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RESEARCH

Doenças crônicas não transmissíveis em idosos: saberes e ações de agentes comunitários de saúde

Diseases chronicles do not encephalopathies in the elderly: knowledges and actions from community health agents

Enfermedades crónicas no transmisibles en los ancianos: saberes y acciones de agentes de salud de la comunidad

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ABSTRACT

Objective: To analyze the knowledge and actions performed by Community Health Agents (CHA), related to chronic non-communicable diseases (CNCDs) in elderly patients. **Method:** Qualitative and descriptive research. The data collection occurred through interviews with 20 ACS. The information was analyzed following the steps of content analysis. **Results:** The data converged for the construction of two categories. One is about knowledge for CHA performance, and the other the educative actions performed by CHA with the elderly population. **Final considerations:** They were identified limitations in the knowledge and actions developed by CHA regarding the CNCD in elderly, restricting the care concerning diseases such as diabetes and hypertension. This condition reflects in the work of these professionals, but it can be modified with educational actions intended to CHA, for which they can qualify their practices along with the elderly population.**Descriptors:** Aged, Chronic disease, Community health workers, Health promotion.

RESUMO

Objetivo: Analisar os saberes e as ações realizados por Agentes Comunitários de Saúde (ACS) relativos às Doenças Crônicas Não-Transmissíveis (DCNT) em idosos. **Método:** Pesquisa qualitativa e descritiva. A coleta dos dados ocorreu por meio de entrevista junto a 20 ACS. As informações foram analisadas seguindo os passos da análise de conteúdo. **Resultados:** Os dados convergiram para a construção de duas categorias. Uma versa acerca do saber para a atuação dos ACS e a outra, as ações educativas executadas pelos ACS junto à população idosa. **Considerações finais:** Identificam-se limitações no saber e nas ações desenvolvidas pelos ACS referentes às DCNT em idosos, restringindo o cuidado para doenças como diabetes e hipertensão. Esta condição reflete no trabalho destes profissionais, mas pode ser modificada com ações educativas destinadas aos ACS, para que estes possam qualificar suas práticas junto à população idosa. **Descritores:** Idoso, Doença Crônica, Agentes Comunitários de Saúde, Promoção da Saúde.

RESUMEN

Objetivo: Analizar los saberes y las acciones de los agentes comunitarios de salud (ACS), relacionados con las enfermedades crónicas no transmisibles (ECNT) en ancianos. **Métodos:** Estudio cualitativo y descriptivo. La recogida de datos se produjo a través de entrevistas con 20 ACS. Las informaciones se analizaron siguiendo los pasos de análisis de contenido. **Resultados:** Los datos convergieron para la construcción de dos categorías. Una versa sobre el conocimiento para el trabajo de los ACS, y otra, las acciones educativas realizadas por ACS con la población anciana. **Consideraciones finales:** Identificarse las limitaciones en el conocimiento y acciones desarrolladas por ACS en relación con las ECNT en ancianos, la restricción de la atención de enfermedades como diabetes e hipertensión. Esta condición está reflejada en el trabajo de estos profesionales, pero se puede modificar con acciones educativas destinadas a los ACS, para que califiquen sus prácticas a lo largo de la población anciana.**Descriptores:** Anciano, Enfermedad crónica, Agentes comunitarios de salud, Promoción de la salud.

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INTRODUCTION

The elderly population grows, in recent decades, both in developed countries as in developing ones, as is the case of Brazil, is a result of the increase in life expectancy of the population, as a result of the decrease in mortality rates and birthrates. In addition, improvement in the quality of care offered by the health services. Data from the National Survey by Household Sample (NSHS), show that between 2001 and 2011 the number of senior citizens of 60 years or older grew from 15,5 million to 23,5 million people. In the population age structure, in percentages, this group increased from 9,0% to 12,1% in the period. Already, the group formed by 80 years or more with gerontes of age reached 1,7% of the population in 2011, which corresponded to about three million individuals.[1]

Allied to this information, it is evidenced that the contingent of elderly presents diversified demands of care and services, due to the peculiarities of organic and psychological aging and, also, the set of diseases that preferentially affect this age group. In this scenario, it is observed that in old age the Chronic Non-Communicable Diseases (CNCD) have higher incidence.

The CNCD morbidities are defined as long clinical course, irreversible and are commonly associated with organic natural fragility of individuals, affecting primarily the elderly. The action plan of the Ministry of health points out that among the most prevalent CNCD are circulatory diseases (arterial hypertension, heart failure), endocrine (diabetes mellitus), respiratory and cancer. These are linked to some social factors that contribute to its development, such as social inequality, differences in access to goods and services, inequality in access to health information, low schooling, and the modifiable environmental risk factors such as smoking, alcohol abuse, lack of exercise, inadequate nutrition and obesity. Thus, the non-communicable chronic morbidities related to the advance of years, added to the social factors that contribute to its development, constitute, for Brazil, the health problem of greater magnitude.[2]

The Ministry of health provides for actions that are essential to monitor the mortality rate by CNCD, enabling teams of health workers, by promoting actions and strategies of prevention, promotion and assistance with definition of indicators, for monitoring and appropriate procedures to regional and local realities.[2] Also, there was the creation of specific programmes to meet this demand as: physical activitywith the popular Academy; tobacco control; healthy eating and expansion of primary health care. Such interventions comprise about 60% of the Brazilian population, with teams working in territory defined by performing actions of promotion, health surveillance, prevention, assistance and longitudinal tracking of users. These programs are essential to the efficaciousness of the monitoring and treatment of users with CNCD.[2]

The Family Health Strategy (FHS), assistencial model created by the Ministry of health to restructure the basic attention and the Sistema Único de Saúde (SUS), constitutes a positive proposal for the individual and collective service of users, its delimited territories for health promotion and prevention of diseases. As for the chronic non-communicable diseases, the FHS aims to meet fully the population, according to the peculiar demands of the main diseases and subsequent Comorbidities that also tend to appear or that accompany the elderly population. From the analysis of each territory, it is necessary to drill down on the CNCD, because these Comorbidities have resulted in high rates of illness and death due to take months or even years to manifest, often because they are neglected by elderly patients, contributing to the difficulty of treatment adherence and change in daily routine.[2]

Thus, from the family health Strategy has required the qualified training and interdisciplinary of multidisciplinary team to meet horizontal and integral manner the needs of the community. Among the professionals who make up the team of FHS are the doctor, nurse, dentist, technician of nursing and community health agent (ACS). The ACS is characterized as the nexus of population approach to health services. Even still, there are disagreements about their specific role, depending on the diversity of demanding characteristics of a community and the necessary intervention by the ACS, this worker constitutes a professional multi-faceted features.[3]

From one of the principles for a person to become an ACS is reside within your community. This feature allows this professional to understand the peculiarities of your area of practice from the inseparable relations it maintains with people, making it possible to bring health services to diverse local needs. With the different demands of the community is notorious the need continues for knowledge update this FHS worker strengthen their practices with the community care.[4]

Among some of the specific duties of the ACS stands out: working with micro areas (assignment of families in defined geographic basis), registering people in your micro area and keep it current, guiding families regarding the use of health services, follow through home visiting families and individuals under their responsibility, develop activities to promote health, prevent disease and injury, health surveillance through home visits, conduct individual and group educational activities in the home and in the community, maintain multidisciplinary staff informed, particularly about risk situations.[5]

Also, fit guidance measures of healthy habits about nutrition, physical exercises, practices reduction/withdrawal of drugs that maleficiam the health of the human being. In addition, guidance on the scheduling and query routines in basic health Unit, active search of defaulting users diagnosed with any illness, regularity and adherence to the use of medicines, in order to benefit from a healthy ageing, allowing the elderly to minimize the effects of age and the harms resulting from an CNCD.[3]

The CNCD can reach any age group, but affect mainly the elderly and are associated with other diseases such as: chronic kidney disease, rheumatic diseases and mental illness, by having diminished metabolic functions, motor capacity reduction compounded by advancing age and social habits resistant to changes, contributing to the decline in the quality of health.[2]

Thus, the ACS detect, guide and support users for better care, becoming indispensable to map and identify with the health team what are the most common chronic diseases in the individual/family/community, so that the team can offer strategies and adopt practical approaches,[5] in order to qualify the attention and, consequently, to increase the membership of the elderly person to treatment.

From the legal duties of the ACS, it is important your training by means of permanent education in health, commonly held by the nurse, which may have an impact in the community in a positive way. Specifically in relation to CNCD, from the information shared and learned, the ACS is able to socialise the guidelines for users, especially the elderly, so that they develop actions of self-care and perform changes in life habits, since it is these guys who have high prevalence of such diseases.

The ACS as part of FHS and as its main mediator between the people and the team, need to be prepared to work with the community, whether in the visits, in the guidelines or fills of registers. In this scenario, identifies that this professional requires constant updating. Permanent education must be understood as the set of educational practices designed to promote professional development opportunities in order to help you operate more effectively and efficiently in your daily work.

Considering what has been here said, this study is to survey question: what are the knowledge and actions developed by ACS regarding non-communicable chronic diseases in the elderly? Centered on this issue is the purpose: analyze the knowledge and the actions carried out by ACS concerning CNCD in the elderly.

METHOD

Qualitative, descriptive research with field study, conducted in a municipality in the State of Rio Grande do Sul, which has a population, according to Census of IBGE,[6] of 34.225 inhabitants and, of these, 3.589 (10,49%) has 60 years or older.

The production of the data occurred in the period from June to August 2013. Participants were community health Agents, linked to Basic Health Units (BHU) of the municipality, with the family health strategy. All UBS were part of the study and they located research participants. What stands out in the city, at the time of collection of the information, there were a total of 24 operating ACS. Of these, two were in health, a license did not attend for interview for the dates, times and locations are scheduled and a non accepted to participate in the study. The criteria for inclusion of collaborators in the study were: to be Community Health Agent and be linked to an FHS. As a means of obtaining the information was used the semi-structured interview, with previously prepared script, containing identification issues and question balizadora on the topic: what actions and guidelines related to chronic non-communicable diseases (CNCD) in the elderly that you develop?

Following these procedures, ACS 20 were interviewed, 19 female and a male, ranging in age from 24 to 51 years of age. In relation to marital status, 13 are married, five singles, a separated and divorced. With regard to schooling, 14 have graduated from high school, three have undergraduate degree completed and three are attending graduate school. The average income is of a minimum wage and means and time of performance in this role ranges from six months to 12 years.

As for the average number of families served by ACS is 180, with a variation of 133 to 265 families. In relation to the number of elderly serviced by ACS, it turns out that the average is 64 elderly by professional, with 25 surge to 130 by geographical area of coverage.

Possession of subjective information, these were organized and analyzed following the precepts of content analysis,[7] which consisted of three steps: Pre-analysis, which was organized and systematized is the initial ideas; material exploration, which took place in the encoding; treatment results of the inference, and interpretation in which the results were treated to be valid and meaningful. In summary, the analysis identified the critical elements, grouped and categorized the reports as relevant to the search.

The research was conducted noting the willing Resolution 196/96 of the National Health Council ethical.[8] For this, the project was approved by the Ethics Committee in Research of the Federal University of Santa Maria, on the advice embodied nº 329.255/2013. To guarantee the anonymity the individuals were nominated by the initials ACS, followed by a number, not necessarily the order in which the interviews were conducted.

RESULTS AND DISCUSSION

From the reading and analysis of grouped information the same for convergence of ideas resulting in two categories: the first focuses on permanent education as the basis for the performance of the ACS and the second discusses the educational activities carried out by ACS along with the elderly population.

Permanent education is the basis for the performance of the ACS

With respect to the qualification of professionals working in the area of human aging, notes that, among the ACS interviewed, one of them is conducting refresher course in the area of Gerontology and all of them have already participated in courses and/or events with the approach area of human aging. One of the respondents, when asked about the knowledge that has to work with the elderly, acknowledges that presents limitations, although it has the nursing technical course. Also understands that there is a need to update

courses to qualify your work along to the population, in particular, that formed by the elderly.

> *I think that there's still quite a lot. My knowledge, not so much from the health agent, I have a little knowledge because I had the nursing technician, then there we have studied a little about the elderly. But I think as a health agent, we should have a lot more improvement to work with this type of patients, to better inform patients (ACS 1).*

Other research members mention that should receive more guidance and participate in discussions, to elucidate doubts that occur in everyday work. Cite as examples, the elderly make use of multiple medications and often seek the ACS for clarification about how to use. Facing an uncertainty the ACS seek clarification with the other professionals of the health team, especially to the nurse.

> *I think it's little, we could have a lot more guidance. Because you're always updating and for us it is not passed on everything. Every month for example. Had to be every week actually, at the meetings, have something for us to clarify something [...]. The elderly are lost too much on medication, they have many meds to take. Thing that people looking at the recipe, you can steer. But if there's anything I can't I come asking for the nurse (*ACS 3*).*

It is clear, in the speech of some ACS, the need to keep updating of knowledge, in order to promote the efficaciousness of the work. These same professionals indicate the mode and to address if there was permanent education, contemplating this contingent of workers.

> *Lack more guidance for us to improve a little. For example, let a day just to get the questions or raise an issue to bring to the people-oriented. Never been opened for us. It was opened, but was never completed. For example, once a month giving a lecture to us. We watch the lectures and learn a lot (*ACS 3*).*
>
> *Is little, because training, until now we did not have. Training on chronic diseases we haven't had (ACS 20).*
>
> *The important thing is you can address the family, stop, listen to family talk between her and you see what the family needs. But often, for this you have to know and stay all morning so I can see everything, so you can see the food (ACS 9).*

The ACS has the role of encouraging the family to participate actively in the promotion of health and prevention of diseases. To do so, S ACS needs to be prepared to guide users about their own health and care, too, with the health of the community, whether constituting in an educational subject, producing knowledge, motivating reflection and critical analysis capabilities, including the daily practice as one of the determinants of their learning in the pursuit of solving problems in the community.[9]

It turns out, also, that the trader is willing to broaden his knowledge in order to offer a qualified care. It should be noted that the provision of education through courses, seminars or discussion constitutes wheel on the most appropriate means for updating. When

that doesn't happen, some of the ACS tend to seek clarification in other sources of information such as the internet, these sources, which sometimes can be unreliable.

> *We never have enough information to pass. We are always open to have more information (ACS 9).*
>
> *So the level of knowledge which I think is an understatement. Have more because we are seeking on the internet (ACS 20).*
>
> *I believe from zero to 10, I'm in 7. Because if I can't here the answer, I'm going on the internet and looking for the answer. Then I try to do the knowledge. I think the information could be more, the city could work more, give more support (ACS 6).*

The continuous updating of knowledge for health care workers by means of permanent education is important since the changes about the knowledge and practices occur very quickly. The phenomenon of globalisation allied with the rapidity of changes taking place in the world and education enables individuals to have greater participation in modern societies. Thus, the global transformations require continuous updating of knowledge. Thus, the permanent education is master spring, allowing the individual to understand what occurs in society and widen your worldview. When it comes to health professionals, permanent training associates itself with the work process, with the purpose of transforming the daily practice.[9]

It is worth noting that the ACS report that, based on the knowledge we possess, carry out general guidelines concerning CNCD, especially diabetes and hypertension, and in situations that require information, seek in other professionals of the health team support necessary to carry out their tasks.

> *We don't know everything because they are limited our guidelines. What we don't know, guide, we pass to the nurse. Something we pick up the phone, call the nurse. All supervised, even because we cannot steer a person on our own. For sure, but the doctor said, was a nurse (ACS 14).*
>
> *The guides us something about the knowledge we have. More we listen. Guides come in the unit, talk to the nurse, the doctor. Something about diabetes, about diet, hypertension. To take care of food. These basic things we talk with them (ACS 15).*

Study on training of communitarian agents of health points out that this professional has basic responsibilities to the community, such as: Locate and identify signals and situations of risk, provide guidance to families and to the community and make referrals to the team of cases and identified situations that require monitoring. Are considered simple actions, but can result in changes in the lives of families assisted.[10]

In this sense, it is observed that some ACS meet part of the activities that are under their responsibility. However, your job could be more Resolutive case possessed knowledge and mastery of all the actions that are envisaged for the exercise of their function.

> *We pass what you know and what the nurse guides and tries to talk as simple as possible. Guide on food, the basic things (ACS 19).*

> *Just the basics. Very technical, to go deeper, don't have. Here we have the Group of hypertensive and diabetic, which happens once a month which also helps a lot, them and us, because we end up participating (ACS 4).*

Study on the new skills of health workers in relation to the population aging of Brazil points out that professionals need to act in the perspective of prevention and comprehensive care, including the factors that interfere with the stability between the individual and the environment, promoting health in the broadest sense. Thus, it is the responsibility of health professionals, to observe the change in the community context and offer specialized care to the elderly, including the actions of self-care, early identification of aggravation of health and offer rehabilitation to keep in community conviviality gerontes.[11]

When asked about the number of elderly, the ACS reported that the number had any chronic disease non-transferable, was an average of 58 elderly. In addition, mentioned how prevalent diseases in this population, diabetes and hypertension. Small proportion of respondents reported the presence of chronic obstructive pulmonary disease (COPD), asthma, bronchitis, arthritis and arthrosis, osteoporosis and heart diseases. The others were not mentioned in the CNCD lines of ACS.

Some ACS respondents are limited as to the theoretical knowledge about the chronic non-communicable diseases, although they know set, for the most part, the concept of diabetes and hypertension. Few ACS expressed have theoretical knowledge of other diseases, such as cancer, asthma, bronchitis, DPOC, arthritis and arthrosis, osteoporosis or heart failure that also commonly, affect the elderly. Identifies, in this study, respondents make guidelines on care targeted to hypertension and diabetes, demonstrating limitation of knowledge.

> *But in this case, high blood pressure, are the high levels of pressure rise, and diabetes is glucose which rises too. That usually they are already aware, very difficult they ask for us. Us seeks more Orient more on feed, especially diabetics, because many times they get lost (ACS 1).*

> *Take care of food, can not eat lots of pasta, bread, sugar, sweetener use. And high blood pressure too, is a change that has to take care in salt, fat. They think so, it took a while, pressure regulated and can stop the medication. They stop by account. We explained that once hypertension, hypertensive forever (ACS 4).*

> *In fact lack enough knowledge about the disease. It's a matter that will be developed over time for people to understand a lot about the disease and have knowledge in time to identify (ACS 15).*

In summary, it can be affirmed that the ACS has a series of assignments, fulfilling part of them, for which it has knowledge and mastery, and whenever I need to seek support from other members of the health team. Reinforce that have major limitations when it comes to watch the population formed by the elderly, including care of health promotion and prevention of diseases of the CNCD.

Highlights that the ACS report that one of the ways in which improved their knowledge, to work with the elderly population, is by means of education and extension actions developed by scholars of the undergraduate program in nursing in partnership with the Municipal Health Secretariat. These activities have provided theoretical learning and that, as a result, were able to exercise them in professional practice.

Educational activities carried out by ACS along with the elderly population

Health education actions performed with the ACS allow themselves to become skilled professionals, to develop his role by the population assigned to their service area. In this scenario, the activities of promotion of health and prevention of diseases, through guidance and clarification, in particular among the elderly, allow these to be active subjects in the control of their health conditions. Thus, the courses offered to ACS contribute to improve the quality of home visits, become valued by the community and cooperates to the legitimacy of their profession. This is because they have greater theoretical basis in the execution of their professional practices, resulting in greater credibility and adherence to preventive measures on the part of the elderly community.

> *Even had an affair with a man who told me he was having a pain in my arm and before he go see I told him that I didn't want to scare him, but it was good that he go to the doctor because you should be with a heart problem, the symptoms he come to me reporting. Then he said to me: well as you told me, I had a heart problem and I didn't care much. I went to the doctor and handled the pressure, but I haven't been to the doctor cardiologist you sent.(ACS 12).*

> *We see so much... because we're a little bit of everything, because we are guiding, psychologists and their doctor. (ACS 16).*

In the fragments of the lines shows that seniors value the ACS guidelines in relation to health care, since they commonly seek services or professionals when they are forwarded because of the need for specialized care or for presenting more serious symptoms of any pathology. From this, it should be noted the importance of educational activities that the ACS relay for the community and on its continuous improvement. This results in satisfaction for health professionals, since they identify your work contributed to improve the health conditions of the population that is under their service area.

It should be noted that is relevant to the development of permanent education, commonly held by nursing staff, in particular, by the nurse, along with ACS and the influence this has on health practices and actions carried out with the elderly population. However, noticeable limitations in activities carried out by these workers in relation to chronic diseases, are reported, mostly, they provide only basic guidelines on diabetes and hypertension, as hair care diet and physical exercise, not including the other chronic diseases, which often affect the elderly.

> *We try to advise on the food issue, especially diabetics, because they often get lost. What many do is stop eating, then end up doing hypoglycaemia, lack of are not feeding. So we're always guiding,*

> *they do not stop to eat, but eat less quantity, eat 2/2 hours, avoiding those foods are very sweet, we're always advising them that way (ACS 1).*
>
> *She is hypertensive and diabetic. Had a crisis this week, then I'm there, I sit, talk, talk. If you have to search, I go there, take the sheet, write, guide her to eat with B, C with D and I give (ACS 6).*
>
> *Until I told him I was a vegetable Eggplant recommended for those with diabetes (ACS 9).*

ACS's work is complex, but with great potential. Thus, this professional in the basic attention is in Keystone, since he is the link between the health service and population, in that both combine forces to face the problems of health and, especially, changing conditions of life.[12]

In addition to the basic guidelines about health problems, passed to the elderly, the ACS also make actions of preventive care, particularly, in relation to accidents that can result in falls.

> *Guide care, mostly with materials at home, look after what may slip, hurt, to be careful (ACS 8).*
>
> *With the elderly we have to remove the beaded mats. Osteoporosis and osteoarthritis, also in order to prevent falls (ACS 9).*
>
> *Oriento techniques for them not to suffer falls indoors. This morning I explained to some, put the soap into the half. They liked it, found it very interesting to put the soap in the middle because not give drops the soap for them to take a bath. They loved it. When I spoke, they said, 'Oh, but you know it's really good!' (ACS 2).*

It is observed that the ACS has a facility to identify the most common accidents which occur in the daily lives of the elderly, which may cause damage to the health of this population, since they have greater fragility and, consequently, greater difficulty in rehabilitation, through its organic senility.

Other attitude of ACS for health promotion of elderly population is to guide, direct and encourage these individuals to participate in groups, whose purpose is to carry out discussion on themes linked to the field of health. This practice allows the elderly to obtain further clarification to perform self-care for your health.

> *We do here with health groups seniors, hypertensive, diabetic, passing more information regarding their health. How it's got to be careful with hypertension with diabetes. The groups, we in the House does pass query information, get doubts (ACS 8).*

In the survey conducted on the design of health promotion groups for the elderly, these are defined as the improvement of the life quality enhancers of these people and in strengthening its bond with the health services and the community, especially to those groups that are performed through the FHS ESF. Also evident by being able to build bonds of

social support, aiming at the promotion of health of gerontes, through the principles of the SUS.[13]

It is worth mentioning that the practice of self-care is developed through a dialogical relationship, in which professionals and patients hold a negotiation shared with the goal to obtain success. Thus, it is necessary that the professionals implement a practice based on interaction and the sharing of experiences among members of the health team, with the purpose of offering integral assistance with development of self-care, necessary for the well-being and human development.[14]

Working with the elderly population also constitutes a challenge, as it commonly presents some resistance to join an orientation, activity or treatment.

> *I have an old man in my area who have DPOC. He is still a smoker. Give us guides you to quit smoking. He's old enough high, almost 80 years. We've tried to bring to the group, but did not succeed. He doesn't want to quit smoking (ACS 1).*

> *Participate in the hypertensive groups, most of the time I try to bring them, but it is very difficult. That thing they're coming, they're not very (ACS 2).*

Study on the difficulty of the elderly in adherence to the pharmacological treatment for hypertension reveals that the factors that stand out for the failure are due to the fact that the elderly are not aware that has determined disease, sometimes this doesn't manifest symptoms, hindering their quest for treatment, the emotional problems, difficulty in handling with the medicines or see the instructions passedIn addition to the lack of resources for the purchase of prescription drugs and side effects from the drugs. Contributing to the difficulty, it is necessary a commitment for the elderly to make periodic health consultations, follow treatment properly associated with a healthy lifestyle change.[15]

In this scenario the ACS, whose actions stand out particularly as regards prevention of complications arising from illness process already underway, such as hypertension and diabetes and guidelines on the risk of falls. Also, include clarifications about the need for insertion into specific groups, which have the objective of clarifying and sharing information of educative and health related.

CONCLUSION

From this study it is possible to identify that there are limitation in knowledge and in the actions developed by the community health agents, by the population of the elderly with CNCD. Also, note that hypertension and diabetes are chronic diseases that most ACS focuses of action and knowledge. Reduced number of ACS expressed meet other diseases, such as cancer, asthma, bronchitis, DPOC, arthritis and arthrosis, osteoporosis or heart

deficiencies, as well as offering guidelines to care about these morbidities, which has high incidence in the elderly population.

It is understood that the actions focused on hypertension and diabetes may be due to the fact that the ACS held the record in the Registration system and monitoring of Hypertensive and diabetic (Hiperdia) of the municipality. Thereby, have more information about these diseases and know the number of seniors affected by the same.

Due to the limitations concerning knowledge about CNCD, the ACS perceive the need for the continuous provision of permanent education spaces, to keep up to date and show interest in expanding their knowledge, with a view to the improvement of its working practices, especially by the population formed by the elderly. Still, they are committed to their work, once who strive to give resolution to demands from the elderly population, as well as perform actions of care with these individuals.

Considers that barriers relating to knowledge of ACS on the CNCD may imply a negative impact on implementation of health actions performed with the elderly community. Observe, too, that this worker, when feel insecure for the implementation of its employment practices, seeking help from other professionals, showing ability to identify their weaknesses and need to have more knowledge in order to fulfill its mission, especially by the elderly population.

This bias, the work of ACS can be qualified from health education and actions to be undertaken by the professional nurse, which has knowledge of the CNCD and is able to instruct the ACS in the actions and guidelines community elderly care. Thus, the ACS are able to broaden their knowledge, thus justifying their practices and the care given to the elderly population, contributing to the same become more active and take care of themselves.

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