

# ELDER HEALTH CARE: INTERDISCIPLINARY HEALTH TEAM

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## ASSISTÊNCIA À SAÚDE DOS IDOSOS: EQUIPE INTERDISCIPLINAR DE SAÚDE

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## ATENCIÓN MÉDICA PARA ANCIANOS: EQUIPO INTERDISCIPLINARIO DE SALUD

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**Objective:** to understand, based on the discourses of the health team, the development of care for the elderly aged over 65 years, in order to remain healthy, active, independent and autonomous. **Method:** qualitative research with interpretative approach, carried out in a Group of Health Centers in Northern Portugal. Data were collected by semi-structured interviews and analyzed through content analysis, by categories, in a sample of physicians, nurses and social workers. **Results:** among the participants, 83% did not have a gerontology training. There were focuses of care evaluation, in which all professionals estimated the same data, but there were data necessary for the follow-up of the elderly that were not evaluated by any professional. The sharing of information for care, when it occurred, fell into situations of illness or changes in the social context. **Conclusion:** findings showed gaps in teamwork developed by health and social professionals, and in health Care Promotion.

**Descriptors:** Aged. Health Promotion. Health Personnel. Patient Care Team. Nursing.

*Objetivo: compreender, com base nos discursos da equipa de saúde, o desenvolvimento da assistência aos mais de 65 anos, para se manterem saudáveis, ativos, independentes e autónomos. Método: pesquisa qualitativa com abordagem interpretativa, realizada num Agrupamento de Centros de Saúde do Norte de Portugal. Dados colhidos por entrevista semiestruturada e analisados por meio de análise de conteúdo, por categorias, numa amostra de médicos, enfermeiros e assistentes sociais. Resultados: entre os participantes, 83% não possuíam formação em gerontologia. Havia focos de avaliação da assistência, em que todos os profissionais estimavam os mesmos dados, mas havia dados necessários ao acompanhamento dos idosos que não eram avaliados por nenhum profissional. A partilha da informação para a assistência, quando ocorria, recaía nas situações de doença ou de alterações do contexto social. Conclusão: achados evidenciaram lacunas no trabalho em equipa desenvolvido pelos profissionais de saúde e sociais, e na assistência no âmbito da Promoção da Saúde.*

*Descritores: Idoso. Promoção da Saúde. Pessoal de Saúde. Equipe de Assistência ao Paciente. Enfermagem.*

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*Objetivo: entender, en base a los discursos del equipo de salud, el desarrollo de la atención a mayores de 65 años, con el fin de mantenerse sanos, activos, independientes y autónomos. Método: investigación cualitativa con enfoque interpretativo, llevada a cabo en un Grupo de Centros de Salud en el Norte de Portugal. Los datos se recogieron por entrevistas semiestructuradas y analizaron a través del análisis de contenidos, por categorías, en una muestra de médicos, enfermeras y trabajadores sociales. Resultados: entre los participantes, el 83% no tenía formación en gerontología. Hubo focos de evaluación de la atención, en los que todos los profesionales estimaron los mismos datos, pero había datos necesarios para el seguimiento de las personas mayores que no fueron evaluados por ningún profesional. El intercambio de información para la atención, cuando se produjo, resultó en situaciones de enfermedad o cambios en el contexto social. Conclusión: los hallazgos mostraron lagunas en el trabajo en equipo desarrollado por profesionales de la salud y sociales, y en la atención de promoción de la salud.*

*Descriptores: Anciano. Promoción de la Salud. Personal de salud. Grupo de Atención al Paciente. Enfermería.*

## Introduction

Promoting healthy aging “[...] requires a transformation of health systems that replaces disease-based curative models with integrated care focused on the needs of older adults”<sup>(1,4)</sup>. In this sense, for a better understanding of the problem under study, this research sought to know the elderly of the studied region. According to research results<sup>(2)</sup> on the habitual physical activity of 1,522 elderly people belonging to the geographic area supported by a Care Unit in the Community of the Municipality, in a study, 70% were inactive or little active and 45.7% had a negative lifestyle profile. In a subsample of 1,322 elderly people, “[...] when asked whether they used stairs instead of elevator, 98.5% answered no”<sup>(2:108-9)</sup>. Investigation<sup>(3,7)</sup> involving people aged over 65 years found that “[...] most of the day, 99.4% do not perform moderate physical activities, such as fast walking and, at leisure, 45.3% do not include light physical activities, such as cycling or walking (twice or more times a week)”.

Despite the numerous adverse effects of a sedentary lifestyle and the benefits, although modest, of the increase in physical activity, physical inactivity still continues to be a constant among several age groups of the population, especially among the elderly<sup>(4)</sup>, being considered the greatest community risk factor for health in Portugal. Therefore, the growing trend of population aging, with worsening in the past decades, “[...] requires a comprehensive public health response”<sup>(1,6)</sup>.

In recent decades, the aging rate of the Portuguese population has worsened, when

recording 141 elderly people for every 100 young people in 2014. According to census data, this index was 102 in 2001 and 128 in 2011. For the first time, in Portugal, the number of elderly people exceeded the number of young people. Population projections for 2050 indicate that the number of people aged over 60 years will exceed twice and over 80 years of age will triple<sup>(5)</sup>. Dependency indexes are associated with this factor “[...] often accompanied by situations of frailty and disability, but often susceptible to prevention”<sup>(6:1)</sup>. World Health Organization report clarifies that healthy behaviors can prevent or delay health problems, “[...] especially if they are detected early enough ... however, the world is far from those ideals”<sup>(1:6)</sup>.

National and international policies on elder health emphasize the concern with the increased life expectancy, recognizing the need to implement interventions focused on the promotion of individual autonomy and the adoption of prevention measures focused on active and healthy aging<sup>(1,6)</sup>. However, in order to obtain gains in health, namely years of life with independence, it will be necessary to improve the practices of professionals working in the area of public health and aging<sup>(6)</sup>.

Despite the existence of public policies directed to the elder health, the literature shows that there are discrepancies in the care model in use by health and social professionals, with a lack of encounter between expectations and provision<sup>(7-8)</sup>. The current provision of health care to the elderly is characterized, in

several countries, by fragmentation and little accountability<sup>(9)</sup>. For this reason, the response of modern health systems to the problems faced by an ageing world population has become an equally important priority from a social, health and public policy point of view. It is important that professionals understand the integration of health and social services directed to the multidimensional needs of the elderly as a challenge, which requires a synergy created by good multiprofessional collaboration<sup>(10)</sup>.

Considering that “[...] in an increasing number of countries, over 1 in 5 people are aged over 60 years [...] including Healthy Ageing in all policies and at all levels of government will therefore be crucial”<sup>(1:22)</sup>. For this reason, this study can contribute significantly to promoting health and improving quality of life, so that the intervention falls within the scope of health promotion using interdisciplinary teamwork.

In this context, the starting point of the study focused on the results of a research conducted in a municipality in northern Portugal and its Group Health Centers called “Models in use in the Elder care”. To clarify the research path and understand the problem under study, the following research question was formulated: How do health professionals (physicians, nurses and social workers) develop work focused on care for the healthy person with a view to health promotion and active aging? The answer to the question presented may provide support to expand knowledge about interdisciplinarity, contributing to improve the quality of health care for the elderly. Therefore, the present study aims to understand, based on the discourses of the health team, the development of care for those aged over 65 years, in order to remain healthy, active, independent and autonomous.

## **Method**

Given the specific nature of the problem under study, it is essential to use qualitative methodology, with an interpretative approach. Qualitative research tries to interpret social phenomena, such as interactions and behaviors, regarding the meanings that people attribute to

it, being commonly referred to as interpretive research<sup>(11)</sup>. This research approach is related to hermeneutics, “[...] as it often focuses on the meaning of how individuals interpret the world from a given context”<sup>(11:205)</sup>. The described corresponds, in this study, to the experiences lived by health/social professionals in a work context, where they develop their professional activity.

The study was carried out in a Group of Health Centers (ACES) in northern Portugal, during the year 2015. For being a public health service, whose mission is to ensure the provision of health care close to the population of a given geographical area, it is composed of several units that integrate multidisciplinary teams. Moreover, the authors know the context given, the substudies previously conducted among the population over 65 years, in which 2,461 elderly people participated, and the results that emerged from it, regarding social and health perception.

The research subjects were intentionally chosen. To understand the care model in use to care for people aged over 65 years in this geographical area, the inclusion criteria were the participation of physicians and nurses with a higher incidence of patients aged over 65 years in their care lists and the participation of social workers who provided care to the elderly for over one year. The selected ones followed the elderly daily, unlike other professionals who were consulted on time. Professionals who did not agree to participate in the study and those with a number of elderly below nine hundred in their care list were excluded. The criterion of saturation of information was used, which presupposes interruption of inclusion of new participants in the research, when the data obtained start to present redundancy or repetition, not being considered relevant to persist in data collection<sup>(11)</sup>.

Data were collected through semi-structured interviews. This modality allowed understanding how the subjects (doctors, nurses and social workers) conceived their world and how they described this conception. This type of interview allows the interviewee greater autonomy of response, helping him/her not only to explain his/her universe but also to make it more

understandable, allowing the researcher to organize and structure thought concomitantly<sup>(11)</sup>. The research sample sought a necessary number of participants to obtain a meaning of the phenomenon under study and resulted from the inclusion criteria, consisting of 8 physicians, 8 nurses and 8 social workers. Each interview lasted approximately one hour.

For research guidance, the following research questions were outlined: How do nurses, physicians and social workers describe the care they provide? Do doctors, nurses and social workers assess different aspects in the aging process of the elderly? How does each professional group develop the intervention, with a view to healthy, active, independent and autonomous aging?

The collected data were submitted to content analysis, which began from the first interview and not only after its transcription, when the researcher is inevitably immersed in the problem under study, performing, from the outset, a reflective work. The content analysis technique used followed the principles described by Bardin<sup>(12)</sup>, using the qualitative data analysis software ATLAS.ti, which proved very useful and reliable for the categorization of the information that would be analyzed. From the process of analysis of the information collected in the interviews emerged units of meaning that originated two thematic categories: process of evaluation of the elderly and teamwork. The latter is subdivided into: means of sharing health

and social information and content or nature of shared information.

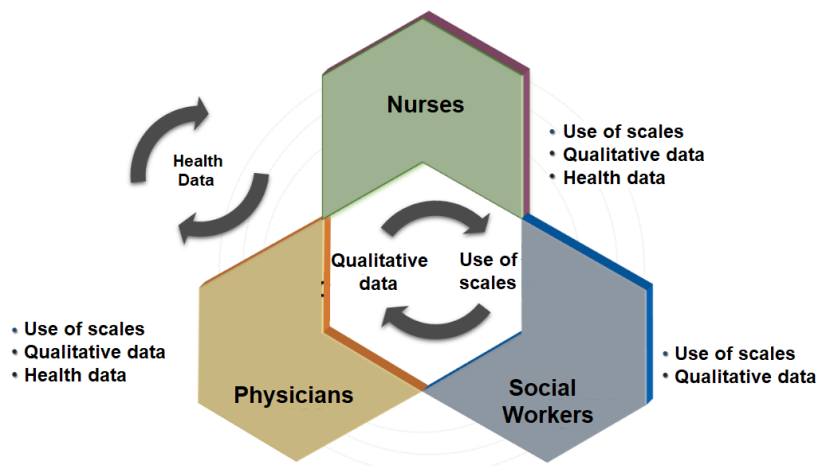
To ensure the anonymity of the research subjects, the interviews were numbered according to the sequence in which they occurred and with the acronym, according to the interviewed professional, that is, IP for physicians, IN for nurses and ISW for social workers.

In order to guarantee the ethical principles inherent to the investigation process, the request was forwarded to the Health Ethics Committee of the Regional Health Administration of the North, being approved with No. 19/2015. All subjects who agreed to participate in the study signed the Informed Consent Form and confirmed the final content of the interviews.

## Results

The research was carried out with 24 participants, one man and 23 women, highlighting that all nurses and social workers were women. The ages of the three professional groups ranged from 30 to 60 years, with predominance of the age group from 31 to 40 years in the groups of social workers and nurses. In the group of physicians, the age group from 51 to 60 years prevailed. Regarding specific training in gerontology, 20 of the professionals under study did not have it. In the scope of the evaluation process, the areas of intervention of each professional with the elderly in the first consultation and the common intervention areas among all are presented in Figure 1.

**Figure 1** – Elder care assessment



Source: Created by the authors.

From the discourses of health and social professionals, common areas of the initial evaluation of the elderly emerged, such as the use of scales, especially the Barthel index.

*[...] we also apply a scale of dependence, which is the Barthel scale, which allows us to make a more or less attentive surveillance to the user. (IN2).*

*Barthel Scale, to know whether he is independent or not. (IP2).*

*[...] we have at an early stage at the time of the application, the Barthel scale, which we adopt even to the level of dependence, which is usually physical provided by this scale [...] (ISW4).*

The participants' discourses also unveiled the collection of qualitative data, such as the socio-family context.

*Yes, we always have to evaluate the user's degree of dependence, in the first visit, the nursing consultation, the conditions, with whom he lives, who is the care provider, if he is in home support [...] (IN3).*

*There is also that social context, if the person lives alone, accompanied, has the support of neighbors, friends or relatives. (IP7).*

*We assess the family and economic situation. (ISW8).*

Among nurses and physicians, it was common to collect health data, as expected, but focused on disease/dependence, pathologies, risk of pressure ulcers, among others.

*If the patient is autonomous, has no motor or cognitive deficit or complaints [...] if he has any kind of alteration, he is adapted. (IP3).*

*I see what the user's problems are, raise the focus and complete a normal initial assessment, regardless of being over 65 years old. (IN2).*

However, only the nurses reported using the *SCLínico* as a technological support resource to perform the evaluation.

*We here, in the service, work with SCLínico in computer terms. In terms of elder health, the program itself already gives us. Opening the health program for the elderly aged over 65 is mandatory, it immediately inserts us in self-care, hygiene, clothing, transfer. We have to ask if there is any type of dependency when performing this type of self-care, but we work more in these areas [...] (IN6).*

The nurses' discourses showed that the initial evaluation was directed to respond to the health program incorporated in the clinical information system, thus becoming a reducer for a multidimensional evaluation, focusing on dependence for self-care. Physicians and social workers prioritized cognitive aspects in their evaluation, using the Mini Mental State Examination (MMSE), as exemplified.

*Yes, we usually use the mini mental. (ISW5).*

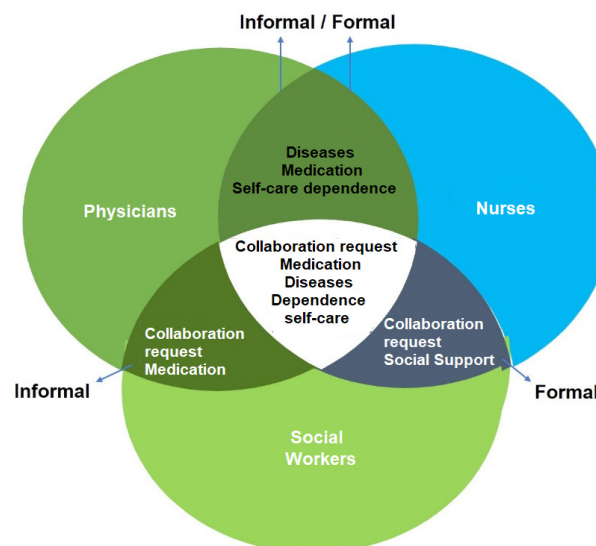
*Cognitive. It is the mini mental that we use the most. (IP3).*

Nurses prioritized physical aspects, using the Norton or Braden scale:

*[...] and then we always do an evaluation of a Norton scale, or of a Braden scale to later assign a care plan to that patient and family. (IN3).*

Concerning teamwork, two relevant areas of communication established between health and social professionals emerged, following the elder care, as shown in Figure 2: means of sharing information and content of shared information.

**Figure 2** – Interdisciplinary communication: shared information and means of sharing information



Source: Created by the authors.

Among the health and social professionals in the study, all used the two means of communication, although the informal mode overlapped the formal mode for physicians, especially dialogue.

*[...] if they are changes that I can make and that I think have some importance for the nursing part or some change in the social context, I will surely communicate. (IP7).*

For social workers, personal or telephone conversation predominated:

*[...] we call the health center directly, we talk to the nurse [...]. (ISW5).*

As for nurses, they resorted more to the formal environment, making use of the clinical information system (SCLínico<sup>â</sup>) or by written letter and/or call protocol.

*We now also have a new system, which is the SCLínico, which shows our data to the doctor and vice-versa [...]. (IN5),*

In addition to this sharing of verbal (undocumented) information, there were also moments when health and social professionals, in their daily lives, only performed it for some reason that justified it. The reasons why social workers required collaboration from a health professional were related to situations of disease to obtain the complement of dependence or even to clarify health/disease doubts, just like happened to nurses.

*For example, when they have some disease. (ISW5).*

*[...] in order to get a medical report, we usually need a medical report. Here nobody goes home without knowing the pathologies they have. (ISW7).*

*[...] only if there is something bizarre or abnormal [...] if it is a normal situation when the user is well, we do not have this habit. (IN5).*

The physician, as the professional who least shared the information, also requested the collaboration of other professionals, but only sporadically, in a situation of illness or change in health status.

*We share the evolution, disease control, whether it is doing well or not, if there is another problem. The nurse also shares with me, if something is not right, because, sometimes, they come to the nursing consultation but not to the medical consultation. For example, when*

*something is out of control in terms of diabetes, AH [Arterial Hypertension], if the user looks a little disoriented. (IP1).*

The discourses shared between physicians and nurses were mainly related to diseases in general, but also to medication and dependence on self-care. However, the nurses shared with the doctor, for dependence on self-care.

*[...] dependent user, we talk about health problems, chronic ones. It is a hypertensive, diabetic or acute patient, she was hospitalized for a respiratory infection, she has those injuries [...]. (IN2).*

The physicians shared the diseases especially with the nurses.

*Here in the health center, those who have chronic diseases, we also end up sharing many information [...]. (IP6).*

In relation to the discourses that physicians shared with social workers, they focused on requests for collaboration for intervention, particularly in situations of abandonment of the elderly and/or other need for support.

*With the social worker, we have already found out some users abandoned at home. So, we call social services. (IP7).*

*With the social worker, it is another situation when there is a need for support or intervention, which is very rare. Even today I think that, even for the elderly, I did not have to resort to it. (IP6).*

Social workers shared with physicians the usual medication of the elderly, also followed by the request for collaboration, in the case of mistreatment, or to request a medical report, aiming to integrate into the home.

*We usually need a medical report. Here nobody goes home without knowing what kind of pathologies they have [...] their therapy. (ISW7).*

Regarding the nurses' discourses with social workers, they focused on the request for collaboration for the acquisition of medicines and social support for poor housing conditions

*A patient who arrives here and we find that he needs some social support, if he has any difficulty in acquiring any medication, we also refer him to social support [...]. (IN6).*

The social workers revealed, from their discourses with the nurses, especially the functional capacity of the elderly, following the requests for collaboration to acquire technical

aid, complement dependence or support in situations of mistreatment,

*[...] I think I no longer have the capacity for some tasks of daily living and then the nurse tells me yes or no. (ISW3).*

*[...] in matters of mistreatment, I always articulate. The assessment is made by me, my psychologist fellow and the health services. Always these three. (ISW8).*

*[...] imagine if I think the person needs some dependence complement, so I ask for an opinion if it would be worth it. For example, the elderly being referred to request the dependence complement. (ISW3).*

## Discussion

In Portugal, “Over the years, the rate of feminization [...] has shown a general growth trend. In 2018 [...], it was 76.5%, which is above the rate of global public administration (60.2%)”<sup>(13:57)</sup>. As in this study, it was found that the sample consisted mostly of women (1 man and 23 women).

A study points out that nursing staff contribute so much to this rate, surpassing other professional groups<sup>(13)</sup>. In the case of social workers in this study, this did not happen, as all were female. The mean age was 42.4 years, with a minimum age of 30 years and a maximum of 60 years, corresponding respectively to nurses and physicians. Most professionals (83.3%) has no training in gerontology, which can interfere in interdisciplinary elder care. From this perspective, there is evidence that indicates “[...] difference between the work processes of the medical professions (focusing on specializations) and social work with generalist training”<sup>(14:97)</sup>, proving that the nature of working with the elderly requires the professional to seek continuous training and the need for constant updating.

### *Process of Elder Evaluation*

Evaluation is understood to be the collection of various data relating to the elderly at the physical, mental, functional and social level carried out by a multidisciplinary team at the first consultation, with the objective of establishing and coordinating care plans, services and interventions that respond to their problems,

their needs and disabilities. The evaluation of the different dimensions allows a more complete and adequate intervention of professionals and, consequently, a better quality of life for the elderly.

For nurses, the evaluation corresponds to the first stage of the Nursing Process, which is extremely important for the identification of needs in nursing care. The Barthel index is the most commonly used instrument to assess whether the elderly are able to perform certain activities independently, comprising ten basic activities of daily living (BALV): eating, personal hygiene, toilet use, bathing, dressing and undressing, controlling sphincters, walking, transferring the chair to bed, going up and down stairs. Still focused on physical aspects, nurses apply the Norton or Braden scale in the health assessment of the elderly. These instruments are often used in the professional practice of these professionals, because pressure injury is a focus of attention highly sensitive to nursing care. However, it is admitted that this practice is not systematized in all health institutions<sup>(15)</sup>.

National and international studies<sup>(16-17)</sup> reinforce the knowledge about the effectiveness of a holistic and multidimensional evaluation of the elderly, including clinical, physical, mental, functional, social, nutritional evaluation, among others, with the use of various instruments. “The evidence suggests that it benefits both healthy individuals and those with significant disabilities and multiple commorbidities”<sup>(17:77)</sup>. It is understood that this evaluation also reveals a paradigm shift, since it is currently not considered for healthy people and is still very directed to identify medical, mental and functional problems of elder frailty<sup>(16)</sup>. Other findings highlight the evaluation of the elderly with significant cognitive alterations, in addition to morbidity and functionality<sup>(16)</sup>. Assuming this multidimensional evaluation performed by a team composed of a physician, nurse and social worker, among others, Primary Health Care are privileged places for interdisciplinary care for the elderly and health promoter.

The global evaluation of the elderly is a strategy that facilitates a multifactorial approach supported by a structured process, using scales or evaluation questionnaires developed in recent decades and scientifically validated.

### *Teamwork*

The complexity of current health care requires that “[...] teamwork (TW) is systematically referred to as a fundamental human factor for the quality of care provided in health institutions”<sup>(18,53)</sup>. It is its purpose to eliminate fragmented thinking and promote integrated care. This is described as a well-organized set of services and care processes focused on the multidimensional needs of the elderly, which gives the articulated performance of the multidisciplinary team better results than individual performances<sup>(10)</sup>. To strengthen the comments previously mentioned, it is advocated that the change to integral care requires restructuring at the level of services, as well as the reformulation of the work developed by health teams with a focus on interdisciplinary collaboration. It should also be considered that teamwork and communication are closely linked to patient safety<sup>(7)</sup>.

### Means of sharing health and social information

Information is very valuable for providing health care with quality and safety, constituting a fundamental condition of nursing care management processes. Thus, the rapid and facilitated access to data has contributed to improve the clinical decision-making process<sup>(19)</sup>, assuming extreme relevance for effective communication between physicians, nurses and social workers working as a team. The means of communication used by the participants differ between formal and informal, with different implications in the care practice, resulting in more or less gains for the health of users. Similar results were found in another study developed in Ontario<sup>(20)</sup>.

The informal means of communication, like the punctual conversations, reflect the

traditional conversation of corridor on subjects of interest to the professional at that time. The formal means of communication consist of systematic documentation of the activity of each professional in the user's clinical process (single process), accessible to all professionals in relevant situations of care delivery (Electronic Health Registry) or, also, the periodic meetings of the team, as well as minutes of meetings, memoranda, computer-assisted communication and communication records<sup>(20)</sup>.

Regular interprofessional meetings are considered as an essential means for the construction of good team communication<sup>(20-21)</sup>. Another information system is the *SCLínico*, interoperable, capable of guaranteeing quality and continuity of care<sup>(22)</sup>. The need to improve the performance of the multidisciplinary team, to homogenize the practices and information collected nationally, is reiterated by the Shared Services of the Ministry of Health of Portugal with the development of the *SCLínico*<sup>®</sup>. This system has made the performance of health professionals more effective and efficient, enabling better support, assistance and follow-up to the user.

Nevertheless, there is still a fragmentation of the documentation of health care provided by the multidisciplinary team, which does not advocate the integrality of the individual. A national study reported, in relation to communication failures, that “[...] 50% of the cases had no effective communication between health professionals, in order to guarantee information continuity in health care”<sup>(23,5)</sup>. Thus, there is need for effective communication between the care sectors, for a joint action, capable of allowing the exchange of knowledge. However, despite the evolution of medical sciences focusing on aspects of prevention and health promotion, in favor of purely curative aspects, there is still a predominance of the biomedical model in the sharing of information in use among health and social professionals.

The following statement corroborates the aforementioned sentence: “[...] the followers of this model have a reductive attitude, of those who see the disease, the organ and devalue the



subjective translation of the disease, with personal, family, social and cultural relationships<sup>(24;36)</sup>. This can be seen in the discourses on the content of the shared information, which will be decisive for its dissemination (or not) among all. This model is in disagreement with practices that promote active, autonomous and healthy aging<sup>(1,6-7)</sup>. Other authors<sup>(22;91)</sup> share the same opinion, admitting that “[...] studies that focus on this phenomenon, of information sharing, between the two most decisive professional groups in health (doctors and nurses)”, establish a new relationship between them, far from the biomedical model, based on interdisciplinarity and not on multidisciplinary. This change allows greater diversity of actions and permanent search for consensus, which requires a horizontal communication between the elements of a team. From an interdisciplinary perspective, the approach to the problem would be seen together, as well as the search for creative solutions to solve it.

#### Content or nature of the shared information

The information concerns data that have been interpreted, organized and structured, resulting from the documentation of care in health information systems, contributing to the promotion of continuity of care, through its use by the various health professionals. A study<sup>(22;88)</sup> found that “[...] content of the information collected, processed and documented by nurses, relevant for the purposes of the professional practice of physicians, is organized into three categories: surveillance parameters, medication and therapeutic attitudes, and intercurrent data”. In this study, the common information areas among all health and social professionals were evidenced: requests for collaboration, medication, pathologies in general and dependence on self-care. These interventions in use in the care of the elderly raise reflections and questions, such as: *Do not the elderly receive health-promoting guidance? Do health and social professionals direct their attention to healthy, active, autonomous and independent ageing? Doctors, Nurses and Social Workers, do they all direct their intervention to the same areas?*

On the other hand, the lack of studies on this theme stimulates the creation and reformulation of public policies that ensure standardized interdisciplinary communication. Thus, it is not possible to talk about quality in health without referring to the quality of interaction and communication between professionals responsible for the care and safety of the patient.

Communication failure is among the main causes of adverse health events internationally. Up to 70% of these events occur among health professionals<sup>(23)</sup>. Research points to hierarchical differences, power and conflicts between the main reasons found, which might inhibit the elements of the interdisciplinary team. It is also emphasized that the difficulty of team articulation is generally related to the different basic formations, ideas and roles of each professional group<sup>(21)</sup>. Before these issues, the development of action training programs on strategies for the improvement of team communication, comprising all the elements covered, becomes increasingly pressing.

Communication is also important for the action of social workers, because these professionals are the ones who most request the other's collaboration, revealing the need for constant interconnection of social service with health professionals. A study conducted in Finland<sup>(10)</sup> admits the need to strengthen the articulation between social and health professionals, so that, as a team, they better meet the elderly's needs. However, a study<sup>(18)</sup> demonstrates that the involvement of health institutions in the formalization and support of interdisciplinary activities greatly contributes to the existence of functional work teams. Likewise, research admits that leadership is effective in promoting mutual understanding between the various professions<sup>(21)</sup>.

For the above, it is necessary to reflect on the necessary commitment of health institutions, managers and team professionals to solve a common problem. The development of this interdisciplinary culture will reflect on the quality of care processes and, consequently, on the safety of customers.

The study's limitation is the fact that all professionals are from one region, which was a limited reality.

## Conclusion

The study professionals did not demonstrate to intervene in a coordinated way and focused on the specificities of the elderly. Most of them also reported not yet having training in gerontology/geriatrics.

On the elderly's evaluation process, some data are prioritized by all professionals and others are not. All collect data on functional status, that is, dependence for the performance of activities of daily living and on the social state and socio-family context, but do not contemplate the healthy elderly. The focus of the actions is only for elderly patients/dependents on third parties.

Concerning interdisciplinary communication, a particularly relevant aspect in the elder care, the results obtained show that the means of sharing information between doctors, nurses and social workers as a team are different and arise only sporadically, that is, when there is a reason. This result reveals the fragmentation of the interdisciplinary care process, which compromises the quality and continuity of care.

It is worth mentioning the content of the information shared in the team, resulting from individual interventions that focus on habitual medication, diseases, dependence on self-care and requests for collaboration, focusing on the respective interventions for the treatment of the disease rather than health promotion. However, the fact that social workers request more collaboration from other professionals highlights the need for constant articulation between social service and the health service.

Therefore, it is urgent to involve the different professions, create synergies between the different areas of knowledge, develop the skillmix for a paradigm shift in the elder care in the field of health promotion.

The lack of studies on this theme stimulates the creation and reformulation of public policies

that ensure a standardized and interdisciplinary system for evaluating the old person.

Understanding the care model in use, from the perspective of health and social professionals, contributes to improving interdisciplinary teamwork and accentuating its potential, providing the development of strategies that increasingly improving elder care.

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1 – conception, design, analysis and interpretation of data: Maria Clara Duarte Monteiro, Maria Manuela Martins, Soraia Dornelles Schoeller;

2 – writing of the article and relevant critical review of the intellectual content: Maria Clara Duarte Monteiro, Maria Manuela Martins, Soraia Dornelles Schoeller and Lucas Antunes;

3 – final approval of the version to be published: Maria Clara Duarte Monteiro, Maria Manuela Martins and Soraia Dornelles Schoeller.

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