

RESPONSIBILITIES FOR THE CARE WITH THE DEPENDENT ELDERLY IN THE HOUSEHOLD

RESPONSABILIDADES PELO CUIDADO DO IDOSO DEPENDENTE NO DOMICÍLIO

RESPONSABILIDADES EN EL CUIDADO DE LOS ANCIANOS DEPENDIENTES EN EL HOGAR

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Objectives: to understand the meaning of the word responsibility for nurses, Community Health Workers and family caregivers of the elderly and identify the responsibilities of those professionals and the family for the care of the dependent elderly in the household. **Method:** a qualitative, descriptive and exploratory study. Data production occurred based on the following instruments: Katz scale, sociodemographic form and semi-structured interview guide, analyzed through the Triadic Configuration, Humanistic-existential-personalistic. **Results:** professionals' responsibilities for the care with the elderly include reception, monitoring, mentoring and visits. For the caregivers, they involve zeal, protection, monitoring and management of finances. **Conclusion:** the responsibilities vary, depending on the responsible person, relating to meeting the needs of the elderly, compromise, assuming the consequences for the actions and promoting the well-being of those involved.

Descriptors: Aged. Nurses. Community Health Workers. Caregivers.

Objetivos: apreender o significado da palavra responsabilidade para enfermeiros, Agentes Comunitários de Saúde e cuidadores familiares de idosos e identificar as responsabilidades desses profissionais e do familiar pelo cuidado do idoso dependente no domicílio. Método: estudo qualitativo, descritivo e exploratório. A produção dos dados ocorreu com base nos instrumentos: escala de Katz, formulário sociodemográfico e roteiro de entrevista semiestruturada, analisada por meio da Configuração Triádica, Humanista-existencial-personalista. Resultados: as responsabilidades dos profissionais no cuidado ao idoso abrangem acolhimento, acompanhamento, orientação e visita domiciliar. Para os cuidadores envolvem zelo, proteção, acompanhamento e gerenciamento das finanças. Conclusão: as responsabilidades variam, a depender do responsável, tendo relação com dar respostas às necessidades do idoso, ter compromisso, assumir consequências pelas ações e favorecer o bem-estar dos envolvidos.

Descritores: Idoso. Enfermeiros. Agentes Comunitários de Saúde. Cuidadores.

Objetivos: entender el significado de la palabra responsabilidad para enfermeras, agentes comunitarios de salud y cuidadores familiares de ancianos e identificar las responsabilidades de estos profesionales y la familia para el cuidado de los ancianos dependientes en el hogar. Método: estudio cualitativo, exploratorio y descriptivo. Los datos fueron

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producidos con base en los instrumentos: escala de Katz, formulario sociodemográfico y guion de entrevista semi-estructurada, analizados mediante la Configuración Triádica, Humanística-existencial-personalista. Resultados: las responsabilidades de los profesionales en el cuidado de los ancianos incluyen recepción, supervisión, tutoría y visitas. Para los cuidadores, implican el celo, la protección, la vigilancia y la gestión de las finanzas. Conclusión: las responsabilidades varían, dependiendo de la persona responsable, relacionándose con el atendimento a las necesidades de los ancianos, compromiso, asumir las consecuencias de las acciones y promover el bienestar de los involucrados.

Descriptores: Anciano. Enfermeros. Agentes Comunitarios de Salud. Cuidadores.

Introduction

Responsibility is associated with the person's condition of being or not responsible. For this purpose, this person must be aware of his/her acts. This awareness gives him/her the obligation to repair the damage caused to the other⁽¹⁾.

In this study, the responsibility background occurs on legal and moral perspectives. This is due to the fact that the nurses and Community Health Workers (CHW) assume legal responsibility, considering the professional exercise. The moral responsibility assumed by caregivers is motivated by the relationships built with the dependent elderly receiving the care.

The legal responsibility has a relationship with the exteriority, in which the person is responsible for the consequences of his/her action on the other, which can require explanations. The moral responsibility relates to the inner intentions, and is based on the moral law. This usually sorts other behaviors⁽²⁾. This replaces the idea of damage by the notion of entrusted role. The person is personable for the other⁽³⁾.

The assumption of responsibility by the care directed to the elderly has been a frequent demand among nurses, CHW and families. According to a study⁽⁴⁾, in the health field, dealing with aging and its peculiarities is one of the challenges of the 21st century.

In health services, the demands arising out of the elderly are growing and complex⁽⁴⁾ and have a relationship with the population aging⁽⁵⁾, requiring multidisciplinary and interdisciplinary care involving their health needs⁽⁴⁾. Thus, nurses need to direct their actions to the peculiarities of

the elderly⁽⁵⁾. For this reason, specific knowledge is indispensable in the areas of gerontology and geriatrics⁽⁴⁾.

In Basic Health Care (BHC), the nurse's care provided to users of services, including the elderly, aims to produce health actions based on specific knowledge and articulated with the other team members in the political and social context of the health sector. Their performance requires competencies, skills and technical-scientific knowledge in various areas⁽⁶⁾. Since the CHW reside in the same community of the elderly, they usually know and experience the needs of the residents. Therefore, the performance of this professional favors the care and the accomplishment of their responsibilities, in which the link between the community and the FHS health team stands out⁽⁷⁾.

In relation to family caregivers, this is the main responsible for the care with the elderly at home, especially when extended, which associates with the existing relationships, gender issues, geographical proximity, values, norms and cultural expectations⁽⁸⁾. In the face of increasing demands of aging, they will remain responsible in this situation of the elderly's dependency.

Taking care of the dependent elderly, particularly on the part of the family, causes stress, especially when the elderly's have a condition of high suffering, chronic pain or cognitive impairment. In contrast, this practice can encourage empathetic relationship, in which the caregiver puts him/herself in the onther's shoes, aiming to understand their needs. Thus, the caregiver is expected to be ready or willing

to get in touch with the other that is fragile, in suffering and dependent on care⁽⁹⁾.

A study shows that FHS nurses have incipient knowledge on care with the elderly⁽⁵⁾. As most CHW⁽⁴⁾ and caregivers, they did not receive training and/or guidelines on health in the elderly's care⁽¹⁰⁾. These circumstances have influenced the integral attention and problem solving of the elderly's demands, as explicit in the National Basic Care Policy (PNAB)⁽¹¹⁾, and can compromise the responsibilities for the actions of health protection and promotion, disease prevention, diagnosis, treatment, rehabilitation, harm reduction and health maintenance.

In this context, the reason for studies using this approach is to reduce gaps in scientific production, in addition to revealing low of knowledge of nurses, CHW and family caregivers in relation to the care with the elderly, according to peculiarities of this population segment. This can somehow influence the responsibilities assumed by those people. Studies show the need to expand their knowledge, skills and/or guidelines under the geriatric and gerontological perspective, for the completion of specific care^(4-5,12-13), which may occur based on health educational practices (HEP). The nurse can be one of the responsible to remedy this deficit.

In this sense, this study becomes relevant in view of the possibility of contributing to the identification of the responsibilities of nurses, CHW and caregivers with the elderly, stimulating new investigations and subsidizing the care planning to this population segment.

The objective of this study is to understand the meaning of the word responsibility for nurses, Community Health Worker and family caregivers of the elderly and identify the responsibilities of those professionals and the family for the care with the dependent elderly in the household.

Method

Qualitative, descriptive and exploratory study. The participants were nurses, CHW and family caregivers of elderly people, female and

male, aged 18 years or more, linked to two FHS of the urban area of the municipality of Manoel Vitorino, located in the countryside of Bahia. The population of Manoel Vitorino (2010 census) is composed of 14,387 individuals. In the urban area, there are 7,359 people. Of these, 871 are elderly. This territory is composed mostly by people with low purchasing power⁽¹⁴⁾.

This study considered as family those people with kinship ties, domestic dependency or rules of coexistence⁽¹⁵⁾; and family caregivers, the person of the family who assists or develops the daily activities of the dependent elderly.

This study is linked to the doctoral thesis "Responsibilities for the Care with the Dependent Elderly and Influence of Health Educational Practices", orally examined at the Postgraduate Program in Nursing at the Federal University of Bahia in 2018, which was developed in three distinct stages, but interconnected. This study used the data produced in the first stage: identification of the responsibilities of nurses, CHW and caregivers for the care with the dependent elderly (situational diagnosis).

Data production, performed by the researcher and a nurse trained for the implementation of the instruments, occurred in the FHS and at the elderly's home or their family's in the municipality, in the period from February to March 2016.

The inclusion criteria adopted for the nurses and CHW were: work in the FHS and age over 18 years; and exclusion, professionals on vacation, leave or absent. The inclusion criteria for caregivers were: relative of the elderly with functional dependency, according to the Katz scale; living together in the same household of the elderly; aged 18 years or more; being the main caregiver; registered in the FHS; taking care of the elderly for at least six months. As an exclusion criterion, the people who, after three visits on different days and times and scheduled, were not found.

For selection of the caregiver and, consequently, of the households, there was support from CHW. For this purpose, each CHW was requested to accompany the researcher in up to three elderly households in which there

was a functionally dependent elderly person. This number of households aimed to cover the two FHS areas and all CHW participating in the research. The choice of households happened that way, since those professionals knew the elderly and their family caregivers, and could present the researchers to the families. This moment was considered necessary to promote the bond, confidence and safety to participate in the research.

Subsequently, people who self-reported responsible for the elderly's care were included. Twenty-six visits were carried out. Of these, 7 households were excluded, because the elderly were functionally independent and had formal caregivers or not from the family. There was no refusal of participation.

Semi-structured interviews were held with the participants supported by the instruments: Katz Index of Independence in Activities of Daily Living (ADL) – Katz Scale –, sociodemographic questionnaire and form. All the interviews were recorded, with the participants' consent, as a way to ensure greater reliability in the record and in the transcriptions of statements.

The Katz scale, adapted to the Portuguese, was applied to assess the elderly's performance in ADL in six functions (bathing, dressing, going to the bathroom, transferring, continence and eating). Its use enabled the identification of the degree of (in)dependence of the elderly, classifying them as independent in all six functions or dependent in one, two, three, four, five or six functions⁽¹⁶⁾.

Data production with nurses and CHW occurred in two moments (one in group and one individually) and with the caregivers, in three (individually). For the first meeting with the professionals, the researcher scheduled a previous collective meeting with the nurse and the CHW in each healthcare unit, inviting them to participate in the research.

In the first meeting with all participants, with an average duration of one hour, there was the approximation, the invitation to participate in the research, signature of the Informed Consent Form (ICF) and the schedule of the remaining

steps. The first visit to the elderly's home occurred with the presence of the CHW.

In the second meeting with the professionals, there was the semi-structured interview with nurses, through semi-structured form. The CHW answered a self-applicable semi-structured questionnaire. For both participants, the instruments contained 12 questions relating to sociodemographic questions and responsibilities for the care with the elderly.

With the caregivers, in the second meeting, there was the application of the Katz scale and the sociodemographic questionnaire (with characteristics of caregivers and the dependent elderly). The answers to the questions of the Katz scale, although used to assess the degree of (in)dependence of the elderly, were provided by family caregivers. This meeting lasted, on average, 40 minutes for each participant.

The third meeting was held with the caregivers. The interview guide related to the responsibilities for the care with the elderly. Some had doubts to describe the meaning of the word responsibility, repeating the question and asking them to respond according to their understanding. After the interviews, the results of the Katz scale were presented to the caregivers, aiming to inform them about the elderly's degree of dependency. This meeting lasted between 15 and 40 minutes.

For each participant, there was a specific semistructured instrument, which contained questions about sociodemographic characteristics, time of work and care, family ties, presence of disease, social support, training, guidance and information on care with the elderly.

In the interview, all participants in the study were asked the following questions: What is the meaning of the word "responsibility" for you? Tell me, at least, three situations of responsibility. What is the responsibility assumed by you in the care with the dependent elderly person?

The individual data produced were fully transcribed and organized in Microsoft Excel 2010 for reading, understanding and presentation of results. The participants' identity was preserved, ensuring confidentiality of responses. To protect

the participants' anonymity, the statements were identified by pseudonym, using the letters N (nurse), H (CHW) and C (caregiver) followed by the number indicating the order of interviews (N1, H1, C1).

The statements resulting from the interviews were analyzed based on the Triadic Configuration, Humanistic-existential-personalistic. This analysis is based in six steps: careful reading of the content expressed, in order to grasp its meaning within the global framework systematically, after its organization, using codes to protect the participants' anonymity; rereading of the text, with a view to identify the effect locutions, based on detailed exploration. In this step, the researcher approached to the manifested content, which contributed to the identification of the effect locutions and elaboration of meanings within the overall structure⁽¹⁷⁾; identification and classification of the aspects whose contents converged, with an overall analysis of the statements, to identify the meanings of each unit; grouping of effect locutions, using text highlight and font color for the meanings that converged into three subcategories and two empirical categories; presentation of groupings descriptively. In this step, there was the participants' data triangulation in the category "concept of responsibility"; and, finally, a comprehensive analysis of the significant data of the groups that compose the results of this study, aiming to expose the main idea⁽¹⁷⁾.

This study was approved by the Research Ethics Committee (REC) of the Nursing School of the Federal University of Bahia, Salvador, Bahia, considering the requirements of Resolution n. 466/2012 of the National Health Council (NHC), the Ministry of Health (MS), as Opinion n. 1.388.138.

Results

Two nurses participating in the study were female, aged from 28 and 30 years, race/color white and *pardo*; married and unmarried, one with three years and the other with six months of work in the FHS in the municipality; one had specialization in collective health.

Regarding the 10 CHW that comprised the sample, they were all female, with minimum age of 26 and a maximum of 62 years, 9 self-reported as *pardas* and 1 white, 8 were married, 7 had complete secondary education; 2, complete higher education; and 1, incomplete higher education. Among them, 5 had 17 years of professional activity; 3, 12 years; and 2, 5 years.

The nurses and the CHW reported not having received specific training in the field of gerontology to provide care and develop visits with the elderly, particularly those dependent.

Referring to the 19 caregivers of the interviewed elderly, 17 were female, aged between 33 and 73 years, 13 self-reported *pardos* and 3, whites; 3 were illiterate, 5 had incomplete primary education, 4 complete primary education and 7 incomplete secondary education; 10 were married or in a stable union; 14 were catholic and 5 evangelical; 17 reported diseases and making use of medications daily. With respect to the kinship with the elderly, 10 were daughters and 2 were sons; 4, wives; 1, sister; 1, granddaughter; and 1, daughter-in-law.

Among caregivers, 4 had been looking after the elderly for less than 2 years, 8 between 2 and 5 years, 4 between 7 and 10 years, and 3 between 14 and 22 years; 14 provided full-time care. When considering the minimum wage of 880.00 R\$ (for the year 2016), 6 received this amount (retirement, pension or other social benefit), 3 received up to 400 reais (informal work and/or family allowance) and 10 had no individual monthly income. In the case of occupation, 18 caregivers had no out-of-home remunerated activity home, 1 worked partially, 14 reported having exercised remunerated work prior to taking care of the dependent elderly at home.

Regarding the social support, 14 caregivers reported receiving help from relatives (sister, daughter, mother, sister-in-law, niece and daughter-in-law) and neighbors in the care with the elderly. The 19 caregivers reported never having participated in courses and/or support groups on aging. Of those, 17 reported that the FHS professionals did not provide guidance on

how to take care of the dependent elderly at home and explained having received it from the nurse, CHW and/or physician.

The analysis of the data collected in the interviews allowed the emergence of two categories and three empirical subcategories.

Category I – Concept of responsibility

The responsibility was conceptualized by nurses, CHW and caregivers as meeting activities, taking the consequences of their actions and promoting the well-being of those involved. For this reason, it required thinking before acting, dedication and commitment.

It means being up to you to do some chores. Work as stipulated in time, efficiently and effectively, always aiming at the well-being of the people involved (H6). It is to look after and being capable (C6). It is to be committed to what we do (H3). It is to fulfill what you've been given and always taking into account your ability (H2). Being sure of what you're doing (C18). Being responsible (N2, H1, C4), for every damage you may cause (N2). It is to think long before acting, not to make mistakes. Not make any mistake in order not to have a negative consequence (C11). Responsibility has much to do with dedication (N1).

Category II – Responsibilities for the care with the dependent elderly

In this category, three empirical subcategories emerged, which described the responsibilities of nurses, CHW and caregivers in the care with the dependent elderly.

Subcategory I – Nurses' responsibilities

The responsibilities of nurses in the care with the elderly were expressed as part of a multidisciplinary care to solve the demands of those people. Those professionals were responsible for the referrals to other services, when they could not solve the health problem in the FHS.

My responsibility with him [elderly man] is to provide a multidisciplinary care, in which it's not only me going there [to the house], as she cannot be here [FHS]. It's her right, the right to health and my duty to solve the problems. We often don't have enough tools and have to go after them. I need to solve their problems and, if I can't, I have to send her to other place where she can solve them as fast as possible. (N1).

Added to those, the nurses described reception actions, respect to the peculiarities of each person, observation of the care and the environment where the elderly lived, monitoring, mentoring and home visits.

Reception (N1,2), respect this person [elderly] with everything she has, her history (N1). Always observe the care. If the patient is being well treated, if she has affection, love. If diabetes and blood pressure are controlled or not. If the medication is right, working or not. If the environment is clean and pleasant (N2). Always monitoring [the elderly person] (N1) and guiding the caregiver, regarding medication and nutrition (N2).

Subcategory II – Responsibilities of CHW

The CHW described their responsibilities for the care with the elderly in the multiprofessional team, which included home visits performed alone, aiming to identify the elderly's health conditions, keeping the team informed on situations observed in the household and paying attention to the demands of families who also had health problems. Moreover, performing visits scheduled and jointly with other professionals from the FHS team.

Home visits (H3). Schedule visits (H1) accompanied by a nursing technician, nurse (H4) and doctor (H3), as often as necessary (H8). To be a supervisory agent (H6) [to] keep the post always informed on the family's situation (H7), to ascertain the health status of the elderly and how their care is (H4). We cannot forget the family that is there and that also has a series of problems, both physical and psychological heal. After all, we are responsible for the whole family and not just for the elderly (H2).

The CHW also described the interventions with families, when necessary, such as referral to health services, guidance on hygiene and medication, information on the programs offered at the FHS, listening and support to the elderly and their family.

Intervene when necessary (H6). Referral (H1) of the family members (H8) to health services (H1). Guide (H5,7,8,10) the family for the responsibility (H5), especially the caregivers (H8) in relation to the programs offered by the FHS (H1), personal hygiene and the home environment, the care they must have (H3) and taking the medication on time (H5). Being willing to bear (H8). Help whenever they need (H7). If he [elderly] has no one to look after him, seek someone trained, whenever possible, to look after him (H8).

Subcategory III – Caregivers' responsibilities

The zeal was expressed as the base of the caregivers' responsibilities, when describing the actions developed daily in the care with the elderly at home. They consisted of looking after, monitoring food, water intake, medication and personal hygiene and the environment. They mentioned using the cell phone as a resource, to aid in the care planning.

It is to look after well (C10). Zeal as God's will (C7). Zeal for food, drink (C6). Everything is my responsibility (C1,2,5,7,16). Feeding and medicating on time (C1,7,14). It's already on my phone, so that we don't miss the time, everything is recorded (C1). I bath him (C1,7,12,13,16,17,18), zeal on bed, I change the diapers. The bed made and clean. I do everything at home (C5,6). I brush his teeth, shave him (C14,16), put his clothes on, take care of the feet, I clean the ears (C16), cut his hair (C14). I take care of the clothes, of where she stays, always clean (C5).

The family caregivers have felt responsible for the elderly's internal and external locomotion, changes in decubitus, support, company with sleep and fall prevention.

I move him [elderly], because sometimes she wants to go outside, to the backyard (C11), walk around the house (C13) or somewhere else (C8,11). I don't leave her alone (C5,7,8,9,16). I put her to sleep (C6,10). I sleep close to her and keep (C1) watching (C10), attentive, because she can fall from bed and get hurt (C8,16). I turn her around at night and lift her to check her out, to see how she is (C6).

Added to this, the elderly's demands, such as scheduling of consultations and tests, attention, affection, purchasing, finance management, monitoring, being together and attentive.

Everytime she needs a test, a word, a bug, whatever she has to solve, I have to be with her [elderly] (C17). I have to do the shopping (C5,6,13), I take her Money, buy things, store them, for whenever we need (C5). I schedule the doctor and the tests (C5,9,12,17). I get a car to take him and accompany him (C13,17). During the day, I'm always paying attention so that no one mess with them. If something is wrong, I'm there to help (C5). It is to be careful (C8,13).

Discussion

The participants described the meaning of responsibility and which they assumed in the elderly's care. The term refers to meanings, such as answering for and being effective⁽²⁾. This

has a relationship with the being responsible and being aware of the acts⁽¹⁻³⁾. Legally, the person is responsible for the consequences of his/her action, such as damage caused, and the responsible person has the obligation to repair the damage caused and face the sentence⁽³⁾. In this legal perspective, nurses and CHW described the meaning of the term responsibilities for the care with the dependent elderly and how the person must assume his/her responsibilities inherent to the profession. Therefore, they understood that the professional needs to answer for damages arising out of his/her action.

The moral responsibility is based on the moral laws. The person is responsible for the other⁽³⁾. Thus, the responsible people act according to their principles and beliefs⁽¹⁸⁾. The family caregivers attributed the concept of responsibility for care with the elderly in a situation of dependence in the perspective of that moral sense. They speculated that the person needs to reflect on the acts, avoiding their negative consequences.

Knowing the legal and moral responsibilities, those specific of nurses, CHW and family caregivers is essential to plan their actions. In this aspect, the Ministry of Health (MOH) describes the duties of the members of BHC teams involved in health care in the FHS. Others may appear in the regulations laid down by the federal, state, municipal and Federal District managers, according to priorities defined by the respective managements. The assignments must consider the legal provisions governing each profession⁽¹¹⁾.

Among the specific duties of the nurse in the BHC, according to the MOH, they are: health care to individuals and families in the health unit, in the household and/or other community spaces, at all stages of human development; the referral of users to other health services; and the achievement of scheduled and care activities to spontaneous demand⁽¹¹⁾. Those assignments were mentioned by nurses in this study in relation to their responsibilities in the care with the dependent elderly, however their knowledge is still poor on their specific attributions in the

full care to this segment of the population in the FHS.

The code of ethics and the main laws for the exercise of Nursing explain that the nurse, in addition to exercising all nursing activities, have some exclusive activities, such as the nursing consultation; participation in the planning, implementation and evaluation of health programming; and organization and direction of nursing services and their technical and assistant activities in service-providing companies⁽¹⁹⁾.

In the BHC, a study demonstrates that nurses act in management and assistance. Their activities occur mainly within the health services, but they also develop the best practices in the community. In this service, they have several assignments, such as nursing consultations, procedures, health promotion, immunization, reception, home visits, prevention, educational practices, listening, referrals, rehabilitation, clinical treatments, supervision and training of nursing technicians and CHW, in addition to planning, supervision and evaluation of services, continuing and permanent education⁽²⁰⁾, which converges in part with the results of this study.

A study revealed that the FHS nurse demonstrates insecurity in the care with the elderly due to poor knowledge about the care for the health of those people, according to their specificities. Their care is not integral, and the service is restricted to those who have diseases and are followed-up in the Hiperdia program, distancing them from health promotion, one of the main objectives of the FHS. Therefore, there is need for training professionals in the areas of gerontology and geriatrics, because they favors the acquisition of knowledge about the elderly's health and care⁽⁵⁾.

According to the results of this study, the nurses had no specific training in care with the elderly. The Code of Ethics of Nursing Professionals (CEPE) explains, in chapter II of the duties, in its art. 55, that the nurse needs "[...] to improve the technical-scientific, ethical-political, socioeducational and cultural knowledge in favor of the person, family and society and the development of the profession"^(19:73). Thus, the

expansion of nurses' knowledge, in view of aging, promotes the planning and implementation of actions directed to the particularities and demands of the elderly in a responsible manner.

Among the specific tasks of CHW in the BHC, according to the MOH, they are: guidance to families regarding available health services; completion of scheduled activities and of spontaneous demand; follow-up of people under their responsibility and achievement of scheduled visits with the family healthcare team, considering the risk and vulnerability criteria; development of actions that allow the integration of the family health team and the population; development of activities of health promotion, prevention of diseases and health problems and of health surveillance; and permanent contact with families, developing educational practices in the households and in the community, in addition to the follow-up of people with health problems⁽¹¹⁾.

In this study, the tasks described by the CHW are in line with the recommendations of the MOH. Nevertheless, these professionals have poor knowledge, which may be associated with a lack of training under the aging perspective. The training aims to contribute to the professional practice of CHW in the FHS and in the household.

A study conducted with CHW found that the majority had no training in the elderly's health to act. The professionals with greater time working in the FHS were those that received it, but limited to the knowledge related to biological aspects of aging. The training of CHW and, consequently, the acquisition of expertise in gerontological area, with the purpose of modifying attitudes, favors the strengthening of their performance in the family health team and improves the quality of the care with the elderly⁽⁴⁾. Thus, there is an obvious need for ongoing education of CHW, particularly in the gerontological area, in view of the breadth of their responsibilities in the care with the elderly. This will certainly influence the quality of care the offered.

The complexity and scope of the work of CHW include practices such as home visits, registration of families, health promotion,

active search, health education, organization of therapeutic groups, typing the registries of families, health surveillance, attention to the elderly, referrals to follow-up people with chronic diseases and bedridden. Thus, the limiting factor of the work of the CHW is the poor technical training, especially people with less than 10 years of professional exercise, due to the small participation in Technical Course for CHW, which has jeopardized their performance undoubtedly. In this context, the permanent education and participatory management intensify the work of CHW. In this way, the Brazilian State is responsible for ensuring the necessary training and adequate support to those workers⁽²¹⁾.

As the population ages and lives longer, there is a need for health professionals to increasingly meet elderly patients and their caregivers. Given the impairment of the elderly's autonomy, challenges arise in the family, in particular for those who will assume the responsibility for the care with those people. In line with a study⁽²²⁾, the family caregivers have assumed such care based on moral, not legal, responsibility. Thus, there are doubts: Are the caregivers aware of their responsibilities and the possible legal implications of their actions? Are the caregivers prepared to take care of the elderly?⁽²²⁾

A study demonstrates that the filial responsibility in the care with the elderly, although traditionally rooted as social norm, has reduced over the years. The families have faced challenges to take care of those people and deal with them differently. Some receive support from family members, when they need it. This support are influenced by culture, values and personal resources available⁽²³⁾. In this study, most caregivers were daughters of the dependent elderly and received support from family and/or neighbors.

The role of the caregiver is to accompany and assist the person under his/her care, only performing the activities the person cannot develop alone. The MOH explains tasks that are part of the routine of caregivers of the elderly in care at home for bedridden people or with physical and/or mental limitations. Among these,

some are reported by the participants of this study, such as: listening, being attentive and supportive; assisting in the care of hygiene and nutrition; aiding in locomotion; changing position in bed and chair, and comfort massages; administering medications, according to the prescription and the orientation of the health team⁽²⁴⁾.

In this study, all caregivers looked after the elderly with some degree of dependence to ADL, according to the Katz scale, which converges with the activities demanded by the elderly. Nonetheless, such care was developed empirically, which justifies the need for health educational practices aiming to know their responsibilities as exposed by the Ministry of Health.

To manage the elderly's care, this study revealed the use of mobile phones by caregivers. The use of technological resources, such as applications with internet connection, can benefit the elderly's health and care, and their search has been increasing, as demonstrated by a study⁽²⁵⁾. Some of the applications that have assisted in providing care to the elderly in a situation of dependence include the guide to help caregivers and family members in the care with elderly people at home; my nurse; elderly care; geriatrics; hiring home caregivers: family guide; and care with the elderly⁽²⁵⁾. In this way, the caregivers' knowledge about their everyday tasks in the elderly's care is poor, since those applications describe especially those related to the ADL. This can associate with their poor training for the integral care at home.

A study demonstrated, almost unanimously, that the caregivers had not received guidance from the health team to perform the elderly's care at home. There was lack of basic knowledge on health and support, as well as the need for health education. All stated that they would like to receive information, especially related to diseases, medicines, diets and physical exercises, aiming to improve the quality of care provided to those people⁽¹⁰⁾. Those results corroborate the ones found by this study.

When referring to the care in view of aging, a study suggests that, above all, the care with the

body has been appreciated, with an emphasis on autonomy and quality of life of the elderly. This biomedical context meets the maintenance of biological life and disregards essential aspects, such as the psychological, affective and ethical, which involve the relationship of the person under the care with the caregiver⁽⁹⁾. In this study, those responsible for the care with the elderly expressed that their responsibilities involved biological, ethical, moral, psychological and social issues.

A limitation of this study was the schooling of family caregivers. They showed difficulties to understand the ICF, questions made during the interviews and influence of their participation in the transfer of income from the government, answering all doubts. In addition to those aspects, there were interruptions related to demands for care with the elderly and/or requests by caregivers' acquaintances. Other studies should be developed to procure data in an environment different from home and to build instruments with language of easy access to this population.

Conclusion

The nurses and CHW saw the legal perspective of responsibility and family caregivers, the moral principles. In both situations, the responsible person must assume his/her specific tasks and respond to them, aiming at the well-being of those involved.

The low knowledge of professionals and family caregivers regarding their responsibilities in the care with the dependent elderly may be related to the lack of training and/or guidelines in geriatric and gerontological areas.

The responsibilities for the care with the elderly vary, depending on the responsible person. In the FHS and/or at home, the nurses working in management and assistance, as well as the CHW, develop various activities, such as health surveillance and care. As a member of the BHC multiprofessional team, those professionals described their responsibilities. Among them, there is convergence, such as home visit, guidance, referrals to health services and monitoring of home care. The caregivers

are responsible for the care with the elderly, especially in basic activities of daily living. To do so, they use the zeal as background.

The responsibilities of nurses, CHW and family caregivers are consistent with the recommended and/or suggested by the Ministry of Health, as well as harmonize with results of other studies, although they are incipient and reveal the need for expansion of knowledge directed to the specific needs of the elderly, especially those functionally dependent.

Thus, municipal managers are expected to promote ongoing education for nurses and CHW under the aging perspective, and professionals are expected to develop health educational practices directed to caregivers about the care with the elderly at home. Those circumstances favor the responsible and quality care, according to the peculiarities of the elderly population.

Collaborations:

1 – conception, design, analysis and interpretation of data: Karla Ferraz dos Anjos and Darci de Oliveira Santa Rosa;

2 – writing of the article and relevant critical review of the intellectual content: Karla Ferraz dos Anjos, Rita Narriman Silva de Oliveira Boery, Kleverton Bacelar and Darci de Oliveira Santa Rosa;

3 – final approval of the version to be published: Karla Ferraz dos Anjos, Rita Narriman Silva de Oliveira Boery, Kleverton Bacelar and Darci de Oliveira Santa Rosa.

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