

# Consensus on scales for an interdisciplinary health assessment tool for the elderly population\*

## Consenso de escalas para um instrumento de avaliação interdisciplinar em saúde da população idosa

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### ABSTRACT

**Objective:** to describe the consensus of the content of an instrument for assessing interdisciplinary health care of the elderly population. **Methods:** consensus study conducted among physicians, nurses, and social workers, contemplating the construction of instrument and the pre-test for selection of scales for use in practice. Questionnaire consisting of questions that identified representative scales in the assessment of the elderly. The scales that obtained consensus criterion of equal to or greater than 75% were considered selected by the experts. Sample was composed through snowball sampling, resulting in 101 participants. **Results:** of the 13 scales submitted, the professionals indicated that eight were suitable for use and two were already applied within their practice. The excluded became part of the recommendations for good practices in elderly care. A discrepancy was identified between what they consider to be useful and of interest versus what is applied in practice. **Conclusion:** consensus among experts allowed us to identify and select interdisciplinary assessment data for a proposed instrument to support the care process. **Contributions to practice:** this contributes to awareness about the use of recommended scales for the elderly and to avoid the overlapping of the same interventions by several professionals, with significant gains for this population. **Descriptors:** Patient Care Team; Health Services for the Aged; Interdisciplinary Research; Consensus; Nursing.

### RESUMO

**Objetivo:** descrever o consenso do conteúdo de um instrumento para avaliação assistencial interdisciplinar em saúde da população idosa. **Métodos:** estudo de consenso realizado entre médicos, enfermeiros e assistentes sociais, contemplando a construção de um instrumento e o pré-teste para seleção de escalas para uso na prática. Questionário constituído por perguntas com identificação de escalas representativas na avaliação dos idosos. Consideraram-se selecionadas pelos peritos as escalas que obtiveram o critério de consenso igual ou superior a 75%. Amostra constituída mediante “bola de neve”, resultando em 101 participantes. **Resultados:** das 13 escalas submetidas, os profissionais apontaram oito passíveis de utilização e duas que aplicavam na sua prática. As escalas excluídas constituem parte integrante das recomendações de boas práticas na assistência aos idosos. Identificou-se discrepância entre o que consideram útil e de interesse versus o que aplicam na prática. **Conclusão:** o consenso entre peritos permitiu identificar e selecionar dados de avaliação interdisciplinares para uma proposta de instrumento, com vistas a subsidiar o processo de cuidado. **Contribuições para a prática:** contribui-se, assim, para a conscientização sobre o uso de escalas recomendadas para idosos e para evitar a sobreposição das mesmas intervenções por vários profissionais, com ganhos significativos para essa população.

**Descritores:** Equipe de Assistência ao Paciente; Serviços de Saúde para Idosos; Pesquisa Interdisciplinar; Consenso; Enfermagem.

## Introduction

Global population aging has sparked a growing interest and search for an understanding about its health consequences and possible changes in care models. According to data from the National Institute of Statistics, between 2015 and 2020, in Portugal, the aging rate increased from 146.5 to 167 elderly people for every 100 young people, and may reach 370.5 in 2080<sup>(1)</sup>. With the exponential increase in demographic aging and corresponding increase in life expectancy, the change in the health profile of this population is imminent.

Living older requires living well. However, elderly care is characterized by fragmented and disjointed health care, without interconnection and coordination among the various professionals; there are unnecessary and considerable costs<sup>(2)</sup> which calls into question the models of health care. Studies corroborate this statement evidencing health care for the elderly based on individualized professional practices, with emphasis on the biomedical model<sup>(3-4)</sup> and segmented care practice<sup>(5)</sup>. Internationally, there are gaps in knowledge about integrated care models of health and social systems for the elderly<sup>(6)</sup>, whereas, a priori, the demographic transition process requires the adequacy of such services to the needs and expectations of this population.

According to elderly health policies, the promotion of healthy aging concerns multisectoral actions and considers the articulation between the various services and professionals to be crucial<sup>(2)</sup>. However, there seems to be a consensus that there are weaknesses in teamwork among physicians, nurses, and social workers pertaining the assessment of the elderly: this is based on a diversity of scales and presents itself as an area in which health professionals and social workers need to share information<sup>(3-4)</sup>. International scientific literature expresses the need to change multiprofessional teams to interprofessional teams<sup>(7)</sup> with a view to an integral, holistic, and continuous assessment of the elderly.

To reverse the logic of the health system, of the curative models that focus on the disease, is a determinant for elderly quality of life. It is considered essential and effective in a contemporary elderly health model to integrate health promotion and disease prevention, chronic disease monitoring, rehabilitation, and palliative care<sup>(2)</sup>, by means of consultations aimed at continuous monitoring of the habitual health profile and early identification of situations susceptible to change. The present study searches for ways to promote active and healthy aging of the elderly population via an interdisciplinary approach.

The main concern is to establish the priority areas identified by physicians, nurses, and social workers in the development of care for people over 65 years to improve joint and articulated actions for health promotion. The focus of the study on these professionals is justified by the fact that they constitute the core team of elderly care in Portugal, given the associated health needs and social challenges faced.

Along with the fragmented practices of professionals, there are knowledge gaps in the country pertaining validated and practically implemented tools for collecting elderly health data, which enable the documentation of joint work, avoid duplication of information among team professionals, and facilitate the early identification of health and social needs. Although the clinical information system in use allows consultation of each professional's intervention, it also suggests an individualized non-interdisciplinary record.

Thus, it is essential to create instruments capable of subsidizing the planning of an interdisciplinary and integral assistance to the elderly, which is the reason why this study was conducted. In turn, the content validity becomes fundamental in this process to verify if the included items are representative to evaluate the phenomenon under study<sup>(8)</sup>.

Given the above, the following guiding question for this study stands out: What are the scales to be used in an assessment instrument for teamwork in confronting the needs of the elderly within the scope

of health promotion and disease monitoring? The objective was defined as: to describe the consensus of the content of an instrument for assessing interdisciplinary health care of the elderly population.

## Methods

Descriptive research with a quantitative approach, using expert consensus on the relevance of scales in the practice. It took place from January to November 2017.

The study population was selected according to some inclusion criteria: physicians, nurses, and social workers working in health care institutions in Portugal for more than six months with older people — which is the period of integration in this area of practice. As exclusion criteria: professionals working in oncology and psychiatric hospitals, areas with different demands, which require specific knowledge, instruments, and assessment strategies. The sample was obtained by a non-probabilistic method, using the snowball sampling technique: the researchers provided the initial contacts who met the inclusion criteria. The three professionals of each category who first accepted to participate were the seeds and invited others of the same profile to participate, resulting in 101 randomly selected professionals: 5 (5%) physicians, 93 (92%) nurses, and 3 (3%) social workers.

The study was composed of two stages: construction of the instrument and pre-test on the use of scales within the practice — the latter by experts. In the first stage, a self-administered questionnaire for Assessing Interdisciplinary Care of the Elderly Population was constructed. The content of the questions regarding multidisciplinary care emerged from the categories identified in a previous study conducted on the “Models currently in use in elderly care” based on interviews with eight physicians, eight nurses, and eight social workers, which has published results<sup>(3)</sup> both from bibliographic research and available scientific evidence.

The questionnaire was organized in two parts.

First, questions aimed at the respondent’s sociodemographic and professional characterization were asked. Second, scales for studying multidisciplinary elderly care were presented.

For this work, an expert was a professional specialist in the field of gerontology and, cumulatively, to have experience as a researcher with scientific publications in the area and to be recognized as a distinguished professional in the care provided to this population.

The group of experts was asked to indicate their response regarding the usefulness, application, and interest in scales for use within the practice. ‘Application’ was understood as the existence of normative measures in the service for the use of certain scales or the use by the professional to help establish clinical judgments; ‘interest’ was understood as the recognition of the benefits of scales to obtain health data from the elderly, which may lead to their use; and ‘usefulness’ was understood as the identification of the scales most likely to be used in daily practice with the elderly.

For the operationalization of the sociodemographic and professional variable, the experts answered the following items: sex, age, education, professional category, length of service, professional experience in gerontology, continuing education in gerontology, academic training in gerontology, and place of work. The response on the usefulness of scales was quantified by means of a Likert-type scale in five levels, in the components: not useful at all (does not see scientific basis within care for its use), not very useful (situations in which it is used are scarce), useful, very useful (when it brings great value to practices), and fundamental (without which it becomes impossible to evaluate care; guarantees higher quality of practices). Dimensions of the ‘usefulness’ variable: degree of assistance in self-care - Barthel; functional capacity - Lawton & Brody; cognition - Mini Mental State Examination; risk of pressure injury - Braden; body balance - Tinetti; nutrition - Mini Nutritional Assessment; family functionality - Family Apgar; family structure - Genogram;

social support - Ecomap; lifestyle - Lifestyle Profile; depression - Geriatric Depression Scale; physical, social, and emotional burden of the informal caregiver - Informal Caregiver Burden Assessment Questionnaire; and caregiver stress - Zarit. For the analysis of the variable 'Usefulness of scales for clinical practice' and to better understand the professionals' choices, a cut-off was made between those who considered them not useful at all or not very useful and, in the opposite direction, useful, very useful, and fundamental for clinical practice.

Information on the application of scales was obtained through a dichotomous response: applies, does not apply; interest followed the same criteria through two options (is interested in applying it; is not interested in applying it), containing the same dimensions as the previous variable, except nutrition - Mini Nutritional Assessment. The variables were selected because they are commonly used in research and clinical practice with the elderly and are already validated for the Portuguese population.

In the second stage of the study, a pre-test was carried out with 101 health and social professionals from various regions of the country with professional experience in gerontology. The term "expert" was adopted to describe the study participants who voluntarily validated the questionnaire's content. In turn, content validity by experts seeks to improve the content of the instrument by making it more reliable, accurate, and decisive in that which it proposes to measure<sup>(8)</sup>, especially at the time of data collection, so that the quality of the research is achieved.

Data collection was conducted via e-mail through a link that provided access to the Google Forms instrument developed by the research team containing the researchers' identification and contact details and an explanation of the study in order to obtain informed consent. It took place over a 30-day period, from January to February 2017.

For data treatment, first they were extracted from the Google Forms using the Excel program and then imported into the program (IBM-SPSS), version 25.0. We proceeded to the statistical analysis of the

experts' answers for each item of the questionnaire using descriptive analysis measures. Although there is no consensus in the literature regarding the values for content validity, and it is up to the researcher to define them, in the present study the items with a consensus equal to or higher than 75% agreement were selected to compose the final version of the questionnaire, regarding the "usefulness" category (useful, very useful, fundamental); and, in the case of "interest" and "application", when the value of 75% was reached in the two most positive categories ("applies it" and "is interested in applying it", respectively).

Given the objective of the study, it was also possible to assess the differences in the opinions of the three professional groups regarding the usefulness, application, and interest in scales to assess the elderly. However, due to the low level of consensus obtained, we still considered analyzing the scales with representativeness equal to or higher than 50%.

The study was authorized by the North Regional Health Administration's Ethics Committee for Health, IP (opinion No. 154/2017). All participants were informed about the research objectives and the guarantee of confidentiality of the data collected, signing the informed consent form.

## Results

The group of experts was composed mainly of female participants (81%) and graduates (57%). As for the professional category, 92% were nurses; 5%, physicians; and 3%, social workers. Of these, 81.8% had professional experience in gerontology. Regarding continuing education in gerontology, 72% did not undergo it; however, 84.9% expressed interest in doing so. Regarding academic training in gerontology, 45% underwent it during undergraduate studies, and 42.5% during graduate studies. Of the sample, 45% worked in the hospital, 42% in the Health Center Groups, and 13% in another location.

Following experts' consensus (greater than 75%) on the usefulness of the scales, the results obtained are presented in Table 1.

**Table 1** – Absolute and percentage frequencies, 95% confidence intervals of the scales recognized by the experts as useful, applicable, and interesting for clinical practice. Porto, Portugal, 2017

Variables	Usefulness	*95% CI	Applicability	95% CI	Interest	95% CI
	<sup>†</sup> f (%)	<sup>‡</sup> Li-Ls	f (%)	Li-Ls	f (%)	Li-Ls
Barthel	91 (93.8)	89.02-98.61	70 (93.3)	87.69-98.98	18 (85.7)	70.75-100.68
Lawton & Brody	67 (75.2)	66.32-84.24	29 (40.8)	29.41-52.28	19 (95.0)	85.45-104.55
Mini Mental State Examination	88 (91.6)	86.14-97.2	30 (46.9)	34.65-59.1	27 (93.1)	83.88-102.33
Braden	91 (94.7)	90.35-99.24	75 (91.5)	85.42-97.51	15 (100.0)	-
Tinetti	71 (80.7)	72.43-88.93	23 (32.9)	21.85-43.86	18 (94.7)	84.7-104.78
Mini Nutritional Assessment	81 (88.0)	81.41-94.67	-	-	-	-
Family Apgar	65 (71.9)	62.97-81.48	9 (14.3)	5.64-22.93	29 (90.6)	80.53-100.72
Genogram	64 (69.5)	60.16-78.97	17 (25.4)	14.95-35.79	23 (85.2)	71.79-98.59
Ecomap	54 (62.0)	51.87-72.26	11 (17.2)	7.94-26.43	23 (85.2)	71.79-98.59
Lifestyle Profile	62 (74.7)	65.35-84.05	14 (23.0)	12.4-33.5	27 (100.0)	-
Geriatric Depression Scale	68 (78.2)	69.48-86.84	11 (18.6)	8.71-28.58	29 (87.9)	76.74-99.01
Caregiver Burden	83 (89.3)	82.95-95.54	17 (30.4)	18.31-42.4	36 (97.3)	92.07-102.52
Zarit	58 (69.8)	60.01-79.75	10 (17.5)	7.67-27.42	28 (87.5)	76.04-98.96

\*CI: Confidence Interval; <sup>†</sup>f: Frequency (Number of answers); <sup>‡</sup>Li: Limit inferior, Ls: Limit superior

Of the 13 scales presented, eight reached the proposed consensus: Braden (94.7%), Barthel (93.8%), Mini Mental State Examination (MMSE) (91.6%), *Questionário de Avaliação da Sobrecarga do Cuidador Informal* [Informal Caregiver Burden Assessment Questionnaire] (QASCI) (89.3%), Mini Nutritional Assessment (MNA) (88%), Tinetti (80.7%), Geriatric Depression Scale (GDS) (78.2%), and Lawton & Brody’s (75.2%). The variable with the lowest percentage was the ecomap (62%).

Regarding the application of scales by professionals during practice, of the 12 scales presented, Barthel (93.3%) and Braden (91.5%) were the only ones that reached consensus, and the remaining scales did not reach 50% representation. The variable that reached the lowest consensus was the Family Apgar (14.3%). As per the interest in applying scales, the sample was unanimous for all scales presented, with percentages above 75%. The values ranged from 85.2% for the Genogram and Ecomap to 100% for the Braden and the Lifestyle Profile (LSP).

As for nurses, in addition to the eight scales that obtained consensus on usefulness, the remaining scales reached a percentage higher than 63%, with Ecomap at the lowest value (63.4%). Regarding physicians, all agree on the usefulness of the MMSE, MNA, and GDS (100%). The lowest values of the excluded variables refer to the Braden, Tinetti, Ecomap, LSP, and Zarit (33.3%). For social workers, all the scales presented obtained consensus (100%).

When comparing the results of physicians and social workers, regarding the application of scales, despite not having reached consensus, it was evident the physicians’ preference for the MMSE (60.0%) and social workers’ preference for Braden and Barthel (66.7%).

More than 50% of the nurses do not apply: LSP (50.6%), Zarit and Tinetti (51.8%), GDS (52.9%), Genogram (54.7%), Family Apgar (57.5%), and the Ecomap (58.8%). The majority “is interested” in applying all the scales presented, noting, however, that 40% do not apply the QASCI, but 40% “are interested” in ap-

plying it, and 51.8% do not apply the Zarit and Tinetti, but 32.5% and 21.7%, respectively, “are interested” in applying them.

In the case of physicians, the non-applied scales stand out: LSP (100%), QASCI (80%), Ecomap, Lawton & Brody, Tinetti and Zarit (75% each), Genogram, Family Apgar and Braden (60% each), and GDS (50%). Regarding the interest in applying them, it was evidenced for all scales except for the LSP and Tinetti, which they did not comment on. Highlighted scales that were not applied: Braden and Family Apgar (60%) and Barthel (40%); however, 40% of physicians expressed interest in applying them in clinical practice.

The opinions of the social workers about the application of the scales were divided regarding Lawton & Brody, Tinetti, GDS, and Zarit, as 50% apply them and 50% do not (respectively). However, also 50% of the professionals apply MMSE and QASCI. Regarding the interest in the scales presented for the practice, it is noteworthy that 100% declared it in relation to the Ecomap and LSP (respectively); 50% apply the QASCI and 50% “are interested” in applying it; and, in the case of the Genogram, although only 33.3% refer to its application in practice, 66.7% of the social workers consider it of interest. Regarding the Family Apgar, 50% do not apply it and 50% “are interested” in applying it.

## Discussion

Regarding the characteristics of the sample, majority female, it corroborates data regarding the national population of health professionals, also explained by the greater representativeness of the professional group of nurses and the respective feminization rate. Although the sample does not present an equivalent distribution by professional group, differences in the representation of professionals in the region studied were identified on a national level (18,474 nurses, 8,370 physicians, and 1,473 senior technicians - social workers are included among the latter)<sup>(9)</sup>, thus being proportional to the number of workers. Moreover,

there are no statistics of professionals who work only with the elderly, which is the reason why this manuscript was developed.

As per the level of education, undergraduate degrees prevailed, converging with national data of workers belonging to the health area (physician, nurse, among others)<sup>(10)</sup>. Although most of them mentioned having professional experience in gerontology, the percentage that does continuing education in this area is smaller; however, most of them admitted having interest. The training of professionals who integrate healthcare teams in the field of aging is considered incipient<sup>(11)</sup>. In turn, gerontogeriatric training carried out with health professionals from Norway, Canada, and the United States shows a significant impact on the acquisition of knowledge, attitudes, and skills of inter-professional teamwork, constituting a synergy<sup>(12)</sup>.

Regarding academic training in gerontology, the interest expressed by professionals in pursuing continuing education for practice reveals the presence of gaps. An integrative review on teaching in gerontology shows that the education/training of professionals should be articulated with health as a social practice, thus ensuring that the needs associated with population and individual aging are met<sup>(13)</sup>. These findings allow us to inquire about the study plans of the three professional groups, whether they contribute to the current care and interdisciplinary practice.

The positive consensus of the study sample on the variable “Usefulness of scales for practice” points to a holistic assessment of the elderly person with the use of several scales, which include physical aspects (Braden, Barthel, Lawton & Brody, Tinetti, MNA), cognitive aspects (MMSE), and emotional and social aspects (GDS, QASCI), which allows multidimensional data to be obtained. Such results are in line with those obtained by several scholars of Elderly Multidimensional Evaluation, and this shows the need to contemplate four domains - clinical, functional, psychological, and socio-environmental<sup>(14)</sup> - based on the principle of interdisciplinary work. However, what we see in practice is the limited and individualized use of scales by

different professionals, and it even happens that all of them assess identical dimensions, leaving other important dimensions undiagnosed. It is also essential to mention that the use of different instruments that share similar constructs can limit and compromise clinical decision making because it becomes more difficult to reach consensus.

The results obtained allow us to identify limitations in the intervention of each professional, still in a fragmented way, without considering fundamental elements to identify health and social needs. The person (client) goes through several professionals, when it would be essential that the information be transversal among all of them and that they understand that they are working according to the person's goals and not to what each one thinks is the most important. The client-centered attention must be the fundamental element in view of the different nuances and aspects that interfere in the aging population.

A point of emphasis regarding the different domains of the care process is the family context and the respective caregiver, which must be considered as a focus of attention in health care. In this sense, the QASCI emerges as a satisfactory element when seeking to identify social and family problems in the elderly care network. Researchers in Brazil evaluated the burden in informal caregivers of elderly patients using the QASCI and concluded that the mean burden was high, with the domain "Implications in personal life" being the one that most contributed to the physical, emotional, and social burden of informal caregivers<sup>(15)</sup>. If the caregiver is overloaded, he/she will certainly not be able to ensure quality care.

We also point out that the studies that were identified do not explicitly respond to the scales used by the professional category, but to the scales most used in the evaluation of geriatric syndromes, compromising the discussion on the theme. Inherent to the assessment process, it is expected that the use of the various scales will enable the prescription of interdisciplinary interventions directed to the real needs identified by physicians, nurses, and social workers in

the scope of preventing deterioration and/or promoting health.

Regarding the scales excluded from the consensus of usefulness by professionals (Family Apgar, Genogram, Ecomap, and LSP), we must emphasize that the evaluation of the elderly goes beyond the physical aspects, extending increasingly to family and marital relationships and social support network of their caregivers. Thus, the devaluation of the aforementioned scales and assessment of family functioning can represent a weakness of the practices. The importance attributed to one or another instrument can also be related to the academic background of the several professionals or to the approach used by each one. In Portugal, there are still difficulties in valuing and intervening in health at the family level.

Other reasons may be: lack of knowledge by some professionals; difficulty in practical application due to the lack of proper tools incorporated into the clinical information system and managing the time available for each consultation; and the curative and therapeutic scope of the intervention, i.e., the current model of care in use, thus compromising the holistic and health-promoting care of the elderly population. Studies show that some professionals see the application of scales as another task to be performed in practice, which requires an increased investment of time and, therefore, as a work overload<sup>(16)</sup>. However, there are differences in their application by nurses since their own knowledge and use of scales in practice are distinct<sup>(17)</sup>.

On the other hand, we are aware that a multi-dimensional assessment requires a balance between the various scales used, otherwise it becomes unaffordable to apply all instruments in practice. Therefore, if there is no single comprehensive instrument, professionals are overwhelmed and slide into inadequate holistic care of the elderly population.

In the experts' judgment of the scales applied in practice, Barthel and Braden, these fall on physical aspects of the elderly: ability to perform activities of daily living, and risk of developing pressure injuries,

respectively. In fact, the scales most scored by the experts show the perspective of the problem, a greater sensitivity to clinical diagnosis and not so much to the monitoring and follow-up of healthy aging, a model that is still quite shy.

Regarding the use of Barthel, a study that aimed to assess functional capacity and determine the factors associated with functional decline in the elderly used this instrument, which was corroborated by the present investigation<sup>(18)</sup>. However, there are other instruments applied in research and clinical practice. In Brazil, an integrative review study diverges from the present study, identifying, among the most used instruments to assess the functional state of the elderly, the Katz index and the Lawton scale<sup>(19)</sup>. The disagreement of the findings with the literature confirms the asymmetry existing in the assessment of the elderly by professionals, in which each one follows a determined model, which may result in practices not based on evidence and/or not directed to the elderly population.

The Braden scale consists of six dimensions, all highly sensitive to nursing care: sensory perception, humidity, activity, mobility, nutrition, friction, and shear force. They support professionals in the implementation of preventive interventions for the development of pressure injuries. In Brazil, a study was developed in which the applicability of the Braden Scale to inpatients with an 'impaired mobility' nursing diagnosis was analyzed. The authors concluded that it proved to be the best risk predictive tool in this population<sup>(20)</sup>; converging with the results of this study, Braden was considered a good scale to use. Research developed in China evidences the opposite: the Braden scale presents insufficient predictive validity and low accuracy in the identification of people with different levels of risk for pressure injuries, which may compromise their characterization<sup>(21)</sup>. More than 40 instruments or scales for pressure injury risk assessment are available, with the Norton, Waterlow, and Braden scales<sup>(17)</sup> being the most widely used.

The consensus reached in this study on the application of scales ratifies the characteristics of the sample, mostly represented by nurses, who use a clinical information system (SCLínico<sup>®</sup>) in their practice, in which these scales are incorporated into the country's Unified National Parameterization and are applied to respond to institutional protocols. Nevertheless, these findings point to an assistance to the elderly person focused on the deficit for performing basic daily living/self-care activities, often based on the biomedical model, neglecting the integral attention to the elderly person and, above all, the actions for healthy aging.

Moreover, this study found differences of opinion between the three professional groups regarding the usefulness, application, and interest in scales for practice, which can be potentialities within teamwork, as well as similarities that could be valued as weaknesses. Physicians and nurses do not apply in their daily practice the LSP, Tinetti, Ecomap, Genogram, Family Apgar, GDS, and Zarit scales, contradicting the recommendations of good practices in elderly care<sup>(2)</sup>. On the other hand, most experts see interest in applying scales, but in practice do not do so.

In view of the results and the discrepancy between what they consider useful and of interest versus what they apply in practice, the need for improvement of assistance to reach the goals indicated by the National Program for the Health of Elderly People is evident, because only then can more effective interventions be developed.

The above reinforces the need to identify specific aspects that affect the health of the elderly and situations of social vulnerability, which require intervention in a preventive, holistic, and interdisciplinary manner. This model of care poses a growing challenge to professionals, one to be overcome with teamwork, configured in a reciprocal and convergence relationship among all, due to the new epidemiological reality.



## Study limitations

Among the limitations of the study is the non-equal representation of all professional categories and the scarcity of studies related to the theme in question, making it difficult to compare the results found with other authors. Another aspect to be explored is the alignment and influence of the scales results for the formulation of diagnoses.

## Contributions to practice

The idea of building an instrument to investigate practices in the use of scales was seen as an opportunity to recognize potentialities and weaknesses in the actions developed by health professionals and social workers and can be used by other researchers in the interdisciplinary care of the elderly, especially in audits to evaluate the care process. The results may serve as a basis for future research or even serve as a basis for rethinking current clinical practice. In the future, further study of the instrument in terms of its validation and practicability from the point of view of physicians, nurses, and social workers will be useful.

In terms of implications for clinical practice, it is proposed to include the recognized scales for the elderly in the clinical information system (SCLínico), as a strategic and tactical planning resource for the definition of multisectoral actions, helping to support decision making, whose effectiveness depends on the joint effort of the three professional groups. In addition, the scales allow managers to know possible weaknesses in the care of this population.

## Conclusion

Based on the consensus among health professionals and social workers, it was evident that the scales to be inserted in an instrument for the evaluation of interdisciplinary health care in the elderly population were: Braden, Barthel, Mini Mental State Examination, Informal Caregiver Burden Assessment

Questionnaire, Mini Nutritional Assessment, Tinetti, Geriatric Depression Scale, and the Lawton & Brody.

The instrument proved to be useful in identifying representative scales in the assessment of the elderly, providing subsidies for planning the interdisciplinary work in health and for assisting this population.

## Authors' contribution

Conception and design, data analysis and interpretation; writing of the paper, relevant critical review of the intellectual content; final approval of the version to be published; responsibility for all aspects of the study, ensuring accuracy or completeness: Monteiro MCD, Martins MMFPS, Schoeller SD.

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