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Transforming Healthcare: Integrating Positive Health Principles for Enhanced Wellbeing and Lifestyle Change

By Sandra van Hogen-Koster & Martine Veehof
Saxion University of Applied Sciences

Abstract- *Aim:* To provide insight into the importance of nursing and (para)medical competencies to act from Positive Health in order to contribute to greater health, well-being and a healthier lifestyle for patients.

Design: This position paper will describe the aim, the first results and the coming focus of the professorship of Positive Health, Lifestyle and leadership.

Methods: We used several methods, like depth interviews and focus groups with about 30 patients (most cardiology and rheumatology) and about 30 professionals (most nurses and (para)medics incardiology and rheumatology), and a cardiologicpatient journey to determine what is necessary for nurses and (para)medics to act from Positive Health. All studies were approved by the Institutional Review Board, and the attributes, benefits and uses of the studies were explained to all participants, and informed consent was obtained.

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Transforming Healthcare: Integrating Positive Health Principles for Enhanced Wellbeing and Lifestyle Change

A Position Paper about the L.INT Professorship Positive Health, Lifestyle and Leadership

Sandra van Hogen-Koster [α] & Martine Veehof [σ]

Abstract- *Aim:* To provide insight into the importance of nursing and (para)medical competencies to act from Positive Health in order to contribute to greater health, well-being and a healthier lifestyle for patients.

Design: This position paper will describe the aim, the first results and the coming focus of the professorship of Positive Health, Lifestyle and leadership.

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Results: There is still too little attention for lifestyle and hardly for sustainable behavioural change. Communication and leadership competencies and multidisciplinary collaboration are essential in this.

Conclusion: Applying Positive Health requires a transformation of the healthcare system and the healthcare professionals themselves. More knowledge is needed about the competencies of nurses and (para)medics to act from Positive Health.

Implications for the Profession and/or Patient Care: A toolbox of tools will be created, based on practice-oriented research with ways to increase the competencies of healthcare professionals and to act more from Positive Health. By encouraging healthcare professionals to think and act differently based on Positive Health, we hope to promote patients' self-management and intrinsic motivation and thus contribute to a healthier lifestyle.

Impact: An unhealthy lifestyle can lead to various diseases. A positive lifestyle change can lead to the prevention, reduction or even disappearance of the disease. It is important that nurses and (para)medics pay attention to lifestyle from a broad view of health, such as Positive Health. In the professorship we develop tools to increase the competencies of nurses and paramedics to act more from Positive Health and integrate lifestyle into daily care and treatment. And so towards greater health, well-being and a healthier lifestyle.

No Patient or Public Contribution

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I. Introduction

In November 2021, the Lecturer Position at Institutes (L.INT) professorship was established by Saxion and Medical Spectrum Twente and as partners physiotherapy practice Pro-F and the Thoracic Centre Twente, with Sandra van Hogen-Koster as a professor. With this, the first Dutch professorship that focuses on the ideas of Positive Health has been launched. Huber et al. (2011) introduced a more dynamic concept of health valuing resilience 'as the ability to adapt and self-manage in the face of social, physical and emotional challenges' (1). Defining health as 'complete physical, mental and social well-being', such as the World Health Organization (WHO) that does is outdated, according to Huber. "If you stated health so rigidly, no one is ever healthy, she said. Everyone is not completely healthy sometimes, so that you should be treated for that. That leads to unnecessary and costly medicalization of healthcare" according to Huber. Positive Health was deliberately not described as a 'definition', but as a 'general concept' intending to be a characterization of a goal to work towards, being enhancement of resilience, overall health and well-being. This concept was further elaborated into Positive Health (PH), which comprises six dimensions: bodily functions, mental wellbeing, meaningfulness, quality of life, participation, and daily functioning(2). These dimensions are derived from the responses from patients and citizens on the question what they perceived to constitute health(2). Positive Health provides insight into what is important to people and often results in (behaviour)change; this desire for change is in turn regularly indirectly linked to a healthier lifestyle.The overarching aim of integrating PH into the healthcare system is to prioritize health over disease and initiate this transformation.

Applying PH requires a transformation of the healthcare system and the healthcare professionals themselves. A toolbox of tools will be developed to increase the competencies of healthcare professionals to act more from PH. Where is the professorship now after 2 years, what are the first results and what is the focus for the upcoming 2 years?

This position paper describes the urgency of transforming Healthcare: Integrating Positive Health Principles for Enhanced Wellbeing and Lifestyle Change.

II. Background

a) Demographic Trends, Burden of Chronic Diseases, Importance of Lifestyle Factors

Global demographics has increased rapidly over the last few centuries, with an increasing prevalence of an aging population and chronic diseases, resulting in additional pressure on healthcare worldwide (3–7), including those in the Netherlands (8,9). Chronic diseases nowadays have the highest disease burden worldwide, and the consequences have increased over the past two decades (7,10,11). Globally, approximately one in three of all adults suffer from multiple chronic conditions (7). It has become increasingly clear that the role of healthy behaviour or 'lifestyle' is of great importance in tackling chronic disease (12-17). Lifestyle can be defined as: 'behaviour for which a relationship with good health or with health problems has been established, which includes behaviours about diet, physical activity, sleep patterns, stress management, and social interactions (17). The relationship between lifestyle and health has become increasingly clear in recent years: unhealthy behaviour such as smoking, little exercise, an unhealthy diet and alcohol use is responsible for almost 20 percent of the disease burden (18). An unhealthy lifestyle can lead to various diseases, which are often treated with medication or surgery. Medication and hospital admissions can in turn lead to side effects/complications and increased health costs. A positive lifestyle change can lead to the prevention, reduction or even disappearance of the disease, such as with diabetes mellitus type 2 (19).It is clear that we must prevent illness and care as much as possible by focusing on health and prevention and the ability of people to take control (1,2,12-18).

b) Introduction of Positive Health

In light of these challenges Huber and colleagues presented in 2011, in collaboration with the Dutch Healthcare council and ZonMw (Dutch Organisation for Health Research and Development) a new paradigm on health(1) and the framework called: 'Positive Health' (PH) (2)like mentioned earlier in this position paper.

PH represents a fundamental shift in our thinking of health, moving beyond the traditional focus on illness prevention and treatment, towards encompassing a broader view on health, that emphasises the resilience, self-direction and adaptability of people, in which the patient has an active position (1, 2). This approach focuses on health and healthy behaviour as a starting point instead of disease and illness (1, 2). PH can contribute to lifestyle change and the prevention of diseases. Stories in MST by lifestyle coaches who work from the ideas of Positive Health have shown that patients really appreciate the broad view of health. They feel more recognized as a person and become more reflective about their own health. For example, a man with diabetes and COPD initially seemed not motivated to work on his lifestyle. Through "the alternative dialogue" he gained more insight and developed intrinsic motivation to eat healthier. His goal was to be able to walk and cycle with his wife again. The lifestyle coach "do not give advice from "themselves, but respond to the patient's wishes. Listening attentively is an essential skill in this. A lot of attention is paid to this skill in the Positive Health" raining.

c) L.INT Professorship

The concept of PH requires a change not only from the system, but also from the healthcare professionals themselves. Really leaving control to the other person and focusing on health, instead of illness, and being more in line with what someone finds important. This requires other competencies and leadership. Working from PH can also contribute to experiencing more meaning and enjoyment in work; this is not so much the focus of the L.INT professorship, but an observation that we have made in recent months during focus group meetings and interviews with healthcare professionals. Focusing on meaning and, therefore, future-proofing from this L.INT professorship is important given the decrease in the number of healthcare professionals, fewer students choosing healthcare studies and an increasing number of healthcare professionals who (want to) leave healthcare.

III. Purpose of the Paper

To realize the healthcare transformation, healthcare professionals will have to think and act differently. The aim of this paper is to provide insight into the importance of nursing and (para)medical competencies to act from PH in order to contribute to greater health, well-being and a healthier lifestyle for patients. This paper uses the first knowledge gained from the L.INT professorship to show why this is important and how it can be achieved.

IV. Methods

We used several methods, like depth interviews and focus groups with patients and professionals, and a

patient journey to determine what is necessary for nurses and (para)medics to act from Positive Health.

Ethical Approval

All studies were approved by the Institutional Review Board, and the attributes, benefits and uses of the studies were explained to all participants, and informed consent was obtained.

V. Definitions and Semantics

As said, Machteld Huber, the founder of PH and the Institute for Positive Health (IPH), has developed a new approach to health in collaboration with (inter)national experts. The major difference with the 1948 WHO definition is in the emphasis on the possibility of being or becoming healthy, even in the case of illness. PH encompasses the breadth of human well-being, divided into six dimensions and is operationalized in a spider web model as a discussion tool (figure 1). These dimensions are derived from the responses from patients and citizens on the question what they perceived to constitute health (2).It is important that the patient determines his own course for a healthy and longer life.

VI. Research Themes L.INT Professorship

To create focus within the L.INT professorship, the focus is on the following three themes:

1. Experiencing Positive Health and wishes for change
2. Positive Health approach in the hospital
3. Effects of applying Positive Health on the individual

See below for a more detailed explanation of these three themes.

1. *Experiencing Positive Health and Wishes for Change*

Before we want to implement interventions to increase health, well-being and a healthier lifestyle, it is important to perform a baseline measurement to determine what the current situation is. How do people experience their own PH, is there anything they want to change or give more attention to and what do they need for that? Because it is important from PH to first consider your own perceived health (20), the research takes place among both: healthcare professionals and patients. A healthcare professional can only take good care of others, if he first takes good care of himself. For this research, the conversation instrument “my positive health”(20) is used, whereby the alternative dialogue is initiated on the basis of the spider web.

2. *Positive Health Approach in the Hospital*

A gap analysis is carried out to provide insight into the current and required competencies of healthcare professionals who contribute to greater health, well-being and a healthier lifestyle and self-management of patients. Methods, such as a patient journey, a scoping review about skills to act from a Positive Health approach and Shared Decision-Making, to dept-interviews and surveys among healthcare professionals, provide insight into the current and desired competencies of healthcare professionals. Interventions, such as interactive training with reflection moments, are then used to promote the competencies of healthcare professionals (from current to desired situation).A toolbox of tools will be developed to increase this competencies and to act more from PH. It will then be investigated whether the interventions contribute to increasing the competences of healthcare professionals to act from PH. Nowadays little attention is given to the specific requirements, skills or competencies that (future) healthcare professionals need to use the PH approach. Therefore we are currently conducting a review, to obtain an overview and comparison of current PH and SDM skills for healthcare professionals, to identify the skills needed to pursue a PH approach.

3. *Effects of Applying Positive Health on the Individual*

In theme 3 we investigate the effect of approaching PH on the individual. For example, we investigate the effect on lifestyle when a patient is approached from PH. In addition, we investigate what influence this approach has on the intrinsic motivation of patients to work on their own health and well-being.The outcome measures vary per research population. For example, quality of life is taken into account, but also vitality and grip strength.

VII. Anchoring with other Themes/Programs

PH is an approach and not a “trick” or separate tool to use. PH can be applied in existing programs, such as Shared Decision Making and can strengthen the effect of these programs.

Positive Health and Shared Decision Making

With Shared Decision Making (SDM), patients work with a healthcare professional to find the treatment or care that suits him or her best. What suits best depends on what someone finds important. SDM takes place in one or more conversations. In it, the patient and the healthcare professional discuss all the options and what they mean for someone's life. PH can be of value in the first structured steps of SDM; especially when it comes to connecting the patient's perspective with the healthcare professional perspective in decision-making (21). SDM can also be applied when it comes to desired and sustainable lifestyle changes: do not lose weight because the doctor says so and it is good for you, but because you want to feel fitter and be able to play football with your grandson again. Or because you would like to pick up the grandchildren from school yourself, 500 meters away. Intrinsic motivation can be stimulated and become a sustainable pattern.

Positive Health, Sustainable Behavioural (Lifestyle) Change and Intrinsic Motivation

Lifestyle is an individual's way of life, in which six pillars influence physical and mental health: nutrition, exercise, interaction, substances, sleep and relaxation (17). Currently, healthcare professionals often provide information and patients are referred to websites to collect information online. These interventions have only limited effect (22). It is important to determine what a patient can and wants to do to achieve a healthier lifestyle and what the patient needs to achieve this (23);PH can be of added value in this. Intrinsic motivation is important for sustainable behavioural change. Knowledge is needed on how to positively influence lifestyle and research must be conducted into which interventions are effective (per patient). An instrument that is in line with PH and provides the patient with tools to determine the right course for a healthy lifestyle is the Lifestyle Wheel (figure 2). As with PH, self-management is central: the patient has the wheel in hands and can make adjustments when he or she sees fit (17). One of the healthcare professionals within the lifestyle portal emphasizes the importance of initially paying attention to what a patient considers important (personal goal). A healthier lifestyle can then emerge from there. For example, a patient with obesity indicated that he missed contact with his neighbour since COVID. His personal goal was not to lose weight, but to pay more attention to social contacts. By resuming contact with his neighbour, they went for coffee and walks together, which improved his condition. As a result, he also recognized the importance of resuming healthier eating habits, leading to some weight loss.

VIII. First Research Results

To act from PH not only leadership ("distributed", "shared" and "adaptive" leadership) is needed; it also requires other competencies, mainly focused on communication (23). Working from PH requires a different deployment of competencies from healthcare professionals. Leaving control with the other person and allowing choices to come from the other person is not self-evident; in addition to communication skills, this also requires leadership. A healthcare professional is often still trained to help someone else, to provide solutions and to use and transfer his or her expertise to the other person. Healthcare professionals provide a lot of (well-intentioned) advice that the patient does not always need. Practice shows that this does not always produce the desired effect when it comes to lifestyle changes. In April 2023, we conducted a cardiology patient journey, consisting of an in-depth interview with a patient and an additional focus group with 11 healthcare professionals. This patient journey showed that control still often lies with the healthcare professional rather than with the patient. There is still too little attention for lifestyle and hardly any for sustainable behavioural change. The differences between healthcare professionals are large. To really achieve a transformation, everyone must be on the same page and providing feedback to each other in a positive way is essential. This does not necessarily require new competencies, but demands a different utilization of existing ones. Practice shows that this rarely happens. Communication competencies are essential in this. It is important that the patient feels trusted and that the healthcare professional listens carefully, without judging. This way you gain insight into what a patient really finds important. You can then connect to that.

In addition to communication and leadership, multidisciplinary collaboration is important. The connection with the general practitioner (GP) and healthcare professionals in the home situation is also important. A patient journey can contribute to strengthening multidisciplinary collaboration. The focus group itself provided valuable insights into everyone's role during the patient's journey. One of the participants of the patient journey stated afterwards: "*The patient journey was a great way to step away from one's own 'islands', to gain understanding for each other's perspective and to see why a process sometimes gets stuck"*.

Next to the patient journey, two focus groups were conducted (February 2023): one with patients (N=3) who visited the MST lifestyle portal and another with health care professionals (N=3) from this portal. From these focus groups, it became clear that the PH approach provides a broad and human-oriented perspective that gives the patient valuable insights. For example, one patient indicated:"*It is not my illness, but I as a person that is central, which is a relief"*. The 'alternative dialogue' ensures that the patient also takes a broader view and sometimes comes to different insights. One patient, for example, thought he wanted to work on the physical dimension, but it turned out that he actually wanted to work more on finding meaning:"*The dialogue gave me insight, it surprised me in a positive way"*.

Based on the patient journey and the focus groups important points regarding lifestyle emerged:

- Create awareness about the benefits of self-management, motivate and encourage self-management;
- Sustainable behavioural change (setting personal goals and paying attention to these in all disciplines);
- Involving social network (for example regarding adjustment of diet and exercise);
- Personalized approach;
- Use of (personalized) technology based on personal goals.

IX. Patient Journey Methodology

During a patient journey from PH, when asking about patients' experiences, the emphasis is on experiencing self-management. To what extent can someone make own choices during the journey? To what extent was attention paid to one's own wishes and needs and what is important to someone? A patient journey based on PH with a focus on health, well-being and self-management could be an innovative intervention (one of the tools in the toolbox) to provide insight into points for improvement and to allow improvements to be made in patient care, with the needs of the patient as a starting point. It has proven to be a useful instrument for mapping current and desired care and promoting the PH approach. The patient journey is an instrument that can be used to map the patient's journey within a care process (24). There are different methods to conduct a patient journey; standardization in this would be desirable (24). No studies have yet been conducted into the effects/effectiveness of a patient journey (25). The effectiveness of the patient journey can also be taken into account in a follow-up study. Finally, it can be investigated to what extent the patient journey contributes to promoting the competencies of healthcare professionals to work from PH and contribute to greater health, well-being and a healthier lifestyle.

The cardiologic patient journey of April 2023 was divided into three phases: (1) first complaint(s) (2) admission to hospital and (3) situation at home after discharge. The following steps were completed in this journey:

1. Interview with the patient to find out what the experiences are during “the journey”, where self-management, lifestyle and PH are central (including transcription, coding and selection of 3 video fragments of the interview);
2. In conversation with all healthcare professionals involved in the patient journey (healthcare professionals in the hospital and at the GP), based on the results of the patient interview and selected video fragments, and jointly formulating points for improvement (focus group).

A patient journey is a challenge when it comes to the commitment it requires from professionals, as well as the differences between patients. Nevertheless, it is extremely educational to really look from the patient's perspective and to examine your own and each other's actions during the journey. The patient journey has made it clear that more attention is needed for lifestyle, self-management and prevention. Technological support can contribute to lifestyle change. More communication is required between healthcare professionals and organizations. In general, the patient journey created interdisciplinary connections and the patient journey itself raised awareness for healthcare professionals to act more from PH. This makes the patient journey one of the tools in the toolbox for healthcare professionals to act more from PH.

X. Conclusion

The aim of the L.INT research program is to achieve greater health, well-being and a healthier lifestyle from the perspective of PH. To achieve this, not only a transformation in the system is required, but also a transformation of the healthcare professional. Promoting patient self-management and intrinsic motivation is hereby very important and requires different skills from professionals. Within the professorship, a toolbox of tools, such as training on listening skills, use of lifestyle tools, patient journeys, will be created, based on practice-oriented research with ways to increase the competencies of healthcare professionals and to act more from PH. We use this toolbox in the education of existing healthcare professionals and in training of students within the healthcare academy of Saxion University of Applied Sciences. We have included a lesson about the patient journey in our nurse specialist training of Saxion. This lesson provides insight into different work settings and disciplines and can thus contribute to a broader view of health. The first experiences with this lesson are very positive. Students found this very educational and plan to apply it in their own practice. The patient journey is one of the tools included in the toolbox because it gives healthcare professionals more awareness to act from PH with more attention to lifestyle and self-management. In the coming years we will conduct more patient journeys, among others within pulmonary medicine and gastroenterology, and further research into other tools for the toolbox. We also want to develop a training module on PH that shows scenarios in which PH is acted upon and where it is not, and what the effect of this is on the patient. By encouraging healthcare professionals to think and act differently based on PH, we hope to promote patients' self-management and intrinsic motivation and thus contribute to a healthier lifestyle.

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Conflict of Interest

None of the authors have a conflict of interest to disclose.

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Experience Report of Strategies for Carrying out Child Care Consultations in a Family Health Center

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Abstract- *Objective:* Report the experience of implementing a "childcare card" instrument and dynamic consultations in assisting children in childcare consultations.

Methods: This was an experience report in a Family Health Center (CSF) in a municipality in the interior of Ceará, carried out from February to July/2023. The target audience were children and their respective guardians who participated in childcare consultations.

Experience Report: The CSF has 107 children under two years of age, where an average of 60 children currently participate in monthly childcare. After evaluating the family records, low adherence was observed associated with alternating appointments without following the childcare protocol calendar.

Keywords: *childcare, primary care, multidisciplinary team.*

GJMR-K Classification: *LCC Code): RJ101*

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Experience Report of Strategies for Carrying Out Child Care Consultations in A Family Health Center

Relato De Experiência De Estratégias Para Efetivação Das Consultas De Puericultura Em Um Centro De Saúde Da Família

Informe De Experiencia De Estrategias Para La Realización De Consultas De Cuidado Infantil En Un Centro De Salud Familiar

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Resumo- Objetivo: Relatar a experiência da implantação de um instrumento "cartão de puericultura" e consultas dinâmicas na assistência às crianças em consultas de puericultura.

Métodos: Tratou-se de um relato de experiência em um Centro de Saúde da Família(CSF) em um município no interior do Ceará, realizada no período de fevereiro a julho/2023. O público abordado foram crianças e seus respectivos responsáveis que participavam das consultas de puericultura.

Relato De Experiencia: No CSF possui 107 crianças menores de doisanos, onde participam atualmente em média 60 crianças da puericultura mensal, após avaliar o prontuário familiar foi observada uma baixa adesão associada uma alternância de consultas sem seguir o calendário do protocolo de atendimento de puericultura. Foi implantado o "cartão de puericultura" e consultas dinâmicas de recreação que utilizavabrinquedo como estratégia terapêutica na assistência às crianças que participam da consulta de puericultura. Após 1 mês de implantação do instrumento percebeu-se uma maior adesão as consultas, tendo um aumento significativo e importante do número de crianças nas consultas.

Conclusão: A educação em saúde na prática de puericultura é um processo que vem contribuindo com a promoção de saúde infantil e constitui um importante instrumento de mudanças de comportamentos e hábitos.

Palavras-chave: puericultura, atenção básica, equipe multiprofissional.

Abstract- Objective: Report the experience of implementing a "childcare card" instrument and dynamic consultations in assisting children in childcare consultations.

Methods: This was an experience report in a Family Health Center (CSF) in a municipality in the interior of Ceará, carried out from February to July/2023. The target audience were children and their respective guardians who participated in childcare consultations.

Experience Report: The CSF has 107 children under two years of age, where an average of 60 children currently participate in monthly childcare. After evaluating the family records, low adherence was observed associated with alternating appointments without following the childcare protocol calendar. The "childcare card" and dynamic recreation consultations were implemented, using toys as a therapeutic strategy in assisting children participating in childcare consultations. After 1 month of implementing the instrument, greater adherence to consultations was noticed, with a significant and important increase in the number of children attending consultations.

Conclusion: Health education in childcare practice is a process that has contributed to the promotion of child health and constitutes an important instrument for changing behaviors and habits.

Keywords: childcare, primary care, multidisciplinary team.

Resumen- Objetivo: Informar la experiencia de implementación de un instrumento de "tarjeta de puericultura" y consultas dinámicas en la asistencia a los niños en las consultas de puericultura.

Métodos: Se trata de un relato de experiencia en un Centro de Salud Familiar (CSF) de un municipio del interior de Ceará, realizado de febrero a julio de 2023. El público objetivo fueron los niños y sus respectivos tutores que participaron en las consultas de puericultura.

Relato De Experiencia: El CSF cuenta con 107 niños menores de dos años, donde actualmente participan en promedio 60 niños en las guarderías mensuales, luego de evaluar los registros familiares se observó baja adherencia asociada a la alternancia de citas sin seguir el calendario del protocolo de guardería. Se implementó la "tarjeta de puericultura" y consultas dinámicas de recreación, utilizando el juguete como estrategia terapéutica para ayudar a los niños que participan en las consultas de puericultura. Luego de 1 mes de implementación del instrumento, se notó una mayor

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adherencia a las consultas, con un aumento significativo e importante en el número de niños que asistieron a las consultas.

Conclusión: **La educación en salud en la práctica de puericultura es un proceso que ha contribuido a la promoción de la salud infantil y constituye un instrumento importante para el cambio de conductas y hábitos.**

Palabras clave: puericultura, atención primaria, equipo multidisciplinario.

I. Introdução

A Atenção Primária à Saúde (APS) se caracteriza por um conjunto de ações de saúde, no âmbito individual e coletivo, que abrange a promoção, proteção da saúde, prevenção de agravos, diagnóstico, tratamento, reabilitação, redução de danos e a manutenção da saúde com o objetivo de desenvolver uma atenção integral que impacte positivamente na saúde das coletividades. Trata-se da principal porta de entrada do Sistema Único de Saúde (SUS) e do centro de comunicação com toda a Rede de Atenção (RAS) dos SUS (BRASIL, 2017).

Para se alcançar uma APS de qualidade é necessário que os atributos dela sejam operacionalizados e avaliados no intuito de melhoria da qualidade da atenção, dentre eles estão: o primeiro contato, servindo como "porta" de entrada do usuário ao sistema de saúde; a longitudinalidade constituída pelo cuidado da equipe de saúde ao usuário ao longo dos anos; a integralidade atendendo as necessidades da população articulada a outros níveis de atenção e coordenação do cuidado, garantida pela continuidade do cuidado (STARFIELD, 2015).

Em 2015 o Ministério da Saúde (MS) instituiu a Política Nacional de Atenção Integral à Saúde da Criança (PNAISC) com a Portaria nº 1.1303, a qual sintetiza de maneira clara e objetiva os eixos de ações que compõem a atenção integral à saúde da criança. Nessa perspectiva, a PNAISC se organiza a partir das RAS e de seus eixos estratégicos, na qual a APS configura-se como coordenadora do cuidado e ponto central desse processo (DAMASCENO *et al.*, 2016).

Aimplementação dos marcos legais brasileiros, comoa Constituição Federal de 1988, que garantiu o direito universal à saúde por meio da criação do Sistema Único de Saúde (SUS) e a proteção integral da criança, através da instituiçãodo Estatutoda Criançaedo Adolescente (ECA), em 1990, possibilita melhoras significativas referentes à saúde da criança. Entretanto, garantir que esses avanços cheguem à população infantil de maneira universal, de modo que atinja também os grupos mais vulneráveis, é uma tarefa constante. Em razão disso, no ano de 2015, houve a elaboração da Política Nacional de Atenção Integral à Saúde da Criança (PNAISC), comointuitode assegurar o pleno desenvolvimento de todas as crianças e o exercício da cidadania das mesmas (BRASIL, 2018).

O nascimento de uma criança, é uma ocasião de plena transformação no ciclo de vida da família, trazendo consigo muitos questionamentos e insegurança. Em boa parte das vezes, para a família, a equipe de saúde é a principal referência, sendo designada a identificar e abordar assuntos que possam trazer riscos, tornando-se um elo para superar as dificuldades desta etapa de adaptação. Diante da maior vulnerabilidade em seu processo de crescimento e desenvolvimento, a criança é considerada uma prioridade nas políticas públicas de saúde, e é na puericultura, nos dois primeiros anos de vida, que se abrem janelas de oportunidade para a formação de crianças saudáveis, sensíveis e emocionalmente equilibradas (FREITAS, *et al*., 2020).

Um dos serviços oferecidos na ABS é a puericultura, arte de promover e proteger a saúde das crianças, através de uma atenção integral, compreendendo a criança como um ser em desenvolvimento com suas particularidades, pode ser resumida como o acompanhamento da criança por equipe multiprofissional para assegurar um bom desenvolvimento físico e mental, levando em conta que a infância saudável promove uma vida adulta saudável (FERNANDES *et al.*, 2023).

A consulta de puericultura é uma ferramenta primordial na garantia da saúde dosinfantes, visto que reúne procedimentos orientados para o cuidado integral, aspirando acompanhar de forma regular e sistemática, o crescimento, desenvolvimento, imunização, aleitamento materno, alimentação e orientações sobre a prevenção de acidentes (FURTADO MCC, 2018).

Assim, na puericultura é realizado, dentre outras ações, o monitoramento do crescimento físico, o desenvolvimento psicomotor, a avaliação do cartão de imunização e orientações aos pais e/ou responsáveis sobre alimentação adequada. Para que este acompanhamento seja adequado, é essencial a atuação de vários profissionais, que compõem a equipe multiprofissional, como enfermeiro, médico, técnico de enfermagem, nutricionista e fisioterapeuta. Este acompanhamento é realizado, preferencialmente, na atenção primária, que para o acompanhamento regular todas as crianças têm o direito e os pais e/ou responsáveis devem leva-las, devendo ser considerada a estratificação de risco da criança para o cronograma de consultas, o que representa os princípios da equidade, integralidade e universalidade. As consultas de acompanhamento regulares garantem o rastreamento de doenças preveníveis e o controle de doenças não preveníveis (ALBERNAZ, 2023).

Pode-se considerar que a consulta de puericultura é uma das portas de entrada do SUS, que fornece a possibilidade da integração entre o indivíduo, a assistência e o profissional. Ainda nesse âmbito, é válido destacar o desenvolvimento de um vínculo

fundamental para obter uma consulta de puericultura de qualidade, representado pelo profissional e o responsável pela criança. Tal conexão é importante no que diz respeito à execução da assistência, pautada nos princípios e diretrizes da promoção da saúde, inclusive na compreensão do ambiente familiar, seus relacionamentos, contexto sociocultural, econômico e ambiental no qual a criança está inserida (MOREIRA MDS, 2017).

Quando a mãe não estiver inserida ativamente no programa, existe uma falha, isso é uma interrupção contraria a frequente busca pelo atendimento. Vários motivos estão relacionados à baixa adesão materna as consultas, inclusive a falta de conhecimento em relação a puericultura, como também baixo nível socioeconômico e escolaridade, contudo faz se necessário ofertar as mães conhecimento relacionado a promoção de saúde utilizando uma linguagem fácil entendimento de acordo com a realidade com sua realidade (SILVA, *et al.*, 2019).

A educação em saúde faz parte direta desse programa, pois compete a equipe da Estratégia de Saúde da Família (ESF) comunicar sobre a os assuntos relacionado a saúde e atividades, que estarão sendo trabalhados com a criança e cuidados que devem ter em domicílio. A comunicação dos profissionais com as mães mostra ser de grande relevância, pois permite a aproximação das mães e das crianças, deixando as mães mais confortáveis, segura em relação aos cuidados assim construindo um vínculo de forma a incentivar o retorno da mesma a unidade (WILLICH, 2019).

A participação da enfermagem na consulta de puericultura na ESF é de fundamental importância, pois cabe ao enfermeiro e sua equipe dar uma assistência voltada a desenvolver ações e/ou palestras que conscientize e estimule as mães a levarem seus filhos ao acompanhamento da puericultura (ARAUJO et al., 2014).

A interação entre os pais e a criança é fundamental para promoção de resultados ideais ao desenvolvi-mento sendo um componente-chave da avaliação infantil durante a primeira infância, a identificação oportuna de um atraso no desenvolvimento é crucial para estabelecer intervenções oportunas. As estratégias antecipadas garantem que as mães estejam cientes das necessidades de desenvolvimento específicos de cada estágio do desenvolvimento (WONG, 2018).

A equipe da ESF deve se responsabilizar pelo seguimento da criança, por meio da consulta de puericultura, cumprindo o calendário preconizado pela OMS. A consulta é uma ferramenta potente para integralidade do cuidado infantil, sendo uma atividade dinâmica de baixa complexidade que oportuniza a implantação da vigilância e do crescimento infantil resultando na realização de ações de proteção, prevenção de agravos e promoção à saúde da criança (MENEZES, *et al.,* 2019).

Diante da importância da puericultura e observando a necessidade de fortalecer as consultas periódicas de puericultura, foi realizada uma ação como plano de intervenção em uma Unidade de Saúde de Atenção Primária em um município no interior do Ceará, que teve como objetivorelatar a experiência da implantação de um instrumento o "cartão de puericultura" e consultas dinâmicas de recreação que utilizava o brincar/brinquedo como estratégia terapêutica de intervenção na assistência às crianças que participavam das consultas de puericultura.

II. Métodos

Tratou-se de um relato de experiência acerca de uma atividade realizada em um Centro de Saúde da Família em um município no interior do Ceará. A população do bairro conta com o número de 3300 habitantes, o número de crianças de que são acompanhadas pela puericultura é de 107 crianças entre 0 a 2 anos. O CSF conta uma equipe compostas por: 01 cirurgiã-dentista, 09 agentes comunitários de saúde, 02 médicos, 01 técnica de enfermagem, 01 auxiliar em saúde bucal, 02 enfermeiros. A estrutura física conta com: 01 sala de reunião, 01 sala de vacinação, 01 SAME (serviço de arquivo médico), 02 consultórios, 01 consultório odontológico, 01 sala para a realização de procedimentos, 01 copa, 01 sala de esterilização, 01 expurgo.

A ação foi realizada no período de fevereiro a julho do ano de 2023. O público abordado foram crianças e seus respectivos responsáveis que participavam das consultas de puericultura. No momento foi realizada uma abordagem sobre o cartão de puericultura elaborado pelos alunos de enfermagem e nutrição que estavam em estágios na unidade, como também foi realizado consultas de puericultura dinâmicas, usando brinquedos e adereços que chamassem a atenção das crianças, fazendo com que elas ficassem mais tranquilas, facilitando assim o trabalho do profissional.

Os aspectos éticos foram respeitados com base na resolução 466 de 2012. Que trata de pesquisas e testes com seres humanos. Cumprindo as diretrizes e normas regulamentadoras estabelecidas pela resolução e atendendo aos fundamentos éticos e científicos também elencados na resolução Estudos Interdisciplinares Nº 266 de 2012 do CNS (Conselho Nacional de Saúde).

III. Resultados

No Brasil o aumento da taxa de mortalidade é um dos grandes desafios para os gestores municipais e estaduais. Em 2004 foi afirmado o pacto pela redução da mortalidade materna e infantil, com isso nas últimas

décadas houve uma queda no índice graças às estratégias implementadas pelo governo federal como ações para diminuir a pobreza, ampliação da ESF, incentivo ao Aleitamento Materno Exclusivo (AME), rede cegonha, qualificação dos profissionais da puericultura na atenção básica (BRASIL, 2019).

O Ministério da Saúde recomenda sete consultas de rotina no primeiro ano de vida (na 1ª semana, no 1º mês, 2º mês, 4º mês, 6º mês, 9º mês e 12º mês), além de duas consultas no 2º ano de vida (no 18º e no 24º mês) e, a partir do 2º ano de vida, consultas anuais, próximas ao mês do aniver-sário. Essas faixas etárias são selecionadas porque representam momentos de oferta de imunizações e de orientações de promoção de saúde e prevenção de doenças. As crianças que necessitem de maior atenção devem ser vistas com maior frequência(BRASIL, 2012).

A ação foi desenvolvida por estudantes de graduação no momento em que iniciaram as suas atividades de estágio, vivenciando momentos significativos de integração ensino-serviço-comunidade, reconhecendo o território e seus espaços sociais, assim como a história da unidade. Inicialmente realizaram uma conversa com os usuários, compreenderam o contexto social e os determinantes da saúde local. Vislumbraram as fragilidades e potencialidades do território, refletindo a respeito da discussão sobre processo de trabalho da equipe.

Durante o reconhecimento do território foi identificado um baixo índice de adesão às consultas de puericultura na unidade. Na área de abrangência do CSF totalizamos uma população de 107 crianças menores de 02 (dois) anos, onde participam atualmente em média 60 crianças da puericultura mensal, porém ao avaliar o prontuário familiar dessas crianças foi observada uma baixa adesão associada uma alternância de consultas sem seguir o calendário do protocolo de atendimento de puericultura.

A partir desta problemática foi possível atuar na implantação de um instrumento o "cartão de puericultura" (Figura 1) e consultas dinâmicas de recreação que utilizava o brincar/brinquedo como estratégia terapêutica de intervenção na assistência às crianças que participam da consulta de puericultura. O cartão teve a proposta de servir de auxílio para que a mãe acompanhe o desenvolvimento da criança e o período exato que a criança deve comparecer a consulta de puericultura, pois em conversas com as mães durante as consultas de puericultura e pré-natais elas relatavam não saber quais as idades que a criança necessitava ser acompanhada pelo profissional através das consultas de puericultura.

Fonte: autoria própria

Figure 1

Nesse cartão continha um calendário com as idades que a criança precisava passar pela puericultura, assim a mãe poderia consultar sempre que tivesse dúvidas e caso o agendamento não tivesse sido realizado, a mãe teria como alertar o ACS ou enfermeiro da ausência da consulta de puericultura naquele mês.

A ação através da aplicação do cartão de acompanhamento da puericultura do crescimento e desenvolvimento da criança propiciou condições para a efetivação das consultas como uma estratégia que visa aumentar a frequência das crianças nas puericulturas, proporcionando uma abordagem sistêmica e holística.

Quanto às consultas dinâmicas as atividades foram desenvolvidas no período da consulta de

puericultura, e englobavam desenhos, jogos, histórias infantis e na criação de ambientes alegres com uma decoração bem atrativa para as crianças. Através dessa ação, pode-se utilizar o brincar/brinquedo como instrumento facilitador da comunicação entre equipe cuidadora e a criança e como estimulador do desenvolvimento global. Portanto, se por um lado à pretensão da puericultura é fazer crescer fisicamente saudável, o seguimento da criança tem a potência de estreitar e manter o vínculo da criança e da família com os serviços de saúde, propiciando oportunidades de abordagem para a promoção de hábitos de vida saudáveis, vacinação, prevenção de problemas e agravos e provendo o cuidado em tempo oportuno. Ela se complementa na busca de elementos que possam dar à criança o desenvolvimento físico, social, emocional e psíquico, para a formação do ser confiante em si, e daí solidário, em harmonia com o outro para sentir-se feliz (MURAHOVSCHI, 2016).

Este recurso pode ser importante para que o profissional compreenda o momento pelo qual a criança está passando, pois além de lhe dar a oportunidade de liberação de temores e ansiedade, proporciona uma melhor relação entre o profissional e a criança, facilitando assim os procedimentos habituais da consulta.

Após 1 mês de implantação do instrumento do cartão de puericultura e as consultas dinâmicas percebeu-se uma maior adesão as consultas, pois a média de atendimentos de crianças menores de 1 ano mensal era de 13 atendimentos, passando para 33 crianças/mês, sendo um aumento significativo e importante.

Na unidade de saúde buscou-se tornar realidade a integralidade do cuidado das crianças menores de dois anos de idade priorizando ações de saúde que possuem comprovada eficácia e resgatando o vínculo de corresponsabilidade entre os serviços e a população. Acredita-se que se a criança obtiver medidas de promoção, proteção e recuperação da saúde nos primeiros anos de vida, estaremos possibilitando condições cruciais para que o crescimento infantil se processe de forma adequada e, consequentemente, uma base sólida para sua vida adulta.

O vínculo com os usuários do serviço de saúde amplia a eficácia das ações de saúde e favorece a participação do usuário durante a prestação do serviço. Esse espaço deve ser utilizado para a construção de sujeitos autônomos, tanto profissionais quanto pacientes, pois não há construção de vínculo sem que o usuário seja reconhecido na condição de sujeito, que fala, julga e deseja (CAMPOS, 1997).

IV. Conclusão

Diante da experiência vivenciada, observamos à importância do acompanhamento multiprofissional a puericultura, pois ela é responsável por ter uma criança "sadia", pela promoção da saúde e pela prevenção de agravos na infância, assistindo-a contínua e integralmente dentro dos ambientes físicos e psicossocial nos quais estão inseridos. Assim, percebemos a importância da assistência multiprofissional as crianças de 0 a 2 anos, sendo essencial para o cuidar, no qual deve-se tratar o paciente de maneira holística. Isso possibilita a equipe planejar o cuidado de maneira organizada, adaptando os conhecimentos técnico-científicos às necessidades individuais de cada tipo de criança, não apenas prestando os cuidados que o mesmo necessita, mas também orientando e ensinando as mães sobre os cuidados que deve ter diante de seus filhos, fato que promove uma assistência mais humanizada, eficaz e de qualidade.

Vale ressaltar que a atividade de educação em saúde na prática de puericultura é um processo que vem contribuindo com a promoção de saúde infantil e constitui um importante instrumento de mudanças de comportamentos e hábitos. Contudo, faz-se necessário a participação ativa da equipe da unidade favorecendo o entendimento e a reflexão dos educadores sobre o significado de cada mudança na sua criança. Desse modo, entende-se que educar não significa simplesmente transmitir informações, mas é preciso que o educador conheça e compreenda os valores sociais e culturais do educando e este exercite o direito de participar e decidir conscientemente.

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Bipolar Disorder – Nature, Origin, and What Caused it

By Prof. Maria Kuman, PhD

Editorial- The name bipolar disorder says it all – it is uncontrollable switch between good and bad moods. It is considered "mental disease", but there is nothing wrong with the mental abilities of these people. Since emotions are involved, it should be called "psychic disease". In the past, the bipolar people were called "possessed by Evil Spirit" because the ancients were considering the good mood as dominating good Spirit and the bad mood as dominating bad (Evil) Spirit. After the First World War they were called schizophrenics, and their disease called schizophrenia. Now the same people are called individuals with bipolar disorder.

I had a brilliant student Dagmar, who was diagnosed with schizophrenia. I think that the reason she had schizophrenia was strong emotional trauma - her father committed suicide when she was a teenager - a time of hormonal rearrangement and emotional instability. Her switches between good and bad moods (which is emotional disorder) were probably caused by this strong emotional trauma. Bipolar disorder could also be caused by strong anger, prolonged fear, or other strong or prolong negative emotions. For the damages of the anger (negative emotion), I spoke in my article [1]. In the present article, I will speak mostly about the paralyzing effect of fear (another negative emotion).

GJMR-K Classification: *NLM Code: WM 207*

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Editorial

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Dagmar was sharing with me the stupid things she did. She had stolen and eaten up the chocolate of her room-made and then for a long time she was paralyzed by fear that the room-made will discover that her chocolate was missing… And she didn't have explanation why she did this because she had the money to go and buy herself a chocolate. But she also shared with me that she had bad inherited karma - during the time of Atlantis she was with the Black Brotherhood of Atlantis and she was seeing (as if it is happening now) the terrible things they did. This made her suicidal in this lifetime – she felt she does not deserve to live.

Not only steeling is a source of fear, lying is also a source of fear. My mother used to say: "There is nothing simpler than telling the truth. Then you don't need to remember the lies and you don't need to live with the fear that they will discover that you lied." Following her guidance, I lived with the simple truth, which saved me a lot of fears. We should always remember (whatever we do) that everyone of us has a strong judge in the Subconscious. Each time we lie, steel, or take things that we shouldn't take, or take advantage of somebody, the strong judge is telling us that we didn't do right. This brings negative emotions, which suppress the brain activity and darken our brain (seen on MRI images as darkness in the middle of the brain, where the Emotional Brain is).

The doctors, who read the MRI, know from experience that the people with darkness in the middle of their brain are predisposed to become addicted to alcohol or narcotics. However, they don't understand that the brains of these people are darkened by their dominant negative emotions, negative thinking, and wrong doing, and the reason they are attracted to alcohol and narcotics is - these are exciting substances, which bring light to their darken by negative emotions and negative thinking brain (the most paralyzing negative emotion is fear - fear that the lies or wrong doings would be uncovered).

The strong judge of the Subconscious is located in the Quantum Computer in the Subconscious, which is the birth-place of our intuition and intuitive creativity. In the hardware of this Quantum Computer, the Creator put what He want us to be: to love one another, love our neighbors, and even love our enemies, forgive their trespasses, and help one another in any way we can. When we do these, we experience (as an award for the good doing) positive emotions, which lighten our brains by bringing psychic energy of excitation to them.

Since the Creator God is Light woven with Love (according to the people who were in a state of clinical death and came back), when we live our lives following God's recommendations (Loving, forgiving, and helping others), our brains are lightened, which makes us God-like. When we trespass God's rules - lie, steel, and take advantage of others, our brains become dark because the brain activity is suppressed by the negative feeling that we didn't do right. Thus, the darkness in the middle of the brain observed on the MRI of bipolar people reflect their dominant negative emotions (like fear and anger), negative thinking, and wrong doing, which suppress the brain activity.

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The guilt of wrong doing brings negative emotions, the brain becomes dark, and darkness is always associated with Evil. That is why in the past the bipolar people were considered possessed by Evil Spirit (or Spirits). Also, the children of bipolar individuals seeing that their bipolar parent is getting angry, lying and cheating, think that it is OK to lie, cheat, and get angry. For that reason, the children of bipolar parent are frequently bipolar. This roller-coaster continues until the bipolar disorder of the parent grows to a degree requiring hospitalization in "mental" hospital, which makes the children feel like orphans.

The presently offered treatment of bipolar disorder is a pharmaceutical drug, which trims the energy of both Spirits. This do decrease the amplitude of switch between the good and bad mood, but leaves the individuals with so little energy that they barely exist. Since the disabled bipolar patients became too many, the mental (psychiatric) hospitals were closed. Even the violent mentally-sick patients were kicked out, and the easy access to guns in the US made the mass-shootings in the US daily events with a lot of innocent people killed.

For almost 9 years I was feeding the homeless and more than 90% of the homeless were patients kicked-out from the "mental" hospital. They were given such small amount of disability money that they had a heavy choice to make – either to have roof and not have what to eat or if they chose to use the money for food, not to have a roof. I wanted not only to provide food for the homeless, but to figure out why they are the way they are and try to help them to get out of the troubles they put themselves in.

I found that they are all negative thinkers and overall negative. I was trying to convince them that at the bottom of their life problem is their negative thinking and overall negativity, but I couldn't convince them to stop being negative. Only one of them while being negative will turn to me and say: "Oh, I was not supposed to be negative." I couldn't convince them to change their way of thinking to positive for their own good. My mother used to say: "You can bring the horse to the water, you cannot make the horse drink". Only one person (the son of my friend Joyce) made the effort to change his way of thinking from negative to positive and this changed his life.

He was no more bipolar and he didn't need alcohol or narcotic drugs to make him feel well. In a few years his Spiritual and Intellectual level grew from 9 to 11 [2]. Bipolar disorder is diagnosed with MRI (it is detected as darkness in the middle of the brain, where the Emotional Brain is. This darkness means suppressed brain activity caused by dominant negative thinking and negative emotions from negative doing. Since detecting bipolar disorder with MRI is very expensive, in my article [3], I offered a cheap alternative way for detecting bipolar disorder with simple electric measurements with high sensitivity.

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By José Maria Ximenes Guimarães

Abstract- This study analyzed working conditions and their impact on the mental health of nurses facing COVID-19. A total of 192 nurses answered an electronic questionnaire. Screening for Common Mental Disorders (CMD) was performed using the Self-Reporting Questionnaire (SRQ-20), and associations between the dependent and independent variables were tested. The prevalence of suspected CMD was 53.1%, and this outcome was associated with female gender ($p<0.005$), sufficient personal protective equipment in quantity and quality ($p<0.006$), sufficient biosafety standards ($p<0.045$), being at risk of transmitting COVID-19 ($p<0.001$), and having a family member with COVID-19 symptoms ($p<0.029$). The study demonstrates the negative impact of the COVID-19 pandemic on nurses' mental health and reinforces the need for psychological support for health workers.

Keywords: *conditions of work. nursing. psychological stress. mental disorders. COVID-19.*

GJMR-K Classification: *NLM Code: WY87, WM172*

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I. Introduction

Since December 2019, the world has been facing the Coronavirus Disease 2019 (COVID-19), initially identified in Wuhan, China. With the growth of cases and deaths, the outbreak of the disease was declared a public health emergency of international concern in January 2020 by the World Health Organization (WHO). In March 2020, COVID-19 was recognized by the WHO as a pandemic, considering its rapid expansion around the world. In Brazil, a public health emergency of national importance was declared in March 2020, and in May, the country reached second place in the world ranking of recorded COVID-19 infections (Frota et al., 2022; Ramos-Toescher, Tomaschewisk-Barlem, Barlem, Castanheira, Toescher, 2020).

COVID-19 represents the biggest public health emergency faced globally in decades, with an overload of health systems (Vieira-Meyer, Morais, Campello, Guimarães, 2021; Ramos-Toescher et al., 2020), arising from the high demand for complex care, especially for critically ill patients, requiring large-capacity hospital units and intensive care beds. Given the challenges above, the need to expand services and reorganize work processes was imposed.

In addition to the impact on physical health, the pandemic has harmed the mental health of populations and healthcare professionals, especially those who work on the front line in health services (Schmidt, Crepaldi, Bolze, Neiva-Silva, Demenech, 2020; Fiorillo, Gorwood, 2020). Researchers have been concerned that epidemics can contribute to the emergence of psychological distress in the population, with repercussions that can be more lasting and prevalent than the epidemic itself, besides the immensurable psychosocial and economic impacts (Ornell, Schuch, Sordi, Kessler, 2020). Therefore, the risk of COVID-19 triggering, in parallel, a second pandemic corresponding to mental health crises in communities and health services is highlighted.

Among the work-related mental health problems, there are Common Mental Disorders (CMD), which do not fully meet the anxiety and depression diagnosing criteria but include symptoms including insomnia, fatigue, irritability, difficulty in concentration, forgetfulness, and somatic complaints among others, which can trigger significant functional loss, in addition to psychosocial harm (Urbanetto et al., 2013; Kirchhof, Magnago, Camponogara, Griep, Tavares, Prestes, Paes, 2009; Santos, Alves, Goldbaum, Cesar, Gianini, 2019).

Studies carried out in different countries show that providing health care for patients with COVID-19 is a cause of distress, resulting in symptoms of anxiety, depression, anguish, and insomnia, especially among nurses (Lai et al., 2020; Rossi et al., 2020; Chersich et al., 2020; Paiano et al., 2020; Moreira, Sousa, Nóbrega, 2020). Similar results were found in studies carried out in Brazil (Silva-Costa, Griep, Rotenberg, 2022), identifying processes of mental illness in nurses working in different settings during the pandemic (Oliveira et al., 2022; Dal'Bosco, Floriano, Skupien, Arcaro, Martins, Anselmo, 2020).

It is noteworthy that nursing professionals represent 50% of the health workforce in the world, corresponding to approximately 28 million professionals according to the WHO (World Health Organization, 2020), of which 2 million and 400 thousand work in Brazil (Peduzzi, Cabral, 2021). These professionals work in different public, private or philanthropic services, located at all levels of care in the health systems facing major challenges in their work process, including low prestige, non-recognition of the relevance of their work, overload, unsatisfactory working conditions, the precariousness of employment relationships, and exposure to situations of significant distress. Indeed, the Covid-19 pandemic has made these problems even

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more evident (Souza, Rossetto, Almeida, 2022; Peduzzi, Cabral, 2021).

During the pandemic, nursing professionals stood out for their work on the front line of health services providing care to patients, which exposed them to suffering arising from aspects such as work overload, risk of health system collapse, insufficient training in the initial phase of the pandemic, shortage of materials and personal protective equipment (in quantity and quality), and lack of clear biosafety standards (Souza, Rossetto, Almeida, 2022; Miranda, Santana, Pizzolato, Saquis, 2020). These aspects put professionals in job insecurity, causing fear of contamination, becoming a source of transmission for family, and causing physical/psychological exhaustion (Miranda, Santana, Pizzolato, Saquis, 2020).

The evidence in the literature on the implications of the COVID-19 pandemic for the mental health of health workers and nursing professionals is unequivocal. However, there are few empirical studies in the Brazilian scenario, particularly in Ceará. It is noteworthy that the first cases of the disease in the territory were registered in March 2020, with high morbidity and mortality and risk of health system collapse (Vieira-Meyer, Morais, Campello, Guimarães, 2021), which led the Government to adopt social isolation measures. Amidst this chaos, health professionals have been summoned to face the pandemic, starting at the beginning of the first wave. This study aimed to analyze working conditions and their impact on the mental health of nurses facing COVID-19.

II. Methods

A cross-sectional web survey was conducted to obtain primary data using the Internet, a feasible strategy for conducting research during the COVID-19 pandemic when social isolation measures were established (Boni, 2020). This article is an excerpt from a larger work on the repercussions of the COVID-19 pandemic on health workers' work processes and mental health, developed during Brazil's first pandemic wave. The study was conducted with nurses working on the front line during the COVID-19 pandemic in Ceará, Brazil - the State with the highest rate of deaths per 100,000 inhabitants in the Northeast of Brazil from May to July 2020 and the second highest death rate in the country, in June 2020 (Portal COVID-19 Brasil, 2020). Data collection took place from April to July 2020. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines were followed (Von et al., 2008).

a) *Participant Recruitment Process*

A convenience sample was recruited through an invitation sent via text messages to health professionals who were found to participate in groups on the following social networks: WhatsApp, Instagram, and Facebook. Nurses who agreed to participate in the study were recruited, considering the following inclusion criteria: having an open/accessible social network for receiving messages (Facebook, Instagram, or WhatsApp) and providing health care to COVID-19 patients in health services such as primary care units, emergency rooms, and hospitals.

b) *Data Collection*

A structured, self-administered questionnaire was used for the data collection, with variables related to participants' sociodemographic characteristics and work processes. These variables were presented in a categorical format, mostly dichotomous. The Self-Reporting Questionnaire (SRQ-20) was used to assess the participants' mental health status. This validated instrument detects increased risk of common mental disorders (CMD) (Gonçalves, Kapczinski, 2008).

Regarding COVID-19 prevention protocols, data collection was operationalized using Google Forms. Text messages containing the general description of the study and the questionnaire link were sent to the public of interest through the social networks mentioned before. The instrument was divided into four screens: (1) informed consent, (2) sociodemographic data, (3) questions about the work processes, and (4) the SRQ-20. All questions were required to be answered, and no changes after submission were allowed.

All those who agreed to participate in the research completed the questionnaire. The Google Forms platform was configured to request an access login per participant, avoiding duplicate entries. No identification of the participants was made. The Checklist for Reporting Results of Internet E-Surveys (CHERRIES) (Eysenbach, 2004) was used to increase the transparency of the methods and interpretation of the results.

c) *Data Analysis*

Initially, a univariate analysis was performed to estimate the absolute and relative frequencies of the variables of interest. Bivariate analysis was also conducted to test the association between the dependent and independent variables, applying Pearson's chi-square or Fisher's exact test. A p-value ≤ 0.05 was considered significant. Data were analyzed using the Data Analysis and Statistical Software (STATA) version 15.0.

The presence of a greater than usual risk for CMD – a value obtained through the SRQ-20 - was defined as the dependent variable, with a cutoff point of 7 points or more (Gonçalves, Kapczinski, 2008). Demographic, social, and work-related characteristics were chosen as independent variables.

d) Ethical Consideration

All participants voluntarily agreed to participate in the study after reading explanations about the purpose of the study and completing the online consent form. The research was approved by the Research Ethics Committee of the University of Fortaleza (opinion No. 3.997.242).

III. Results

A total of 192 nurses working in the direct care of COVID-19 patients were included in the study. There was a predominance of females (85.5%), aged 30-39 (39.6%), married (65.1%), with more than 10 years of university education (49.0%), and with an income of up to five minimum wages (62.5%). Table 1 presents the sociodemographic characteristics of the sample and correlations between these characteristics and suspected CMD.

A rate of 53.1% (95%CI: 45.8–60.4%) of the sample had results indicating suspected common mental disorders. The bivariate analysis revealed a significant correlation between gender and suspected CMD (Table 1).

Table 1: Sociodemographic profile of nurses at risk of developing Common Mental Disorders

Variables (n)	Participants		Suspected CMD		p-value
	n	%	n	%	
Gender					
Female	164	85.4	94	92.2	0.005
Male	28	14.6	8	7.8	
Total	192	100.0	102	100.0	
Age					
20 – 29	39	20.3	20	19.6	
30 – 39	76	39.6	40	39.2	
40 – 49	54	28.1	32	31.4	0.648
50 – 59	20	10.4	8	7.8	
>= 60	3	1.6	2	2.0	
Total	192	100.0	102	100.0	
Marital status					
Married	125	65.1	65	63.7	
Single	65	33.9	36	35.3	0.903
Widowed	2	1.0	1	1.0	
Total	192	100.0	102	100.0	
Monthly income					
1 - 5 min wages	120	62.5	65	63.7	
6 - 10 min wages	65	33.8	34	33.3	0.833
>= 10 min wages	7	3.7	3	2.9	
Total	192	100.0	102	100.0	
Length of time since bachelor's degree attainment					
< 1 year	13	6.8	7	6.9	
1 - 5 years	41	21.3	22	21.6	0.694
6 - 10 years	44	22.9	20	19.6	
> 10 years	95	49.0	53	52.0	
Total	192	100.0	102	100.0	

Regarding the work-related variables (Table 2), most participants worked in the capital city (58.3%), in public services (94.8%), and the Family Health Strategy (49.5%). Most participants reported that adaptations were made in order to serve patients with COVID-19 during the pandemic (86.5%), recognized themselves as front line workers (75.5%), reported not having been trained (59.9%), and reported working with insufficient personal protective equipment (PPE) (40.1%). It was also observed that most participants did not consider

the PPE used in their facilities good enough to avoid getting infected (58.9%) and reported lacking biosafety standards (49.5%). Therefore, it can be inferred that these professionals acknowledge that they were at risk of getting COVID-19 in their facilities (90.6%) and of transmitting the disease to family members (92.2%). Most participants also reported having observed staff members with symptoms of COVID-19 (74.0%), but the majority also reported not having observed the presence of the infection among family members (81.2%).

The association between work-related characteristics and suspected CMD was tested through bivariate analyses (Table 2). The variables female gender ($p<0.005$), insufficient personal protective equipment ($p<0.006$), low quality protective equipment ($p<0.006$), insufficient biosafety standards ($p<0.045$), being at risk of transmitting COVID-19 to a family member ($p<0.001$), and having a family member with symptoms of COVID-19 ($p<0.029$) were related with the outcome.

Table 2: Association between work-related characteristics and suspected common mental disorders

Variables	Participants		Suspected CMD		p-value
	N	%	n	%	
Location of work					
Capital	112	58.3	60	58.8	
Countryside	80	41.7	42	41.2	0.883
Total	192	100.0	102	100.0	
Type of work management					
Private	10	5.2	4	3.9	
Public	182	94.8	98	96.1	0.393
Total	192	100.0	102	100.0	
Type of facility					
Hospital	83	43.2	40	39.2	
Primary care unit	95	49.5	54	52.9	0.490
Emergency unit	14	7.3	8	7.8	
Total	192	100.0	102	100.0	
Have you notice any adaptation in your workplace to serve patients with Covid-19?					
No	26	13.5	15	14.7	0.616
Yes	166	86.5	87	85.3	
Total	192	100.0	102	100.0	
Have your working hours increased?					
No	157	81.8	84	82.4	0.824
Yes	35	18.2	18	17.6	
Total	192	100.0	102	100.0	
Are you a front-line worker?					
No	47	24.5	23	22.5	0.508
Yes	145	75.5	79	77.5	
Total	192	100.0	102	100.0	
Have you received training on infection control procedures during the COVID-19 pandemic?					
No	115	59.9	65	63.7	0.249
Yes	77	40.1	37	36.3	
Total	192	100.0	102	100.0	
Do you consider the quality of PPE provided for the health workers in your facility to be enough?					
No	113	58.9	71	69.6	0.006
Yes	43	22.4	17	16.7	

Partially	36	18.7	14	13.7	
Total	192	100.0	102	100.0	
Do you consider the quantity of PPE provided for the health workers in your facility to be enough?					
No	77	40.1	49	48.0	
Yes	40	20.8	13	12.7	0.006
Partially	75	39.1	40	39.2	
Total	192	100.0	102	100.0	
Do you consider the biosafety standards adopted in your facility to be enough?					
No	95	49.5	59	57.8	
Yes	22	11.5	9	8.8	0.045
Partially	75	39.0	34	33.3	
Total	192	100.0	102	100.0	
Do you think that you are at risk of contracting COVID-19?					
No	1	0.5	0	0.0	
Yes	174	90.6	97	95.1	0.065
Maybe	17	8.9	5	4.9	
Total	90	100.0	102	100.0	
Do you think that you can transmit COVID-19 to other people?					
No	1	0.5	0	0.0	
Yes	177	92.2	101	99.0	0.001
Maybe	14	7.3	1	1.0	
Total	192	100.0	102	100.0	
Have you observed any staff member with symptoms of COVID-19 in your facility?					
No	38	19.8	20	19.6	
Yes	142	74.0	78	76.5	0.354
Maybe	12	6.2	4	3.9	
Total	192	100.0	102	100.0	
Have you observed the presence of the infection among family members?					
No	156	81.2	77	75.5	
Yes	36	18.2	25	24.5	0.029
Total	90	100.0	102	100.0	

The group of symptoms with the highest frequency of affirmative answers was decreased vital energy (Factor II), with 502 responses (33.3%), followed by somatic symptoms with 449 (29.8%) - a result very close to depressive-anxious mood, with 448 (29.7%). Regarding the SRQ-20 questions, the highest frequencies of affirmative answers occurred in the following items: "Do you feel nervous, tense, or worried?" (76.6%), "Do you feel unhappy?" (68.2%), "Do you sleep badly?" (64.1%), "Do you feel tired all the time?" (52.1%), "Do you often have headaches?" (50.5%), "Do you find it difficult to enjoy your daily activities?" (49.5%), "Do you feel tired all the time?" (45.3%), "Do you cry more than usual?" (44.8%), "Are you easily frightened?" (43.8%), "Do you have uncomfortable feelings in your stomach?" (43.8%), "Is your digestion poor?" (40.6%) and "Do you find it difficult to make decisions?" (40.6%).

IV. Discussion

This study has identified a high frequency of suspected CMD among nurses in different healthcare settings. The rate of suspected CMD in our study was higher than that of 30% estimated by the WHO (World

Health Organization, 2001). Other studies that have also used the SRQ-20 questionnaire in periods that preceded the COVID-19 pandemic and in different settings (primary care units, hospitals, and universities) revealed frequencies of suspected CMD lower than those of the present study, ranging from 14.6% to 35.0% (Kirchhof et al., 2009; Dilélio et al., 2012; Araújo, Aquino, Menezes, Santos, Aguiar, 2003; Tavares, Beck, Magnago, Zanini, Lautert, 2012; Oliveira et al., 2020; Pinhatti, Ribeiro, Soares, Martins, Lacerda, 2018; Rodrigues, Rodrigues, Oliveira, Laudano, Sobrinho, 2014).

Since the first wave of the pandemic, several studies have shown an increasing incidence of CMD among health professionals, especially nurses. High depression, anxiety, insomnia, and distress rates have been reported in studies in China (Lai et al., 2020) and Italy (Rossi et al., 2020). However, unlike the studies above, our investigation was not limited to front line nurses.

Several studies have been conducted on the physiological and psychological effects of the COVID-19 pandemic on Brazilian healthcare staff. A study with nursing professionals (nurses and assistant nurses) from a hospital in Ponta Grossa, Brazil (Dal'Bosco et al., 2020) identified high anxiety and depression exceeding the acceptable levels for the profession. Another study with nurses from Pelotas, Brazil (Oliveira et al., 2022), in which the SRQ-20 was used, found a prevalence of suspected CMD of 44%. Indeed, in our study, the prevalence of suspected CMD was higher than that reported in studies conducted in Brazil and other countries. For example, a study with Pakistani doctors found a prevalence of suspected CMD of 42.7%, based on the SRQ-20 (Amin, Sharif, Saeed, Durranni, Jilani, 2020). Therefore, our study confirms that nurses and health professionals are more susceptible to develop CMD than non-healthcare professionals.

It should be noted that the instruments adopted for screening anxiety, depression, and other signs and symptoms of CMD differ between studies due to their heterogeneity (populations and measures), which can interfere with the outcomes (Dal 'Bosco et al., 2020). It is relevant to consider that the instruments used do not provide a diagnosis. Many answers in these instruments characterize adaptive processes to a tensiogenic situation, hence alerting to the non-pathologization of conditions that could be resolved by improving working conditions and providing emotional support (Oliveira et al., 2022).

In addition to representing half the health workforce in the world, the nursing profession is predominantly female. In Brazil, 85% of nurses are women (Peduzzi, Cabral, 2021). This predominance refers to historical and cultural dimensions related to the care exercised in daily work activities, including meeting the demands of children and partners and taking responsibility for household chores, which can favor the emergence of psychic burden in this group (Dal'Bosco et al., 2020; Sena, Lemes, Nascimento, Rocha, 2015). Similar to our findings, a significant association between the female gender and the presence of signs and symptoms of anxiety and depression was found in studies carried out in China (Lai et al., 2020), Italy (Rossi et al., 2020), and in Southeast Brazil (Dal'Bosco et al., 2020), during the COVID-19 pandemic. Contrastingly, when investigating CMD among nurses from Ponta Grossa (PR), an inverse association with males was found (Oliveira et al., 2022). However, in some pre-pandemic scenarios, no statistically significant relationship was identified between gender and CMD (Dilélio et al., 2012).

It is recognized that the social role of gender permeates the work context, in which women face an imbalance between life and work (Dal'Bosco et al., 2020). This aspect is observed, above all, in Brazilian nurses, who frequently lack professional appreciation, and are affected daily by work overload, lack of time, and adequate space for rest, in addition to low wages, leading them to work in more than one job. Such aspects exacerbate the implications of the pandemic for women, especially health professionals, for whom the domestic burden was more intense, reflecting the inequality of the pandemic effects. The context described above contributes to the weakening of mental health with the emergence of anxiety, depression, sleep and cognition disorders, and physical discomforts (Oliveira et al., 2022; Vieira, Anido, Calife, 2022).

Also noteworthy are associations between work-related variables (inadequate quantity and quality of PPE and lack of biosafety standards) and suspected CMD. Besides, most participants recognized they were at risk of getting and spreading COVID-19, although no significant correlation was found between these variables. A positive relationship was identified between being afraid of transmitting the disease to family members, having a family member with symptoms of COVID-19, and suspected CMD.

The findings above are consistent with a previous study carried out in the southern region of Brazil, in which associations between suspected COVID-19 infection and suspected CMD were found, in addition to the association between lack of PPE and depressive episodes (Oliveira et al., 2022). A positive association between exposure to COVID-19 and depression was reported in Italy (Rossi et al., 2020). Besides, studies carried out in European countries have identified that adequate provision of PPE is an important predictor of better mental health outcomes (Sampaio, Sequeira, Teixeira, 2020; Felice, Di Tanna, Zanus, Grossi, 2020).

Regarding the risk of contamination, it is interesting to note that health professionals who provide direct care to patients with COVID-19 are often afraid of getting sick and, therefore, are a vulnerable group to mental suffering. A survey in Italy showed that approxi-

mately 59% of workers perceived they were at risk of getting COVID-19 (Puci et al., 2020). In a study carried out in Brazil, associations were found between risk perception and symptoms of depression and anxiety – healthcare staff with high perception were at greater risk for severe symptoms of anxiety (OR: 4.35) and depression (OR: 4.67) (Silva-Costa, Griep, Rotenberg, 2022).

Being a nurse during a worldwide pandemic affected the mental health of these professionals, especially during the first wave when the high transmissibility of COVID-19 was recognized. Little knowledge was available about the treatment and control of the disease, there were recurrent changes in clinical protocols, insufficient PPE, and recurrent biosafety threats, triggering uncertainties, fear, and impotence, putting professionals in a situation of vulnerability.

Regarding the predictive symptoms of CMD, the anxious-depressive mood was prevalent (Factor I, assessed through the question "Do you feel nervous, tense, or worried?"), similar to a prior study (Oliveira et al., 2020). In the face of the pandemic, anxiety symptoms seem to have worsened due to daily challenges such as dealing with uncertainties and unpredictability regarding the disease, the need to adopt disease control measures, facing suffering and death daily, and being constantly concerned with the risk of disease contamination and transmission, among other aspects.

Regarding the reduction of vital energy (Factor II, assessed through the questions "Are you easily tired?" and "Do you find it difficult to enjoy your daily activities?"), our findings differed from those of a study carried out in the pre-pandemic period (Oliveira et al., 2020). The high patient demands generated a collapse of health services, reflected in the insufficiency of beds, equipment, and supplies. Consequently, healthcare workers have become overloaded by activities involved in patient care, such as walking more than usual from one unit to another, performing duties that demand heavy physical effort, and lifting heavy loads. The need to perform repetitive tasks rapidly and remain standing or in uncomfortable positions for long periods leads to physical and psychological exhaustion (Kirchhof et al., 2009; Humerez, Ohl, Silva, 2020).

Somatic predictors of CMD (Factor III) were also found in our study through affirmative answers to the questions "Do you sleep badly?" and "Do you often have headaches?". The above findings were similar to those of Oliveira et al. (2020). There is a direct relationship between the physical demands of work and the prevalence of psychosomatic problems (Kirchhof et al., 2009). Thus, somatic complaints and their implications in work processes must be considered, as they can compromise the attention required in the execution of care practices, causing incidents that jeopardize patient safety (Oliveira et al., 2020; Urbanetto et al., 2013), negatively affecting the professional performance and the quality of health care.

The prevalence of depressive symptoms (Factor IV) was generally low. However, there was a high prevalence of "Have you lost interest in things?". This finding is similar to that of Oliveira et al. (2020). However, it differs from a study carried out in a hospital in the southern region of Brazil (Urbanetto et al., 2013), in which the question "Are you unable to play a useful part in life?". The daily working routine and the resulting exhaustion linked to the pandemic crisis, combined with sanitary measures (such as social isolation) and reduction of leisure activities, account for the emergence of the symptoms, as mentioned earlier.

In sum, this study reinforces that work-related aspects have harmed the mental health of healthcare professionals (even more in the pandemic crisis) putting them at risk of CMD that, in turn, compromise essential components of healthcare quality (interpersonal relationships, care management, and decisions).

Table 3: Distribution of nurses according to the group of symptoms and positive answers to the SRQ-20 questionnaire

SQR-20 Factors	Yes		No	
	n	%	n	%
Factor 1 - Anxious depressive mood				
Do you feel nervous, tense or worried?	147	76.6	45	23.4
Are you easily frightened?	84	43.8	108	56.2
Do you feel unhappy?	131	68.2	61	31.8
Do you cry more than usual?	86	44.8	106	55.2
Factor II - Decreased vital energy				
Are you easily tired?	100	52.1	92	47.9
Do you find it difficult to make decisions?	78	40.6	114	59.4
Do you find it difficult to enjoy your daily activities?	95	49.5	97	50.5
Do you have trouble thinking clearly?	72	37.5	120	62.5
Is your daily work suffering?	70	36.5	122	63.5
Do you feel tired all the time?	87	45.3	105	54.7
Factor III - Somatic symptoms				
Do you have uncomfortable feelings in your stomach?	84	43.8	108	56.2
Is your appetite poor?	35	18.2	157	81.8
Do you often have headaches?	97	50.5	95	49.5
Do you sleep badly?	123	64.1	69	35.9
Is your digestion poor?	78	40.6	114	59.4
Do your hands shake?	32	16.7	160	83.3
Factor IV - Depressive thoughts				
Have you lost interest in things?	58	30.2	134	69.8
Are you unable to play a useful part in life?	23	12.0	169	88.0
Do you feel that you are a worthless person?	19	9.9	173	90.1
Has the tough of ending your life been on your mind?	9	4.7	183	95.3

[a]

V. Conclusions

The findings of this study indicate the need to adopt health protection measures and adequate dimensioning of nursing staff. Nurses need better working conditions, an adequate workload, sufficient PPE, adequate biosafety standards and protocols, and ongoing support of continuing education since there is a need for continuous learning to keep up to date in current practice. Thus, psychological, emotional, and social support to mitigate the repercussions of work on mental health is of utmost importance to overcome the psychological suffering of nurses and other health care professionals.

The study revealed some work-related aspects that compromise nurses' mental health. However, some study's limitations must be considered, including the cross-sectional design (that does not allow the analysis of working conditions and their repercussions over time) and the fact that the data collection was carried out online, which may have caused the low response rate (20%). The possibility of response bias is also highlighted, as the questionnaire was self-administered.

Authors' Contributions

JMXG worked on the conception, design, analysis, and interpretation of data, manuscript writing, and approval of the final version to be published. APGFVM and CGF worked on the analysis and interpretation of data, critical review of the manuscript, and approval of the final version to be published. EPAA, APPM, AMCP, and JJCS worked on the critical review and approval of the final version to be published.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Navigating Complex Realms: Anthropological Insights into Professional Dynamics of Elderly Care

By Gabriele Di Patrizio

Abstract- The objective of this article is to show how the presence of the professional in the activity he is carrying out is linked to his own anthropological constitution. This pragmatic anthropological research deals with what man makes with himself. It is compared with knowledge from the sociology of work, the activity clinic and ergology to highlight the process of reflective awareness as a means of acquiring self-knowledge in professional action. This process is based on an objective determination of action from several realms whose relevance has been verified in the professions of support and care carried out in nursing homes through the exploitation of a case study. This research aims to identify ways to promote empowerment at work.

Keywords: *gerontology, professionalism, plural realms, reflective awareness, power to care.*

GJMR-K Classification: *LCC Code: HQ1063.6, HV1461*

Strictly as per the compliance and regulations of:

Navigating Complex Realms: Anthropological Insights into Professional Dynamics of Elderly Care

Explorer les mondes complexes: Perspectives anthropologiques sur l'implication des professionnels en EHPAD

Gabriele Di Patrizio

Abstract- The objective of this article is to show how the presence of the professional in the activity he is carrying out is linked to his own anthropological constitution. This pragmatic anthropological research deals with what man makes with himself. It is compared with knowledge from the sociology of work, the activity clinic and ergology to highlight the process of reflective awareness as a means of acquiring self-knowledge in professional action. This process is based on an objective determination of action from several realms whose relevance has been verified in the professions of support and care carried out in nursing homes through the exploitation of a case study. This research aims to identify ways to promote empowerment at work.

Keywords: gerontology, professionalism, plural realms, reflective awareness, power to care.

Résumé- L'objectif de cet article est de montrer en quoi la présence du professionnel à l'activité qu'il est en train d'effectuer est liée à sa propre constitution anthropologique. Cette recherche d'anthropologie pragmatique traite de ce que l'homme fait de lui-même. Elle est mise en parallèle avec des connaissances issues de la sociologie du travail, de la clinique de l'activité et de l'ergologie afin de mettre en évidence le processus de conscientisation réflexive comme moyen d'acquérir une connaissance de soi dans l'agir professionnel. Ce processus s'élabore à partir d'une détermination objective de l'agir à partir de plusieurs mondes dont la pertinence a été vérifiée dans les métiers de l'accompagnement et du soin exercés en EHPAD *via* l'exploitation d'un cas d'école. Cette recherche vise à identifier des moyens pour promouvoir la puissance d'agir au travail.

Mots-clés: gérontologie, professionnalité, mondes pluriels, conscientisation réflexive, puissance d'agir.

I. Introduction

In France, the review of policy initiatives led by Y. Clot et al. (2021), spanning from the 2015 law on society's adaptation to ageing to the "Ségur de la santé" of May 2020, underscores a growing political and social awareness of the urgent need to address the complexity of the issues surrounding the population ageing. However, there is an undeniable neglect of this urgency at the operational level, as highlighted by the recent postponement of the proposed "Ageing Well" law (2023). This law aims to ensure the right to age with dignity and prepare society for its ageing population. Stakeholders in the sector have expressed their frustration with what appears to be a lack of concrete action following promises. Despite assurances from the minister that a law on the elderly will be passed by the end of 2024, these announcements have been met with significant skepticism from various organizations and federations in the sector. They face with a decrease in the attractiveness of professions for the elderly despite a growing demand (El Khomri, 2019). The issue of staff shortages, although already studied for years (Archambault, 2006) continues to worsen the situation. However, any potential for improvement in the future must draw upon the accumulated experience and expertise of those working in nursing homes. They are essential "to rebuild their profession" (Clot *et al*., op. cit., p. 64) and make it attractive and fulfilling again.

This study, initiated in January 2021, responds to an urgent context, and is based on a structured and comprehensive set of humanities and social sciences. It approaches issues with a complexity-based perspective, enabling human engagement in activities without relying solely on subjective interpretations. J. Rhéaume asserts that human activity, and by extension work, reflects the ontological essence of human beings. As beings capable of "living, imagining and thinking" (2017, p. 249), humans possess to acquire knowledge or develop an understanding of activities based on lived experiences. This study seeks to delve into these inquiries by adopting a relatively unexplored anthropological approach, particularly in understanding activities within nursing homes. This approach prompts fundamental inquiries into human nature and the preservation of human agency. Accordingly, we will begin by outlining our research problem, followed by its theoretical underpinnings. Subsequently, we will detail our methodology and analytical framework, concluding with a discussion of our findings.

a) Problematic

Supported by professionals in gerontology, 'family caregivers" endeavor to keep their elderly relatives at home. However, this assistance reaches a critical point when the demands of caring for a dependent loved one become overwhelming. Despite public policies aimed at promoting home care, many situations become unmanageable, leading to the use of Residential Establishments for Dependent Elderly People (EHPAD). Although these facilities serve as a final place of residence for many individuals, they are

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criticized for providing a poor quality of life to residents (Vercauteren & Connangle, 2021, p. 72).

In this research, we will explore the role of health professionals as subjects of their own activity (Barber, 2017), providing care and support to the elderly. We will investigate the extent to which these professionals can harness their intrinsic energy to maximize their engagement in their "to be present and available" (Norberg *et al*., 2001) work and thus influence outcomes in terms of adequate care. We will examine how these existential characteristics directly impact the quality of care provided and the experience of older adults in nursing homes. Additionally, we will question the ability of professionals to express their existential traits in a genuine manner, aiming to enhance their dedication and effectiveness in their roles.

Through an anthropological approach, we aim to comprehend how to infuse humanity into the involvement of professionals in their work. We will analyze the shift from a humanized, individual-focused approach to an activity centered on human agency, highlighting the power of individuals to act as the subjects of their activities.

Central to our research is the notion of the subject, as professionals primarily operate as such. Drawing from M. Sachot's work, we understand that the word "subject" comes from Latin *subiectum* ("submissive", "submissive") and that this term "translates in the fifth to sixth century the Greek *hypokeimenon* which has no connotation of submission or subjection. It means (...) 'which is underlying'" (Sachot, in, Ancori*et al*., 2014, pp. 77-100).

Therefore, our research hypothesis posits that the subject possesses an intrinsic capacity to engage in activities, constituting a fundamental anthropological asset for the subject's ability to act in a work environment. These existential traits significantly influence the quality of care and the well-being of the elderly individuals they assist.

II. Theoretical Framework

a) *Epistemological Choice of our Approach*

This study is grounded in the framework of pragmatic anthropology, drawing inspiration from Kant's work (1993) which explores the individuals' actions and their influence on their personal evolution. We investigate how individuals perform their tasks and how they affect their personal development. With this in mind, we will consider the "way of being", *a priori*, abstract according to Cicero[1] yet universally relevant to all human activity. We also incorporate insights from the sociology of work and the clinic of activity to enrich our analysis.

Educational sciences also contribute significantly by providing a conceptual framework, including emphasizing the close links "between education and care" (Honoré, 2003; Di Patrizio, 2020, p. 185). This point of view enriches our reflection on work in nursing homes.

Our theoretical framework focuses on professional status, viewing individuals as employees engaged in the overarching "establishment project" of their employing nursing home.

b) *The Professional*

A professional is defined as "an active being" (Durrive, 2019) whose work generates goods or services. He or she performs "socially useful value-producing tasks" (Vernant, 1996, p. 274), hence deserving a salary.

However, it's crucial to acknowledge that in the professional environment, not all actions necessarily ensure success; they may also lead to mistakes or failures, as pointed out by Malglaive (2005, p. 77)

To reduce the risk of errors, "good practice frameworks" have been established with the aim of improving the quality of care for the elderly in institutions. (Puisieux (Coord.), 2007, p. 4). Nevertheless, it should be recognized, in line with Y. Clot's perspective, that these frameworks can sometimes falsely ensure the professionalization of individuals by artificially rationalizing their performance. Indeed, according to him, the application of these "good practices" is often a response to the difficulties encountered in reality, thus seeking to standardize professional actions (2015).

c) *Knowledge Mobilized for the Activity*

The knowledge necessary for practice in the field of gerontology is clearly defined. To ensure the relevance and effectiveness of their work, professionals mobilize organized and operational knowledge, which Malglaive describes as "knowledge in use" (2005, p. 87-106).

i. *Necessary Unification*

Through engagement in complementary activities, professionals offer a service that must be adapted to the specific needs of an environment where vulnerable people reside. To achieve this, each professional makes operational decisions that are necessary in a given context, requiring the synthesis of the following elements:

- "Theoretical knowledge" which defines the necessary actions based on a framework of fundamental knowledge for any justified practice.
- "Procedural knowledge" which addresses the "how". This adds an analytical dimension that leading to the selection of an appropriate procedure. This is professional intelligence, understanding and connecting specific circumstances to theoretical knowledge.
- "Practical knowledge" concerning the implementation of the action. This contributes to the construction of

[1]*Qualitas* "way of being", quality is a term coined by Cicero, derived from the Greek *ποῖος (poios),qualis* in Latin: "what".

professional experience by associating contingency and operationality.

- A singular "know-how" updating the performed practice.

Thus, it is obvious that good practice frameworks have their limits, because the professional does not enact an action according to a pre-established protocol and directed towards an objective external to their own situation. It is also the responsibility of each professional to commit to mobilizing this knowledge, reflecting a concentrated act of responsibility in their complex activity.

ii. *Knowledge of use and Professionalism*

In professional domains involving human interactions, especially those faced with situations of high dependency, professional action is based on a combination of relationships inherent to the activity itself, without reducing the professional to the simple performance of a utilitarian task. The concept of knowledge in use implies that individuals are not seen as mere instruments for carrying out tasks, but rather as essential participants in the performance of those tasks.

Consequently, what constitutes "good" practice, often perceived as mere adherence to procedural norms, brings forth a practical ethical dilemma regarding the professional's dedication within the work milieu. It prompts reflection on the underlying significance of honed skills, such as reflexivity. Professionality is then defined as the quality of the professional in the activity in which he participates, thus going beyond the simple notion of competence to encompass the pleasure resulting from his commitment to work. (Dejours & Gernet, 2012).

iii. *A Step towards the Notion of Experience*

In this way, the professional continuously develops his competence not only through the acquisition of knowledge and know-how, but also by fully investing his commitment in his work, as emphasized by Clot (2015), integrating it into an experiential learning process. In this way, work acquires a deeper dimension than the mere performance of prescribed tasks, because its achievements also contribute to the fulfillment of existential ends.

Work with and for others then becomes intrinsically linked to the individual, forming a set of experiences that enriches the value of individual and collective action. Consciously or unconsciously, this can generate a "power to act at work", according to P. Roche's concept (2016). This experience is characterized by:

- Reflection – because, according to Dewey (2018), knowledge devoid of thoughtful action remains inert, weighing heavily on the mind.
- Reciprocity – emerging from interpersonal interactions,
- Autonomy – where the acknowledgment of past influences and responsibility for future consequences integrates symbolically and subjectively into the present, echoing Ricœur's insights (1990).

III. Research Methodology

We have chosen a two-phase approach for gathering data. In the first phase, we will establish a descriptive reference system through an ethnographic approach. This descriptive framework will serve as the foundation for the subsequent analysis in the second phase, which will involve two distinct groups of professionals from various institutions. Prior to these exchanges, the researcher will introduce the established analytical framework to assess the relevance of the hypotheses.

a) Use of the Field: an Ethnographic Approach

According to F. Laplantine, without an ethnographic description, anthropology is not feasible (2021, p. 49). Therefore, we adopted this precautionary measure as our starting point before proceeding further. Our aim was to gather diverse situations that highlight dysfunctions within the working environment of professionals in nursing homes. To achieve this, we accessed a directory of emails belonging to healthcare executives in these facilities and randomly selected five to reach out to. We communicated our intention to analyze work scenarios featuring various dysfunctions. Two of them promptly agreed to participate in interviews[2].

At the outset of the non-directive interviews, we instructed the respondents to organize their responses as freely as possible, as outlined by Sauvayre (2021, p. 23). The focus was on description without immediate attempts at explanation or analysis of the identified dysfunctions. The events recounted during these two 45-minute interviews were meticulously recorded and transcribed. Drawing from all available data, we constructed a narrative interweaving "beautiful cases," "thorny cases," and "borderline cases," forming a composite of "typical configurations" as described by Passeron and Revel (2005, p. 12).

The resulting "textbook case" did not emerge from immediate, intuitive insight but rather from mediated, distanced, deferred, and re-evaluated knowledge, as elucidated by Laplantine (*op.cit*., p. 50). This document underwent review by the two healthcare executives interviewed, with their feedback duly incorporated. The final text was validated for its credibility, emphasizing the significance of the dysfunctions identified as pertinent for a "textbook case"

[2] In the end, the 5 people responded favorably to our request. But the 3 later responses were not converted into research interviews.

intended for presentation and reflection among practicing professionals.

b) Presentation of the "Textbook Case"

The subsequent reference text will exclusively incorporate relevant elements essential for analysis, adhering strictly to the structural constraints of a scientific presentation. The focus of the examined scenario revolves around team workflow, commencing with their involvement in the "transmissions" conducted by the preceding team and concluding with the handover of transmissions to the succeeding team at the end of their shift.

i. *Nursing Home Overview*

- Facility housing 63 residents
- Caregiver staff scheduled from 6:30 a.m. to 2 p.m.: 7 caregivers

ii. *Distribution of female professionals across services*[3]

- Ground floor: Sandrine (AS) and Aline (alternate)
- 1st floor: Bénédicte (AS) and Marjorie (AMP)
- 2nd floor: Sophie (AMP) and Valentine (alternate)
- All sectors: Isabelle (IDE)

iii. *Unfolgingevents*

6:45 a.m. Bénédicte phone to explain her "*slight delay of 10 minutes due to her son...* »

In the locker room, the first contencious topic revolves around absenteeism.

Marjorie Remarked: "Well, that is a relief; we will have ample staff today as the manager has substituted for the absent colleagues."
Sophie commented: "What a reinforcement... They're two newcomers who are unfamiliar with the residents or the facility!"
Sandrine: "Let's not discuss individualized care because it'll be rushed this morning!"

In the treatment room, the IDE informs everyone about Bénédicte's slight delay and takes charge of the crucial "transmission" gathering. She provides updates on the morning's significant events, specifically highlighting the various appointments scheduled:

- Mrs. Dumont (1st floor): Scheduled hairdresser appointment on-site at 9 a.m.
- M. Collombier (DRC): Pedicure appointment on-site at 9:30 a.m.
- Mrs. Tartuffe (2nd floor): Physiotherapy session in her room at 8:45 a.m.
- Ms. Michelet (1st floor): Ambulance pick-up at 10:00 a.m.
- Mrs. Tartampion (DRC): Advised not to have breakfast before blood sugar level test this morning.

Three additional categories of situations contribute to the complexity of the work.

1. Adverse events

- Mrs. Cocasse (ground floor) was found on the floor in the toilet of her room with head injury.
- Mr. Lorrain (2nd floor) ripped his protective padding, resulting in significant stool contamination on his body, bed, and bed rails (stool +++ on the body, the bed and the rails).

2. Planned activities for today

- Vegetable peeling workshop at 9:30 a.m.
- Mass at 10:30 a.m.

3. A life project meeting is scheduled at 11:15 a.m. with a resident, the health manager, the psychologist, and the referring caregiver (Marjorie).

At 7:25 a.m., the caregivers arrive at their respective wards.

- Ground floor: Sandrine immediately instructs Aline (substitute) "*Join me for the 8 challenging toilet tasks first... We'll tackle them first since they're the most demanding... After that, things should calm down and relaxed.*"
- 1st floor: Bénédicte and Marjorie start their treatments as usual. Marjorie said to Sandrine before going upstairs, "*I'll lend you a hand on the ground floor as soon as I am able.*"
- 2nd floor: Valentine asks Sophie, "*Could you please advise me on what tasks I can manage alone?*" Sophie provides her with a list of 6 residents who require assistance with toilet tasks at the sink. Then, she goes her own way. Valentine doesn't know exactly which rooms she has to go to do her work.

The manager begins her shift at 8:30 a.m.

- Upon her arrival on the ground floor, Sandrine called out to her: "*Do you believe it's helpful to assign replacements who are unfamiliar with the tasks? I'm doing my best, but please don't expect miracles... I fear I might fall ill too!*" Aline, standing nearby, blushes and appears visibly embarrassed.

iv. *Issues and explanations*

Relief and transmissions commence during the afternoon shift at 1:30 p.m., with both morning and afternoon caregivers present.

Nurse Isabelle expresses her frustration to the executive:

- "*The paramedics were furious with me because Mrs. Michelet wasn't ready for her radiology appointment!*"
- "*The pedicurist waited 15 minutes for Mr. Collombier to arrive, only to scold me about the sorry state of his feet... It's shameful! If the family found out, it would have caused a scandal!*"
- "*We'll see tomorrow about Mr. Tartampion's blood sugar. It's been forgotten for the past two mornings.*

[3] Lists of abbreviations used: AS (nursing assistant), AMP (medical-psychological assistant), IDE (state-certified nurse)

It's baffling that nobody understands he shouldn't have breakfast before I can take his blood test..."

- ""*And isn't it wonderful that Mrs. Larivière was bathed! ... Despite having her hair done yesterday at the salon... The family will surely be pleased to pay the hairstylist for nothing!*"
- "*Let's not forget about Mr. Lafond, who was left behind and missed Mass.*"
- Reactions:
- Sandrine (DRC) retorted angrily, "*In any case, it's impossible to handle everything, especially with Mrs. Cocasse falling this morning! There was blood everywhere… I can't be in two places at once! »*
- The executive intervened, stating firmly"*It is unacceptable not to review and approve the care plans of each resident! »*
- Sophie (2nd floor) responded sarcastically, "*Oh naturally...! As if we don't already struggle to attend to the residents, now we have to find time to review care plans… !!*"

She, then, became irritated, suggesting to the nurse, "*Pehaps I should have left Mr. Lorrain in his room to accompany Mr. Lafond to Mass? »*

- Bénédicte (1st floor) chimed in, "*You should have notified me! I could have assisted some accompaniments on the 2nd and the ground floors...*

c) Analytical framework developed by the researcher

We used the plural realm model of anthropological sociology by L. Boltanski, L. Thévenot and È. Chiapello(Boltanski, L. & Chiapello, E. 2011; Boltanski, L. & Thévenot, L., 1991) as the basis of our analytical framework.

We will retain the division of these common realms for their relevance to aspects of human experience. These divisions will serve as analytical benchmaks to understand whether the "concept of presence at the activity" can be derived from this typology. Nevertheless, However, our aim is to move from an action within multiple realms to an action from multiple realms that constitute the subject. Without intending to narrow the extensive scope of the original model, we describe these realms as follows:

- In the "realm of inspiration", individuals have access to ways of being and acting that foster values such as creativity, authenticity, imagination, and openness- essential for embracing the similar as well as the different.
- In the "domestic realm", individuals conduct themselves according to values of loyalty, propriety and discretion which are ingrained in their habits and define their character (Boltanski, L. & Thévenot, L., *op. cit.*, p. 210).
- In the "realm of opinion", individuals are motivated by self-esteem and measure their worth based on the regard others hold for them. Priorities include fame, glory and recognition.
- In the "civic realm", emphasis is placed on the collective rather than the individual. Personal commitment to collective endeavors defines one's greatness, achieved through surpassing oneself for the common good. Actions initiated within this framework focus on activities contributing to joint projects, rather than merely coexisting with others.
- In the "market realm", individuals showcase their greatness by their ability to acquire goods or services. Values such as self-interest, selfishness, and competition prevail, with individual interests outweighing collective ones.
- In the "industrial realm", efficiency, performance, and functionality reign supreme. However, this pursuit sometimes comes at the cost of dehumanizing individuals, treating them as mere objects (Boltanski, L. & Thévenot, L., op. cit., p. 262). In addition, as V. de Gaulejac highlights it, efforts to resolve contradictions in this realm often overshadow opportunities for collaboration and synergy (2011, p. 304).
- In the "projects-based realm", individuals demonstrate their capacity to form or integrate into networks. Success requires effective communication, trust, adaptability, and compelling presence. As failure to embody these traits may result in exclusion.

d) Facing the "textbook case"

To gain insight into the underlying dynamics of practices and functioning within nursing home environments, a proposal was made to the management of two establishments. The suggestion was to present a "textbook case" for study by professionals over a 90-minute session. Upon validation, this participation was extended to recognized professionals involved in assisting residents with daily tasks, though representation from other professions like doctors, psychologists, occupational therapists, and technical staff was absent. Consequently, two groups, each comprising six employees from various functions, were formed.

Respecting the modalities of the collective interview approach (Haegel, 2005) or "focus group" (Sauvayre, 2021, p. 26-27), the discussions of the 2 groups of professionals were recorded and transcribed with a view to our operation.

Event:

- Groupe 1 (G1) Constitution: 5 women + 1 man (2 ASH, [4]1 AMP, 2 AS, 1 IDE)
- Groupe 2 (G2) Constitution: 5 women + 1 man (2 ASH ff, 2 AS, 1 facilitator and 1 IDE)

Award:

1. Individual reading (duration: about 15 minutes for the 2 groups)
2. We facilitated the explanation the of the plural realms[5] and acted as moderator occasionally prompting participants to contribute or inquire (Duration of the presentation of the realms: nearly 30 minutes (G1) and more than 20 minutes (G2)).
3. We conducted an analysis of the "textbook case", enabling participants to share their reactions to the mornings's events, based on the presented realms. These discussions lasted approximately 40 minutes for G1 and 50 minutes for G2.

IV. Results

a) Reviewing the Thematic Units of Meaning Associated to the Realms

The gathered data underwent empirico-inductive processing to present the findings and comprehend the issues concerning the quality of attendance at the activity.

Our thematic analysis commenced with identifying thematic units (UTs) in which a reference to realms appeared.

The table below illustrates the occurrences for each realm.

Table 1: Occurrences of Thematic Units counted for each word

UT(Realm)	G1	G2
UT_P (projects-based)	3	4
UT_D (domestic)	2	3
UTw(work)	3	3
UT_C (civic)	2	4
UT_M (mercantile)	3	4
UTo(judgment)	4	7
UT_I (inspiration)	3	2
TOTAL UT	20	27

Considering the speaking time allocated to discussions and the number of occurrences of Thematic Units, it becomes evident that the characterization of realms makes sense for professionals since it is used for comprehensive purposes. The *verbatim* excerpts we will utilize in the subsequent analysis demonstrate that the conducted work can be examined from this typology, thereby providing a concrete and anthropological approach to dysfunctions.

b) Qualitative Analysis: The Subject as it is constituted, characterization of plural realms

We will present them below in the order in which they appeared during the exchanges.

i. *The Projects-based Realm*

The "projects-based realm" has been apprehended in a different way from that defined by the authors. For the professionals interviewed, this is the "realm where projects requiring action are carried out" (IDE G1).

The tasks performed by professionals are essential both for healing and caring. Primarily focused on satisfying physiological needs such as "*Grooming*", "*Giving breakfast*", "*Attending to diaper changes, and all related tasks...* (AS G2). These supportive actions are geared towards preserving the residents' autonomy. The statement: "*our job is to do everything for the well-being of the elderly*" (ASH ff G2) s suggests that relational aspects also influence their actions to address diverse needs. Hence, it is imperative that the technical tasks of professionals be executed with a keen focus on the person. These tangible aspects highlight how the activities of professionals significantly shape the life trajectories of nursing home residents, positioning professionals at the forefront of action. This is illustrated by AS G1's reference to Mr. Lafond's situation: "*If a resident wishes to attend Mass, it holds significance for him. It's our responsibility to facilitate it... It's part of the plan. Oops, Sophie!* "

Each one is engaged in a structured set of activities, scheduled at specific moment within this projects-based realm.

The projects-based realm plays a pivotal role in shaping the individual and in justifying the professional in their activity.

ii. *The Domestic Realm*

It includes occurrences in the professional's personal sphere that may persistently preoccupy their thoughts even beyond their home life. In the context of this study. This is exemplified by "Bénédicte's son", who impacts the projects-based realm by even before assuming her position (delay).

No one in the two focus groups points out this aspect in the analysis. Therefore, we posed an open-ended question ourselves: "And what do you think about Bénédicte's delay?" In the G1 an AS responds: "*It can really happen to anyone*" we noted four knowing glances directed towards her. In the G2, the response "*I is still thoughtful to have given a heads-up, not everyone does that*" (AS) received similar approval. And the G2 facilitator asks (himself) without waiting for an answer

[4] ASH stands for hospital services officer, followed by ff which specifies that this agent performs a function as a caregiver without being qualified.

[5] A document was projected onto a board with the following clarifications so that participants could refer to it as needed.
Realm of inspiration: what would be of the order of creativity or openness; domestic realm: what would come from home, from home; realm of judgment: what would concern opinions about people or work; civic realm: what would be in the nature of mutual aid and helping out between colleagues; mercantilerealm: that which would be of selfish interest; realm of work: what would be related to the organization, expectations, institutional objectives; projects-based realm: which would show desires for evolution.

"*So, Bénédicte's son represent the domestic realm, doesn't he?* »

In an era where the concept of quality of life at work emphasizes the importance of better balancing "personal and professional life", the domestic realm, with its shared concerns regarding health, family, personal organization, and other related risks, is collectively the most cherished.

However, can we hypothesize that Bénédicte, potentially unsettled and still concerned about her child's circumstances, might consequently disrupt her participation in the activity and alter her behavior? This question has not been raised, as it would have exceeded the scope of our methodology and its objectives.

iii. *The Realm of Work*

While the project-based realm pertains to the array of required activities and each individual's specific tasks at any given time, the industrial realm encompasses the political, social, organizational, and material framework within which work is conducted.

It constitutes a regulatory component of the nursing home environment where "I" am working. This aspect is referenced during group discussions when it is remarked "*we must not hide our faces, we work so much on a just-in-time basis. Replacements are not helpers if they are not colleagues who take their rest, the squad is full as Marjorie says, but it's not enough, that's clear...*" (IDE G2).

Consequently, the industrial realm can intrude upon the project-based realm. This is what a G1 AS justified by saying that "*the life project meeting, even if it has to be done, should have been postponed, that's for sure!* »

In both groups, it was unanimously suggested to replace the term "industrial realm" with "*realm of work*" because "one does not work in factories, although..." (AMP G1).

iv. *The Civic Realm*

In a complex operation where the pace of actions directly impacts the core of the business, announcements statements like, "*I'll lend you a hand on the ground floor as soon as I am able"* offer reassurance and support to a overwhelmed colleague. However, an ASH ff G2 asks, "*But did actually do it? It's good to speak like that, but if it's not followed through... These nice words are heard everywhere. But sometimes, when you ask for help, colleagues say no! That's even worse!*"

Consequently, the civic realm questions the individual inclination of colleagues to give priority to the collective functioning, as "*in any case, it is for the resident that we do it*", responds the G2 facilitator, citing an example of his involvement in a treatment. An ASH G1 adds, "*I must admit that for me, I don't mind stepping in at short notice, I live right next door. It's convenient.*"

If the civic realm of the subject calls for unity, it's because it enables us to act collectively. "*Mutual support always enhances the situation,*"*remarks* the IDE and an ASH ff from G2. Is the civic realm wisely engaged, or is its omission that limits the positive contribution to the functioning of the collective that serves efficiency in the accompaniment and care provided?

v. *The Mercantile Realm*

An AS G1 asks: "*Doesn't Sandrine's exasperated statement, I'm doing my best, but please don't expect miracles... I fear I might fall ill too!' reflect this sentiment?*"

This intention to do as much as possible reveals, in a sense, a desire to maintain self-respect to ensure personal well-being. The IDE G2 acknowledges: "*For everyone, absenteeism serves a protective measure when the workload becomes overwhelming. We shouldn't let it lead to burnout! I've seen it happen to some colleagues.* Supporting another perspective, this G1 ASH relativizes the previous protective interpretation by declaring: "*What about those colleagues who gossip instead of offering help? Is that self-preservation, or just selfishness?*"

Doesn't this observation shed light on another aspect of the same self-preservation instinct, no longer as a protective measure but rather in its individualistic and self-centered form? Consequently, individual interests may sometimes take precedence over the needs of collective functioning. So, would its mastery promote a commitment to give and receive support in the workplace, thus fostering service in a mutual and more balanced manner?

vi. *The realm of Judgment*

Ideas and opinions regarding certain facts often vary and can even diverge among colleagues, particularly concerning issues related to support and care. While having a variety of viewpoints can contribute to the ongoing improvement of the overall functioning of tasks within projects, it's important to acknowledge that when these opinions turn into judgments of practices or individuals, they can lead to compartmentalization of relationships among professionals, hindering collaborative efforts between both the sender and receiver, who share a common humanity. Opinion becomes problematic when it transforms into judgment.

This concern is precisely highlighted by an AS from G2: "*You know, there aren't many judgments expressed here, but in general, it's the gossip: 'and then she said this,' 'she didn't do it,' 'it's always the same...,' you know... That's the worst!*" The group participants chuckled and confirmed this observation.

Sandrine's comment gains significance when she mentions, in front of an embarrassed colleague, the use of "people who know nothing about it". An ASH G1

remarked: "*That's just the tip of the iceberg.*" Although she doesn't elaborate further, the IDE G1 quickly interjects, specifying: "*You know, ASH often feel belittled by the judgments of caregivers, either because they lack diplomas or when they exceed their roles.*" Another colleague AS G1 adds, "*It's true, I've heard it before, and sometimes they know the residents better than we do. It's also women among themselves...* "

The realm of judgment poses a risk of undermining the individual's engagement in their tasks by fostering a mental disposition that weakens their actions.

vii. *The Realm of Inspiration*

Sandrine's comment "*because it'll be rushed this morning!*" is highlighted in both groups:

- "You know, when I hear that, it makes my hair stand on end. We haven't started yet, and some of them are leaving with these negative ideas... It's not everyday thing, but it still occurs (...). Personally, I tell myself that I wouldn't want to place my parents in a nursing home. That's why I always come in with a positive attitude! It's crucial! (AS Man G1).
- "You can immediately sense the tension... Why is she starting the day like that? Moreover, later, she tells the intern, "*We'll tackle them first since they're the most demanding... After that, things should calm down and relaxed.*' But what example does this set for?" (ASH ff G2).

Does this suggest that, in contrast to these two situations, the realm of inspiration could generate positive energy to invest more in the activity "with enthusiasm" (AS homme G1)?

Could it be an inspiration seeking to give meaning to the practice? Would it trigger an action that verifies how much doing is an anthropological gesture, enabling the subject to construct his or her professional (presence at the activity) identity (power to be)?

c) *Modelling the impact of the constituent realms of the subject on the projects-based realm (cf. Fig. 1)*

Taken together, these findings confirm our hypothesis. Indeed, it seems possible possble to comprehend, in an anthropological sense, the presence of the professional in the activity through the underlying realms that constitute the subject in all his humanity. We have seen that the projects-based realm is central to the constitution of the subject because it encompasses everything that he does at the time he does it, in his participation in the project of support of the nursing home. It specifically pertains to the present moment of an activity and all these moments. The other realms are directly linked to it and are always present, as they are inherent to human existence. Their impact varies depending on what the subject experiences, encounters and, above all, interprets.

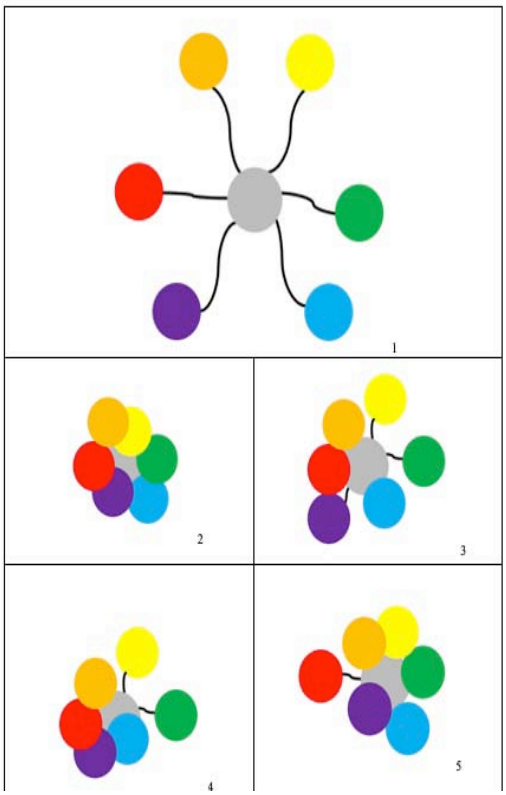

Figure 1: Modelling the impact of realms on projects-based realm

Legend: The 5 diagrams that we propose in Figure 1, depict the seven various realms, each represented by a distinct color. The primary projects-based realm is depicted in grey. Collateral realms are represented as follows: in orange, the realm of work (industrial); in yellow, the domestic realm; in green, the realm of inspiration; in blue, the realm of judgment (opinion); in purple, the mercantile realm and in red, the civic realm.

Figure 1 illustrates the composition of the 7 underlying realms influencing the subject's activity. The central realm projects-based one to which the other 6 are interconnected.

Diagrams 2, 3, 4, 5 represent 4 hypotheses outlining the mental disposition of "presence at activity," based on the anthropological impact of these realms on 4 different subjects at the "moment t" of their participation in the projects-based realm where the power to act is concretized (depicted by remaining gray area). Subject 3 demonstrates a greater capacity for action compared to Subject 5, which surpasses Subject 4, and then Subject 2 in terms of power to act.

The anthropological reality underlying each professional's activity is likely to influence the activity to varying degrees, thus impacting the professional's actions and, consequently, the outcome.

The constituent realms of the subject directly shape their presence in the activity (cf. Fig. 1). Therefore, it is this "presence at the activity" that can either diminish or augment the "power to act," thereby influencing the quality of the activity itself.

V. Interpretation

The model of "acting from several realms" can make sense to professionals who analyze their activities, for two reasons. First, it allows for a "reflexive awareness", and secondly, it declines an anthropological form of "parasitism" of activity.

a) Reflective Awareness

This referential model of "acting from several constitutive realms of the subject" can facilitate "perlaboration, i.e. the possibility for the subject to elaborate, psychically and mentally" (V. de Gaulejac, 2011, p. 309), a logic of action for which he is the primary architect.

The concept of presence in activity does not imply a fixed state, but rather suggests the potential for engaging in a reflective process of awareness. This process enables individuals to enhance their effectiveness in activity by acknowledging the "unnecessary" pregnancy of certain realms and deciding for themselves their relevance in a given moment.

The presence in activity represents the subject's responsibility in the current moment of their action. This process involves two types of self-reading:

- An "*ex*-" interpretation positions the subject with benevolence "outside" of himself, enabling self-observation as an object.
- A "*peri*-" interpretation fosters reflexive awareness "around" the impact of different realms. Recognizing an excessive influence of certain realms might prompt the subject to seek a more balanced engagement.

Reflexive awareness implies transcending the instinctive understanding of reality to engage in critical analysis. By viewing themselves as a comprehensible entity, the subject adopts an epistemological and ultimately ontological stance, enabling them to observe their own anthropological role in their work.

The process of reflection brings a certain lucidity to all professionals, irrespective of their roles, functions, or positions. Does it also uncover the "origin of this 'deliberate' energy that is essential for engaging in the actual work of organizing activity 'in the ground" as described by Y. Clot (2015, p. 177)? The occupational psychologist asserts that "[n]o formal organization of work can replace the employees themselves in this regard, despite what many companies still believe" (*ibid*.).

b) Other Issues

Let's propose three additional extrapolations from the model:

Could it aid in understanding how teamwork is typically perceived, interpreted, and supported in nursing homes? If "working as a team" is a component of the project-based realm, to what extent can the presence of team members at the activity be optimized to ensure that professionals are the most effective partners?

Could it offer management an additional perspective on understanding individuals, both men and women, to facilitate achieving results by guiding professionals through illuminating aspects that may disrupt underlying work that needs to be addressed?

And finally, could this model of "presence at the activity" serve as a resource for each professional to optimize their ability to manage themselves by actively deciding, through voluntary effort, how to navigate the peripheral realms without being consumed by them? Thus, the complexity of agency appears to be linked to achieving a balance upon which subjects possess these knowledges and take action can exert influence.

c) The Ingenium in Action

All movement originates from within the individual, making self-observation crucial. This starting point brings us to the concept of ingenium, described by G. Vico as the intrinsic force that allows for the connection of disparate elements (Grassi & Graziani, 2001). *Ingenium* serves as the active substance of a pragmatic anthropology, enabling self-reflection—an essential aspect emphasized throughout this research.

Therefore, it is essential to underscore, at the conclusion of this research, that workplace well-being is

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intertwined with the individual's ability to self-structure within their tasks. In this regard, isn't being fully engaged in one's activities a means to enhance the precision of one's actions and, consequently, promote better health at work? From this perspective, as individuals experience this mindful approach to work, the focus of workplace quality of life transitions from mere well-being to a deeper concept of "human-being-beauty at work", where self-care and action coexist harmoniously.

VI. Conclusion

J.-P. Vernant highlights in Homer's Odyssey (XIV, 228) the assertion by Ulysses that "To each the activity that suits him" (1996, p. 288). Beyond the hierarchical structure of ancient Greek society, this emphasizes the subject's ability to consciously determine their level of engagement in the work. in which he is employed.

The hermeneutic process of reflexive consciousness leads to a humanization of activity that machines or artificial intelligence cannot replicate. In the workplace, this consciousness manifests in the actions themselves, as well as in recognizing both the other and oneself "in the possibility of finding oneself in what one does" (Clot, 2015, p. 176). Also, from this anthropological perspective, would all gerontology professions be valued in the same way in nursing homes.

Our study focuses on two institutions, and its applicability should be tested more broadly in this sector, which currently faces challenges. Furthermore, its validity should be verified across other professions.

Despite the inherent difficulties of working in nursing homes, it is possible to prevent burnout and maintain a vibrant and empowered professionalism through the experiential practice of presence.

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Perception of the Family Caregiver in Care for Chronic Older Adults after Discharge

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Abstract- *Introduction:* The global trend of population longevity has highlighted the need for studies with advanced age groups. With the significant increase in the number of older adults, it is logical to reason that there will be an increase in demand for health care.

Objective: The study aims to describe, through Bardin's phenomenological analysis, the family's perception of the continuity of care for chronic older adults after discharge.

Method: This study is a descriptive and exploratory field study with a cross-sectional character and a qualitative approach. The study was conducted in a West Zone of São Paulo - Brazil hospital. The study subjects were family members of elderly clients expected to be discharged from the hospital. The data was collected through interviews and analyzed using Bardin's phenomenological analysis, which involves a systematic and rigorous process of categorizing and interpreting the data.

Keywords: *family, assistance, elderly, hospital discharge.*

GJMR-K Classification: *NLMC Code: WT100, WY200*

PERCEPTIONOFTHEFAMILYCAREGIVERINCAREFORCHRONICOLDERADULTSAFTERDISCHARGE

Strictly as per the compliance and regulations of:

Perception of the Family Caregiver in Care for Chronic Older Adults after Discharge

Juliana de Oliveira Musse [α], Cristina Braga [σ], Aloísio Olímpio [ρ], Christian Douradinho [ω], Adriana Paula Jordão Isabella [¥], Alfredo Ribeiro Filho [§], Fabio da Silva Leão [χ] & Monica Chaves [ν]

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Results: During the analysis, it was possible to identify, through the subjects' responses, the daunting task of caring for chronically ill older adults, which is still carried out predominantly by women with some degree of direct kinship with the older adult. The reality of chronic illness changes the family structure, presenting numerous challenges that often go unnoticed. However, the socioeconomic condition of most of the Brazilian population does not allow family members to benefit from a health professional who meets the elderly's care needs.

Discussion: Often, insecurity regarding the care provided, as well as the lack of knowledge about the pathology and its implications, can make caring for this older adulta tough challenge for both the family and the healthcare professional accompanying them. The caregiver's well-being, a crucial factor, directly affects the quality of care for older people.

Final Considerations: A family member who is well-oriented, healthy, and well-supported will guarantee engagement in self-care, adhering to the therapeutic and preventive scheme, so that they reach the best level of health and, consequently, the best possible quality of life.

Keywords: family, assistance, elderly, hospital discharge.

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I. Introduction

The change observed in the Brazilian demographic profile was due to an increased number of older adults. In 2017, the number of older adults surpassed the 30.2 million mark, with projections for 2039, when the country will have more people over 65 than children [1].

It is clear to observe that accompanied by the growth of the elderly population, concerns arise regarding the health issues of the elderly, as the aging process can be responsible for causing changes in the daily life of the elderly, and these changes, added to an unhealthy lifestyle, socioeconomic and educational issues and various related factors to which they are exposed, predispose them to the appearance of common diseases in the elderly population, such as Chronic Non-Communicable Diseases (NCDs). Among these diseases, Arterial Hypertension (silent and fatal if not treated) and Diabetes Mellitus stand out, and their occurrence increases the chance of older adults developing some degree of dependence on Basic Activities of Daily Living - BADL[1,2,3].

Unfortunately, the high prevalence of chronic diseases, influenced by factors such as genetics and lifestyle, significantly compromises the autonomy and independence of older adults. This is particularly true when the aging process is associated with degenerative diseases, such as cardiovascular, musculoskeletal, psychological, and neurological diseases, especially those that affect cognition, such as dementia. When combined with these diseases, the aging process can lead the older adult to present total or partial limitations, compromising the performance of their daily activities.

This is an increasingly common reality in our country, underscoring the urgency and relevance of our research in understanding the family's perception of the continuity of care for these older adults after discharge[2,3].

In the face of the increasing number of older adults with chronic diseases, the role of family caregivers becomes increasingly significant. As the number of older adults with chronic diseases continues to rise, the presence of a family caregiver in the home environment becomes more common. This trend is directly linked to the increase in older adults with some degree of dependence who require constant care. This underscores the importance of our study, which aims to understand the challenges and perceptions of these family caregivers in providing continuity of care for older adults after discharge[4].

However, another problem requires discussion. Over time, the population became aware of the difficulties in raising their children, and the number of children per family decreased. This generated a lower fertility rate and increased life expectancy, making family support for older adults increasingly tricky if they develop any dependence[5, 6, 7.]

Home care aims to improve and recover the client, providing the maximum possible physical and emotional well-being so they can be independent in daily activities. The purpose is to keep the client at home with their family members, aiming for better emotional development as they feel safer with them. To enhance the quality, effectiveness, and maintenance of home care, the involvement of the client and their family (and other in/formal community elements) is necessary based on collaboration and trust [8,9].

Increasing life expectancy does not necessarily mean aging with quality of life. It is associated with frailty due to aging, making the elderly vulnerable to different life and health situations, as the presence of associations of different diseases that generate functional and instrumental incapacities in carrying out activities of daily living is increasingly striking. Among them, diseases such as hypertension, diabetes, osteoporosis, neoplasms, dementia, depression, Parkinson's disease, and Alzheimer's disease stand out, causing impairment of the elderly's functional capacity, which can lead to a situation of incapacity and dependence [10, 11].

The health professional must have adequate knowledge about the magnitude and complexities of the aging process to enable systematized, qualified, and holistic assistance in-home care for frail older adults[12].

The lack of knowledge about how to deal with the elderly often causes their family members to refuse to accept discharge due to fear and difficulties in providing care. The quality of information received by clients and family members, which affects their difficulty in accepting hospital discharge due to misinformation about how to continue care at home, is the major problem reflected in this research [4,13].

Therefore, the study's objective was to describe the family's perception of the continuity of care for chronic older adults after discharge through a phenomenological analysis by Bardin.

II. Method

This is a descriptive and exploratory field study with a cross-sectional character and a qualitative approach using Bardin's content analysis. Data collection was carried out in 2015 in a hospital in the West Zone of the city of São Paulo, with prolonged hospitalizations of geriatric clients, which prioritizes family monitoring during hospitalization. The study subjects were four family members of elderly patients expected to be discharged from the hospital, and they agreed to participate in the study by accepting the informed consent form.

To carry out the study, the authors prepared a questionnaire to collect information from the research subjects. Questionnaires are written instruments designed to gather data from individuals regarding their knowledge. The application of questionnaires allowed total anonymity.

Data were obtained using a questionnaire consisting of two parts as a data collection instrument. The first consisted of questions determining the interviewee's profile, and the second included guiding questions.

The questionnaire comprised six questions to identify the sample's socio demographic profile and two guiding questions.

The selection and inclusion criteria were the voluntary participation of family members of elderly clients expected to be discharged from the hospital.

The family members of the older adult who refused to participate in the research were excluded; moreover, those who did not agree to participate by accepting the ICF were excluded.

There were minimal risks to the participants' health since the questionnaire was guided in a structured way with the freedom to decide whether or not to participate in the study.

On the other hand, this study is expected to contribute subsidies to facilitate the provision of specialized assistance and be an excellent source of information for further studies.

The study was approved under CAE number 40896914.4.0000.5494 in compliance with resolution 466/12 related to the ethical aspects of research with human beings, following the opinion required by the committee.

A phenomenological analysis of the data content was conducted from Bardin's perspective. This analysis refers to content analysis as constantly

improved methodological instruments applied to diverse discourses to characterize the sample. The names of precious stones were used to guarantee the confidentiality of participants.

III. Results

Considering the historical context of the hospital, previously as a space of social exclusion and from the 18th century onwards as a therapeutic and healing setting, the hierarchical and standardized relationships carried out there become compatible with its new characteristics and the spaces duly occupied, considering the position that each one assumes within them[14].

It is believed that when a family member is hospitalized, companions face an environment that is strange to them, with set times, institutional protocols, and people who sometimes inform, manipulate, or omit information about what they should, can, or cannot do. In these circumstances, this family member does not always respect regulatory discipline, creating friction that sometimes results in conflicts in the relationship they establish, especially with the nursing team, which is usually made up of professionals who remain at the hospital uninterruptedly and, therefore, they are those with which the family member interacts the most and has the most access[15,16].

According to the statute of the elderly, the family member can accompany the older adult during their hospitalization. However, the companion does not always act in the way expected by the nursing team, and conflicts may arise in the relationship. In the hospital, the nursing team monitors and watches the accompanying family member, expecting cooperation with the nursing work[17, 18, 19].

It is understood that the family, in any of its established constitutions, when an older adult is hospitalized, becomes a contributor to subsequent treatment care and, therefore, needs support and a clear understanding of their role in the completeness of the treatment to be carried out, before, during, and after hospital intervention[19, 20].

To enable analysis, categories organized the results, characterizing the subjects according to their perceptions and strategies for coping with the phenomenon studied and family participation in the continuity of care for the elderly after discharge.

Regarding the characterization of the interviewees, the following observations were raised.

When characterizing the sample about the socio demographic profile, 100% (4) were female; all respondents reported living in the same residence as the older adult and receiving support from other family members regarding care. In this context, we cannot forget that the condition of longevity is associated with weakening due to aging, making the elderly vulnerable to different life and health situations. In Brazil, it is estimated that 85% of older adults have at least one chronic disease, and of these, at least 10% have overlapping concomitant diseases. The current situation of chronicity and longevity of Brazilians contributes to the increase in older adults with functional limitations, implying the need for constant care. Generally, this care is provided by the family and the community, with the home being the natural socio cultural space. About the family, care falls typically on one of its members, who is called the primary caregiver because he or she is responsible for the care of the elderly. Other family members can assist in complementary activities; hence, they are called secondary caregivers[21, 22]

When asked about marital status, three caregivers reported being single, and only one was married. The respondents ranged from 28 to 41 years old about religion; 50% (2) of the sample declared them selves evangelical, and 50% (2) declared themselves Catholic. Regarding occupation, 50% (2) reported being housewives, 25% (1) sales assistants, and 25% (1) nursing assistants. The degree of kinship of the responding family members was 75% (3) clients' daughters and 25% (1) daughter-in-law.

This is like current literature in which most caregivers are female, mainly wives, daughters, and granddaughters. This fact can be explained by the tradition in the recent past in which women did not perform functions outside the home, justifying their greater availability for family care. However, this reality has been modified by the insertion of women in the job market, often being the sole providers of your home[23, 24, 25].

About the presentation of the guiding questions of this study, the following results can be identified and described:

In Chart 1, we sought to describe the family member's feelings regarding the situation faced where, after reading the collection instruments with the respondents' responses, the following categories were observed: sadness, ingratitude, impotence, difficulty, new stage, as follows:

Chart 1: Reported Attitude of the Family Member Regarding the Functional Situation of the Older Adult. São Paulo, 2015

Identification	Speech	Analysis	Categories
Pearl	"It was unfortunate to see that a mother does everything she can to give a better life to everyone, and when she needs support, no one can help. When she was good and stayed at the stove all day, the house was full of people, children, cousins, nephews; today, if someone needs someone to give them a glass of water, no one will come."	SADNESS: Dejection, consternation. INGRATITUDE: Lack of gratitude.	SADNESS, INGRATITUDE
Amethyst	"Impotence because it is happening to the one I love most."	Impotence: Lack of strength.	IMPOTENCE
Ruby	"Sad and difficult, his sisters live far away, and there is not much communication; they often go years without meeting."	SADNESS: Dejection, consternation., DIFFICULTY: Embarrassment, hindrance, impediment.	SADNESS, DIFFICULTY
Emerald	"A new stage of life for the whole family."	STAGE: Distance between two stopping places on any route.	NEW STEP

Source: Authors, 2015

The activity of caring for a sick and dependent elderly family member at home takes place in the space where a significant part of life is lived, in which knowledge and memory of facts and intimate relationships are essential for both the caregiver and the person being cared for. The care has peculiarities in this environment. They are regulated by subjective and affective relationships built on a familiar and personal history. The care implemented by the family aims to preserve the lives of its members and achieve the full development of their potential according to their possibilities and the conditions of the environment in which they live. To develop your living process, the family generates its care system, in which its knowledge about health and illness is reflected, imbued with values and beliefs that are structured in daily life. In this way, the participation of each of its members, who, based on their own experiences, possibilities, and needs, develop, strengthen, and become more dynamic according to the historical moment they find themselves [23,24, 26].

The question regarding the family member's feelings about the situation the older adult finds themselves in regarding the illness, the sadness category was mentioned in Pérola and Rubí's statements:

"Very sad to see that a mother does everything she can to give a better life to everyone and when she needs support, simply no one can help" (Pérola)

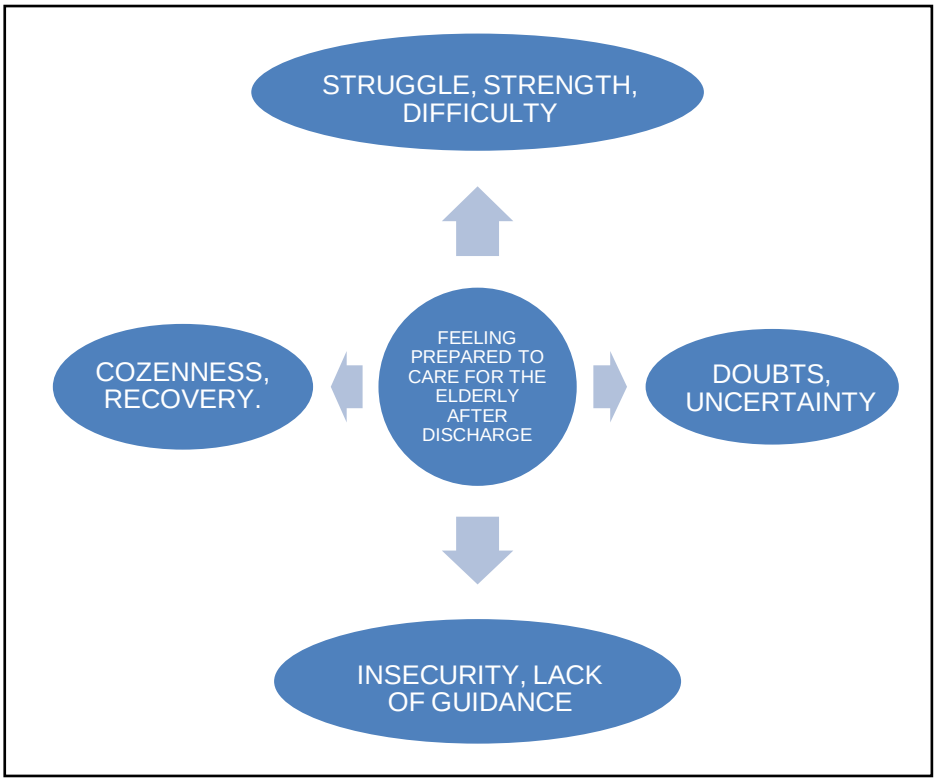
"Sad and difficult, your sisters live far away, and there is not much communication" (Rubi)

They are dealing with the chronic illness of one of its members or any other stressful event that could cause family disruption, such as alcoholism, AIDS, and dementia. These facts can generate tension and worries in the family. It imposes on the caregiver the initiative to develop their intervention plan to face the demands of the individual under their care, which requires the caregiver to adapt to family roles since they may become weakened along the way. The difficulties in providing care with pleasure and without conflict are even more significant when the older adult is highly dependent, with physical and cognitive disabilities. The more the older adult's illness progresses, the greater the physical and financial demand on the caregiver, as they become more vulnerable to illnesses, reducing their ability to care. The very vulnerability of dependent older adults brings about negative feelings such as sadness that can interfere with the dynamics of comprehensive care for these older adults [23 and 24].

Chart 2: Reported Feelings of the Family Member about the Elderly Discharge. São Paulo, 2015

Identification	Speech	Analysis	Categories
Pearl	"I am prepared, but I know the fight will be big; I will have to have much strength, and it will be tough days."	FIGHT: battle.; STRENGTH: Moral energy., DIFFICULTY: Embarrassment, hindrance, impediment.	STRUGGLE, STRENGTH, DIFFICULTY
Amethyst	"No, to various doubts and uncertainties afflict us, such as bathing, care, bandages, what you can eat, what abnormal things we should observe since everything is abnormal now."	DOUBTS: Difficulty making a decision; hesitation; UNCERTAINTY: Hesitation.; ABNORMAL: That deviates from the ideal, the archetype.	DOUBTS, UNCERTAINTY,
Ruby	"No, because I need guidance on her care; I feel very insecure about taking care of her alone, as my son does not have time; he works and studies; I need time to practice care and feel confident; I know it will be difficult."	INSECURITY: Lack of security; GUIDANCE: Direction, guide, rule.	INSECURITY, LACK OF GUIDANCE
Emerald	"Yes. Family comfort, with children and grandchildren, can help a lot in my father's recovery."	COZY: Domestic comfort; comfort, outerwear; RECOVERY: reconquest, restoration.	COZENNESS, RECOVERY.

Source: Authors – São Paulo, 2015



Source: Authors. São Paulo, 2015

Figure 1: Categories were observed when asked, such as "Do you feel prepared to care for the elderly after discharge?"

The condition of chronically ill older adults gives rise to the need for a person who performs the role of caring. This role is generally played by a family member (spouse, daughter, daughters-in-law, or son), with the responsibility of remaining with the closest family member due to kinship, a bond of gratitude, or economic dependence. The family member becomes a fundamental part of maintaining the life and health of the older adult when it will often be the older adult's voice, hands, legs, and feelings whose health condition and independence are hampered by a chronic illness[27].

IV. Discussion

Several reasons contribute to family members becoming responsible for caring for sick,older adults: moral obligation due to cultural and religious aspects; marital status, the fact of being a husband or wife; the absence of other people for the task of caring, in which case the family member assumes this task not by choice, but, generally, due to circumstances; financial difficulties, as in the case of unemployed daughters who care for their parents in exchange for support[28, 29].

Most hospitals adopt a home care policy as an alternative to reduce the risk of opportunistic infections and hospital costs. Chronically ill older adults find their homes the ideal place to stay, where they have the comfort of their family and greater chances of recovery[30, 31].

Families are often caught by surprise and must organize themselves based on the health needs of the older adult[31].

Many of these people do not have proper guidance; they feel insecure, and they have many doubts and uncertainties about this new stage of life where they will take on the role of caregiver; they are unaware of the disease and the problems arising from it. They are unaware of how to treat, combat, prevent, and promote the health of the elderly, and face many difficulties that affect the quality of the relationship between the elderly and their family members, as well as other disorders that affect the family structure, social life, and their emotional state[32].

The older adult's attitude towards their family member can often interfere with their treatment. The family member is influenced by the personality and character of the older adult and the relationship over the years. It was noticed that if the elderly are treated with contempt, they are treated this way; if they are treated with affection, they will also be treated that way. The negative way in which the elderly treat their family member, in a way, can be understood as non-acceptance of the dependent relationship. This occurs mainly in the relationship between spouses when the husband becomes dependent on his wife, who needs to assume full responsibility[31].

Final Considerations: During the analysis, the subjects' responses revealed that the task of caring for chronically ill older adults is still predominantly carried out by women with some degree of direct kinship with the older adult. This task requires emotional and financial resources, time, and dedication and is often a source of overload for a single person who does not have support from other family members.

The reality of chronic illness changes the family structure; however, the socioeconomic condition of most of the Brazilian population does not allow family members to benefit from a health professional who meets the elderly's care needs. Therefore, someone in the family often becomes responsible for the constant care of the chronically ill older adult. Often, insecurity regarding the care provided, as well as a lack of knowledge about the pathology and its implications, can make caring for this older adult a tough challenge for both the family and the healthcare professional accompanying them.

Added to the great demand for time and dedication, it removes the family caregiver from leisure activities, self-care, and contact with friends and relatives. The caregiver's well-being directly affects the quality of care for the elderly. A family member who is well-oriented, healthy, and well-cared for will ensure that basic essential actions are carried out for the dependent older adult.

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Tips for writing a good quality Medical Research Paper

1. Choosing the topic: In most cases, the topic is selected by the interests of the author, but it can also be suggested by the guides. You can have several topics, and then judge which you are most comfortable with. This may be done by asking several questions of yourself, like "Will I be able to carry out a search in this area? Will I find all necessary resources to accomplish the search? Will I be able to find all information in this field area?" If the answer to this type of question is "yes," then you ought to choose that topic. In most cases, you may have to conduct surveys and visit several places. Also, you might have to do a lot of work to find all the rises and falls of the various data on that subject. Sometimes, detailed information plays a vital role, instead of short information. Evaluators are human: The first thing to remember is that evaluators are also human beings. They are not only meant for rejecting a paper. They are here to evaluate your paper. So present your best aspect.

2. Think like evaluators: If you are in confusion or getting demotivated because your paper may not be accepted by the evaluators, then think, and try to evaluate your paper like an evaluator. Try to understand what an evaluator wants in your research paper, and you will automatically have your answer. Make blueprints of paper: The outline is the plan or framework that will help you to arrange your thoughts. It will make your paper logical. But remember that all points of your outline must be related to the topic you have chosen.

3. Ask your guides: If you are having any difficulty with your research, then do not hesitate to share your difficulty with your guide (if you have one). They will surely help you out and resolve your doubts. If you can't clarify what exactly you require for your work, then ask your supervisor to help you with an alternative. He or she might also provide you with a list of essential readings.

4. Use of computer is recommended: As you are doing research in the field of medical research then this point is quite obvious. Use right software: Always use good quality software packages. If you are not capable of judging good software, then you can lose the quality of your paper unknowingly. There are various programs available to help you which you can get through the internet.

5. Use the internet for help: An excellent start for your paper is using Google. It is a wondrous search engine, where you can have your doubts resolved. You may also read some answers for the frequent question of how to write your research paper or find a model research paper. You can download books from the internet. If you have all the required books, place importance on reading, selecting, and analyzing the specified information. Then sketch out your research paper. Use big pictures: You may use encyclopedias like Wikipedia to get pictures with the best resolution. At Global Journals, you should strictly follow here.

6. Bookmarks are useful: When you read any book or magazine, you generally use bookmarks, right? It is a good habit which helps to not lose your continuity. You should always use bookmarks while searching on the internet also, which will make your search easier.

7. Revise what you wrote: When you write anything, always read it, summarize it, and then finalize it.

8. Make every effort: Make every effort to mention what you are going to write in your paper. That means always have a good start. Try to mention everything in the introduction—what is the need for a particular research paper. Polish your work with good writing skills and always give an evaluator what he wants. Make backups: When you are going to do any important thing like making a research paper, you should always have backup copies of it either on your computer or on paper. This protects you from losing any portion of your important data.

9. Produce good diagrams of your own: Always try to include good charts or diagrams in your paper to improve quality. Using several unnecessary diagrams will degrade the quality of your paper by creating a hodgepodge. So always try to include diagrams which were made by you to improve the readability of your paper. Use of direct quotes: When you do research relevant to literature, history, or current affairs, then use of quotes becomes essential, but if the study is relevant to science, use of quotes is not preferable.

10. Use proper verb tense: Use proper verb tenses in your paper. Use past tense to present those events that have happened. Use present tense to indicate events that are going on. Use future tense to indicate events that will happen in the future. Use of wrong tenses will confuse the evaluator. Avoid sentences that are incomplete.

11. Pick a good study spot: Always try to pick a spot for your research which is quiet. Not every spot is good for studying.

12. Know what you know: Always try to know what you know by making objectives, otherwise you will be confused and unable to achieve your target.

13. Use good grammar: Always use good grammar and words that will have a positive impact on the evaluator; use of good vocabulary does not mean using tough words which the evaluator has to find in a dictionary. Do not fragment sentences. Eliminate one-word sentences. Do not ever use a big word when a smaller one would suffice.

Verbs have to be in agreement with their subjects. In a research paper, do not start sentences with conjunctions or finish them with prepositions. When writing formally, it is advisable to never split an infinitive because someone will (wrongly) complain. Avoid clichés like a disease. Always shun irritating alliteration. Use language which is simple and straightforward. Put together a neat summary.

14. Arrangement of information: Each section of the main body should start with an opening sentence, and there should be a changeover at the end of the section. Give only valid and powerful arguments for your topic. You may also maintain your arguments with records.

15. Never start at the last minute: Always allow enough time for research work. Leaving everything to the last minute will degrade your paper and spoil your work.

16. Multitasking in research is not good: Doing several things at the same time is a bad habit in the case of research activity. Research is an area where everything has a particular time slot. Divide your research work into parts, and do a particular part in a particular time slot.

17. Never copy others' work: Never copy others' work and give it your name because if the evaluator has seen it anywhere, you will be in trouble. Take proper rest and food: No matter how many hours you spend on your research activity, if you are not taking care of your health, then all your efforts will have been in vain. For quality research, take proper rest and food.

18. Go to seminars: Attend seminars if the topic is relevant to your research area. Utilize all your resources.

19. Refresh your mind after intervals: Try to give your mind a rest by listening to soft music or sleeping in intervals. This will also improve your memory. Acquire colleagues: Always try to acquire colleagues. No matter how sharp you are, if you acquire colleagues, they can give you ideas which will be helpful to your research.

20. Think technically: Always think technically. If anything happens, search for its reasons, benefits, and demerits. Think and then print: When you go to print your paper, check that tables are not split, headings are not detached from their descriptions, and page sequence is maintained.

21. Adding unnecessary information: Do not add unnecessary information like "I have used MS Excel to draw graphs." Irrelevant and inappropriate material is superfluous. Foreign terminology and phrases are not apropos. One should never take a broad view. Analogy is like feathers on a snake. Use words properly, regardless of how others use them. Remove quotations. Puns are for kids, not grunt readers. Never oversimplify: When adding material to your research paper, never go for oversimplification; this will definitely irritate the evaluator. Be specific. Never use rhythmic redundancies. Contractions shouldn't be used in a research paper. Comparisons are as terrible as clichés. Give up ampersands, abbreviations, and so on. Remove commas that are not necessary. Parenthetical words should be between brackets or commas. Understatement is always the best way to put forward earth-shaking thoughts. Give a detailed literary review.

22. Report concluded results: Use concluded results. From raw data, filter the results, and then conclude your studies based on measurements and observations taken. An appropriate number of decimal places should be used. Parenthetical remarks are prohibited here. Proofread carefully at the final stage. At the end, give an outline to your arguments. Spot perspectives of further study of the subject. Justify your conclusion at the bottom sufficiently, which will probably include examples.

23. Upon conclusion: Once you have concluded your research, the next most important step is to present your findings. Presentation is extremely important as it is the definite medium though which your research is going to be in print for the rest of the crowd. Care should be taken to categorize your thoughts well and present them in a logical and neat manner. A good quality research paper format is essential because it serves to highlight your research paper and bring to light all necessary aspects of your research.

Informal Guidelines of Research Paper Writing

Key points to remember:

- Submit all work in its final form.
- Write your paper in the form which is presented in the guidelines using the template.
- Please note the criteria peer reviewers will use for grading the final paper.

Final points:

One purpose of organizing a research paper is to let people interpret your efforts selectively. The journal requires the following sections, submitted in the order listed, with each section starting on a new page:

The introduction: This will be compiled from reference matter and reflect the design processes or outline of basis that directed you to make a study. As you carry out the process of study, the method and process section will be constructed like that. The results segment will show related statistics in nearly sequential order and direct reviewers to similar intellectual paths throughout the data that you gathered to carry out your study.

The discussion section:

This will provide understanding of the data and projections as to the implications of the results. The use of good quality references throughout the paper will give the effort trustworthiness by representing an alertness to prior workings.

Writing a research paper is not an easy job, no matter how trouble-free the actual research or concept. Practice, excellent preparation, and controlled record-keeping are the only means to make straightforward progression.

General style:

Specific editorial column necessities for compliance of a manuscript will always take over from directions in these general guidelines.

To make a paper clear: Adhere to recommended page limits.

Mistakes to avoid:

- Insertion of a title at the foot of a page with subsequent text on the next page.
- Separating a table, chart, or figure—confine each to a single page.
- Submitting a manuscript with pages out of sequence.
- In every section of your document, use standard writing style, including articles ("a" and "the").
- Keep paying attention to the topic of the paper.
- Use paragraphs to split each significant point (excluding the abstract).
- Align the primary line of each section.
- Present your points in sound order.
- Use present tense to report well-accepted matters.
- Use past tense to describe specific results.
- Do not use familiar wording; don't address the reviewer directly. Don't use slang or superlatives.
- Avoid use of extra pictures—include only those figures essential to presenting results.

Title page:

Choose a revealing title. It should be short and include the name(s) and address(es) of all authors. It should not have acronyms or abbreviations or exceed two printed lines.

Abstract: This summary should be two hundred words or less. It should clearly and briefly explain the key findings reported in the manuscript and must have precise statistics. It should not have acronyms or abbreviations. It should be logical in itself. Do not cite references at this point.

An abstract is a brief, distinct paragraph summary of finished work or work in development. In a minute or less, a reviewer can be taught the foundation behind the study, common approaches to the problem, relevant results, and significant conclusions or new questions.

Write your summary when your paper is completed because how can you write the summary of anything which is not yet written? Wealth of terminology is very essential in abstract. Use comprehensive sentences, and do not sacrifice readability for brevity; you can maintain it succinctly by phrasing sentences so that they provide more than a lone rationale. The author can at this moment go straight to shortening the outcome. Sum up the study with the subsequent elements in any summary. Try to limit the initial two items to no more than one line each.

Reason for writing the article—theory, overall issue, purpose.

- Fundamental goal.
- To-the-point depiction of the research.
- Consequences, including definite statistics—if the consequences are quantitative in nature, account for this; results of any numerical analysis should be reported. Significant conclusions or questions that emerge from the research.

Approach:

- Single section and succinct.
- An outline of the job done is always written in past tense.
- Concentrate on shortening results—limit background information to a verdict or two.
- Exact spelling, clarity of sentences and phrases, and appropriate reporting of quantities (proper units, important statistics) are just as significant in an abstract as they are anywhere else.

Introduction:

The introduction should "introduce" the manuscript. The reviewer should be presented with sufficient background information to be capable of comprehending and calculating the purpose of your study without having to refer to other works. The basis for the study should be offered. Give the most important references, but avoid making a comprehensive appraisal of the topic. Describe the problem visibly. If the problem is not acknowledged in a logical, reasonable way, the reviewer will give no attention to your results. Speak in common terms about techniques used to explain the problem, if needed, but do not present any particulars about the protocols here.

The following approach can create a valuable beginning:

- Explain the value (significance) of the study.
- Defend the model—why did you employ this particular system or method? What is its compensation? Remark upon its appropriateness from an abstract point of view as well as pointing out sensible reasons for using it.
- Present a justification. State your particular theory(-ies) or aim(s), and describe the logic that led you to choose them.
- Briefly explain the study's tentative purpose and how it meets the declared objectives.

Approach:

Use past tense except for when referring to recognized facts. After all, the manuscript will be submitted after the entire job is done. Sort out your thoughts; manufacture one key point for every section. If you make the four points listed above, you will need at least four paragraphs. Present surrounding information only when it is necessary to support a situation. The reviewer does not desire to read everything you know about a topic. Shape the theory specifically—do not take a broad view.

As always, give awareness to spelling, simplicity, and correctness of sentences and phrases.

Procedures (methods and materials):

This part is supposed to be the easiest to carve if you have good skills. A soundly written procedures segment allows a capable scientist to replicate your results. Present precise information about your supplies. The suppliers and clarity of reagents can be helpful bits of information. Present methods in sequential order, but linked methodologies can be grouped as a segment. Be concise when relating the protocols. Attempt to give the least amount of information that would permit another capable scientist to replicate your outcome, but be cautious that vital information is integrated. The use of subheadings is suggested and ought to be synchronized with the results section.

When a technique is used that has been well-described in another section, mention the specific item describing the way, but draw the basic principle while stating the situation. The purpose is to show all particular resources and broad procedures so that another person may use some or all of the methods in one more study or referee the scientific value of your work. It is not to be a step-by-step report of the whole thing you did, nor is a methods section a set of orders.

Materials:

Materials may be reported in part of a section or else they may be recognized along with your measures.

Methods:

- Report the method and not the particulars of each process that engaged the same methodology.
- Describe the method entirely.
- To be succinct, present methods under headings dedicated to specific dealings or groups of measures.
- Simplify—detail how procedures were completed, not how they were performed on a particular day.
- If well-known procedures were used, account for the procedure by name, possibly with a reference, and that's all.

Approach:

It is embarrassing to use vigorous voice when documenting methods without using first person, which would focus the reviewer's interest on the researcher rather than the job. As a result, when writing up the methods, most authors use third person passive voice.

Use standard style in this and every other part of the paper—avoid familiar lists, and use full sentences.

What to keep away from:

- Resources and methods are not a set of information.
- Skip all descriptive information and surroundings—save it for the argument.
- Leave out information that is immaterial to a third party.

Results:

The principle of a results segment is to present and demonstrate your conclusion. Create this part as entirely objective details of the outcome, and save all understanding for the discussion.

The page length of this segment is set by the sum and types of data to be reported. Use statistics and tables, if suitable, to present consequences most efficiently.

You must clearly differentiate material which would usually be incorporated in a study editorial from any unprocessed data or additional appendix matter that would not be available. In fact, such matters should not be submitted at all except if requested by the instructor.

Content:

- Sum up your conclusions in text and demonstrate them, if suitable, with figures and tables.
- In the manuscript, explain each of your consequences, and point the reader to remarks that are most appropriate.
- Present a background, such as by describing the question that was addressed by creation of an exacting study.
- Explain results of control experiments and give remarks that are not accessible in a prescribed figure or table, if appropriate.
- Examine your data, then prepare the analyzed (transformed) data in the form of a figure (graph), table, or manuscript.

What to stay away from:

- Do not discuss or infer your outcome, report surrounding information, or try to explain anything.
- Do not include raw data or intermediate calculations in a research manuscript.
- Do not present similar data more than once.
- A manuscript should complement any figures or tables, not duplicate information.
- Never confuse figures with tables—there is a difference.

Approach:

As always, use past tense when you submit your results, and put the whole thing in a reasonable order.

Put figures and tables, appropriately numbered, in order at the end of the report.

If you desire, you may place your figures and tables properly within the text of your results section.

Figures and tables:

If you put figures and tables at the end of some details, make certain that they are visibly distinguished from any attached appendix materials, such as raw facts. Whatever the position, each table must be titled, numbered one after the other, and include a heading. All figures and tables must be divided from the text.

Discussion:

The discussion is expected to be the trickiest segment to write. A lot of papers submitted to the journal are discarded based on problems with the discussion. There is no rule for how long an argument should be.

Position your understanding of the outcome visibly to lead the reviewer through your conclusions, and then finish the paper with a summing up of the implications of the study. The purpose here is to offer an understanding of your results and support all of your conclusions, using facts from your research and generally accepted information, if suitable. The implication of results should be fully described.

Infer your data in the conversation in suitable depth. This means that when you clarify an observable fact, you must explain mechanisms that may account for the observation. If your results vary from your prospect, make clear why that may have happened. If your results agree, then explain the theory that the proof supported. It is never suitable to just state that the data approved the prospect, and let it drop at that. Make a decision as to whether each premise is supported or discarded or if you cannot make a conclusion with assurance. Do not just dismiss a study or part of a study as "uncertain."

Research papers are not acknowledged if the work is imperfect. Draw what conclusions you can based upon the results that you have, and take care of the study as a finished work.

- You may propose future guidelines, such as how an experiment might be personalized to accomplish a new idea.
- Give details of all of your remarks as much as possible, focusing on mechanisms.
- Make a decision as to whether the tentative design sufficiently addressed the theory and whether or not it was correctly restricted. Try to present substitute explanations if they are sensible alternatives.
- One piece of research will not counter an overall question, so maintain the large picture in mind. Where do you go next? The best studies unlock new avenues of study. What questions remain?
- Recommendations for detailed papers will offer supplementary suggestions.

Approach:

When you refer to information, differentiate data generated by your own studies from other available information. Present work done by specific persons (including you) in past tense.

Describe generally acknowledged facts and main beliefs in present tense.

The Administration Rules

Administration Rules to Be Strictly Followed before Submitting Your Research Paper to Global Journals Inc.

Please read the following rules and regulations carefully before submitting your research paper to Global Journals Inc. to avoid rejection.

Segment draft and final research paper: You have to strictly follow the template of a research paper, failing which your paper may get rejected. You are expected to write each part of the paper wholly on your own. The peer reviewers need to identify your own perspective of the concepts in your own terms. Please do not extract straight from any other source, and do not rephrase someone else's analysis. Do not allow anyone else to proofread your manuscript.

Written material: You may discuss this with your guides and key sources. Do not copy anyone else's paper, even if this is only imitation, otherwise it will be rejected on the grounds of plagiarism, which is illegal. Various methods to avoid plagiarism are strictly applied by us to every paper, and, if found guilty, you may be blacklisted, which could affect your career adversely. To guard yourself and others from possible illegal use, please do not permit anyone to use or even read your paper and file.

Criterion for Grading a Research Paper (Compilation) by Global Journals

Please note that following table is only a Grading of "Paper Compilation" and not on "Performed/Stated Research" whose grading solely depends on Individual Assigned Peer Reviewer and Editorial Board Member. These can be available only on request and after decision of Paper. This report will be the property of Global Journals.

Topics	Grades		
	A-B	**C-D**	**E-F**
Abstract	Clear and concise with appropriate content, Correct format. 200 words or below	Unclear summary and no specific data, Incorrect form Above 200 words	No specific data with ambiguous information Above 250 words
Introduction	Containing all background details with clear goal and appropriate details, flow specification, no grammar and spelling mistake, well organized sentence and paragraph, reference cited	Unclear and confusing data, appropriate format, grammar and spelling errors with unorganized matter	Out of place depth and content, hazy format
Methods and Procedures	Clear and to the point with well arranged paragraph, precision and accuracy of facts and figures, well organized subheads	Difficult to comprehend with embarrassed text, too much explanation but completed	Incorrect and unorganized structure with hazy meaning
Result	Well organized, Clear and specific, Correct units with precision, correct data, well structuring of paragraph, no grammar and spelling mistake	Complete and embarrassed text, difficult to comprehend	Irregular format with wrong facts and figures
Discussion	Well organized, meaningful specification, sound conclusion, logical and concise explanation, highly structured paragraph reference cited	Wordy, unclear conclusion, spurious	Conclusion is not cited, unorganized, difficult to comprehend
References	Complete and correct format, well organized	Beside the point, Incomplete	Wrong format and structuring

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