DOI 10.18471/rbe.v39.64110 Original Article

PRACTICES OF HEALTH PROFESSIONALS WITH THE ELDERLY IN COVID-19 PANDEMIC

PRÁTICAS DOS PROFISSIONAIS DE SAÚDE COM A PESSOA IDOSA NA PANDEMIA DA COVID-19

PRÁCTICAS DE LOS PROFESIONALES DE LA SALUD CON LAS PERSONAS MAYORES EN LA PANDEMIA COVID-19

Raylaine Priscilla de Mattos Stella[1]
Verônica Francisqueti Marquete[2]
Tereza Maria Mageroska Vieira[3]
Célia Maria Gomes Labegalini[4]
Maria Antonia Ramos Costa[5]
Maria Gabriela Cordeiro Zago[6]
Dandara Novakowski Spigolon[7]

How to cite this article: Stella RPM, Marquete VF, Vieira TMM, Labegalini CMG, Costa MAR, Zago MGC, et al. Practices of health professionals with the elderly in Covid-19 pandemic. Rev baiana enferm. 2025;39:e64110.

Objective: to know the practices of professionals related to Primary Health Care in relation to the care of the elderly in the Covid-19 pandemic. Method: qualitative and descriptive research, conducted with 10 professionals from a Family Health Strategy Team, through semi-structured interview. Data were submitted to thematic analysis of Bardin. Results: the results were organized into three categories: Education and health guidance: foundation of self-care; Health care and guidelines of the Unified Health System; and Relationship of family members and caregivers with the elderly: channel of communication with primary care. Final considerations: the health professional demonstrated knowledge about the importance of performing activities directed to the care of elderly people. In the pandemic, adaptations were necessary for health care to reach this population through telehealth, the link between family and professionals, and guidance on self-care.

Descriptors: COVID-19. Primary Health Care. Aged. Health Personnel. Pandemics.

Objetivo: conhecer as práticas dos profissionais vinculados à Atenção Primária à Saúde em relação ao cuidado com a pessoa idosa na pandemia da Covid-19. Método: pesquisa qualitativa e descritiva, realizada com 10 profissionais

Corresponding Author: Verônica Francisqueti Marquete, veronicafrancisqueti@hotmail.com

[1] Universidade Estadual do Paraná. Paranavaí, PR, Brazil. https://orcid.org/0009-0007-6133-8282 .
[2] Universidade Estadual do Paraná. Paranavaí, PR, Brazil. https://orcid.org/0000-0002-8070-6091.
[3] Universidade Estadual do Paraná. Paranavaí, PR, Brazil. https://orcid.org/0000-0002-3514-4376.
[4] Universidade Estadual do Paraná. Paranavaí, PR, Brazil. https://orcid.org/0000-0001-9469-4872.
[5] Universidade Estadual do Paraná. Paranavaí, PR, Brazil. https://orcid.org/0000-0001-6906-5396.
[6] Universidade Estadual do Paraná. Paranavaí, PR, Brazil. https://orcid.org/0000-0002-5426-3688.
[7] Universidade Estadual do Paraná. Paranavaí, PR, Brazil. https://orcid.org/0000-0002-9615-4420.

de uma Equipe da Estratégia Saúde da Família, por meio de entrevista semiestruturada. Os dados foram submetidos a análise temática de Bardin. Resultados: os resultados foram organizados em três categorias: Educação e orientação em saúde: alicerce do autocuidado; Atenção à saúde e diretrizes do Sistema Único de Saúde; e Relação do familiar e do cuidador com a pessoa idosa: canal de comunicação com a atenção primária. Considerações finais: o profissional de saúde demonstrou conhecimento sobre a importância da realização de atividades direcionadas ao cuidado das pessoas idosas. Na pandemia foram necessárias adaptações para que a assistência à saúde alcançasse essa população por meio da telessaúde, vínculo entre o familiar e profissionais e orientação sobre o autocuidado.

Descritores: COVID-19. Atenção Primária à Saúde. Idoso. Pessoal de Saúde. Pandemias.

Objetivo: conocer las prácticas de los profesionales vinculados a la Atención Primaria de Salud en relación al cuidado con la persona mayor en la pandemia de la Covid-19. Método: investigación cualitativa y descriptiva, realizada con 10 profesionales de un Equipo de la Estrategia Salud de la Familia, mediante entrevista semiestructurada. Los datos fueron sometidos a análisis temático de Bardin. Resultados: los resultados se organizaron en tres categorías: Educación y orientación en salud: fundamento del autocuidado; Atención a la salud y directrices del Sistema Único de Salud; y Relación del familiar y cuidador con el anciano: canal de comunicación con la atención primaria. Consideraciones finales: el profesional de la salud demostró conocimiento sobre la importancia de realizar actividades dirigidas al cuidado de las personas mayores. En la pandemia se necesitaron adaptaciones para que la asistencia sanitaria alcanzara a esta población por medio de la telesalud, vínculo entre el familiar y profesionales y orientación sobre el autocuidado.

Descriptores: COVID-19. Atención Primaria de Salud. Anciano. Personal de Salud. Pandemias.

Introduction

The decline in fertility and the average increase in life expectancy, combined with improved quality of life and a decrease in mortality, have led to the progressive population aging, a phenomenon that is already a reality in Brazil at the global level[1-2].

This context also relates to access to information and health, articulated with public policies that aim at the longitudinality, integrality and quality of life of older people. Thus, it is possible to promote healthy aging with safety, autonomy and independence for older people, especially in educational and health promotion actions[1-2].

The aging of the population is a particularly relevant phenomenon in developing countries, constituting one of the main health challenges of the contemporary world. Despite the public health policies promoting healthy aging through initiatives such as improving primary health care and training of older adults in collective health, the current health status of the elderly population remains worrying[3].

The life estimate of the elderly population was compromised and impacted by the pandemic caused by Covid-19, with high morbidity and mortality rates, a scenario that generated new challenges for the care of the health of the elderly, with changes and adaptations in various social spheres and life habits[4]. Due to the consequences and high mortality rates caused by the Covid-19 virus, life expectancy has worsened, since before the pandemic it was expected that there would be an annual increase of approximately two months and 26 days more than the milestone recorded in 2019[5].

It is important to highlight that the estimation of deaths due to worsening COVID-19 had a particularly negative impact on the elderly population, especially among those aged 80 years or older. Approximately 15% of the infected in this age group did not survive the disease, reflecting high mortality. The 70-79 age group reported mortality in 8% of infected patients, and those aged 60-69 years had an estimated death rate of 9%. In this regard, the risk of death is evident due to the worsening of the disease according to their age; this fact may be related to the physiological vulnerability of aging, together with morbidities that older people have[6].

Thus, the Primary Health Care (PHC) had to reorganize itself using the National Contingency Plan for Human Infection by the new COVID-19 Coronavirus, which contains general guidelines that were adapted according to the context and reality of each place. However, it is substantial, especially in the post-pandemic context, to identify and plan actions to meet the possible demands arising from the pandemic, especially for the elderly population, that need to be inserted in new public policies linked to the society in transformation, especially in the context of PHC. It is expected that in its health surveillance services, the shared management of its care line promotes a safe environment for clients present and active in primary care[4].

Given the changes in the health context caused by the pandemic, it is essential to understand the practices and actions of PHC professionals in caring for the elderly population, with a special focus on the Covid-19 pandemic. This understanding will allow professionals to intervene effectively in the concepts of prevention and health promotion, aligning themselves with the principles of comprehensive care and maintenance of health, considering the existing morbidities[7]. In addition, this approach can help prevent exacerbations or the emergence of new complaints among the elderly, contributing to the improvement of the care offered and to the prevention not only of Covid-19, but also of the development or aggravation of other pre-existing diseases.

Therefore, the development of this study is of great importance, since, by identifying the knowledge and practices of professionals involved in the care of elderly people, it is possible to develop strategies to promote healthy aging. This can be achieved through the creation of educational materials and activities directed at this audience. Thus, the study is anchored in the following guiding question: What are the practices of professionals related to PHC in the care of elderly people with emphasis on the Covid-19 pandemic? Thus, the objective was to know the practices of professionals related to PHC in relation to care for the elderly in the Covid-19 pandemic.

Method

This is a qualitative and descriptive research. Qualitative research is an approach that focuses on the quality and depth of data, descriptive studies aim to describe succinctly and thoroughly the phenomenon investigated[8]. Thus, this study knows the attention with the elderly provided by PHC professionals.

The study is based on the international guide Consolidated Criteria for Reporting Qualitative Research (COREQ) and was conducted in a convenience-chosen PHC unit located in the northwestern region of the state of Paraná. The participants were health professionals approached in the health service, in place, day and time previously scheduled, in the period from January to April 2022.

The inclusion criteria were: to work in PHC for more than 6 months and be more than 18 years. The exclusion criterion was adopted for professionals who were inactive during the data collection period. Two professionals were excluded because they were on maternity leave and one because he was absent due to belonging to the risk group of greater vulnerability in relation to the contagion of Covid-19, three health professionals refused to participate in the study because they claimed not to have a relationship with elderly patients.

The data were collected through a semi-structured interview script, prepared by the researchers, consisting of items resulting from the practices of professionals in health care for elderly people in the pandemic and sociodemographic and professional characterization items. It was used as a guiding question: What actions/activities are directed to the elderly in the Basic Health Unit during the pandemic? The support questions were adopted: What are the main health needs of older people?; Changed after the pandemic? If so, in what way?; What actions do you take to care of the elderly?; Changed after

the pandemic? If so, how?; What can be done to improve the care of older people?

The collection was conducted in a face-to-face and individual way, by an academic of the 4th year of Nursing, previously trained by two researchers with PhD in Nursing with experience in qualitative research. The interviews prepared by the researchers were conducted in a private room of the unit, recorded in audio, with an average duration of 30 minutes, and transcribed in full. Data were analyzed by thematic analysis of Bardin[9]. The interviews occurred until reaching the theoretical saturation of the data, when no new properties were found in the interviews taking place their repetition.

The thematic analysis was carried out following the steps of pre-analysis of the collected data, exploration of the content and treatment of the interpreted results. It began with the floating reading of the interviews, seeking the hypotheses and coordination of the ideas that emerged in full. As a way, the exploitation of the content collected through the identification of the units of the records was carried out. After this step, the results were treated by their interpretation and the existing categories were delineated[9].

The study followed all the ethical precepts of Resolution n. 466/2012, of the National Council on Health, approved by the Research Ethics Committee of the educational institution under Opinion n. 5.157.072/2021. All participants were informed about the research and agreed to participate by signing the Informed Consent Form (ICF). Thus, to preserve anonymity, participants were identified according to their profession, named by the initial of each function: T= nursing technician; E= trainee; A= community health agent (CHA); ENF= nurse and M= doctor, followed by the Arabic number, according to the order of participation in the interview. For example, ENF1 (ENF = nurse(s) and 1 = order of participation).

Results

Ten people were interviewed, five community health agents, two nursing techniques, one nurse, one nursing trainee and one doctor, all linked to a Family Health Strategy team. All ten participants are female, aged between 18 and 51 years, with an average age of 41 years. The findings were organized into three thematic categories, described below.

Education and health guidance: foundation of self-care

Participants identified the difference between actions that were performed before compared to actions that were executed during the pandemic, which followed due care and restrictions to avoid the contagion of Covid-19. They even pointed out that many of the existing projects had to be closed or adapted due to the isolation rules imposed by the pandemic.

The professionals also pointed out the fragility of specific activities for the elderly population, mainly directed to physical-mental and socioeconomic care. They highlighted that there was a drop in the process of direct care with the elderly person, as well as in relation to activities and social interaction in the elderly community:

> *Before the pandemic, there were groups with guidance for hypertensive and diabetic patients, light activities with a physical education professional, general health lectures for the elderly, but with little frequency, after the start of the pandemic it stopped.* (A4).

> *At the moment, no activities are directly aimed at the elderly, but before the pandemic, there were meetings, visits, and physical education teachers were brought in to promote light activities, lectures, and leisure activities on Senior Citizens' Day. After the start of the pandemic, the activities ended and only visits remained, with reduced days.* (A2).

The actions offered by the basic health units (BHUs) were reorganized in order to reduce the flow of demand for care at BHUs; with the adoption of telehealth care, communication has almost always become by phone:

> [...] *as CHA comes as a home visit, monitoring with the doctor, with the nurse, and after the pandemic it did change, home visits became more via telephone. (A1).*

> *After the pandemic, it became difficult, because contact could only be made by telephone, personal contact was not feasible, over the telephone we only asked questions and provided guidance on some things.* (A5).

In the home, first, the CHA, through active search, identified situations where more specific

care was needed, and an intervention of the nursing and medical staff was requested. And thus, they offered health guidance according to the most acute clinical condition, without observing the comprehensiveness of care. This was more directed to check vital signs, dressing and renewal of drug prescriptions:

> *As a technician, I am more concerned with dressings and providing advice on how to maintain them at home; outside the unit, I help with hygiene, feeding, and attention*. [...] (T2).

> *Before, we gave lectures and had appointments scheduled just for them, etc. After the pandemic, things changed a lot, because they don't leave their homes for fear of the pandemic. We have to call to find out how they are, to deliver prescriptions only through the gate or in the mailbox, everything is very complicated*. (A5).

> *I help in the active search for patients who are given permission for specialist consultations and guidance on the importance of taking care of themselves, there are patients who no longer have the energy to go for a consultation*. (A4).

Thus, the care turned to prioritize only acute complaints, absent attention in the concept of prevention of chronic diseases or/and worsening of pre-existing comorbidities:

> *There are many projects, but none are active. Visits are usually to the elderly, but due to the activities of the units, visits are to the "bedridden" and consequently they are usually elderly, it is not a specific action for this population. During the pandemic, these visits decreased*. (T2).

Even if the actions were carried out in a more punctual way, it is necessary to develop guidance regarding self-care of elderly people, ensuring quality time for leisure activities that could be done at home:

> *Monitoring of existing diseases, which are usually hypertension and diabetes, so it would be necessary for the health team to monitor these diseases, so that they do not worsen, so checking BP, capillary blood glucose, and then it is the same as I said at the beginning of the pandemic, they became more fearful, some even bought the devices to do it at home, and those who do not have the means to measure blood pressure and check blood glucose go to the unit*. (ES1).

> *Communication between patient and BHU, bringing and taking information to maintain the connection between both, which is now at a distance. I think that activities that motivate the elderly to take care of themselves can bring the family closer, create a good relationship that brings health in all forms, mainly*. (A4).

> *They need to take care of their diet, take medication, follow the right schedule and maintain hygiene. They need to be accompanied by their family. And, when the CH Health care and guidelines of the Unified Health System visits, we try to advise them on activities and medication. This happened after the pandemic, by phone. Even though we monitor them, we continue to monitor them. (A1)*.

Health care and guidelines of the Unified Health System (UHS)

The professionals identified several difficulties and obstacles in their work routine to adapt to the guidelines of the Unified Health System. Such difficulty occurred due to the isolation standards and the overload in health services to attend the population, which prevented the team from performing quality care in relation to the process of health-disease and comprehensive quality care to its patients, requiring only basic care services, almost always by telephone:

> *We recommend doing physical activity, we bring prescriptions to the UBS for the doctor to renew, we try to schedule an appointment, let him know the exact time and, as it became more restricted during the pandemic, we try to find out more information about him over the phone*. (A1).

> *And at the beginning of the pandemic, they became more fearful and then, now, at the end of 2021, he was attending the unit more, but now with this outbreak, they became fearful again*. (E1).

Relationship of family members and caregivers with the elderly: channel of communication with primary care

Due to social isolation, older people were afraid to seek health services because they belonged to the risk group for Covid-19. Thus, the family should act as a foundation for communication with the PHC team, aiming to ensure that care is provided in an appropriate manner:

> *I think that activities that encourage self-care in the elderly can bring the family closer, create a good relationship that leads them [to have] health in all ways, especially*. (A4).

> *Return to activities, more frequent visits, family guidance to maintain the care that is lacking in primary care, and as mentioned, return to leisure activities*. (A3).

> *Family attention, always have companions at appointments* [...] (M1).

However, this process had some failures because sometimes the communication was not

carried out in an adequate way, even occurring lack of family support for the elderly person. Therefore, the importance of communication being executed in an appropriate, clear and objective way was highlighted, so that there would be no interruption of health care:

> *Attention at a psychological and family level, in which many elderly people are abandoned without help and without any support. These abandonments have increased with the excuse of not being able to see them.* (A2).

> *Group meetings can be held with the family, as there are family members who do not even know how to care for the elderly.* [...] (A5).

> *After the pandemic, a lot has changed, because they don't leave their homes for fear of the pandemic, we have to call to find out how they are, to deliver prescriptions only through the gate or in the mailbox, everything is very complicated.* (A5).

Discussion

The Covid-19 pandemic has brought a series of negative consequences to health services, especially in PHC, considered the gateway for public care. The findings of this study showed the difficulty in adapting health personnel to perform care with elderly patients, establishing new work methods and practices for care services. All this, following the norms that were imposed in the pandemic period, such as social isolation.

The measures of restrictions for protection against the contagion of Covid-19 affected the elderly person, because some of these, when removed from their daily life activities, had their daily life altered, did not have a final goal of satisfaction and leisure, due to the feeling of absence, transmitted in relation to the lack of communication, dialogue and interaction with the external world[10].

Social isolation was a strategy that ensured the safety of risk groups and prevented, even more, the contagion of the virus among the population. However, other life-touching of the elderly population were negatively affected in relation to physical and mental health, such as potential growth rate of geriatric syndrome, isolation, social block, phobias, sudden changes in lifestyle habits, in the activities of daily life and in the appearance of cases of senile elderly people[11].

In addition, with the insecurity of leaving home, it was significantly impacted the health process of elderly people, reducing the practices of self-care, leisure, promotion of well-being, increasing the needs for health care of the health unit, of health professionals and especially the family of these elderly people[12]. It is emphasized that the family is a support network, which provides protection against senescence of elderly people, promoting qualified and healthy aging[13].

Due to the distinct vulnerability of the elderly population in relation to the Covid-19 pandemic, it is important to receive health care with a focus on the service of humanized care, honoring the principles of equity, comprehensiveness and universality. Also, as noticeable, the integral accompaniment and assistance[14].

To provide qualified care for the elderly population, we have a proposal and management organized specifically for a particular line of care, aiming to address health care in an integral and universal way in public establishments. The Ordinance n. 2.528, of October 19, 2006, aims at prioritizing according to its vulnerability index and pathological history, age, sex and risk factors, so that they can meet the high levels of services and demands directed to health services, focusing on the purpose of caring according to the principles imposed by the Unified Health System[1,10].

However, in the present study, it was found that weekly visits decreased and all support groups, health education and self-care performed in person were closed without a return date. However, seeking to meet the Ordinance n. 2.528/2006, it was addressed the practice of health care, using technological means, so that contact between patient and unit began to be made by telephone calls.

Considering that the Ordinance n. 2.546, published on October 27, 2011, includes the use of telehealth services in Brazil as a way to care for the general population using teleconsultation,

telemonitoring, teleeducation, teleorientation, positive points were pointed out in relation to the daily life habits of the affected public[15-16].

In addition, some elderly patients, due to their level of education and aversion to technological products, did not have good adherence to the strategy adopted telehealth. Thus, active search services were offered and home visits were performed only for severe cases and only once a week. A qualitative study conducted in Southern Brazil, observed that the new implementation of technological use during quarantine in elderly people, added positively to the concept of autonomy, since face-to-face activities were closed. The use of contact by telephone and other equipment provided guidance to care and health monitoring with the patient in a period of 24 hours[17].

Another study conducted in Milan, Italy, aimed to define a methodology to measure urban accessibility to health services as indicators of quality of life for the elderly in the city of Milan affected by COVID-19, both in normal work scenarios and during the pandemic. The results of this study show that the elderly populations of entire neighborhoods suffered from low accessibility to primary health services, especially in the suburbs of the city, and their condition deteriorated further due to the limitation of services and activities. Discussed methodological strategies for urban planning that seeks to ensure equal access to essential primary health services for the vulnerable population, especially the elderly[18].

Each country and local had to reorganize, and the present study demonstrated health actions for the population, both in care and in the control and prevention of Covid-19. In this sense, the actions that were previously addressed in groups to promote self-care and health guidance ceased due to the risk of contagion from Covid-19, and new strategies were optimized. Therefore, understanding the changes in relation to control, symptoms, functionalities of these individuals' daily life activities, and how to prevent Covid-19 within this, was one of the most discussed factors.

The study from Recife, with 144 elderly people, observed that COVID-19 prevention was identified as a form of self-care and that it is influenced by functionality related to the autonomy and independence of the elderly person[19]. It is also worth noting that, with the evolution of the individual, some determining factors accompany the arrival of the 3rd age, with physiological, anatomical, economic and social changes. Among these, a valid and remarkable example is the decrease in the effectiveness of your immune system, the development of chronic pathologies and the lack of physical and mental conditioning. This can lead to the impairment of the elderly person's health-disease process and their activities in daily life[20-21].

The main consequence of the vulnerability condition transmitted by this line of care, associated with pathological history of chronic non-communicable diseases, and evaluating its risk stratification in Functional Clinical Vulnerability Index (IVCF-20), transformed the condition of social isolation as the most accessible and qualified method of care to promote protection to the affected public[20].

In the face of the above, older people became more vulnerable to sedentary behaviors and inadequate nutrition, causing the onset of physiological symptoms, comorbidities and chronic conditions acquired by changing daily life habits, In addition to aggravating the symptoms of certain factors and conditions already existing, such as: addiction that can be considered in alcohol, drugs, processed foods, games and other determinants[13].

In this context, a review study identified that the pandemic triggered damage to the mental health of older people due to the pending in relation to their basic human needs, such as the sense of leisure, comfort, security, professional assistance, a healthy life process and habits. Thus, it was the gateway to the appearance of a pattern of sadness, manifestations of mental disorders, with as main: anxiety, depression, panic syndrome, and others that are gaining importance and notoriety among those involved[10,22].

It is also worth remembering those who share housing with relatives, such as spouse, children, grandchildren, among others and that, due to the restrictions of the pandemic, acquired the service of coordinating the home, providing support in domestic care, feeding of hygiene, special care with children, or even with other elderly people more debilitated, in different forms and routines, without having time to work on their mental and physical well-being, because of being overwhelmed by the other situations experienced[23].

Despite the negative factors imposed by social isolation, it was notable that family relationships positively interfere in the health of the elderly person and their means of care, as a support to the communication channel with society, the strategies of care and the exchange of knowledge about strengthening networks in their routine, improving the concepts of autonomy, independence and self-esteem[24-25].

A cross-sectional study conducted by the *Universidade Aberta à Pessoa Idosa*, in São Paulo, identified that, with the pandemic, some elderly people had decreased family ties. However, it was discussed that the coexistence with relatives promoted the facility of social support, transmitting feelings of comfort, which demonstrate positive points in the relationship of emotional and physical development in the lives of elderly people[25].

Even if the actions were carried out in a more punctual way, it is necessary to develop the autonomy of elderly people through the guidelines and evaluations of complaints from users and family members. In the pandemic period, it was remarkable the difficulty in working with guidance, dialogue, family support, transcending motivation to physical activity practices, education and encouragement to adapt to healthy habits, promoting conditions for self-care[6,19].

Complementing the analysis of this study, and relating the information associated with aging, An integrative review article identified that the reports shared by professionals pointed out that the health needs of older people exceed what can be offered remotely, based on diet, in hygiene and especially in the control of drugs for continuous use, which includes the need for family support, which usually does not occur and was intensified during the pandemic[12].

These factors lead to a negative life potential for those who live their daily lives in this way, due to stress, excessive tiredness and by reconciling self-care with the care of the present family[23].

The sudden changes in their activities of daily life and its routine, resulting from social performance and limitation, caused obstacles to achieve healthy aging and prevent senility, due to the decrease or dissemination of physical exercise practices, insufficient water and nutritional intake[22].

Considering the difficulty of communication between elderly people and family, it was essential to adapt and use technological means to be used in ambiguity, how to prevent the inevitable loneliness caused by lack of verbal communication and promote improvement of daily care assistance. However, a qualitative study conducted with elderly people in southern Brazil found that the use of technology in quarantine was experienced by a series of obstacles due to socioeconomic situations, per capita income, low education and difficulty of access[21].

To intervene in this context, the professionals of the present study and scope review highlight that the rights of older people should be protected. This public should be prioritized during the actions of PHC, besides developing strategies to improve the link between patient and unit, increase the follow-up in home visits, perform correct and continuous stratification, in order to identify the need of each Prioritizing the neediest without leaving others unassisted[2,22].

For this and many other reasons, the role of nurses in managing their multiprofessional team is essential, as well as providing support, integral assistance, comfort and safety to clients linked to their work institution. To ensure good care for the public and its lines of care, exercising health promotion, integrality, equity, universality, must create methods that can be carried out according

to risk groups and circumvent the consequences adapted by social isolation[23-24].

Given the challenges posed by the pandemic, PHC professionals, together with their multiprofessional team, need to develop strategies that have as main focus to promote and maintain the best quality of life for the patient, to prevail the principles of equity and autonomy, enable the realization of risk stratifications, application of IVCF-20, ensuring a health-disease process focused on health education of elderly people, family members, caregivers, support the establishment of autonomy and independence in relation to their daily life activities (DLA)[2,25].

In addition, it can be used as one of these strategies, the use of telehealth services in care, ensuring better access to the patient in an integral way, which remains as a method of care used until today. In addition, it provides great support between PHC and other health service networks, considering the care according to their rights and vulnerability in their health conditions, unnecessary searches in hospitals and emergency care units.

This study has some limitations regarding the qualitative approach adopted. First, the sample was intentional and restricted to a specific group, which may limit the generalization of results to other situations and contexts. Finally, it is important to note that the findings of this study reflect a specific moment and scenarios, which may vary over time.

The research presents contributions to the health area by identifying the strategies used by professionals and the challenges faced, providing subsidies to improve the assistance provided to older people during the Covid-19 pandemic.

Final Considerations

The study allowed knowing that health professionals know the importance of developing health care activities with older people. However, they have difficulty in providing quality care when implementing adaptations and care actions for the elderly due to the measures of isolation and social distancing imposed by the pandemic. The lack of interaction with the outside world, a consequence caused by the decrease of in-person activities such as social groups, community interaction and health services, altered the care goals of professionals with the elderly patient, in view that the complaints answered became acute and mental issues, leaving as a second plan the prevention care and health education.

It is of paramount importance to consider as essential the recent practice of telehealth, implemented in the daily life of professionals with care for elderly patients, used as a way to combat the spread of the Covid-19 virus, besides promoting a more accessible contact. In addition, it made it possible to have the family as a communication tool of PHC with the elderly person, facilitating the exchange of experiences and helping in the management of self-care.

The use of technology in relation to the health of elderly people remains today, being used also to promote education, orientation and health promotion, increasing the quality of service and assistance to this line of care.

Collaborations:

1 – conception and planning of the project: Raylaine Priscilla de Mattos Stella, Tereza Maria Mageroska Vieira and Célia Maria Gomes Labegalini;

2 – analysis and interpretation of data: Raylaine Priscilla de Mattos Stella and Verônica Francisqueti Marquete;

3 – writing and/or critical review: Raylaine Priscilla de Mattos Stella, Verônica Francisqueti Marquete, Tereza Maria Mageroska Vieira, Célia Maria Gomes Labegalini, Maria Antonia Ramos Costa, Maria Gabriela Cordeiro Zago and Dandara Novakowski Spigolon;

4 – approval of the final version: Raylaine Priscilla de Mattos Stella, Verônica Francisqueti Marquete, Tereza Maria Mageroska Vieira, Célia Maria Gomes Labegalini, Maria Antonia Ramos Costa, Maria Gabriela Cordeiro Zago and Dandara Novakowski Spigolon.

Competing interests

There are no competing interests.

References

1. Yabrude ATZ, Souza ACM, Campos CW, Bohn L, Tiboni M. Desafios das Fake News com Idosos durante Infodemia sobre Covid-19: Experiência de Estudantes de Medicina. Rev Bras Educ Méd. 2020;44(Suppl1):e140. DOI: https://doi.org/10.1590/1981-5271v44.supl.1-20200381

2. Souza EM, Silva DPP, Barros AS. Educação popular, promoção da saúde e envelhecimento ativo: uma revisão bibliográfica integrativa. Ciênc saúde coletiva. 2021;26(4):1355-68. DOI: 10.1590/1413-81232021264.09642019

3. Brasil. Ministério do Desenvolvimento e Assistência Social, Família e Combate à Fome. Nota Informativa nº 5/2023 MDS/SNCF: Envelhecimento e o direito ao cuidado [Internet]. Brasília (DF); 2023 [cited 2021 Mar 15]. Available from: https://www.gov.br/mds/pt-br/noticias-e-conteudos/desenvolvimento-social/noticias-desenvolvimento-social/mds-lanca-diagnostico-sobre-envelhecimento-e-direito-ao-cuidado/Nota_Informativa_N_5.pdf

4. Souza FVS, Correio ASS, Correio BAOR. Envelhecimento populacional, políticas públicas voltadas para o idoso e a pandemia da COVID-19: alguns apontamentos possíveis. Longeviver [Internet]. 2021 [cited 15 Mar 2023];(12):1-10. Available from: https://revistalongeviver.com.br/index.php/revistaportal/article/view/931/990

5. Instituto Brasileiro de Geografia e Estatística. Nota sobre as Tábuas Completas de Mortalidade 2021 e a pandemia de Covid-19 [Internet]. Rio de Janeiro; 2021 [cited 2023 Mar 15]. Available from: https://www.ibge.gov.br/novo-portal-destaques/35600-nota-sobre-as-tabuas-completas-de-mortalidade-2021-e-a-pandemia-de-covid-19.html#:~:text=Instituto%20Brasileiro%20de%20Geografia%20e%20Estat%C3%ADstica&text=Dessa%20forma%2C%20sem%20os%20impactos,(76%2C8%20anos)

6. Hammerschmidt KSA, Santana RF. Saúde do idoso em tempos de pandemia Covid- 19.Cogitare Enferm. 2020;25:e72849. DOI: http://dx.doi.org/10.5380/ce.v25i0.72849

7. Silva CC, Silva VL, Medeiros GC, Arruda JL, Moreira RS. Qualidade da atenção primária à saúde da pessoa idosa durante a pandemia da covid-19: uma revisão sistemática. Rev bras geriatr gerontol. 2024;27:e230239. DOI: https://doi.org/10.1590/1981-22562024027.230239.pt

8. Marconi MA, Lakatos EM. Metodologia Científica. 8. ed. São Paulo: Atlas; 2017.

9. Bardin L. Análise de conteúdo. Edição revista e ampliada. São Paulo: Edições 70; 2016.

10. Oliveira VV, Oliveira LV, Rocha MR, Leite IA, Lisboa RS, Andrade KCL. Impactos do isolamento social na saúde mental de idosos durante a pandemia pela Covid-19. Braz J Health Rev. 2020;4(1):3718-27. DOI: https://doi.org/10.34119/bjhrv4n1-294

11. Moura MLS. Idosos na Pandemia, vulnerabilidade e resiliência. Rev bras geriatr gerontol. 2021;24(1):e210060. DOI: https://doi.org/10.1590/1981-22562021024.210060

12. Bezerra PA, Nunes JW, Moura LBA. Envelhecimento e isolamento social: uma revisão integrativa. Acta paul enferm. 2021;34:eAPE02661. DOI: http://dx.doi.org/10.37689/actaape/2021AR02661

13. Barbosa KTF, Oliveira FMRL, Fernandes MGM. Vulnerability of the elderly: a conceptual analysis. Rev Bras Enferm. 2019;72(Suppl 2):337-44. DOI: http://dx.doi.org/10.1590/0034-7167-2018-0728

14. Ceccon RF, Soares KG, Vieira LJES, Garcia Júnior CAS, Matos CCSA, Pascoal MDHA. Atenção Primária em Saúde no cuidado ao idoso dependente e ao seu cuidador. Ciênc saúde coletiva. 2021;26(1):99-108. DOI: https://doi.org/10.1590/1413- 81232020261.30382020

15. Brasil. Ministério da Saúde. Guia metodológico para Programas e Serviços em Telessaúde [Internet]. Brasília (DF); 2019 [cited 15 Mar 2023]. Available from: http://www.ans.gov.br/images/MS-telessaude-manual_2019.pdf

16. Brasil. Ministério da Saúde. Portaria N° 2.546, de 27 de outubro de 2011. Redefine e amplia o Programa Telessaúde Brasil, que passa a ser denominado Programa Nacional Telessaúde Brasil Redes (Telessaúde Brasil Redes) [Internet]. Brasília (DF); 2011 [cited 2023 Jul 13]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2546_27_10_2011.html

17. Velho FD, Herédia VBM. O Idoso em Quarentena e o Impacto da Tecnologia em sua Vida. Rosa dos Ventos. 2020;12(3):1-14. DOI: https://doi.org/10.18226/21789061.v12i3a10

18. Guida C, Carpentieri G. Quality of life in the urban environment and primary health services for the elderly during the Covid-19 pandemic:

An application to the city of Milan (Italy). 2021;110:103038. DOI: https://doi.org/10.1016/j.cities.2020.103038

19. Silva ASO, Moreira RS, Pereira AM, Silva VL. Associação entre funcionalidade e conhecimentos, atitudes e práticas de prevenção da covid-19 em pessoas idosas. Rev Bras Geriatr Gerontol. 2023; 26:e230063. DOI: http://dx.doi.org/10.1590/1981-22562023026.230063.pt

20. Pereira AM, Silva ACRL, Cardoso RS, Porto RF. Impactos da pandemia frente à vulnerabilidade do idoso: Uma revisão de literatura. Rev Educ Incl. 2022 [cited 2023 Jun 13];6(2):17-27. Available from: https://revista.uepb.edu.br/REIN/article/view/590

21. Romero DE, Muzy J, Damacena GN, Souza NA, Almeida WS, Szwarcwald CL, et al. Idosos no contexto da pandemia da COVID-19 no Brasil: efeitos nas condições de saúde, renda e trabalho. Cad Saúde Pública. 2021;37(3):e00216620. DOI: 10.1590/0102-311X00216620

22. Harden K, Price DM, Mason H, Bigelow A. COVID-19 Shines a Spotlight on the Age-Old Problem of Social Isolation. J Hosp Palliat Nurs. 2020;22(6):435-41. DOI: 10.1097/NJH.0000000000000693

23. Cunha CAP, Siqueira BR, Sousa MR, Figueiredo Júnior HS. A saúde mental dos idosos em tempos de pandemia: uma revisão de literatura. Rev Eletrônica Acervo Saúde. 2022;15(2):e9636. DOI: https://doi.org/10.25248/reas.e9636.2022

24. Paula AS, Hammerschmidt KSA, Lenardt MH, Betiolli SE, Souza AO, Fugaça NPA. Necessidades humanas básicas dos idosos com COVID-19: revisão de escopo. Nursing Edição Brasileira. 2022;25(291):8364-77. DOI: https://doi.org/10.36489/nursing.2022v25i291p8364-8377

25. Lira PC, Silva WF, Barros EAS, Correia JM, Santos AN. Atuação do Enfermeiro na Atenção Primária à Saúde no contexto de pandemia por covid-19. Res, Soc Dev. 2022;11(3):e28811326424. DOI: http://dx.doi.org/10.33448/rsd-v11i3.26424

Received: October 07, 2024

Approved: February 03, 2025

Published: April 17, 2025