when acting in the perspective of comprehensive and extended care, one must consider all the determinants of the health-disease process, integrating its different dimensions and also valuing the singularities of the elderly.[16,17] Therefore, in the integral care, the needs of the elderly in all its dimensions must be considered for the promotion of their autonomy, for the possibility of conducting their life having their rights preserved.

The reflection on this issue during the workshops and the core of meaning "LTCIE as a deposit of the elderly" brings in its root the social representation of the elderly to the contemporary society and are related to the determinants that lead the elderly to the institutionalization and the transformations in the dynamics caused by this process. In this perspective, it is also associated with the way in which society represents LTCIE and its residents.[13]

The myths and prejudices attributed to long-term care institutions for the elderly as places for elderly individuals live in the expectation of the end of their lives, as well as the social representation of the elderly as fragile individuals confirm the persistence of negative images rooted in the Brazilian cultural imaginary. In this sense, it is necessary to transform the conception about them, in order to invest in them so that they become decent places for the residence of the elderly and not in a place of deposit of these individuals.[18]

It is worth mentioning that the shortage of work that specifically addresses the management in the long-term care institution for the elderly nationally and internationally, makes it difficult to know the practices adopted by these institutions. Unfortunately, in the social context to which these institutions are inserted, prevails the administration by managers, and although they have a "good will", do not have a specific qualification for the functions for which they are allocated.[14]

In the study conducted by Damaceno and Chirelli, it was observed that there are still difficulties to implement the National Policy on the Health of the Elderly Person (PNSPI) in Brazilian municipalities.[22] There are few specific actions given to the elderly, unprepared professionals to take care of these specificities of the elderly, requiring the expansion of intersectoral actions to address health problems. That is, the national policy needs to be expanded and more incisive at the municipal level.

Study on the solution of the European countries to deal with the forms of care for the elderly emphasizes the importance of establishing public support policies in institutions or home care performed by nurses or professional teams.[23] It is about rights and to consider the elderly as a citizen, who, in his aging process, may be able to decide how he can receive this care.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

Both the managers and the professionals of the studied LTCIE conceptualize the care based on three similar central ideas: to give affection, to satisfy needs and extended care. However, the workshops allowed the emersion of different thematic axes. It was observed that representations about the relations between care, the elderly as a fragile and often infantile individual, and the management of long-term care institutions influence the way in which professional agents work in these institutions, since there is maintenance of the assistant approach of the care process and the charitable model of producing health.

It is identified that in the institution of long-term care and in the health services, there is still need to advance in the way in which the practices are conceived and realized from the vision we have of the elderly in Brazilian society. When considering the elderly as a person no longer economically productive for society, with some degree of dependence or that is not accepted by the family by issues of the relationships established throughout life, becomes a "burden", without social rights or even without the right to be supported by family and institutions. It is urgent to review this vision and overcome it through the processes of training of health professionals, as well as the training of the managers of these institutions. The implementation of the PNSPI must be taken care of in a broad way, advancing in the discussions with the responsible bodies.

One of the limits of the research is the investigation of the vision of high schools and higher education institutions that form the professionals and of the possibilities to modify the approaches to the qualification of those in front of the emergent demands of care for the elderly and specifically in institutions of long-term care.

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