

REQUIREMENTS OF AGING FOR NURSES, COMMUNITY HEALTH AGENTS AND FAMILY CAREGIVERS FOR THE CARE OF DEPENDENT ELDERLY*

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ABSTRACT

Objective: describing the demands of aging from the perspective of nurses, community health agents and family caregivers of dependent elderly members of health educational practices.

Method: it is a qualitative study developed from educational practice computations of health with nurses, community health agents and family caregivers. The data were analyzed using the Triadic Configuration Technique, Humanist-existential-personalist. **Results:** educational practices evidenced demands of aging, such as care for the elderly who do not have a family; referrals to referral services; support of the family, community and state in care; financial support and guidance for carers; and training of health professionals. **Conclusion:** it was found that the demands of aging are inevitable, and greater social and health investments are needed for the elderly and their families, and the educational practices developed by health professionals are considered fundamental strategies for the empowerment of those involved in the care of the elderly.

Descriptors: Aging, Aged, Caregivers, Nurses, Community Health Workers, Primary Health Care.

RESUMO

Objetivo: descrever demandas do envelhecimento na perspectiva de enfermeiros, agentes comunitários de saúde e cuidadores familiares de idosos dependentes integrantes de práticas educativas em saúde. **Método:** um estudo qualitativo desenvolvido a partir de prática educativas em saúde com enfermeiros, agentes comunitários de saúde e cuidadores familiares. Os dados foram analisados por meio da Técnica da Configuração Triádica, Humanista-existencial-personalista. **Resultados:**

as práticas educativas evidenciaram demandas do envelhecimento como a de cuidado ao idoso que não tem família; encaminhamentos para os serviços de referência; apoio da família, da comunidade e do Estado no cuidado; apoio financeiro e orientações para cuidadores; e capacitação de profissionais de saúde. **Conclusão:** verificou-se que as demandas do envelhecimento são inevitáveis, sendo necessários maiores investimentos sociais e de saúde aos idosos e suas famílias, e as práticas educativas desenvolvidas por profissionais de saúde são consideradas estratégias fundamentais para o empoderamento dos envolvidos no cuidado ao idoso. **Descritores:** Envelhecimento, Idoso, Cuidadores, Enfermeiros, Agentes Comunitários de Saúde, Atenção Primária à Saúde.

Descritores: Envelhecimento; Idoso; Cuidadores; Enfermeiros; Agentes comunitários de saúde; Atenção Primária à Saúde.

RESUMEN

Objetivo: describir las demandas del envejecimiento desde la perspectiva de enfermeras, agentes de salud comunitarios y cuidadores familiares de ancianos dependientes de prácticas educativas sanitarias. **Método:** un estudio cualitativo desarrollado a partir de la práctica educativa sumas de salud con enfermeras, agentes de salud comunitarios y cuidadores familiares. Los datos fueron analizados utilizando la Técnica de Configuración Triadic, Humanista-Existencial-Personalista. **Resultados:** las prácticas educativas evidenciaron demandas del envejecimiento, como el cuidado de los ancianos que no tienen familia; referencias a servicios de referencia; apoyo de la familia, la comunidad y el estado en el cuidado; apoyo financiero y orientación para los cuidadores; y formación de profesionales de la salud. **Conclusión:** se encontró que las demandas del envejecimiento son inevitables, y se necesitan mayores inversiones sociales y sanitarias para las personas mayores y sus familias, y las prácticas educativas desarrolladas por los profesionales de la salud se consideran estrategias fundamentales para el empoderamiento de las personas involucradas en la atención de los ancianos.

Descriptores: Envejecimiento, Anciano, Cuidadores, Enfermeros, Agentes Comunitarios de Salud, Atención Primaria de Salud.

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INTRODUCTION

In Brazil, the elderly population grows quickly, contrary to what happened in some developed countries, and projections indicate that the number of elderly people will continue to grow in the coming years. They can acquire diseases, disabilities and sequelae, and demand from public services, at various levels of care, which will reflect the planning and priorities of social public policies, so that they can intervene in an integrated way with actions of prevention, treatment and care for chronic diseases that can compromise the elderly, as well as strengthen the promotion of active and healthy aging.¹

The elderly have characteristics known as involvement of chronic diseases and frailties, high costs, reduced social and financial resources. Aging, even without diseases, is related to functional impairment. With varying conditions, care for these people needs to be planned differently from other age groups. A model of elderly health care to be efficient should cover all levels of care, that is, have a very delineated flow of education practices, health promotion, prevention of preventable diseases, delayed health problems, perform early care and rehabilitation by multidisciplinary and trained health professionals, which will allow to intervene specifically when necessary and involve various services and the support of family members. This should be developed to preserve the quality of life (QoL) and social participation of the elderly.²

There are several difficulties pointed out for the performance of care for the elderly, such as the lack of specific actions; lack of preparation of professionals and, consequently, insufficient knowledge for the performance, as well as the insufficient development of intersectoriality,³ fundamental aspects for the promotion of comprehensive care for the elderly, and, particularly, dependents and/or with health problems.

Facing the challenges of aging is urgent in the face of increased life expectancy at birth, which requires the creation of specific public policies appropriate to the needs of the elderly, and the State must be prepared for its provision, as well as for the financing of support structures and monitoring of its activities. In addition, it is essential to implement mechanisms that strengthen the elderly health care model and invest in the workforce and training of professionals such as geriatrics and gerontology, to create skills to act in prevention, care and comprehensive health care for the elderly, to meet the demand for aging.¹ In addition, in addition, in addition, it is necessary to implement the various existing public policies concerning the elderly.

A study with primary health care managers (HCM) and professionals from the Family Health Strategy (FHS) showed the need for training and continuing education in health (CEH) for professionals such as nurses and community health agents (CHA) around elderly health. This is because several work and have not been trained to do so, which has interfered in the proposition of practices and technologies that meet the needs of this population, based on the expanded clinic and the constitution of people in the care of the elderly, since life expectancy has expanded.³

The CHA have not received significant training in the health service to work with the elderly and their family caregivers. In order to perform home visits, they intuitively recognize vulnerable risk groups such as the elderly and sick people.⁴ This lack of training in the area of gerontology can influence the care offered to the elderly, according to their particularities.

In this sense, it is necessary to rethink the formation of the multidisciplinary team at the undergraduate, graduate and health services levels to meet the demands and needs of the transition of the demographic and epidemiological profile of Brazil.³ Professional qualification will certainly contribute to the quality of care offered to the elderly and their family caregivers.

In addition, the lack of training of family caregivers and, at the same time, knowledge related to the care of the elderly, which can interfere in the maintenance of the health of those involved. Studies point to the needs of information and detailed guidance for the performance of care for the elderly, another person who helps in care, in the expansion of the support network and of health professionals to support family caregivers.⁵⁻⁶ It is necessary not only to guide caregivers, but also to evaluate the family to identify factors that may contribute to difficulties for care performance.⁶

This study is justified by expanding knowledge related to the demands of aging evidenced from those responsible for the direct or indirect care of dependent elderly, as well as due to the gaps identified in national and international scientific production on the theme and development of educational practices in health (EPH), when it is associated with the responsibilities of the three categories of caregivers - nurses, CHA and family members. The incipience of studies was identified in the databases of the Coordination for the Improvement of Higher Education Personnel (CAPES), the Scientific Electronic Library Online (SciELO) and SCOPUS, in the period from 1994 (promulgation of the National Polycy in of the Elderly) to 2017.

The study has the question: what are the demands of aging for nurses, community health agents and family caregivers of dependent elderly participating in educational practices in health?

OBJECTIVE

To describe the demands of aging from the perspective of nurses, community health agents and family caregivers of dependent elderly people who are members of health educational practices.

METHOD

This qualitative study was carried out in the urban area of the municipality of Manoel Vitorino, Bahia, in the southwest region, with a population of 14,387 people, in which 7,359 people live in the urban area, of which 871 are elderly.⁷ This belongs to the Doctoral Thesis "Responsibilities for the care of the dependent elderly and influence of educational practices in health", carried out in three stages. This article used data from the second stage of the research - implementation of EPH from the perspective of care for dependent elderly people.

We surveyed 2 nurses, 8 CHA and 6 family caregivers of elderly, aged 18 years old or over, linked to the two FHS of the municipality of Manoel Vitorino, based on EPH based on Brazilian regulations and manuals of the Ministry of Health that address aging, care for the elderly and caregivers. The inclusion criterion was defined: having participated in the first stage of the research (situational diagnosis - which collected sociodemographic, health and care data for the elderly, as well as data from nurses, CHA and caregivers participating in the study).

Data collection by 2 trained teaching nurses (Master and Doctor) occurred in March 2016, on three consecutive days, in the morning (1) and late (3) shifts, with an average duration of two hours each EPH meeting, which were recorded with a digital recorder, after authorization of those involved. Thirty-one participants of the first stage of the research were invited, with acceptance of 16 people. The non-participation of the others was related to the medical certificate and/or unavailability of someone to take care of the elderly while participating in the educational activity.

The invitation to participate in the EPH occurred in a verbal and printed face-to-face manner. Two days before its development, professionals were remembered by telephone and caregivers through home visits. There were four EPH meetings, one with family caregivers and three with professionals, at different times, suggested by caregivers, because they did not feel comfortable participating together with the members of the health team.

In the first stage of the research, the participants informed the topics of interest to address in EPH for the acquisition and/or expansion of knowledge, which permeated: aging and biopsychosocial changes, care for dependent elderly, self-esteem and caregiver care. These themes were fundamental for the planning of EPH, with addition to others defined by the researchers in accordance with the profile of the participants (Figure 1).

For all participants, in the first meeting there was socialization from the interaction dynamics (web technique with the use of string), an opportune moment to apprehend information about the care of the elderly. The other meetings continued the activities with dialogued exposure made

by the researchers and reflections of the participants on the care of the elderly in situations of dependence.

After interaction dynamics, printed material was made available to professionals with phrases created by the researchers and resources (pen and craft paper) so that they could discuss, elaborate and write their answers and share collective constructions with the other participants. This study considered the answers of the phrase: "comment on what they know about responsibilities for the care of the elderly". In addition, statements seized in varied meetings (chart 1), with the presence of different participants in EHP. It is emphasized that, even though the theme of the meeting was not related to the demands of aging, they emerged in the participants' statements.

The answers of the participants' constructions were written on wood paper and fixed on the wall, as a way of visualising all the answers and favoring the group's reflections. For family caregivers, after the interaction dynamics, the researchers began the dialogued exdisplay on the suggested themes and answered doubts. The statements of each EPH meeting were analyzed to identify the manifest demands (Figure 1). The participants' answers were identified with the letters: "N" (nurse), "C" (CHA) and "C" (caregiver), followed by numbering according to their performance (E1; A1; C1).

Participants/day*	Objective(s)	Contents
First day (professionals) E1, A1, A3, A4, A5, A10	- Present about aging, its demands, implications and challenges.	- Aging, chronic non-communicable diseases (NCDs), functional capacity and dependent elderly. - Demands (care and caregiver), implications and challenges of aging.
Second day (professionals) E2, A1, A2, A3, A6, A8	- Reflect on responsibilities and responsible for the care of the dependent elderly.	- Policies for elderly care. - Responsible and responsibilities for the care of the dependent elderly (with a focus on nurses and CHA). - Family and care for the elderly.

Third day A6, A8, A10 (professionals)	- Present and discuss aspects of the guidelines for family caregivers of dependent elderly at home, from the perspective of care.	- Biopsychosocial changes with aging. - Guidance on body care, food, hydration, decubitus change, comfort and environment massage. - Use of medications, sexuality of the elderly and caregivers, prevention of falls, attention at home, abandonment and ill-treatment and relationship of the elderly with family and friends.
First day (family caregivers) C4, C5, C9, C10, C16, C18	Guide about care for dependent elderly at home.	- Increase in the elderly population and demands of aging. - Biopsychosocial changes with aging. - NCDs, functionality, dependency, and autonomy. - Responsibility and responsible for the care of the dependent elderly. - Caregiver and changes in their daily lives after taking care of the elderly. - General care: body, food, hydration, comfort massage, sleep and rest, self-esteem, well-being, patience and environment. - Care for the bedridden elderly. - Family support.

Figure 1. Description of the participants, objectives and contents of EHP developed with nurses, CHA and family caregivers of the elderly. Salvador (BA), Brazil, 2018.

Legend: *Nurse (N), CHA (C) and caregiver (C).

Nurses, CHA and caregivers participated in EHP with comments and reports of their experiences in care, in a written and oral manner. These data were transcribed in full, organized in the Microsoft Office Word 2010 program, for reading and comprehension. It was suggested by the participants the development of other educational activities, with the demonstration of care practices for the elderly.

The EHP data were analyzed from the technique of The Triadic, Humanist-existential-personalist Configuration, according to the steps: I - Attentive reading of the content manifested by the participants, with the purpose of apprehending its meaning within the global structure; II - Rereading of the material, to apprehend the effect locutions, within the global structure; III - Identification and classification of aspects that converged in the statements for global analysis; IV - Grouping of units of meaning into subcategories and thematic categories; V - Presentation of groupings and; VI - Comprehensive analysis of the significant data of the groupings and the presentation of the main idea.⁸

Study approved with the opinion embodied: 1,388,138 and CAAE: 47661615.2.0000.5531, by the Research Ethics Committee of the School of Nursing of the Federal University of Bahia (EEUFBA), according to Resolution N° 466/2012, of the National Health Council (CNS), of the Ministry of Health (MoH). The participants were guaranteed their names in anonymity, confidentiality of information, voluntarily participated and signed the Informed Consent Form (ICF).

RESULTS

Participated in the educational practices 16 people, of which 2 were nurses, 8 CHA and 6 family caregivers, all females. None participated in specific activities and/or training on care for the elderly, prior to the development of this research.

The nurses had between 6 months and 3 years of work in the FHS, and 1 had a specialization in public health. Of the 8 CHA, 5 with complete second degree; 2 with complete upper and 1 with incomplete upper; 4 had 17 years of experience, 2 with 12 years and 2 with 5 years.

Among the 6 caregivers, 3 were aged 44 to 59 and 3 from 65 to 69; 3 were daughters, 2 wives and 1 sister; 4 cared for between 5 and 9 years old; 1 for 16 years old and 1 for 22 years old. Of these, 5 cared in full and 1 partial care of elderly with Alzheimer's disease, Parkinson's disease, hypertension, diabetes mellitus, prostate cancer, osteoporosis and mental retardation. As for income, 4 received family scholarship, 2 retirees (R\$ 880.00 reais for the year 2016). They did not perform activities outside the home, and half reported having performed renumbered work before taking care of the elderly.

From the analysis of the dialogues of nurses, CHA and caregivers in the EHP emerged 1 empirical category presented below.

Category - Requirements of aging

This category describes the demands of aging in the perception of nurses, CHA and family caregivers. Among the concerns that most concern them are the responsibility for the future of the person who will become an older person without a family, given the possibility of dependence; the

attitudes and the offer of social support of the people around him (neighbors, professionals) and the availability of social resources (Reference Center for Social Assistance - CRAS).

I [caretaker] have no husband, I do not have a daughter and i don't have a son to take care of me (C4). Not having someone who takes care, you don't find anyone, it's hard, it's hard (C5). I wanted to know what we can do with the elderly who have no family, who take care of them? (A4, E2). What attitude are you going to have with this old man? The neighbor won't take care of him. If he wants to take good care of it, if not. It's not the CHA's obligation. See that the elderly are not able to be alone, conditions to take care of themselves, we must look for what? The CRAS or the social worker to at least see where he will forward this elderly person, he just cannot be under the care of himself (E2).

The professionals described that several elderly people present health problems and frailty; with age, biological changes occur and there is a need for guidance to families to prevent health problems, such as pressure injury in the elderly, especially bedridden people.

We find many sick [elderly] (A3). The arm has no strength. He has difficulty getting up to drink water and can fall (A8). He's dependent. Due to fall is on the bed (A5). He's in bed and he's got ulcer [pressure injury]. Be careful not to chronic the pressure injuries (E1). It needs to guide [the family] to prevent pressure injury (E1). The elderly person to catch an infection is like a child, the immune system is low (E2). He said he doesn't feel like he's (A10). Some skin doesn't frown too much, it doesn't get wrinkled. He's got some little nuts, but he's 80-something (A8). All gray hair. Others in their 90s and do not have a white hair, is short (A8).

Accountability for the care of the dependent elderly is not shared among family members. This is revealed from the refusal of commitment, care that is faced as sacrifice, the fear of leaving it in a long-stay institution for the elderly (LSIFE) and criticism from families, who prefer to put their loved ones in an ILPI and abandon them.

When the elderly person is under the care of a relative, others do not want to make a commitment, do not want to collaborate, do not want to help (A6), do not share (A6, A10). I'm afraid to leave him alone (C5). I don't leave him alone. When I go out, I leave my girl [daughter] there [at home], with the neighbor (C9). Sometimes the people [people] talk like this: why not intern [ILPI] him? Then I say: we can't do that, put him there to be Jewish (C5). Had a family talk to take to the shelter [ILPI], I didn't accept. I prefer to make a sacrifice, which is difficult for me not to rest, but to take to the shelter no (C18). They have many children who intern their parents, play there, and still take their money, leave them abandoned as if they had no relative (C5). Here [in the municipality] there is no asylum (E2).

The CHA reported that most caregivers are elderly, with health problems and potentially dependent. For caregivers, having children is a possibility to receive care, however, there are situations in which they cannot care, and that the elderly also do not accept to be cared for by them, preferring to live alone. They question the lack of financial support for caregivers and mention the right of the elderly to the Benefit of Continued Benefit (BCB).

Most caregivers are also elderly (A6). The caregiver will need a caregiver as well (A3). The wife [caregiver] is a little lady too, who is already full of arthrosis, who can't take it anymore or walk (A5). If you have children, it is the children who care (C5). The elderly go to this son's house, this son will take care of him (A6). But you can't stay because you have to go out to work. All are married, have their families to take care of (C5). I hope I have a son who takes care of me (C16). When the son speaks I can not [care], the government enters with the BPC, which is a financial resource. Why was this case never thought of by the caregiver? Who has his private life, which is being private, in favor of the elderly, he vegetat! (A6). There are also elderly who do not accept or live and that no one will live with them (A2). They live alone (E1).

The participants expressed that, in the absence of information on gerontological aspects, they take care of their way. Another demand of them is the fulfillment of the educational duty on the part of the nurse in the monitoring and provision of explanations, at least once a month during the visit at home. They feel the need for an organ that is responsible for periodic courses for caregivers and families, and consider, as a counterpart, the applicability of learning and the need to supervise the practice of care for the elderly.

From here [municipality] there is no explanation (C5, C9, C10, C16). I take care of [caregiver] my way (C16). You must ask for family support. It's tough, isn't it? (C5). There must be a nurse to be accompanying, explaining at our home at least once a month (C16). If there was a responsible body, which cared about families, to give a local course for caregivers and collect (A5). Because sometimes just a course, then they take it here, get out of here and get home and not go to practice. If there was someone supervising, oh I'm going to have a tax man, someone will come here to inspect me, maybe i could solve (A5). An example, they weigh in the family purse. You always have the worry of coming to grief, because we talk about what? If you don't weigh it, the benefit will be cut. If in the elderly there were, like this, either you take care of the elderly, or the benefit of him will be blocked (A5).

DISCUSSÃO

In this study, as found in the literature, nurses, CHA and caregivers predominate females,⁹⁻¹¹ ratifying the historical feminization of care. Regarding the schooling of CHA, there is a search for professional qualification,⁴ which can positively influence their work in the community, with the elderly and their families.

Regarding the family member who cares for the elderly, other studies^{6,11-12} also point to children and conjugues as the main caregivers,^{6,11-12} with advanced age, without paid activities, with care every day of the week for more than five years. The time of prolonged care in years and hours daily may explain its influence on the health and well-being of family caregivers,¹² which has been a concern due to their exposure to the overload of daily activities since care has often happened without support from other people.

Given the marked aging population and the growing demands for care for the elderly that Brazil has experienced in recent years, the FHS has faced challenges to meet the emerging needs of these people.¹³ In this study, the demands are mainly related to health problems that affect the elderly and to biopsychosocial changes associated with aging; making them often fragile; care needs, social support and health education for the elderly and caregivers; as well as professional training for the FHS health team.

Among nurses, there are difficulties in developing health actions according to the principles of the FHS, mainly associated with EHP. This is related to people's demand for services with the disease already installed, the influence of cultural aspects of the community and the training of the professional. Therefore, they recognize the need for qualification from improvement and post-graduation courses.⁹ This study is a demand and, particularly, regarding the specificity of the elderly since no nurse was able to exercise care for this population with singular specificities.

The valorization of the work of CHA needs to be considered, as well as their training in the context of aging and PHC. This is due to the important place that this professional occupies in the FHS, such as health promotion actions and care practices for the elderly in the community, which converge with the implementation of public policies directed to this population. The practice of care of CHA based on welcoming and attentive listening needs to meet the demands of the assisted person.¹⁰

In the care of the dependent elderly at home, the caregiver has become an increasingly representative figure,¹⁴ which is corroborated by this study, evidencing the need for greater attention of the professionals of the FHS, as nurses and CHA, for family caregivers, in order to prevent possible health problems, situations of dependence, prevent them from also needing care in the near future, as well as maintaining care at home, as suggested by Brazilian regulations regarding the elderly.

The Statute of the Elderly explains that the care of the elderly should be prioritized at home by his family to the detriment of the LSIE, except for cases in which they do not have a family or are unable to maintain their own survival. It is also noteworthy that elderly homeless or without family are guaranteed care with priority in public and private agencies providing services.¹⁵

In this study, it was found that the elderly who do not have a family, live alone and/or cannot take care of themselves, as in situations of addiction. It is worrying to know, the availability of social support to these people. Family, friends, neighbors and LSIE are possibilities, although in the LSIE the caregivers fear mistreatment and/or abandonment of the family. And, it is questioned, what are the responsibilities of the Brazilian State in these situations.

Law Nº 8742/1993, which deals with the organization of Social Assistance (LOAS),¹⁶ Law n. 10,741/2003, which provides for the Statute of the Elderly¹⁵ and Decree Nº 6,214/2007, which regulates the BPC of social assistance¹⁷, describe that people aged 65 years old or older, who do not have the means to provide their subsistence, or to have provided it by their family, are guaranteed the monthly benefit of a minimum wage, according to the LOAS. It is considered incapable of providing maintenance for the elderly, the family whose monthly per capita income is less than 1/4 (one quarter) of the minimum wage.¹⁵⁻¹⁷

The elderly, when within the criteria established by law, have the right guaranteed to the BPC. This benefit, in some way, contributes to the care of the elderly by families who are not able to maintain themselves. In this study, the CHA asked about the possibility of some benefit for the family caregivers of the elderly, since they had to give up several of their activities to care, regardless of this being elderly. On the other hand, there was the supervision of the quality of care provided.

In Brazil, there is no availability of financial resources for family caregivers, however, Law Nº 8,213/1991, which provides for social security benefit plans, explains in its Art. 45 that "The amount of disability retirement of the insured, who needs the permanent assistance of another person will be increased by 25%".^{18:18} Decree Nº 3,048/1999 provides for situations in which this right can be effected, among which, total blindness, alteration of mental faculties with severe disturbance of organic and social life, a disease that requires continuous permanence in bed and permanent incapacity for activities of daily living.¹⁹ These situations are common among dependent elderly people and that, in some way, the financial resource contributes to the income of the caring family. Therefore, the information and guidance of the families that meet these criteria is fundamental for the realization of this right, and nurses and CHA can contribute to their performance with this support.

Even if the legislation in Brazil regarding the care of the elderly population is advanced, one of the challenges is to implement actions related to aging, according to the legal framework.¹³ In

this context, nurses and CHA are also responsible for the realization of the rights of the elderly and their families, according to Brazilian legislation, which demands greater participation of these agents in supporting this population.

A study developed with people of different nationalities shows that several children give up activities related to their lives to care for their parents and that, in most families, strong ties permeate the lives of their members. Among Lebanese, the responsibility that children have for their parents is expressed by welcoming in old age. The elderly should be cared for by family members and not by third parties, or in LSIE. If they can take care of it, they must do so, because the interactions between the members create perspectives, define social objects and symbols and determine the relationship between one person and another and/or environment. For the Chinese, this care is manifested by the conduct of maximum reverence and must be transmitted between generations, since it is part of eastern culture.²⁰

In addition, among Paraguayans there is concern and zeal for the elderly, almost always inserted in extended families, and children are responsible for caring for these people. Among Brazilians, the feeling of unity and the concern to remain close to their children prevailed, since aging within the family provides joy and satisfaction. In Arab culture, children owe full obedience and respect to their parents, and man has the responsibility for maintaining the family and caring for parents in old age.²⁰ However, for various reasons, there are elderly people who prefer to live alone or in LSI.

In the study, we found feelings of caregivers when caring for an elderly family member such as gratitude, retribution in the relationship, obligation, donation and dissatisfaction because they felt they could be careful or be taking better care of the person.²¹ Values that permeate different cultures.

The data found in this study evidenced the family's moral duty to take care of the elderly. Although there is an obligation associated with Brazilian norms intrinsic to this responsibility, it is compliance with the norms, rules, customs and/or cultural aspects that underlie this decision, in addition to the caregivers' hope of being cared for by their children when they become elderly and/or dependent. For diverse reasons, they recognize that some children cannot care for the dependent elderly at home.

In relation to training and/or guidance, unanimously, no caregiver received information from the FHS health team about care for dependent elderly at home, which shows a lack of knowledge.²² Even though caregivers recognize the relevance of receiving guidance that, in turn, contributes to

the quality of care for the elderly at home, this study demonstrates that the care developed by the family is based on the empirical knowledge that is transmitted between generations.

The fact is that families are often forced to solve without guidance the various problems presented by the elderly. Thus, care becomes, in some circumstances, a burden for them and assumes on account of the relationship of kinship or closeness. This lack of preparation for care results in family exhaustion, commitment to the quality of care, impairment in the health of the binomial - dependent elderly and family caregiver²² due, as seen, care requires a lot of responsibility of the caregiver, especially for having to reconcile personal, domestic and care activities for the dependent elderly.

The incipience and/or lack of support for family caregivers by professionals, such as training for the care of the elderly in performing activities of daily living is evident,^{21,23} which has overloaded them and caused negative repercussions on the physical and mental aspects. Thus, recognizing that the caregiver needs social support is essential, given the negative implications that their absence can cause in their health and quality of life.²¹

Among the changes that occur in the daily life of caregivers, after the assumption of care to the elderly, there is a social support network. As found in a study,¹¹ psychoeducational interventions and support contribute positively to caregivers in psychological, physical and social aspects, the acquisition of knowledge and the quality of care provided; as well as for the elderly, such as reducing the use of health services and expanding self-care capacity.¹¹

However, most caregivers do not have formal and informal support for the performance of care for the elderly, which hinders the development of their personal and social activities. Thus, when they need support, the main support network is family, friends, neighbors, the community and the church, marked by geographical proximity and frequent contact.²² These results are similar to those of this study, in which, even in view of the complexity of care for the dependent elderly, there is no sharing among family members, which makes it impossible for the caregiver to leave the home to participate in social activities, which recognizes the emergence of support networks for family caregivers.

The National Health Policy for the Elderly (PNSI) by recognizing the family as responsible for the execution of care for the elderly, explains the need to determine qualified and permanent support to those responsible, such as the family and the caregiver, with the ABS, through the FHS, an essential role. In addition, when identifying the condition of frailty of the elderly, it is essential to evaluate the local resources available to deal with the situation, to facilitate care at home, include the caregiver as a partner of the care team, foster the network of solidarity for the frail elderly and their family and promote their reintegration into the community.²⁴

EHP are part of the work of nurses and CHA, and these should consider the needs of the population, such as the elderly and their family caregivers. A study²⁵ points out that educational practices aim to overcome the approach focused on disease and information transmission and to consider the dialogue and subjectivity of people in the educational process and not of behaviors to be prescribed,²⁵ in view of the singularities of those involved and the experiences in the exchange and (re)construction of knowledge.

The experience of caring for the elderly at home can be complex and, particularly, when there is no appropriate support and guidance, which can have consequences for the health of the caregiver. Nurses are responsible for training and teaching caregivers coping strategies to minimize health problems related to care; expand home visits to the elderly and their families and (re)evaluate the needs of social support for caregivers.⁵ Actions such as these contribute to the demands of aging and, concomitantly, improvement of assistance to families, which also requires training since professional. As soon as, EHP are potential for the expansion of the knowledge of nurses, CHA and family caregivers of the elderly and, consequently, improvement of the care offered to the elderly with dependencies.

Regarding the limitations of the study, the interval of days between the meetings and the number of moments for the performance of EHP were reduced and its expansion could have favored greater the participants' support in the activities developed. As a potentiality, the sample was composed of three categories of caregivers - nurses, CHA and family members, as well as, even delimiting the themes to be worked, others arose depending on the participant's demand on the day of educational practice.

It is recommended that other investigations be carried out longitudinally with periodic educational interventions, considering the time and interval of EHP, the cultural and locoregional context, the inclusion of men caregivers and other professional categories, such as physicians, dentists and nursing technicians, who work in the BHC. Also, the development of theoretical and practical activities of how to care in specific situations, depending on the health injury of the elderly. Because, as evidenced, caregivers feel the need to learn in practice, such as caring for dependent elderly at home, with morbidities and varied dependencies.

CONCLUSION

EHP revealed demands of aging, such as the concern of nurses, CHA and family caregivers with the future of people who will become elderly, often without a family, with health problems and potentially dependent. The care offered to the elderly with varied needs is not shared among

family members, which sometimes makes it complex, burden and sacrifice for caregivers who decide to care at home.

It was seen that, although some elderly people prefer to live alone, when they have children, the possibility of being cared for at home is elevated, even in the face of the economic and structural difficulties of some. The absence of financial support for caregivers was questioned, in view of the abdicating of their daily activities and work to care for the dependent elderly.

EHP allowed the exchange, acquisition and (re)construction of knowledge among the participants. This opportunity made it possible to identify the demands of dependent elderly and/or their caring families. For caregivers, other moments of dialogue and listening are essential to support them and serve as opportunities for leisure and distraction.

It was evidenced the need for those responsible for the care of the elderly to be trained and/or oriented, so EHP are indispensable and when implemented should consider the social, cultural contexts and resources available to those involved.

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CONFLICT OF INTEREST

Nothing to declare.

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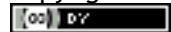
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