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Empowering Formal Caregivers in Residential Care Facilities for the Elderly to Provide Safe Care – Intervention of the Community and Public Health Nurse

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Abstract

Introduction
The current national demographic reality shows a significant aging of the population, with a growing number of elderly individuals residing in Residential Care Facilities for the Elderly (RCFE), leading to an increased need for formal caregivers (FC). The literature indicates that the lack of skills among FCs in RCFE affects the quality of care provided, with direct impacts on resident safety. By assessing the knowledge level of formal caregivers, it was possible to structure an intervention aimed at empowering them.

Objective
Empowering formal caregivers in Residential Care Facilities for the Elderly to provide safe care in the intervention area of a Community Care Unit (UCC).

Methods
The methodology applied was based on Health Planning grounded in Betty Neuman's theoretical framework, the Systems Theory. The foundation of the project based on scientific evidence was supported by a Scoping Review according to the methodology proposed by the Joanna Briggs Institute (JBI. The tool used for the situational assessment was a questionnaire developed by researchers and administered to formal caregivers to identify their training needs. A non-probabilistic convenience sample was comprised of 161 formal caregivers. To ensure compliance with all ethical, deontological, and methodological principles, this intervention project was developed following a favorable opinion from the Health Ethics Committee (HEC) under reference 51/CES/INV/2023.

Results
The situational assessment revealed a compromised caregiving capacity due to a lack of knowledge about the contents of the first aid kit, checking the first aid kit, procedures in case of an accident, first aid, and maintenance of the cold chain. Health Education and Health Communication were used as intervention strategies. Evaluation, based on process and outcome indicators, shows positive contributions to the empowerment of formal caregivers, reflected in 84% of caregivers identifying how to act in case of an accident, 94% identifying when to place someone in the recovery position, and 82% identifying the Basic Life Support algorithm.

Conclusion
This project contributed to the empowerment of formal caregivers through community nursing intervention, as well as providing insights into how to develop interventions with formal caregivers in Residential Care Facilities for the Elderly to empower them to provide safe care.

Keywords
Formal Caregiver; Empowerment; Community Nursing.

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Introduction

To care is a verb that is present throughout our existence, we care, we are cared for, and we watch over the care of others.[1]
According to Manuel et al.[2], the caregiver emerges from mutual help, defining caregivers as "someone who carries out activities aimed at the personal care of someone with a certain degree of dependency". [(p.2)] Moreira et al.[3] defines a caregiver as one who "must be empowered to perform basic hygiene care, provide feeding conditions, help with locomotion and create alternatives that provide the patients in their care with a better quality of life". [(p.2)]
According to the WHO[4], a formal caregiver is defined as someone who helps people with one or more disabilities, who belongs to an organization (profit or non-profit, governmental or private), or someone (excluding family, friends or neighbors) who provides regular and paid-for assistance, but who is not associated with any organization. Since there is no single definition of formal caregiver, unlike informal caregivers, it was decided to define formal caregivers for this project as all workers, regardless of their training, who are hired and paid to provide services in RCFEs.
According to the World Social Report 2023[5], it is estimated that in 2050 there will be 1.6 billion people aged 65 and over, which indicates an increase of twofold compared to the figures for 2021; moreover, it is also estimated that the population aged 80 and over will triple in 2050 to a number of 425 million. These figures represent a growth of 3% per year, much faster than the other age groups. The aging of the Portuguese population goes hand in hand with this reality. According to the latest data available from the National Institute for Statistics (INE)[6], Portugal had an aging rate of 178.4% in 2021, revealing that the elderly population significantly outnumbers the young. Alongside this indicator, the old age dependency ratio has also increased in recent decades, standing at 36.9% in 2021. The longevity rate, which stands at 48.7%, has also been increasing, which means that as well as having a growing elderly population, it is also getting older. According to INE[6], Portugal is home to 2.5 million people aged 65 or over, and 368,400 of these are aged 85 or over, for a total resident population of 10,467,366.
This reality puts great pressure on the responses required from health and social protection systems. Paixão[7], states that the increase in longevity and dependence of the elderly results in a greater need for care and, consequently, caregivers. The current way of life of families is one of the factors contributing to the increase in the number of institutionalized elderly individuals. However, institutionalization is also a way of trying to solve the problem of loneliness and progressive incapacity, Moreira[8] and difficulty in self-care. The Residential Care Facilities for the Elderly (RCFE), defined as an "establishment for collective accommodation meant for temporary or permanent use, in which social support activities are developed and nursing care is provided"[8 (p.1324)], focus essentially on a model of social responses, however, the high levels of dependency and associated comorbidities reveal it as a model in need of renewal, where health responses should take on a more central role. Among the set of activities that RCFEs provide, Article 8(g) states "Nursing care, as well as access to health care" and Article 8(h) states "Administration of drugs, when prescribed"[9 (p.1325)], which are the nurse's skills, set out in the Regulation that defines the nurse's duty.[10] According to the Basic Health Law[11], Base 2 "people have the right to access healthcare appropriate to their situation, promptly and within the time considered clinically acceptable, (...)"[7 (p.56)], it is the RCFEs' responsibility to ensure this response as a guarantee of the safety of its residents, since one of the aspects that most contributes to the occurrence of adverse events for RCFE users is delayed or inadequate intervention.[12] According to the Basic Health Law[11], patient safety is one of its fundamental components, and the State is its promoter and safeguard through the National Health Service (SNS) or any other institution. For the National Plan for Patient Safety (PNSD 2021-2026), guaranteeing safety is fundamental "the implementation of policies and strategies that reduce these incidents, part of which are avoidable, is recognized internationally and nationally as leading to health gains and is now an unequivocal commitment to health".[13 (p.96)] One of the five pillars of the PNSD 2021-2026 is a culture of safety, which "corresponds to the set of individual and group values, beliefs, norms and competencies that determine commitment, style and action regarding patient safety issues". [13(p.99)] One of the challenges for the quality and safety of caregiving is related to the qualification of RCFE employees, Gartshore et al.[14] and Pinheira et al.[15], indicate that one of the main problems related to human resources is based on the lack of qualification for the provision of direct care to the elderly. The training of these caregivers mainly takes place in the workplace, given by their peers, which can impact the quality of such training, as it is unstructured and takes place before the start of their duties.[15]
The development of societies and the knowledge they produce requires them to be constantly updated, as well as the permanent and deliberate process of acquiring this knowledge with the aim of contributing to the development of institutional competencies through the development of individual competencies is known as empowerment. The empowerment of formal RCFE caregivers is extremely important to ensure that the elderly receive the necessary care in a safe way, and the intervention of Community and Public Health Nursing (CPHN) plays a fundamental role here in supporting caregivers and their empowerment. It is therefore important for Nurses Specializing in Community and Public Health (NSCPH) to identify the needs of

caregivers and the areas in which they need the most support in relation to the needs of the elderly. For Feitor et al[16], when the client of nursing care is a community, the community *empowerment* model should be adopted as a form of empowerment, considering it a practical and valuable working tool for community nurses. Empowering individuals and communities to adopt healthy behaviors is a responsibility upon which the NSCPH must play a central role, given their favorable position in the relationship with the individual. The NSCPH is responsible for developing interventions that empower caregivers about what to do, how to do it and when to do it, providing the necessary information so that caregivers are active agents in carrying out the interventions, contributing to the safety of the person being cared for.

This article aims to summarize the implementation and evaluation of a community intervention project, based on the Health Planning methodology, which allows for the assessment of a community's needs, their prioritization and the evaluation of the strategies and interventions carried out as a way of responding to these needs, developed throughout the Master's Degree in Community Nursing, within the field of Community and Public Health Nursing. The project was grounded in scientific evidence through a *Scoping Review*, according to the methodology proposed by the *Joanna Briggs Institute* (JBI), based on the PPC mnemonic: population: caregivers in RCFE; concept: safety and vulnerability; context: RCFE. The *CINAHL Complete* and *Medline Complete* databases were used, with the following inclusion criteria: publication date equal or later than 2017, access to full text in Portuguese or English, age + 65 years and free access.

The general objective of this study was the development, implementation, and evaluation of a community nursing intervention project that would empower formal caregivers (FC) in Residential Care Facilities for the Elderly to provide safe care.

Methods

This is a descriptive cross-sectional study that was supported by the Health Planning methodology, which is defined as a continuous and dynamic process that enables, based on identified needs, the efficient use of (often scarce) resources[17] and is grounded in Betty Neuman's theoretical framework, Systems Theory. The health planning methodology is divided into the following phases: situational diagnosis; definition of priorities in relation to the problems identified; definition of objectives and strategies to achieve them, then a program or project is drawn up, the operationalization is prepared, it is implemented and at the end it is evaluated.[18]

The community intervention was carried out within the area of influence of the Community Care Unit (CCU), which serves a population of 84,859[19], of whom 21,797[19] are aged 65 or older. The project's target population consisted of formal caregivers in RCFEs that belong to the CCU's geographical area, the inclusion criteria were: formal caregivers in RCFEs that belong to the CCU's area of influence; formal caregivers in RCFEs with an audit report carried out by the Public Health Unit (PHU) between January and July 2023 and formal caregivers who agreed to participate voluntarily in the study. The sample was non-probabilistic and convenience-based, consisting of 161 formal caregivers.

The data collection instrument used to address the first phase of health planning – situational diagnosis – was a questionnaire designed by the researchers, based on the audit reports conducted by the PHU on the RCFEs within its geographical area of coverage, and the cross-checking of this information with the findings of the *Scoping Review*, which was validated by experts and pre-tested in an RCFE, between 20.10.2023 and 23.10.2023, with twelve formal caregivers. The results showed that there was no difficulty in reading and interpreting all the items by the employees, making it possible for them to complete the questionnaire themselves. The instrument was divided into two parts: Part A - consisting of five questions, aimed at characterizing formal caregivers in terms of sociodemographic data; and Part B - consisting of 22 areas grouped into four main areas of intervention: Environmental safety; Response to accidents; Drug safety; Continuity/adequacy of care, which made it possible to identify the training needs of formal caregivers. The sampling process was carried out using a non-probabilistic, purposive sample of participants, between November 15 and December 3, 2023.

In order to ensure the ethical soundness of the intervention, a formal request to conduct the project was submitted to the executive director of the ACeS LN (Group of Health Centers of North Lisbon), the PHU coordinator and the CCU coordinator. Finally, an opinion was requested from the Health Ethics Committee (CES) of the Regional Health Administration of Lisbon and Tagus Valley (ARSLVT) on June 21, 2023, which was given a favorable opinion for the diagnostic phase on November 15, 2023, through Opinion 51/CES/INV/2023. After carrying out the diagnosis, a new request for an opinion was made to CES ARSLVT for the intervention phase, to which a favorable response was received on December 12, 2023. The following phases of health planning, from the definition of priorities, objectives, intervention, and evaluation, which dealt with 73 FC, took place immediately after receiving the opinion and continued until February 9, 2024. As a method of evaluating the interventions, a new questionnaire was developed by the researchers, based on the topics addressed during the Health Education (HE) sessions, and applied to the FCs after the interventions had taken place.

The data collected was processed using descriptive statistical analysis, using the *Statistical Package for the Social Sciences (SPSS)* program version 29.

Results

The age of the formal caregivers varies between 22 and 72 years old with an average of 43.8 years, the maximum age corresponding to a FC who owns an RCFE. The mode is 40 years, and the median is 43 years. Looking at the standard deviation, it is below the average (12.25), which indicates a certain level of homogeneity within the sample. It was found that 89% of the formal caregivers are female and 11% are male. The educational qualifications variable shows that 31.5% of the formal caregivers have completed higher education and 28.8% have attended secondary education. In terms of educational background, 16.4% of the samples have attended school up to the 2nd and 3rd cycle (equivalent to middle school), 13.7% attended a professional technical course and 9.6% have only the 1st cycle (primary education). Regarding training in the care of dependent elderly people, 57.5% of the caregivers reported having received training and 42.5% reported having no training in the area. Regarding the length of time they have worked professionally in caring for the elderly, caregivers have an average of 9.7 years, with 0.5 years as the minimum length of time and 35 years as the maximum. On a *Likert-type* scale of 1 to 5, where 1 corresponds to "no difficulty" and 5 to "always having difficulty", it was found that the areas of response to accidents and drug safety had the highest scores, which means that these are the areas that present the most difficulties. The results of the knowledge assessment were categorized as: very good, good, satisfactory, poor, and very poor. Assessing the categories poor and very poor, the area and intervention – response to accidents ranked first, followed by the area – drug safety. According to the data obtained in the situational diagnosis, and since it was not possible to intervene in all identified areas, the problems were prioritized (the second phase of health planning) using the adapted *Hanlon* prioritization method, with the following weighting criteria: magnitude (A); severity (B) and effectiveness of the intervention (C)[18], applied in the following formula: (A+B) x C, from which the following nursing diagnoses emerged, according to the ICNP® taxonomy[20], 2019 release: Impaired ability to perform caretaking due to knowledge deficit about the contents of the first aid kit; Impaired ability to perform caretaking due to knowledge deficit about checking the first aid kit; Impaired ability to perform caretaking due to knowledge deficit about the procedure in an accident situation; Impaired ability to perform caretaking due to knowledge deficit about first aid and Impaired ability to perform caretaking due to knowledge deficit regarding response procedures in the event of cold chain maintenance.

Based on the prioritized problems, and in order to address the third phase of health planning, general objectives and specific objectives were defined, these were defined as the "desirable and technically feasible outcome of the evolution of a problem that alters, in principle, the natural evolutionary trend of that problem, translated in terms of outcome or impact indicators".[18(p.79)] Thus, the general objective is: Empower formal caregivers in the context of RCFE and the specific objectives are defined as follows: Increase formal caregivers' knowledge about the first aid kit; Educate formal caregivers on how to respond to the most common accidents; Educate formal caregivers in first aid (Basic Life Support and Recovery Position) and Increase the proportion of formal caregivers with knowledge of the cold chain procedure.

In line with the defined objectives and in response to the fourth phase of Health Planning – Selection of strategies, the following health promotion strategies were chosen: Health Education (HE), according to Rodrigues[21] which enables health literacy and empowers individuals to manage their health, the World Health Organization[4] also considers HE to be a fundamental strategy that enables individuals and communities to improve their health, expanding knowledge and thus influencing empowerment. The other strategy used was Health Communication, which enables the dissemination of information with the purpose of promoting health.[22] This strategy included the development of informational materials (cards, procedures) in physical and digital format, intended for formal caregivers. After establishing the priorities and defining the strategies to be implemented, the themes to be covered in the HE sessions were identified. This stage began with an approach to the RCFE's technical directors to present the results of the data collection, the areas subject to intervention and to negotiate the locations, dates and times for the HE sessions. As far as the HE sessions are concerned, an initial plan was developed; a didactic tool (slides) was created to present the content of the sessions; a set of cards was prepared for each RCFE, a procedure and a short video made available via a link for later consultation. A questionnaire was also developed and administered at the end of the HE sessions to assess trainees' satisfaction and knowledge acquisition, as well as a certificate of participation and an attendance sheet.

Evaluation constitutes the sixth and final stage of Health Planning. "In a planning or programming situation, most of the elements used in evaluation take the form of indicators. It is through them that we get to know the reality and measure the progress achieved".[18(p.178)] At the end of each session, an evaluation questionnaire was administered on the topics covered, allowing for the assessment of the knowledge of the formal caregivers who participated in the HE sessions. The evaluation of this project was based on activity and result indicators, as shown in Table 1.

Table 1. Activity and results indicators.

Activity indicators	Target	Result
% of formal caregivers attending the health education sessions	70%	84%
% of health education sessions conducted	100%	133%
Activity indicators	**Target**	**Result**
% of formal caregivers who identify 6 essential items in the first aid kit	100%	100%
% of formal caregivers who identify the 5 common accidents	80%	83%
% of formal caregivers who identify how to respond to 3 types of accidents	80%	84%
% of formal caregivers who correctly identify when to place a person in the Recovery Position	90%	94%
% of formal caregivers who identify the sequence of the Basic Life Support algorithm	80%	82%
% of formal caregivers who identify at least 1 cold chain procedure	80%	86%
% of formal caregivers who identify the correct procedure for cold chain maintenance	80%	94%

Table 1 shows that the targets initially proposed for the defined objectives were achieved in their entirety. The HE sessions had a high level of participation from the formal caregivers, and more sessions were held than initially planned, at their request, to allow a greater number of caregivers to attend. However, evaluating the results using only a questionnaire administered immediately after the HE sessions does not allow for a thorough measurement of their impact, the results obtained provide evidence of transformation, but equivocal evidence of sustained change.

Discussion

This study aimed to empower formal caregivers in RCFE to provide safe care, using an approach based on Health Planning and grounded in Betty Neuman's Systems Theory. One of the challenges to ensuring the quality and safety of the care provided in RCFEs is related to the qualifications of their staff. This project helped to strengthen the mapping of scientific evidence obtained through the *Scoping Review* carried out by the researchers*,* according to Gartshore et al.[14] and Pinheira et al.[15], one of the main problems related to human resources is based on the lack of qualifications for providing direct care to the elderly. The training of these caregivers mainly takes place in the workplace, given by their peers, which can impact the quality of such training, as it is unstructured and takes place before the start of their duties, Pinheira et al.[15]

The results show that the empowerment of formal caregivers in Response to Accidents and Cold Chain procedures had a positive impact on improving their knowledge. The results are consistent with the existing literature, which highlights the importance of training formal caregivers to improve the safety and quality of care in RCFEs. Several authors, such as Ree et al[23], point out that increasing caregiver qualifications and improving communication and cooperation among professionals are critical factors for safety in long-term care. The literature shows that a robust security culture and adequate staffing are essential to overcome these obstacles.[14] The results suggest that, in addition to empowerment, greater investment in human and organizational resources may be necessary to ensure total safety in the care of the elderly.

The findings indicate that the empowerment process contributed to a substantial improvement in caregivers' knowledge and practices in areas critical to residents' safety. The methodology used, grounded in Betty Neuman's Theory, made it possible to identify and prioritize the *stressors* that affect the caregivers' performance, providing a theoretical foundation that guided both the assessment of needs and the development of interventions. It was found that, when guided to identify and minimize risk factors as well as intrapersonal and interpersonal *stressors*, caregivers were better prepared to respond to emergencies and to carry out procedures safely. In a client system (FC) that is intended to remain in balance, as a way of achieving this purpose, the possible factors that could generate *stress* and collide with the flexible line of defense and compromise the normal line of defense were identified. The strengths of the formal caregivers were identified with the same objective, which in this project translated into empowering the RCFE formal caregivers to provide safe care. Thus, the intervention in this research was at the level of primary prevention.

This study has some limitations that should be taken into account. Firstly, the sample was limited to formal caregivers from a single geographical area (CCU), which may restrict the generalization of the results for other RCFEs or regions with different contexts. Secondly, the data was collected through a questionnaire administered after the HE sessions, which may introduce a response bias, as participants may have reported improvements based on the expectation of what was considered adequate and it is not possible to assess knowledge retention, changes in practice, or actual transformation. Future studies with long-term follow-ups could provide a more detailed understanding of the sustainability of the improvements and the continuous

impact of the knowledge acquired. Another point to consider is that the infrastructure and resources available in each RCFE may have varied, affecting the implementation of safety practices.
The results of this project highlight the importance of Nurses Specializing in Community and Public Health and the use of strategies such as Health Education sessions in continuous empowerment and in interventions focused on the safety of formal caregivers in RCFEs. The literature and the findings of this study indicate that developing skills in the areas of safety and first aid, by integrating standardized protocols and continuous assessment tools, can have a direct impact on the quality of care provided and the safety of residents. RCFEs should, therefore, consider implementing periodic and updated training that addresses the specific needs of caregivers and aligns with the principles of the National Plan for Patient Safety.[13]
This study opens doors to further research that could explore the effectiveness of continuous empowerment programs in RCFEs in other regions and with a larger sample. Moreover, longitudinal studies that monitor the impact of these empowerments over time are recommended to verify the persistence of the results and identify areas needing reinforcement. Another area of interest would be to investigate the relationship between caregiver training and the turnover of professionals in RCFEs, considering that team stability is pointed out in the literature as a factor that positively influences the quality of care and the safety of residents.[24]

Conclusion

The present community intervention project, grounded in the Health Planning methodology and structured by Betty Neuman's theoretical model, seeks to ensure that the client system, in this project, the formal caregivers, are able to maintain the balance of their system, that is, their well-being. With the aim of achieving this goal, the potential stress factors that could compromise both the flexible line of defense and the normal line of defense were identified. At the same time, the competencies of the formal caregivers were analyzed with the purpose of empowering them to provide safe care in RCFEs, focusing the intervention on primary prevention. In an aging demographic landscape and with an increasing number of elderly people living in residential facilities, it is important that all formal caregivers have the tools necessary to provide safe care to the elderly. It is therefore important for the Nurses Specializing in Community and Public Health, who work with and for the community, to act as an interlocutor, who can and should assess the needs and consequent empowerment of formal caregivers, with the quality and safety of care being the primary objective of nurses.
The results indicate that the interventions implemented led to significant improvements in the knowledge and safety practices of caregivers, especially in the areas of response to accidents and the cold chain. These improvements reflect the importance of structured and continuous empowerment, demonstrating that the qualification of caregivers not only increases resident safety, but also contributes to the quality of the services provided.
The execution of this project, with the achievement of the proposed objectives and the attainment of all the defined goals, thus enabled continuous improvement in the quality of care, by empowering formal caregivers, namely in the area of response to accidents, not only as professionals, but also as individuals and members of a community.
In summary, this study contributes to community nursing practice by showing that empowerment of formal caregivers is an effective strategy for ensuring safety in RCFEs, addressing an emerging need in societies with increasingly aging populations. By prioritizing training and safety, RCFEs can promote not only the well-being of residents, but also the quality of life and motivation of the caregivers themselves, aligning with the goals of public health and the promotion of safe and quality care.

Authorship and Contributions

MG: Conception and design of the study; Collection of data; Analysis and interpretation of data; Writing of the manuscript; Final approval of the manuscript and assumption of responsibility for it.
ES: Conception and design of the study; Analysis and interpretation of the data; Revision of the manuscript; Final approval of the manuscript and assumption of responsibility for it.
AV: Conception and design of the study; Analysis and interpretation of the data; Revision of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.

Conflicts of Interest and Funding

No conflicts of interest have been declared by the authors.

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