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ORIGINAL ARTICLE

PERFORMANCE AND CONTINUING EDUCATION PROCESS IN LONG-TERM CARE INSTITUTIONS FOR THE ELDERLY

Antonio Caldeira da Silva*
Maria Elenice Vicentini**
Maria de Lourdes Sperli Geraldes Santos***
Natalia Sperli Geraldes Marin dos Santos Sasaki****
Amena Alcantara Ferraz*****
Camila Garcel Pancote******

ABSTRACT

Objective: To assess the performance of Long-Term Care Institutions for the Elderly (LTCIs) with a focus on proposing monitoring indicators. **Method:** A quantitative study was conducted in 41 nonprofit institutions under the XV Regional Health Department in the São José do Rio Preto-SP region. Monitoring spreadsheets agreed upon with Municipal Health Surveillance agencies were analyzed; these were completed monthly by the institutions and consolidated annually. Descriptive statistics and indicator calculations, composed of rates and ratios, were employed for data analysis. **Results:** The annual consolidation showed an installed capacity of 1,402 beds, an occupancy rate of 92.5%, and a coverage rate of 6.1 per 1,000 elderly. Among the residents, 21.4% came from municipalities other than the institution's location; 70.3% were over 70 years old; 50.6% were men; 18.6% were level III dependency; 14.6% had an Alzheimer's diagnosis; and 63.1% of the workforce were direct care professionals (equating to 2.1 care professionals per level III resident). On average, 5.1 health surveillance visits, 0.6 council visits, and 12.1 primary care visits were conducted annually. **Conclusion:** Expanding the monitoring indicators made it possible to analyze and understand the situation of institutionalized elderly people, organize workflows, ensure access to SUS services, and develop prioritized actions in the Elderly Care Network.

Keywords: Homes for the aged. Health services for the aged. Health of institutionalized elderly. Health surveillance services.

INTRODUCTION

The increasingly rapid and challenging trend of population aging reinforces the need for a deeper assessment of elderly care services and care models that can meet current and future needs[1,2]. Changes in family structures, increased longevity combined with greater vulnerability and higher functional dependence generate uncertainty for older adults regarding access to care, making Long-Term Care Institutions for the Elderly (LTCIs) the destination for a significant portion of this population[3].

In Brazil, in 2017, there were approximately 1,451 listed LTCIs, 836 of which were located in the Southeast region (57.6%), with a total of 45,868 institutionalized older adults. Although this represents about 1% of the Brazilian population, this number is expected to increase significantly in the coming years due to family structure changes and population aging[4].

The performance of health institutions is related to their ability to meet goals and deliver quality services and actions based on adequate planning and evaluation parameters through indicators that reflect actual conditions[5-7]. Brazilian Resolution RDC 283/05 lists some key indicators for health surveillance agencies, but they are insufficient to fully support the organization of care by healthcare teams[8]. In 2021, this RDC was revised; however, it did not result in the expected growth regarding the proposal of new indicators suited to the current context[9].

In addition to evaluating indicators, another important tool for ensuring the quality of care

[1] Manuscript resulting from the master's dissertation "Long-term care institutions for the elderly: a portrait of the support network" of the Graduate Program in Nursing at the School of Medicine of São José do Rio Preto.

*Physician, São José do Rio Preto School of Medicine, Unilago, acalds@uol.com.br; https://orcid.org/0000-0002-8622-4982
**Nurse, São Paulo State Health Department, elen.vicentini@hotmail.com; https://orcid.org/0000-0003-4628-1373
***Nurse, São José do Rio Preto School of Medicine, mlsperli@gmail.com; https://orcid.org/0000-0001-6110-619X
****Nurse, São José do Rio Preto School of Medicine; natalia.geraldes@famerp.br; https://orcid.org/0000-0002-8627-9713
*****Biologist, Unilago, amenaferraz@gmail.com; https://orcid.org/0000-0002-0150-8733
******Pharmacist, Unilago, camilapancote@hotmail.com; https://orcid.org/0000-0002-8823-675X

provided is continuing professional education. This aims for effective outcomes in transforming work processes through learning and the exchange of experiences based on everyday practice scenarios[10].

Thus, this study aimed to evaluate the performance of LTCIs with a focus on proposing monitoring indicators.

METHOD

This is a cross-sectional study with a quantitative approach, carried out in LTCIs located in the northwest region of the State of São Paulo, under the XV Regional Health Department (DRS XV). The study was based on the analysis of indicators outlined in an expanded spreadsheet, which was agreed upon collectively during bimonthly meetings with representatives of the LTCIs, municipal health surveillance agencies (VISAs) covering municipalities with LTCIs in their jurisdiction, and the DRS XV. These meetings, which lasted an average of two hours, addressed the realities of each institution and the need to monitor the proposed indicators.

In 2018, as a result of the bimonthly meetings involving VISA teams, LTCIs, and researchers, continuing education activities were implemented. These included agreements on the indicators established by RDC 283/05[8] as well as additional indicators prioritized by the group for institutional monitoring. Data collection took place from January to December 2019. The spreadsheets were completed monthly by LTCI teams, following training sessions, and sent to the VISAs and the XXIX Health Surveillance Group (GVS XXIX).

The LTCIs selected for this study are charitable institutions with partnerships already established with the municipalities. These institutions were chosen due to the municipal social and health teams' easy access. Additionally, an ongoing continuing education process was already in place, with bimonthly meetings between municipal surveillance teams and LTCI staff, which facilitated the definition of priority indicators. The LTCIs are located within the coverage area of GVS XXIX, part of the State Health Department of São Paulo. This area has a total population of 1,293,390 inhabitants, of which 17.6% are older adults (aged 60 years or older), making it the most aged region in the State of São Paulo[11]. The area includes 67 municipalities divided into four councils, named in this study as C1, C2, C3, and C4 to preserve institutional anonymity. The region of São José do Rio Preto, encompassing 102 municipalities, has 97 LTCIs registered with VISAs from 33 municipalities (49.25%), 41 of which are nonprofit and all of which were included in the study[4].

Dependency levels were also classified by the teams in accordance with RDC 283[8]. The consolidated data in Excel were organized, grouped, and analyzed by region to expand the situational diagnosis and outline the regional profile of the Care Networks.

The spreadsheets included demographic variables (sex and age group of residents); organizational variables (installed capacity, available beds, number of residents, dependency level, being level I: independent individuals; level II: individuals dependent on up to three activities of daily living [ADLs] with or without controlled cognitive impairment; level III: individuals dependent on all ADLs and/or with cognitive impairment)[8]; human resources (nursing team, nutritionists, caregivers, cleaning staff; all considered care professionals except those responsible for cleaning de facilities); day center (short-stay facility for older adults); clinical variables (deaths, acute diarrheal diseases, scabies, dehydration, pressure injuries, malnutrition, falls, and femoral fracture); and monitoring variables (VISAs visits, visits by the Municipal Council for the Rights of the Elderly [CMDIs], public prosecution office, and Primary Health Care).

For descriptive data analysis, the chi-square test was used, adopting a 5% significance level ($p \leq 0.05$) for inferential analysis. For the analysis of indicators, descriptive statistics (absolute numbers and frequencies) were employed, as well as the calculation of indicators, incidence rates, prevalence, mortality, and ratios. The ratio of care professionals per level III resident was calculated due to the complexity of care, in addition to the sizing of specialized professionals[8].

The formulas used for calculating the indicators proposed in the study and outlined in RDC[8] are:

1.Bed availability rate for older adults: $\frac{Installed\ capacity}{Population\ aged\ 60\ and\ older} X1000$

2.Ratio of care professionals per resident: $\frac{Total\ number\ of\ care\ professionals}{Number\ of\ residents}$

3.Ratio of care professionals per level III resident: $\frac{Total\ number\ of\ care\ professionals}{Number\ of\ grade\ III\ residents}$

4.All other rates used the number of residents in

the month as the denominator: mortality among residents, incidence of acute diarrheal disease, incidence of scabies, incidence of dehydration, prevalence of pressure injuries, malnutrition, falls, and femoral fracture.

This study complies with Resolution 466/12 of the Brazilian National Health Council and was approved by the Research Ethics Committee for Human Subjects of União das Faculdades dos Grandes Lagos (Unilago), under opinion No. 3706351 and CAAE: 10490319.6.0000.5415.

RESULTS

Currently, the 41 LTCIs included in this study have an installed capacity of 1,402 beds, 92.5% of which are filled. According to the indicator proposed in this study, the bed availability rate for older adults was 6.1 per 1,000 inhabitants aged 60 or older. The region offers 75 Daycare Center vacancies through collaborations with LTCIs, with a significant proportion (90.7%) situated in region C3. The origin of LTCI residents shows that 78.6% come from the municipalities where the institutions are located. Region C2 had 47.8% of residents coming from other municipalities.

Table 1 presents the distribution of demographic characteristics, clinical conditions, and dependency levels, according to RDC 283/05, across the councils. It was observed that 50.6% of residents were male, with this predominance in all regions. Regarding age, 31.7% were 80 years or older, with similar percentages around 30% across all regions. Residents classified as level III dependent accounted for 18.6% in the LTCIs included in the study, with region C3 showing the highest proportion at 26.2%.

An Alzheimer's diagnosis was reported for 13.7% of the residents, with a higher percentage in LTCIs in region C2, where 29.3% of residents were diagnosed with the condition. In region C3, 26.1% of residents were classified as level III dependent (Table 1).

Regarding recorded procedures, urinary catheterization was performed on 2.3% of residents, with the highest rate in region C3 (3.1%). Nasogastric or nasoenteral feeding tubes were used by 2.8% of the older adults. Antibiotics were used by 33.1% of residents, mainly in region C1, which had the highest rate of use (47.6%). Antidepressants were used by 16.3% of LTCI residents, with 23.9% belonging to region C4 (Table 1).

Table 1. Distribution of demographic characteristics, clinical conditions, and dependency levels of elderly residing in LTCIs by council, GVS XXIX, 2019

Variables		C1	C2	C3	C4	P-value	Total
		N (%)	N (%)	N (%)	N (%)		N (%)
Residents (total)		**475 (36,6)**	**82 (6,3)**	**455 (35,1)**	**285 (22,0)**		**1297 (100,0)**
Installed capacity		**492 (35,1)**	**90 (6,4)**	**508 (36,2)**	**312 (22,3)**		**1402 (100,0)**
Sex	**Female**	237 (49,9)	35 (42,7)	227 (49,9)	137 (48,1)	**<0,001**	**636 (49,4)**
	Male	238 (50,1)	47 (57,3)	228 (50,1)	148 (51,9)		**661 (50,6)**
Age range (years)	**<60**	15 (3,2)	-	14 (3,1)	5 (1,8)	**<0,001**	**34 (2,6)**
	60-69	171 (36,0)	16 (19,5)	91 (20,0)	73 (25,6)		**351 (27,1)**
	70-79	151 (31,8)	38 (46,3)	194 (42,6)	117 (41,1)		**500 (38,6)**
	80-89	64 (13,5)	23 (28,0)	115 (25,3)	67 (23,5)		**269 (20,7)**
	90 and over	74 (15,6)	5 (6,1)	41 (9,0)	23 (8,1)		**143 (11,0)**
Dependency level	**Level I**	222 (46,7)	42 (51,2)	170 (37,4)	128 (44,9)	**<0,001**	**562 (43,3)**
	Level II	177 (37,3)	33 (40,2)	166 (36,5)	118 (41,4)		**494 (38,1)**
	Level III	76 (16)	7 (8,5)	119 (26,2)	39 (13,7)		**241 (18,6)**
Morbidity*	**Alzheimer's disease**	53 (11,1)	24 (29,3)	55 (12,1)	46 (16,1)	**<0,001**	**178 (13,7)**
	Dementia	62 (13,0)	22(26,8)	77 (16,9)	68 (23,8)		**229 (17,6)**
	Pneumonia	49 (10,3)	8 (9,6)	60 (13,2)	33 (11,6)		**150 (11,6)**
	Urinary incontinence	146 (30,7)	1 (1,2)	199 (43,7)	101 (35,4)		**447 (34,5)**
	Urinary tract infection	110 (23,1)	2 (2,4)	59 (13,0)	10 (3,5)		**181 (13,9)**
Devices	**Urinary catheter**	11 (2,3)	-	14 (3,1)	5 (1,8)	**0,362**	**30 (2,3)**
	Nasogastric or Nasoenteric tube	13 (4,7)	3 (3,7)	13 (2,9)	8 (2,8)		**37 (2,9)**
	None	451 (36,7)	79 (6,4)	428 (34,8)	272 (22,1)		**1230 (94,8)**
Medication**	**Antidepressant**	76 (16,0)	-	67 (14,7)	68 (23,9)	**<0,001**	**211 (16,3)**
	Antibiotic	226 (47,6%)	12 (14,6)	127 (27,9)	64 (22,4)		**429 (33,1)**

*Exclusion of missing cases. **Only individuals who used medications are presented

Regarding the human resources framework, it was observed that nursing staff accounted for less than 50% of personnel in all institutions, with region C3 having the lowest percentage (32.4%). Direct care professionals (nurses, nursing technicians, nutritionists, and caregivers) represented 79.6% of the total human resources in the LTCIs included in the study, with percentages above 70% in all councils (Table 2). Only 34.1% of the 41 LTCIs reported having registered volunteer staff.

The human resource indicators analyzed included the ratios of direct care professionals to total staff, to all residents, and level III residents: 0.6 per staff member, 0.2 per resident, and 1.3 per level III resident, respectively. In region C2, the ratio of care professionals to total staff was lower than the overall rate. All councils showed ratios of care professionals per resident and per level III resident higher than the overall average (Table 2).

Visits conducted by the VISAs averaged 5.2 per LTCI, with region C3 recording an average of 9.2 visits, while region C1 had the fewest, with an average of 1.9 visits. Regarding visits by the public prosecutor's office and the CMDI, there were none in region C2, and the overall average was 0.3 and 0.6 visits, respectively. Primary Care visits averaged 12.4 per year per LTCI within the GVS XXIX coverage area, with region C2 having the highest average (25.5 visits per LTCI) and C1 the lowest (4.9 visits per LTCI) (Table 2). It was observed that region C2 had the highest mortality rate (28.0%), prevalence of pressure injuries (7.3%), and prevalence of diabetes (31.7%). Region C3 showed the highest prevalence of acute diarrheal disease (13.0%), scabies incidence (4.2%), prevalence of systemic arterial hypertension (67.5%), and hospitalization rate (47.1%). The prevalence of malnutrition was highest in regions C1 and C3 (1.3% in both). Region C4 recorded the highest prevalence rates for dehydration (5.6%), pressure injuries (8.1%), and femoral fractures (2.5%) (Table 2).

Tabela 2 Distribution of human resources by council and monitoring indicators, GVS XXIX, 2019

Variables	C1	C2	C3	C4	TOTAL
	N (%)	N (%)	N (%)	N (%)	N (%)
LTCI	14 (34,1)	2 (4,9)	15 (36,6)	10 (24,4)	**41 (100,0)**
Total HR	274 (37,6)	45 (6,2)	277 (38,0)	133 (18,2)	**729(100,0)**
Nursing Team	117 (42,7)	22 (48,8)	90 (32,4)	49 (36,8)	**278 (38,1)**
Caregiver	56 (20,4)	1 (2,2)	87 (31,4)	33 (24,8)	**177 (24,3)**
Nutritionist	42 (15,3)	9 (20,0)	51 (18,4)	23 (17,2)	**125 (17,1)**
Cleaning Staff	59 (21,5)	13 (28,8)	49 (17,6)	28 (21,0)	**149 (20,5)**
Care Professional	**215 (78,5)**	**32 (71,1)**	**228 (82,3)**	**105 (78,9)**	**580 (79,6)**
Ratio of direct care professionals to total human resources	0,6	0,5	0,6	0,6	**0,6**
Ratio of direct care professionals to residents	0,4	0,3	0,4	0,3	**0,2**
Ratio of direct care professionals to level III residents	2,2	3,2	1,4	2,1	**1,3**
Mortality rate*	16,6	28,0	18,0	19,5	**17,4**
Incidence of acute diarrheal disease*	5,3	8,5	13,0	9,5	**9,1**
Incidence of scabies*	1,1	1,2	4,2	1,4	**2,2**
Incidence of dehydration*	1,3	1,2	2,4	5,6	**2,6**
Prevalence of pressure injuries*	3,2	7,3	2,6	8,1	**4,3**
Prevalence of malnutrition*	1,3	0,0	1,3	1,1	**1,1**
Prevalence of falls*	11,4	30,5	32,5	21,1	**22,1**
Prevalence of femoral fractures*	1,5	2,4	2,0	2,5	**1,9**
Prevalence of SAH*	48,8	62,2	67,5	47,0	**55,0**
Prevalence of diabetes*	20,7	31,7	18,0	19,3	**19,8**
Prevalence of hospitalizations *	29,7	20,1	47,1	3,0	**100,0**

LTCI: Long-Term Care Institution for the elderly. SAH: Systemic Arterial Hypertension. *Per 100 residents.

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DISCUSSION

The study showed that performance assessment through the expansion of LTCI indicators contributed to identifying weaknesses and key needs for improving the quality of care provided, especially in managing health conditions and chronic diseases. It also made it possible to routinely estimate the need for adjustments in human resources according to the increasing dependency.

The standardization of indicators and the teams' understanding of their relevance among LTCI staff, surveillance agencies, and municipal

councils were limiting factors of the study.

High staff turnover and insufficient human resources, along with changes in residents' profiles of frailty and dependency, point to the need to improve[12–14] RDC 283/05[8] and 502/21[9]. The lack of guiding documents and integrated policies that define care models for institutionalized older adults represents a significant barrier for management teams and those responsible for providing care, resulting in staff overload and harm to residents[13,14].

The increasing longevity of the institutionalized population is a challenge for comprehensive care in the coming years[12,14]. Work overload and the lack of qualified human resources accelerate dependency and frailty among older adults, leading to higher hospitalization rates and negatively impacting health and autonomy[15].

The continuing education workshops conducted were key strategies for experience sharing among teams, empowerment, and the practical application of tools for monitoring indicators and assessing LTCI quality dimensions[10,16]. These meetings also encouraged supervision processes by VISAs and municipal Primary Health Care Units.

This study revealed that LTCIs have been operating close to full capacity and likely face waiting lists, which may indicate limited access due to admission criteria. In this regard, the proposed indicator for monitoring available beds relative to the total older adult population will enable tracking and optimizing bed availability, especially in regions with fewer reference services, as identified in other parts of Brazil[12,13].

Another significant finding of the study was the incidence of residents younger than 60 years old, which contradicts the LTCIs' bylaws and the standards established by RDCs 283/05[8] and 502/21[9]; this situation often results from court orders. Generally, these individuals have conditions that limit self-care, such as different physical or mental disabilities or substance use, resulting in further pressure on the care team[17].

Regarding dependency levels, the findings show a predominance of residents classified as Level I, with Level III being a minority. The literature shows similar results for nonprofit institutions and a predominance of total dependency in private institutions[15]. In this regard, dependency levels may be influenced by the type and frequency of activities offered, which affect older adults' functionality. It is therefore important to encourage participation in different activities, especially those that lead to mobility and balance[15,18], which could be an important indicator to include in future agreements.

As for the diagnosis of Alzheimer's disease, the results showed significant discrepancies, suggesting the need for assessments involving the institutional teams to clarify these findings. In this sense, they highlight the challenge of standardizing dependency level classification and the accuracy of Alzheimer's diagnoses through a continuing education plan for LTCI teams and SUS and SUAS (Unified Social Welfare System) reference services. Furthermore, as the disease progresses, care demands become more complex, requiring skilled professionals to address these needs[19].

Regarding the morbidity indicators proposed by the RDC, it is important to clarify that the incidence of acute diarrheal diseases in LTCIs serves as an indicator for assessing the health conditions of older adults, requiring the identification of warning situations and immediate collective interventions. The monitoring carried out with team support enabled the identification of sanitary conditions through visits by relevant bodies such as the Municipal Council for the Rights of the Elderly (CMDI), the public prosecutor's office, and VISA teams, even if these visits were insufficient[16].

The prevalence of hypertension found was similar to that reported in another study[17]. Indicators reflecting medication use in LTCIs affect the evaluation of the quality of health services and the care provided to ensure better living conditions. Furthermore, adverse reactions caused by the indiscriminate use of medications increase the risk of negative outcomes, with older adults being the most vulnerable[20]. It is worth noting that not all LTCI teams conduct qualified monitoring of chronic conditions with risk classification, which remains a challenge for LTCIs and Primary Health Care in developing individualized therapeutic projects[21,22].

The prevalence rate of falls and femoral fractures was lower than that reported in other studies[23,24]. RDC 283/05 establishes the following caregiver-to-resident ratios according to residents' dependency levels: level I – 1 caregiver per 20 older adults (8 hours a day), level II – 1 caregiver

per 10 older adults per shift, and level III – 1 caregiver per 6 older adults per shift[8]. This provision represented progress; however, it does not align with the current realities of daily LTCI operations. The institutions face significant challenges related to a lack of funding to expand health care teams capable of ensuring adequate care and compliance with requirements set by health surveillance agencies and professional councils[12–14].

Although the new RDC 502/2001 does not require it, LTCIs may include health professionals in their staff[9]. There is a clear need for indicators that provide greater detail regarding the distribution of professional categories within established day and night shifts[25].

Another relevant aspect of the study was the expansion of Day Center services for older adults. This model provides care for partially dependent individuals, prioritizing the creation of family and community bonds through activities related to health, culture, and recreation, thus preventing total institutionalization[26]. Volunteer work, defined by Law 9608/98[27] as unpaid activity provided by an individual to public entities or nonprofit institutions for personal assistance, should be encouraged through regulation in institutional bylaws, registries, and protocols to be implemented. This practice was identified in all LTCIs included in the study and is essential for the work of the care teams.

Another perspective in organizing the Elderly Care Network is to train human resources for the condition of aging[28]. One proposal discussed within the *Comissão de Integração Ensino Serviço do Noroeste Paulista* (Northwest Paulista Teaching-Service Integration Commission) is to establish structured internships for health-related degree programs in these institutions. In the region, this potential has been developed under the concept of the *Universidade Amiga do Idoso* (Age-Friendly University).

Given this context, there remains the challenge of revisiting care and support models for older adults within the service network and, especially, in philanthropic institutions that have historically taken this social role, often linked to or partnered with Social Assistance. This Brazilian model still has many similarities with so-called total institutions, which are outdated in terms of managing health care and/or housing services for the elderly.

CONCLUSION

The proposed indicators served as tools that helped expand the possibilities for analyzing alert situations, developing control actions, and promoting health within institutional work processes, thereby contributing to the quality of care for older adults. The prioritization of additional indicators beyond those established by the RDCs also contributed to improving Care Lines for chronic conditions and the prevention of health complications.

The study underscored the major challenge faced by the Elderly Care Network in the region, given that many municipalities lack institutions and reference services for sheltering vulnerable older adults. It also contributed to improving the monitoring process by involving institutional teams, Reference Health Units, and municipal managers from the perspective of joint policies.

DESEMPENHO E PROCESSO DE EDUCAÇÃO PERMANENTE EM INSTITUIÇÕES DE LONGA PERMANÊNCIA DE IDOSOS

RESUMO

Objetivo: Avaliar o desempenho das Instituições de Longa Permanência para Idosos com enfoque na proposição de indicadores de monitoramento. **Método:** Realizou-se um estudo quantitativo em 41 instituições sem fins lucrativos pertencentes ao Departamento Regional de Saúde XV, na região de São José do Rio Preto-SP, com análise das planilhas de monitoramento pactuadas com as Vigilâncias Municipais, preenchidas mensalmente pelas instituições e consolidadas anualmente. Para a análise dos dados, empregou-se estatística descritiva e cálculos de indicadores compostos por taxas e razões. **Resultados:** O consolidado anual mostrou uma capacidade instalada de 1.402 vagas, taxa de ocupação de 92,5% e taxa de 6,1/1.000 idosos; 21,4% procedentes de municípios diferentes da sede das instituições; 70,3% com mais de 70 anos; 50,6% homens; 18,6% apresentavam dependência grau III; 14,6% tinham diagnóstico de Alzheimer; 63,1% dos recursos humanos eram profissionais de cuidado (equivalendo a 2,1 profissionais de cuidado por residente grau III). Foram realizadas anualmente, em média, 5,1 visitas da Vigilância Sanitária, 0,6 dos Conselhos e 12,1 da Atenção Básica. **Conclusão:** Com a ampliação dos indicadores, foi possível conhecer e identificar a realidade

das pessoas idosas institucionalizadas, organizar fluxos, garantir acesso aos serviços do SUS e desenvolver ações priorizadas nos cuidados na Rede de Atenção à Pessoa Idosa

Palavras-chave: Instituição de longa permanência para idosos. Serviços de saúde para idosos. Saúde do idoso institucionalizado. Serviços de vigilância sanitária.

DESEMPEÑO Y PROCESO DE EDUCACIÓN PERMANENTE EN INSTITUCIONES DE LARGA ESTADÍA PARA PERSONAS MAYORES

RESUMEN

Objetivo: evaluar el desempeño de las Instituciones de Larga Estadía para Personas Mayores con enfoque en la proposición de indicadores de monitoreo. **Método**: se realizó un estudio cuantitativo en 41 instituciones sin fines de lucro pertenecientes al Departamento Regional de Salud XV, en la región de São José do Rio Preto-SP/Brasil, con el análisis de las hojas de monitoreo acordadas con las Vigilancias Municipales rellenadas mensualmente por las instituciones y consolidadas anualmente. Para el análisis de los datos, se empleó estadística descriptiva y cálculos de indicadores compuestos por tasas y razones. **Resultados**: el consolidado anual mostró una capacidad instalada de 1.402 plazas, tasa de ocupación de 92,5% y tasa de 6,1/1.000 personas mayores; 21,4% procedentes de municipios distintos a la sede de las instituciones; 70,3% con más de 70 años; 50,6% hombres; 18,6% presentaban dependencia grado III; 14,6% tenían diagnóstico de Alzheimer; 63,1% de los recursos humanos eran profesionales de cuidado (equivaliendo a 2,1 profesionales de cuidado por residente grado III). Se realizaron anualmente, en promedio, 5,1 visitas de la Vigilancia Sanitaria, 0,6 de los Consejos y 12,1 de la Atención Básica. **Conclusión**: con la ampliación de los indicadores, fue posible conocer e identificar la realidad de las personas mayores institucionalizadas, organizar flujos, garantizar el acceso a los servicios del SUS y desarrollar acciones dirigidas a los cuidados en la Red de Atención a las Personas Mayores.

Palabras clave: Institución de larga estadía para personas mayores. Servicios de salud para personas mayores. Salud de la persona mayor institucionalizada. Servicios de vigilancia sanitaria.

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Corresponding author: Antonio Caldeira da Silva Endereço: Alameda Vitalino Urbano, 191, CEP: 15.061-854, Parque Residencial Damha 4, São José do Rio Preto-SP.

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