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ORIGINAL ARTICLE

SITUATIONAL DIAGNOSIS OF THE PILLARS METHOD-PERSONNEL-TOOLS FOR IMPLEMENTING THE NURSING PROCESS WITH RELIGIOUS ELDERY WOMEN

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Highlights:
(1) Pillars for the Nursing Process with religious elderly women were diagnosed.
(2) Identify strengths and weaknesses in the care process for elderly women.
(3) Identify strategies to assist in the care process for elderly women. (4) Potential to assist in implementing the Nursing Process in the care of elderly women.

ABSTRACT

The objective was to perform a situational diagnosis of the method-personnel-instruments pillars, to implement the Nursing Process in a religious home care facility for elderly women. This is the diagnostic phase of a strategic, qualitative action research study conducted with 19 nursing professionals and three managers from a religious home care facility for elderly women. The data collected in February 2022, using semi-structured interviews, were submitted to a discursive textual analysis technique. Ten diagnostic categories were listed, related to the three fundamental pillars for implementing the Nursing Process and the strategies suggested by the professionals to help with the weaknesses experienced. Regarding the Method pillar, the absence of a formal care process structure and the quality and humanization of care for the elderly were identified. In the Personnel pillar, the sizing of personnel, the fragmentation of the team, and the presence of a multidisciplinary team were recognized. In the Instrument pillar, the absence of instruments, materials, and protocols, as well as the presence and supervision of nurses in the daily care of the elderly, were diagnosed. Strategies included returning to training and meetings, staffing levels, and developing guidelines, manuals, and care protocols. Strengths and weaknesses were identified in each of the pillars, along with strategies to address the shortcomings, which will serve as inputs to assist in implementing the nursing process.

Keywords: elderly; Long-term Care Facility for the Elderly; nursing care; nursing process; health management.

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INTRODUCTION

The global elderly population has gradually increased in recent decades due to declining birth rates and increased life expectancy. In 2020, the population aged 60 and over was approximately one billion, representing 13.5% of the world's population. Estimates indicate that by 2030, one in six people will be aged 60 or over; by 2050, this number could reach 2.1 billion, meaning that one in five people will be elderly1. In Brazil, the number of elderly people has also skyrocketed, reaching 22.2 million, representing 10.9% of the Brazilian population2.

As people age, they become more susceptible to physical, mental, psychological, and social changes affecting their health care needs. For elderly people with a religious life, this care can be provided in Religious Home Care Facilities (CRCD, in Portuguese). These environments offer shelter, comfort, and care for elderly sisters who require assistance in their physiological aging process (senescence) or are associated with disease conditions (senility)[3]. In CRCDs, care is provided by professionals from different backgrounds to meet the unique and multidimensional needs of each elderly person. Among these, the work of nursing professionals stands out, as, due to the nature of their profession, they are the ones who provide direct and comprehensive care to the elderly. This care is managed by nurses, who must promote an organized and structured environment4.

The organization of the nurse's professional work is based on the Nursing Process (NP), defined as the method that guides the nurse's critical thinking and clinical judgment, directing the nursing team to care for the person, family, community, and special groups. To this end, it must be implemented in all environments where nursing care occurs, considering five stages: assessment, diagnosis, planning, implementation, and nursing evolution5.

However, to be effective in the care context, it is necessary to consider the fundamental pillars: method, personnel, and instruments. The method pillar refers to the orientation of the care to be developed through the Nursing Process (NP), that is, it is linked to clinical nursing practice. The personnel pillar involves human resource management to ensure sufficient nursing professionals to guarantee quality care. The instruments include service supervision, and the organization of care activities based on forms, care protocols, Standard Operating Procedures (SOPs), schedules, and clinical assessment instruments, among others6.

However, even though it is a legal requirement and there is research on the subject in different countries7-11, the NP is not yet implemented in all contexts, especially in elderly care settings, such as the CRCD, demonstrating this research's novelty and relevance in the investigated[12] scenario. In this sense, carrying out a situational diagnosis of its fundamental pillars is essential to implement the PE in this reality. In this regard, Article 11 of Resolution No. 736/2024 of the Federal Nursing Council (Cofen) determines that nursing professionals should strive to incorporate research results on the PE and its stages into practice5.

In addition, research aimed at caring for the elderly is necessary in Brazil, as highlighted in the National Research Priorities Agenda13. This research is therefore justified, since conducting a situational diagnosis of the method, personnel, and instruments pillars in the CRCD elderly care environment is an essential step in planning and implementing the NP, which in the short to medium term will contribute to better organization and quality of care for the elderly.

Given the above, the question arises: how is the work process organized, based on the method-personnel-instruments pillars, in a religious home for the elderly? To this end, the objective was to perform a situational diagnosis of the method-personnel-instruments pillars, to implement the Nursing Process in a religious home for the elderly.

METHOD

This research is part of a macro project: Implementing the nursing process for elderly people in a religious home care facility. It is a strategic action research project whose transformation is planned by the researcher, responsible for monitoring the effects and evaluating the results of its application[14]. It was developed through eight steps that resulted in four phases, as shown in Figure 1.

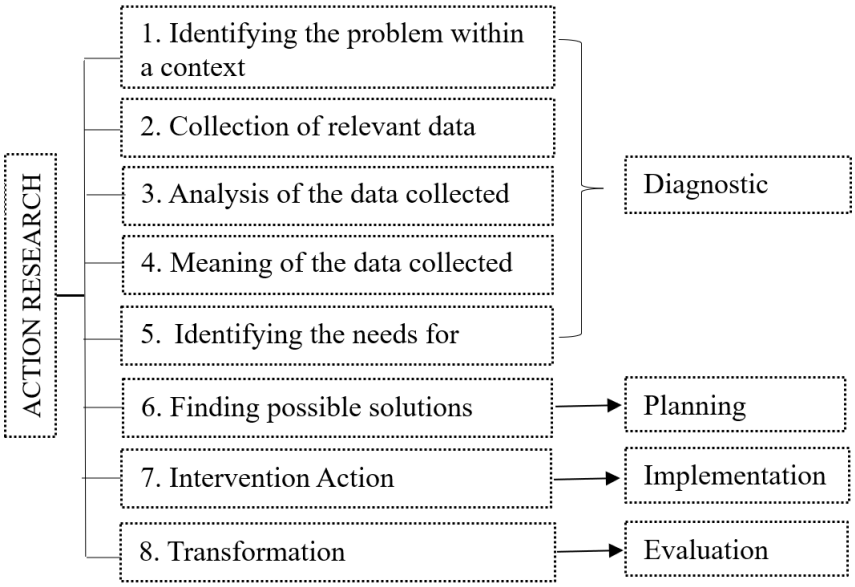

Figure 1 – Schematic representation of action research.

Source: Adapted[15].

This article addresses one of the project's specific objectives, "to identify how nursing care is provided to elderly residents of a religious home care facility." The data were obtained during the diagnostic phase of the study. To ensure clarity and consistency in the writing of this report, the *Consolidated Criteria for Reporting Qualitative Research* (Coreq) checklist was used[16].

The research was conducted with nursing and management professionals at a CRCD for elderly women in Rio Grande do Sul, Brazil. At the time of the study, the institution had two wings, where 105 elderly women with different levels of dependency lived. Of these, 67 received minimal care, 26 received intermediate care, and 12 received high dependency care.

The facility is maintained with its resources, medications provided by the state, and retirement benefits for elderly women. This setting was chosen for research because it houses a considerable number of elderly people and nursing professionals, which justified the need to investigate the care provided to the fundamental pillars for the implementation of the NP.

It has 39 workers in care and non-care services, including four nurses, 17 nursing technicians, one assistant doctor, one volunteer doctor, one nutritionist, one physical therapist, two professionals responsible for hygiene, nine kitchen assistants, and three management professionals. For the study, nursing and management professionals working during the data collection period and who met the selection criteria were considered. The nursing team was chosen to participate in this research because it comprised professionals responsible for the execution, organization, and supervision of the NP[5,6]. Management professionals were also considered, given that managers' support is necessary for a work method's success.

The following inclusion criteria were established: being a nurse, nursing technician, or management professional working at the institution for at least 30 days, a sufficient period for them

to have experienced the institution's reality. Professionals who were on sick leave or leave of absence were excluded. It should be noted that among the 24 nursing and management professionals during the study period, two were not eligible: one because she did not meet the length of service criteria, and the other because she was the principal author of this research. Thus, the 22 eligible professionals met the selection criteria and agreed to participate in this research, including 16 nursing technicians, three nurses, and three management professionals.

The data were collected in February 2022 through a semi-structured interview designed specifically for this study. It was initially applied to one of the participants as a pilot test to assess its clarity. As no changes to the instrument were necessary, the data obtained from it were considered for the study. The interviews were conducted individually at a single time with each participant. They were conducted by one of the researchers, a nurse with qualitative and clinical research experience in gerontology. The interview script consisted of two parts: the first with items related to the participants' profile, such as gender, age, education, length of training, professional experience, and work experience in the study setting. The second part consisted of open-ended questions, such as: How is the care process for older adults developed in the place where you work? Do you see any potential or weaknesses in the daily work at the religious house where you work? If so, what would be the main strengths? What would be the main weaknesses? What strategy do you suggest to assist in the care process?

The interviews were audio recorded with an MP3 device and transcribed fully by the researchers using Microsoft Word (version 16.31). They were then returned to the participants for validation. Next, they were subjected to a discursive textual analysis technique, organized according to a recursive sequence of three components: unitarization, establishment of relationships, and communication[17].

Initially, the researchers examined the texts intensively and in depth, forming the central category based on the situational diagnosis of the fundamental pillars for implementing the NP. This was divided into three units of meaning, corresponding to the pillars – method, personnel, and instruments – that is, the reports consistent with each of these were grouped into each unit. Afterward, each report included in the units of meaning was read thoroughly and separated into different units that gave rise to the categories. Finally, the last stage of the analysis method was carried out, where the researcher presented the understandings achieved from the two previous focuses, through the communication process, resulting in the metatexts describing and interpreting the phenomena investigated[17].

The ethical and legal precepts involving research with human beings were considered, under resolutions 466/12 and 510/2016 of the National Health Council. The Research Ethics Committee approved the project, registration no. 5.151.626 and CAEE: 52445021.4.0000.5306. Participation in the research was subject to signing a Free and Informed Consent Form (FICF). Participants were assured of anonymity and confidentiality of information and were identified by the letter P (Participant), followed by a number, according to the interview order (P1, P2...P22).

RESULTS

Of the 22 participants, all (100%) were female, three (13.6%) were nurses, 16 (72.8%) were nursing technicians, and three (13.6%) were management professionals, aged between 19 and 62 years. Of the six participants with higher education, four (66.6%) had specialization, and two (33.3%) were currently studying. The length of training varied from 45 days to 36 years, and professional experience ranged from 30 days to 30 years. The length of service at the CRCD varied from 30 days to seven years.

The data analyzed resulted in a central category: situational diagnosis of the fundamental pillars of the Nursing Process. This category was divided into three units of meaning, one representing the

pillars of the NP and one related to strategies to assist in the process. These gave rise to 10 analysis categories, as seen in Figure 2.

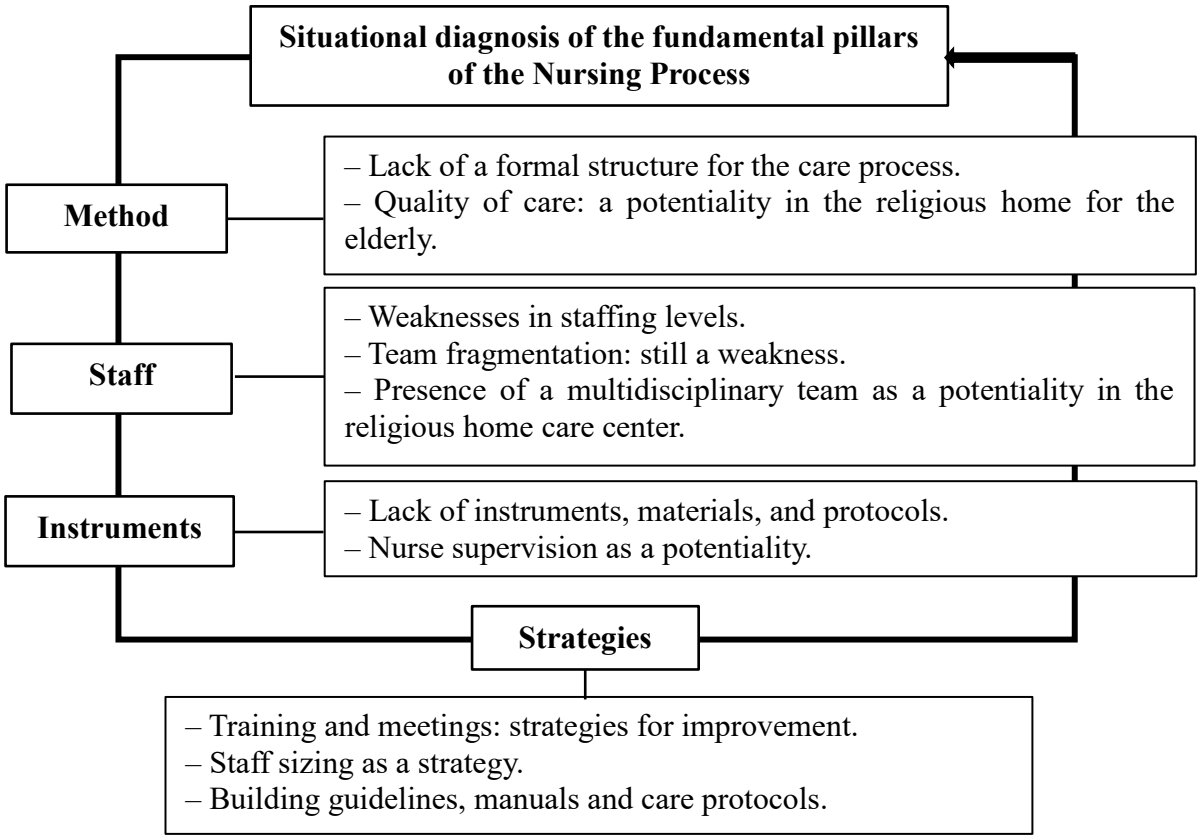

Figure 2 – Schematic representation of the interconnection between the central category, the units of meaning, and the categories of analysis.

Source: Prepared by the authors.

Lack of a formal structure for the care process

The participants' reports clearly show that although the nurse provides guidelines, there is no formal structure for caring for the elderly. Care is provided based on predetermined routines.

> [...] we constantly try to follow the routine that we, the older ones, have established. We always prioritize their well-being, our sisters, and take care of them (P4).
>
> What guides me are the nurse's instructions. I focus on what I must do [...] I follow the instructions she gives me during shifts and stick to the routine [...] (P9).
>
> The nurse on duty guides us [...] we always learn a little about everything. (P10).
>
> I think there is a specific routine [...] (P21).
>
> Just the guidelines, the rules of those who hire us, they pass them on to us, guide us on how things are, how the routine will be, how you must present yourself. The nurse, too (P22).

Quality of care: a potential in the religious home for the elderly

Although there is no formalized PE structure in the investigated setting, participants report the quality and humanization of care for the elderly as potentialities experienced at the Religious Home Care Facility:

> [...] We try to care for ourselves as best we can. When we have questions about something, we always ask the nurse or a colleague so we can improve [...] I constantly try to be available to the sisters, to help them [...]. Care has improved a lot, from getting the sisters up every shift. Of course, the nurse must keep repeating [...] when one is on in the morning, she goes and does it. When she is on in the afternoon, she continues. We provide continuity of care. If we can't finish something, the next team continues the care (P7).
>
> This keen eye, of seeing the patient not only as a physical illness [...] that holistic view [...] is because often it is something that goes beyond the physical, physical pain, pain in the fingers, and head. [...] It is not just physical, and you begin to understand that they typically say they have a headache and, suddenly, want attention, even those who are not conscious, a caress on the hand (P11).
>
> The team's interaction with the sisters [...] and their affection and respect for their religion are significant. The necessary care, I think, the availability of medication, if they need medication [...] (P17).
>
> [...] I realize that the issue of care, with the individuality of each one, is that the girls know what each sister likes, and if a wound appears, they let us know, they notice. So, this is not something you find everywhere. The issue of affection, the closeness between the technicians and the sisters [...] (P21).

Weaknesses with staff sizing

Staffing levels were a weakness mentioned by the research participants, who reported that there were too few staff on shifts, especially at night, to provide quality care for the elderly.

> [...] There are too few people to care for them; they need help. Many more needy sisters and others require more attention. We can't pay attention to them all since we have a lot to do and few people. [...] (P3).
>
> [...] There are nights when it seems like the two of us won't be able to manage; there are so many little things to do. Last night was quiet, but the night before, when there were complications with the sister, I thought we couldn't finish. There was a lot to do, and it was already 6:30 [...] It would be good to have three technicians at night, one on the lower and two on the upper wards. I think that's about right [...] (P6).
>
> And the number of nurses is a weakness, so much so that we still haven't implemented the Nursing Process. We also need to keep up with changes in the law [...] (P12).
>
> [...] There should be more professionals, [...] more technicians (P15).
>
> The weaknesses are more due to the lack of staff because occasionally, there are only three nursing technicians for so many people, so there's no time to do checks and systematization. It ends up breaking the process [...] at night, so many patients for one technician [...] (P17).

Team fragmentation: weaknesses still present

The participants mentioned the following weaknesses they experienced in their daily work: team fragmentation, competition among colleagues, lack of communication between shifts, and incomplete records, which contributed to the team's overall insecurity.

> The weakness is the team itself. Some colleagues don't show up, don't do their job, do it reluctantly [...] negatively; there's always that dispute between colleagues, that friction; there's always one who doesn't follow and thinks that the way her colleague does it is wrong. Standardizing care will improve things (P4).
>
> Occasionally, the lack of communication and record-keeping on the night shift, when we arrive in the morning, has left a lot behind [...] I think it's this issue of one person leaving things for another: "I'm not going to do it now; let the other shift do it." This hurts the nurses. So, I think these are the weaknesses: lack of communication and leaving things for the other group to do. [...] There is a real lack of interest in the team. (P13).

> [...] There is no group work or teamwork. You try, but it doesn't happen; it's fragmented I think that's the main weakness here [...] (P18).
>
> [...] The lack of team unity makes them a little resistant. Some people accept things well, and others don't (P19).
>
> On the negative side, the lack of communication between teams sometimes has this communication problem [...], which is the negative point that I see (P22).

Presence of the multidisciplinary team as a potential in the religious home care house

The participants' reports indicate that the presence of the multidisciplinary team is one of CRCD's strengths, contributing to the quality of care provided to the elderly.

> Now there is also a physiotherapist who comes more often to help them [...] (P1).
>
> [...] The fact that we have a nurse who is always researching and helping us, clarifying doubts about changing positions, injuries, and dressings, helps a lot. We also have a physiotherapist who helps us position the sisters, which helps prevent injuries. This is a positive point. There are also times when they get together for beauty treatments, haircuts, and there is a nutritionist (P2).
>
> [...] It is much better after the nurse came and took over here. We have care and medication for the sisters, who didn't go out, didn't have tests, so in that sense, it has improved a lot. It's much better. We have two nurses now, one in the morning and one in the afternoon, and it's easier [...] for us to ask questions and clarify doubts. The nurses are always there to help us (P3).
>
> [...] It improved to the point that the nurse arrived and put "order in the house." [...] The organization of the nursing station also improved; sometimes we couldn't cope with the rush, but it has improved a lot [...]. We used to work in a rush, lacking expired materials, and today that no longer happens (P6).
>
> [...] medical care, there are nurses, there is the whole team [...] (P15).
>
> [...] the physical therapist and the doctor came in to be part of this work and help us. We sit down and discuss care, so interprofessional and multidisciplinary work is essential here. We must sit down and discuss care with the nurses because occasionally, I have one view, and together (all the professionals), we provide good care in the end [...] (P18).

Lack of instruments, manuals, and protocols

The lack of instruments, manuals, and protocols and the absence of the NP were weaknesses mentioned in the professionals' statements. Two participants added that perhaps the technical nursing professionals are not even familiar with the NP.

> We don't have any guidelines or manuals on providing care; we do it according to routine or their needs (P1).
>
> There is no manual; we do what each person wants (P2).
>
> There are no manuals, protocols, or POP (P5).
>
> [...] There is no Nursing Process here, perhaps many technicians do not even know what it is, probably the majority, and this lack of knowledge is a weakness (P12).
>
> I believe that many technicians are not even familiar with the Nursing Process, adequacy of care [...] (P20).

Nurse supervision as a potential

The participants mentioned the supervision of the nurse as a potential strength in the daily care of the elderly.

> [...] This issue of having someone in charge, coordinating the team, has improved a lot with the arrival of the nurse [...] (P1).
>
> [...] They are well cared for, the nurse is always on top of things, very attentive, and the vast majority are well cared for (P4).
>
> [...] Our immediate superiors demand that we develop the correct procedures and always challenge us to seek answers to discover why a certain procedure is necessary, and a certain medication is prescribed. This is essential and brings us together as a team. It's cool; I like it a lot (P11).
>
> [...] The nurses have the materials to improve their care, from food to medication. Everything is in quantities needed, including diapers, and all the necessary materials are provided by the nurses and supplied by the facility (P14).
>
> [...] It's perfect to have nurses; I always think so; it's essential. There are nurses where there are technicians, but we know this is not the case in many places. If the nurse is not there, we know from experience that things don't run as they should. And I see that the nurse has this ability to involve the technician; she is very skilled [...] (P16).

Training and meetings: strategies for improvement

As strategies to help in the day-to-day care of the elderly, the participants mentioned the return of the training/courses that were previously held, the existence of periodic meetings, and more moments of conversation with the team.

> [...] having a meeting with the whole team together, where we can ask questions and get guidance at the same time [...] (P4)
>
> [...] talking, setting aside time for team study, training, which even helps us grow, group conversations, listening to others speak, and stopping to make specific comments [...] (P8)
>
> Training courses are one way, a monthly course. When working on dressing techniques and the whole nursing care process, it's essential to have training. [...] There should be refresher courses to help; that would greatly improve things (P9).
>
> [...] training workshops [...] we learn in training [...] team meetings, where we can bring up our most significant questions and what we have difficulty with [...] our team meetings are like the training she talks about. If there were a meeting with the whole team once a month, providing guidance, I believe that little by little it would improve [...] (P13).
>
> The lectures, the training, that will help, and group meetings [...] are essential. Through meetings, they could be weekly, to discuss things, and through lectures [...] The nursing technicians would feel more confident performing this function and have an environment/moment to ask questions. [...] It would be much easier, through training, to provide proper care [...] (P18).

Staff sizing as a strategy

Staffing levels emerged as a strategy for improving the care provided to older people in the setting investigated. Participants referred to this need as quality of life and individualized care for each older person.

> [...] it would be good to have two more nurses [...] (P2).
>
> [...] another nurse to help downstairs, in my opinion [...] (P6).
>
> A geriatric doctor is essential for the nurses, working only with them, having an extra eye and touch, and working on that extra point (P9).
>
> [...] more nursing technicians, always [...] in the morning and afternoon, more in the morning [...] (P10).
>
> [...] a nurse, that's something we managed to get [...] another technician, maybe [...] (P15).

Construction of guides and manuals and care protocols

Manuals, SOPs, and protocols also emerged as strategies suggested by professionals to improve the quality of care for older adults.

> There could be a manual on providing care, dressing wounds, performing suction, and inserting catheters to standardize procedures (P1).
>
> There could be a manual or protocols on providing the best care to the nurses (P5).
>
> […] Consider tools, materials, and SOPs to improve care (P12).

DISCUSSION

Care for institutionalized elderly people should focus on their unique needs. To support this care, it is necessary to adhere to leadership, people engagement, process approach, continuous improvement in care, evidence-based decision-making, and people and conflict management[18].

In this sense, we understand the importance of paying attention to the three essential pillars for implementing NP and enhancing evidence-based nursing practice[6]. In the present study, when analyzing the "method pillar," there was no formal structure for assisting the elderly in the CRCD. That is, the NP was not implemented in the daily routine investigated, and, therefore, care was developed based on predetermined routines. However, the participants recognized the quality of care and its humanization, especially for the elderly.

However, when analyzing the responses on the quality of care, it was noticed that they referred more to affective issues and relationships with the elderly than to those related to the clinical aspects of care. In this context, it is essential to note that in addition to the affective aspect, which is fundamental in the care process, nursing, and management professionals must encompass the clinical aspects of caring for the elderly. In this sense, for evidence-based decision-making to occur, each stage of the NP[5] must be fully developed.

Regarding the "personal pillar," it was noted that the nursing work process was carried out with fewer staff than expected in all shifts, especially at night, which can undermine the quality of care for the elderly. This data corroborates a retrospective study that analyzed 80 inspection processes by the Rio de Janeiro Nursing Council on nursing staffing levels in long-term care facilities for the elderly (LTCF)[19]. The study revealed that the institutions did not fully comply with the legislation regulating LTCFs, particularly with the classification of the level of dependency of the elderly and the number of nursing staff. They had an average of 1.2 nurses, 6.7 nursing technicians, and 2.3 nursing assistants for an average of 48 elderly people, which is insufficient for safety and quality care.[19]

Cofen Resolution 743/24 establishes the number of nursing staff and considers the Patient Classification System (PCS) and the professional/patient ratio in different work shifts[20]. The Resolution determines: one nursing professional for every six patients requiring minimal care; one for every four patients requiring intermediate care; one for every 2.4 patients requiring high dependency care; one for every 2.4 patients in semi-intensive care; and one for every 1.33 patients in intensive care[20].

Staffing levels below those recommended directly interfere with the quality of care, increase staff overload, and result in a lack of time to provide care, negatively affecting the outcome of care. Adequate nursing staff sizing involves quantitative and qualitative staffing forecasts to meet the needs and demands of each sector, aiming at better quality of care[21]. However, adequate staffing alone does not guarantee quality of care[6].

In this sense, the participants in this study also mentioned team fragmentation, competition among colleagues, lack of communication between shifts, and incomplete records as weaknesses

experienced in their daily work. This contributes to the insecurity of the team as a whole. Thus, nurses must manage conflicts to ensure quality care and organizational health[22]. A study conducted with nursing professionals in northeastern Brazil showed that the nursing team's performance generates conflicts and that managing them is challenging for nurses[23].

It still concerns the "personal pillar," and the presence of a multidisciplinary team emerged as one of the potential factors for quality care for the elderly. This finding corroborates research that considers that the training of human resources in nursing cannot occur in isolation from other professions, since in daily professional practice, nursing professionals develop comprehensive care[6]. To this end, coordination and integration with other interdisciplinary team members are necessary to meet each person's unique and multidimensional needs. Thus, discussing the NP beyond disciplinary calculation and its interrelationships can enable other health team professionals to understand the scope of practice and the contribution of nurses and the team in health care. This strengthens autonomous and collaborative practice.[6]

Regarding the "instrument pillar," the absence of manuals and protocols was identified, as well as the absence of the PE in the daily care of the elderly. The participants also reported that some nursing technicians were possibly unaware of the NP, data like those of other studies[24-25]. A study that evaluated the results of ethical and professional nursing supervision in 51 LTCFs demonstrated weaknesses related to the absence of instruments, manuals, and protocols[24]. In turn, a study that evaluated nursing technicians' perceptions of the Systematization of Nursing Care also highlighted the weakness in these professionals' knowledge of the subject[25].

The lack of knowledge among professionals about NP may be linked, among other factors, to the training process of nursing technicians, since topics related to NP are not emphasized during their training. This contributes to professionals having difficulty defining the skills and duties applicable to them during the work process. In this sense, research conducted in Ethiopia highlights the need to deepen knowledge about NP to contribute to recognizing nursing as a scientific profession of a social nature. NP is essential for practice in guaranteeing autonomy and strengthening the professional category.[8]

Nurse supervision was identified as a potential strength in the "instrument pillar," since it promotes better care of the elderly by the team. This data reaffirms the potential of nurses in the management of gerontological care, since they are the protagonists when it comes to the organization of health services. This is due to their dual role in daily work with the elderly. In addition to participating in the care process, nurses manage processes and services[26]. Thus, the presence of nurses in the care setting is essential for planning and implementing care actions with the team. Such care should be focused on health needs, promoting the qualification of care, which enhances care for the elderly[27].

Concerning strategies to assist in the daily care of the elderly people investigated, the need to promote training/courses, periodic meetings, and more opportunities for conversation with the team were identified. These strategies align with the "method pillar," since the guidance for the care to be developed and the implementation of the NP require the qualification and awareness of the team, which the suggested strategies can enhance. It should be emphasized that moments of effective listening, courses, and training are essential for improving the team's work process. This data corroborates a study conducted in China, where researchers report that interactive learning experiences are crucial and favor clinical nursing practice[10].

In this sense, it is worth mentioning that regular team meetings are the responsibility of professionals in different social contexts, to discuss planning and evaluating team actions based on available information and data[28]. Thus, meetings are essential tools for organization, structuring, and knowledge exchange, for the qualification and continuing education of professionals, and for being

a potential space for decision-making in the care of older adults. They enhance the convergence of different types of knowledge, promoting the integration of professionals through discussions for the daily construction of the work process and the planning of the team as a whole[28].

Staffing levels were also identified as a strategy for improving the care provided in the setting investigated, as they enhance the quality of life and individualized care of each older person. These strategies align with the "human resources pillar," which encompasses human resource management, including the staffing levels of nursing professionals to ensure quality care[6]. A study indicated that insufficient number of nurses can lead to errors and adverse events. At the same time, adequate staffing levels are associated with better clinical outcomes, contributing to improved quality of life and satisfaction among professionals working in this setting[29].

Thus, adequate staffing of nursing teams directly impacts the quality of care and patient safety[29]. In this sense, prioritizing is essential to face the challenges imposed by healthcare[30].

Addressing the weaknesses of the "instruments pillar," manuals, SOPs, and care protocols were identified as a strategy for improving the quality of care for older adults. Using these instruments in the nursing work process is essential, as they can assist in the effectiveness and safety of interventions, reduce costs, and improve the quality of care by investigating and identifying problems and standardizing procedures. Thus, they should be considered essential for systematizing and managing care[31].

FINAL CONSIDERATIONS

Based on the pillars of method, personnel, and instruments, this research enabled a situational diagnosis in the CRCD for elderly people to implement the NP. Regarding the Method pillar, the absence of a formal care process structure was identified, as care was provided based on predetermined routines. Despite this, the participants recognized the quality and humanization of care for older adults as strengths in the reality investigated. Concerning the personnel pillar, it was possible to identify staffing levels and team fragmentation as weaknesses. However, one strength stood out: the presence of a multidisciplinary team consisting of nursing technicians, nurses, a doctor, and a physical therapist. The Instrument pillar diagnosed the absence of instruments, materials, and protocols. However, the presence and supervision of nurses in the daily care of the elderly stood out as a potential strength. As strategies, the participants suggested returning to training and meetings, adequate staffing, and developing guidelines, manuals, and care protocols.

These data contribute to gerontogeriatrics, especially to the care of elderly people in the CRCD research setting, as they provided input to assist in organizing the service and implementing the NP. In addition, this diagnosis can serve as a basis and stimulus for other institutions providing care to older adults to seek to diagnose gaps and potential, focusing on implementing the NP based on each reality's resolutions and regulations. This contributes to the quality of care for older adults. Despite this, there may be regional differences according to each location surveyed. Thus, it is understood that the data from this study should be interpreted with caution, as they represent a specific reality of care for elderly women in religious communities and should not be generalized.

Thus, we suggest that further research be proposed on different realities and scenarios of care for the elderly, with the aim of analyzing the items necessary for implementing the NP. This will impact on the quality of care.

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