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Original Article

Geriatric nursing consultation in primary care: structural aspects of care

Consulta de enfermagem gerontogeriátrica na atenção primária: aspectos estruturais do cuidado

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Vitória Victor Menezes[1]
Patrício de Almeida Costa[2]
Adrya Thayanne Henriques da Silva[3]
Caio Bismarck Silva de Oliveira[4]
Bruno Jonathan Queiroz Silva[1]
Maria Paula Ramalho Barbosa[1]
Matheus Figueiredo Nogueira[1]

[1]Universidade Federal de Campina Grande. Cuité, PB, Brazil.
[2]Universidade Federal do Rio Grande do Norte. Santa Cruz, RN, Brazil.
[3]Universidade Estadual da Paraíba. Campina Grande, PB, Brazil.
[4]Universidade Federal da Paraíba. João Pessoa, PB, Brazil.

Corresponding author:
Vitória Victor Menezes
Rua Fernando dos Santos Leal, 724
Cidade Universitária. CEP: 58397-000
Areia, PB, Brazil.
E-mail: vmnezes@gmail.com

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EDITOR IN CHIEF: Ana Fatima Carvalho Fernandes
ASSOCIATE EDITOR: Francisca Diana da Silva Negreiros

ABSTRACT

Objective: to explore the structural aspects of geriatric nursing consultation carried out by nurses working in primary care. **Methods:** a qualitative study was conducted with eight nurses selected through purposive sampling. Data collection included a socioprofessional questionnaire and semi-structured interviews. Data were processed using IRAMUTEQ and analyzed with content analysis. **Results:** five classes emerged: Characterization of the approach to older adults in the Basic Health Unit, Biomedical perspectives of care, Nursing perspectives on frailty in older adults, Organizational flow of geriatric nursing consultations, and Recording and assessment methods used during the consultation. Two thematic categories were identified: (I) Nursing consultations with older adults focused on disease-oriented care; (II) The deficit in multidimensional care for older adults, from user embracement to longitudinal care. **Conclusion:** the biomedical model predominated in consultations, with limited use of multidimensional assessment tools, a lack of specific planning for older adults, and a shortage of professional training. Conversely, the use of the electronic health record was highlighted as a potential enabler. **Contributions to practice:** the findings underscore the need for professional training and may support the implementation of humanized practices, care protocols, and public policies aimed at comprehensive care for older adults in primary care.

Descriptors: Primary Health Care; Office Nursing; Geriatric Nursing; Comprehensive Health care; Aged.

RESUMO

Objetivo: conhecer os aspectos estruturais da consulta de enfermagem gerontogeriátrica realizada por enfermeiros da Atenção Primária à Saúde. **Métodos:** estudo qualitativo com oito enfermeiros, selecionados intencionalmente. A coleta foi realizada por meio de questionário socioprofissional e entrevista semiestruturada. Os dados foram processados pelo *software* IRAMUTEQ e analisados pela técnica de Análise de Conteúdo. **Resultados:** identificou-se cinco classes que abordaram: a caracterização da abordagem à pessoa idosa, o cuidado na perspectiva biomédica, a ênfase na fragilidade do idoso, o fluxo organizacional da consulta e os métodos de registro durante a consulta. Das classes surgiram duas categorias temáticas: I) A consulta de enfermagem à pessoa idosa focada no cuidado à doença; II) O *déficit* da atenção multidimensional à pessoa idosa: da acolhida ao cuidado longitudinal. **Conclusão:** houve predomínio do modelo biomédico nas consultas, com baixa utilização de instrumentos de avaliação multidimensional, ausência de planejamento específico para idosos e carência de capacitação profissional. Em contrapartida, o uso do prontuário eletrônico foi destacado como potencialidade. **Contribuições para a prática:** os achados reforçam a necessidade de capacitações e podem subsidiar a implementação de práticas humanizadas, protocolos assistenciais e políticas públicas voltadas à atenção integral à pessoa idosa na atenção primária.

Descritores: Atenção Primária à Saúde; Enfermagem Ambulatorial; Enfermagem Geriátrica; Assistência Integral à Saúde; Idoso.

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Introduction

The work process refers to how professional activities are organized and performed, guided by defined objectives and structured through the interaction of different factors that change as a result of human action[1]. In nursing, this process encompasses five dimensions: providing care, managing, teaching, conducting research, and engaging in political action, which may occur in an integrated manner or independently[2].

The care dimension in nursing focuses on care directed toward individuals, families, groups, and communities to promote, maintain, and restore health[3]. In primary health care (PHC), nurses play specific roles, among which the continuous and organized monitoring of people at all stages of the life cycle stands out. This process occurs through nursing consultations, grounded in technical and scientific knowledge and applied for both educational and care purposes, enabling responses to the complexity of each person's health needs[4–5].

Regarding care for older adults, increasing attention has been observed due to advances in health technologies and demographic transitions, which have brought changes to the work processes of the Brazilian Unified Health System (SUS)[6]. Nursing, integrated into this context, has sought to generate and disseminate knowledge in the field of geriatric nursing, in order to reorient practices and knowledge toward health promotion, autonomy maintenance, frailty prevention, and improved quality of life[7].

In this context, geriatric nursing is established as a dynamic field, supported by active listening and the planning of actions centered on older adults and their families. During consultations, nurses should consider not only clinical and functional aspects but also psychosocial, cultural, and spiritual factors that influence health and self-care[8]. The Nursing Process guides this practice, enabling the identification of needs, development of diagnoses, and implementation of individualized care. Evidence shows that valuing sociocultural dimensions fosters more humanized and effective practices, respecting diverse beliefs, values, and life contexts[9-10].

Nevertheless, despite its relevance, nursing consultations with older adults still present significant gaps. Studies have revealed deficits in care, primarily expressed in the limited gerontological competencies of nurses, including a lack of knowledge or an inability to carry out multidimensional assessments of older adults, a core tool for geriatric nursing consultations. This assessment is a systematic and interdisciplinary process aimed at identifying clinical, functional, psychological, social, and environmental aspects[11].

Geriatric nursing care extends beyond the clinical management of chronic diseases characteristic of traditional geriatric care, demanding a broader, interdisciplinary practice that is sensitive to the multiple determinants affecting aging. However, the application of the Nursing Process remains incipient in health services, whether due to structural limitations, a lack of specific protocols, or a shortage of trained professionals[12].

Thus, investigating geriatric nursing consultations from the perspective of PHC nurses may help identify structural strengths and weaknesses, as well as support the development of strategies to improve care, promote active aging, and prevent common frailties in old age. Accordingly, this study aimed to explore the structural aspects of geriatric nursing consultation carried out by nurses working in primary care.

Methods

This qualitative study was carried out with nurses from 10 Basic Health Units (BHUs) in a small municipality located in the countryside of the state of Paraíba, Brazil. The study was designed and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The study population consisted of nine nurses working in the municipality's BHUs, selected through purposive sampling. All nine professionals working in the ten BHUs were invited to participate, with exclusion criteria limited to those on medical leave or

other forms of absence, which did not occur. Thus, all nurses were initially eligible. Ultimately, the sample comprised eight participants: one nurse worked in multiple rural units, and another could not be reached despite repeated contact attempts.

Data were collected between November 2023 and February 2024 using two instruments: a socio-professional questionnaire, which included variables such as sex, age group, length of professional experience, years working in the Family Health Strategy, academic degree (graduate certificate, master's, doctorate), and qualification in older adult health; and an interview guide addressing the structural elements of geriatric nursing consultations. This guide was collaboratively developed by the researchers, based on a literature review and primary health care guideline. It included aspects related to the context of the consultation (individual or family approach, setting, mode of access, and eligibility criteria), stages and methods used (clinical procedures, assessment tools, health record documentation), as well as nurses' perceptions of weaknesses, challenges, and potential of this type of care. After its formulation, the instrument underwent a pilot test among the researchers, which allowed adjustments regarding clarity, relevance, and suitability to the study's objectives. The semi-structured individual interviews combined open-ended and closed-ended questions, using the revised guide as a framework.

The interviews were conducted by the principal investigator, a nurse with a PhD in public health, and a nursing student trained by the supervisor to conduct the research. Initial contact was made with the participants to check their availability of dates and times and to present the study objectives and the interview guide so that they could have an initial idea of what participation would involve.

Such interviews were conducted in the nursing offices of the BHUs, ensuring confidentiality, privacy, and audio recording for subsequent verbatim transcription. On that occasion, participants received the Informed Consent Form (ICF), which was signed in two copies—one filed by the researchers and the other given to the participant. The interviews were carried out without interruptions; however, participants were given as much time as needed to respond, or, if preferred, could choose not to answer, which did not occur. The average duration of the interviews was 30 minutes.

After the interviews, the audio recordings were transcribed in Microsoft Word, and the content was organized into a single textual corpus. The transcripts were not returned to participants for comments or corrections. This material was exported to the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRAMUTEQ). The output generated a dendrogram of the classes, hierarchically presenting the words according to their occurrences and the connections among them, based on their statistical association (considered significant at $p < 0.05$ and $\chi^2 > 3.84$).

To complement the analysis and visualize the relationships between classes and terms, Correspondence Factorial Analysis (CFA) was applied, producing a graphical representation on a Cartesian plane, which facilitated data interpretation by crossing word frequency with the identified classes. To ensure anonymity, participants' identities were coded in the transcripts using the abbreviation "N," followed by a sequential number corresponding to the interview order (e.g., N1, N2, and so forth).

Once the dendrogram and Cartesian plane were generated, the data were submitted to content analysis conducted in three methodological stages. The first stage, called pre-analysis, involved organizing and the initial reading of the material, allowing the selection of relevant content. The second stage, material exploration, consisted of coding and categorizing the data based on the classes generated by IRAMUTEQ, previously defined by the researchers. Finally, the third stage, treatment of results and interpretation, enabled the systematization of the most relevant information in light of the study objectives[10].

All methodological procedures adhered to the ethical principles established by Resolution No. 466/2012 of the National Health Council. The project was submitted to the Research Ethics Committee of

the Federal University of Campina Grande, via *Plataforma Brasil*, and was approved under opinion number 6,497,882/2023, Certificate of Ethical Clearance Presentation 62123822.2.0000.0154.

Results

All eight participants were women, aged 29–48 years (mean age of 36), with five to nine years since graduation and experience in the Family Health Strategy. Most (n = 6) held a graduate certificate, although not specifically in the field of older adult health.

The analysis performed with Descending Hierarchical Classification identified a textual corpus composed of eight texts and 100 text segments (TS). Of these, 70 were retained for analytical purposes, corresponding to a retention rate of 70%. Organizing and reading the corpus resulted in five distinct meaning classes. These classes, which represent lexical clusters with content similarity, are illustrated in Figure 1 as a dendrogram, visually showing the relationships among clusters and highlighting proximities and distances within the analyzed discourses.

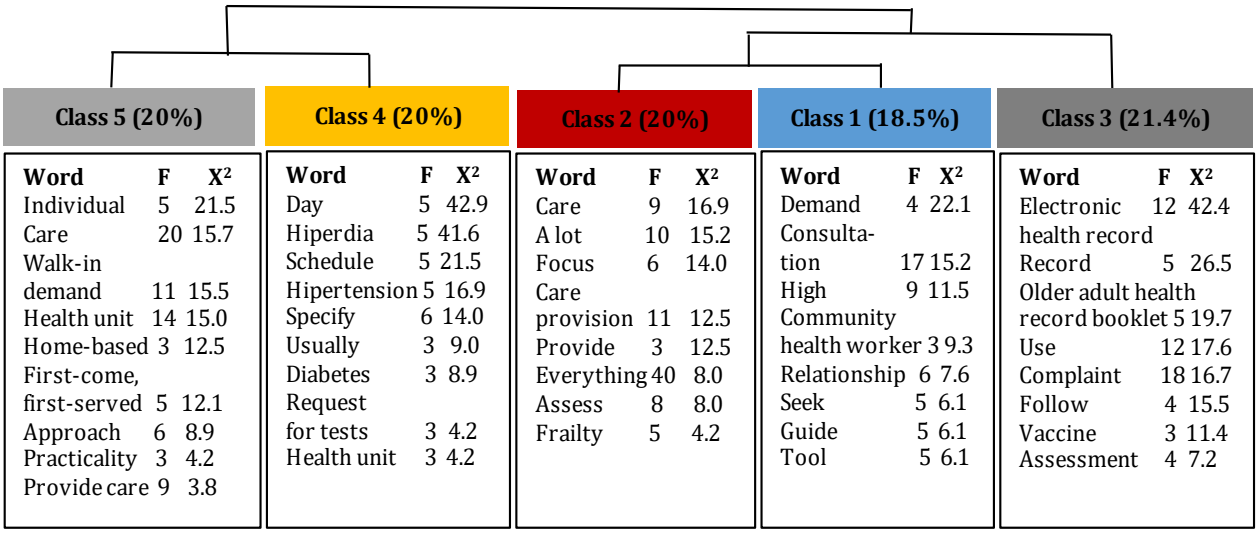

Figure 1 – Descending Hierarchical Classification of the structural elements of nursing consultations conducted by nurses in BHUs. Cuité, PB, Brazil, 2024

The dendrogram revealed that the textual corpus generated a class structure organized into two main segments. The first segment included Class 5, "Characterization of the approach to older adults in the Basic Health Unit" (14 TS; 20%), and Class 4, "Biomedical perspectives of care" (14 TS; 20%). The second segment brought together, in an articulated way, Class 2, "Nursing perspectives on frailty in older adults" (14 TS; 20%), and Class 1, "Organizational flow of geriatric nursing consultations" (13 TS; 18.5%), at a lower hierarchical level. Also in this second segment, in isolation and at the highest hierarchical level, was Class 3, "Recording and assessment methods used during the consultation" (15 TS; 21.4%).

Accordingly, Figure 2 presents the Cartesian plane of the correspondence factorial analysis, confirming the proximity and association of context units between Classes 5 and 4, mainly represented by the words *individuals*, *walk-in demand*, *care*, *Hiperdia*, *day*, and *schedule*, located in the upper and lower left quadrants; the articulation between Classes 2 and 3, demonstrated by the distribution of words such as *demand*, *consultation*, *care*, *focus*, and *care provision*, especially in the lower right quadrant; and Class 5, practically isolated in the upper right quadrant, structured by words such as *electronic health record*, *older adult health record booklet*, *record*, *complaint*, and *access*.

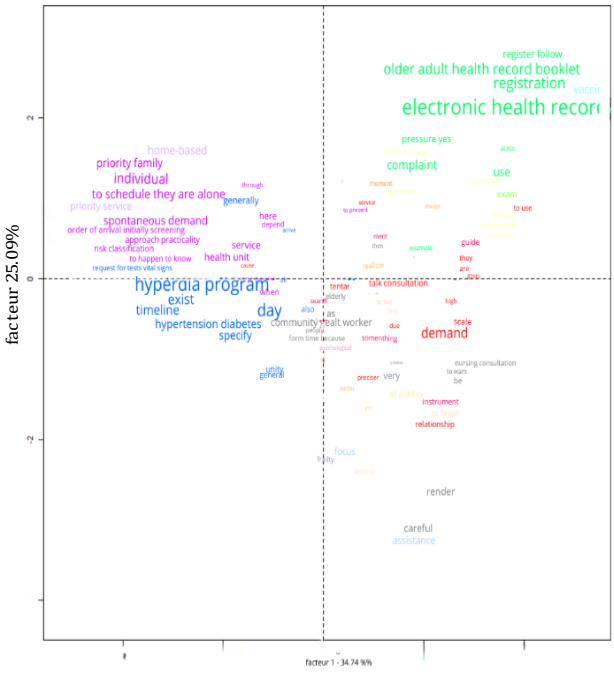

Figure 2 – Cartesian plane of the Correspondence Factorial Analysis of the structural elements of geriatric nursing consultations conducted by nurses in BHUs. Cuité, PB, Brazil, 2024

Based on the classes and hierarchically classified words, two thematic categories were developed for content analysis: Thematic category I — Nursing consultations with older adults focused on diseaseoriented care, which included Classes 4 and 5; and Thematic category II — The deficit in multidimensional care for older adults, from user embracement to longitudinal care, including Classes 1, 2, and 3.

Thematic category I — Nursing consultations with older adults focused on disease-oriented care

When asked how geriatric nursing consultations are carried out, participants' statements indicated that, despite awareness of the need for comprehensive care, there remains a substantial deficit in implementing this tool, as highlighted in the excerpts below: *I think sometimes we are so focused on the disease that we start by asking what the complaints are, what the person is feeling. That is what directs the consultation — the main complaints... Unfortunately, in primary care nowadays we tend to treat disease more than we prevent it or promote health* (N1). *I do user embracement depending on the patient's complaint. I try to talk at length to assess health conditions. I have not yet used scales* (N6).

Another relevant point mentioned by participants concerns the method Subjective, Objective, Assessment, and Plan (SOAP) and the International Classification of Primary Care, which guide the conduct of geriatric nursing consultations in PHC. The interviewees reported using the standard established in the citizen's electronic health record on the e-SUS platform: *Here, in the nursing consultation, we follow the pattern of the electronic health record and follow the patient's complaint. If they come wanting tests, we listen to the complaint and carry out the consultation...* (N2). *I use the electronic health record, based on the SOAP method. I think it is necessary to record the complaints and the assessment* (N3).

An approach focused on older adults within the Hiperdia program also emerged. From a broader perspective, this may be regarded as a weakness, as it limits care for older adults to the management of chronic diseases such as diabetes mellitus and hypertension, as illustrated in the narratives: *There isn't a specific day for older adult care, but it is generally within Hiperdia. Usually those with some comorbidity—diabetes and hypertension, for example* (N6). *Usually, when they come, it is for Hiperdia... There isn't anything specifically aimed at this population* (N7).

Thematic category II — The deficit in multidimensional care for older adults, from user embracement to longitudinal care

The interview analysis revealed that multidimensional assessment was not implemented in most services and was identified as a weakness in care, as illustrated in the excerpts below: *Unfortunately, I cannot use scales because of the high demand here at the health unit. Depending on the complaint, we do not conduct a complete consultation* (N5). *I do not use instruments, such as scales, due to the high demand. I use the electronic health record for documentation and follow the sequence it suggests. ...Not using these available instruments ultimately undermines the quality of care, which could be much more robust*

if we used them (N8). *Yes, if I applied scales and used protocols, the consultation would improve the quality of care* (N3).

Another frequently reported element concerned knowledge gaps about using instruments during clinical care, as seen in the following excerpts: *I think the lack of training is an issue — when we arrive at the unit, everything is new. When I graduated it was one way; now it has changed, new protocols keep coming, and we end up unable to keep up or access them because of the high workload and accumulated service demands* (N5). *I think one way to improve would be training courses so we can better meet this population's needs* (N8). *We do not use the older adult health record booklet because we do not know how to use it* (N7).

Discussion

Regarding care provided to older adults, several studies underscore the need for comprehensive care that encompasses multiple dimensions—clinical, psychoemotional, family, social, and spiritual—that directly shape the health–illness process. Accordingly, it is increasingly necessary to reinforce that care practices must move beyond clinic-centered approaches still rooted in the traditional biomedical model[11]. In this scenario, the geriatric nursing consultation emerges as a strategic tool to operationalize comprehensive care. However, its effectiveness depends on structured planning grounded in technical guidelines and sustained by systematic nursing practice[7].

This study found that, in day-to-day primary health care (PHC), a complaint-driven logic with a predominant focus on biomedical aspects continues to prevail. This finding aligns with prior research pointing to the neglect of subjective and psychosocial factors in older adults, which are essential for comprehensive assessment[12]. Consequently, the disease-centered focus remains a barrier to the effective implementation of multidimensional care.

From nurses' accounts, we identified weaknesses in the practical application of the aforementioned dimensions, given that consultations have addressed only the clinical dimension — specifically the presenting complaint. A broad review of the literature likewise revealed neglect of frailty assessment and of the multidimensional assessment of older adults, as well as the incipient nature of actions to promote active and healthy aging[13].

Thus, barriers to accessing health services have been observed, along with difficulties in ensuring continuity of care and a lack of adequate resources and support for effective follow-up[14]. It is important to emphasize that older adults seeking care at the BHU should not be viewed solely through the lens of the presenting disease, but rather considered in their entirety, with attention to their physical, emotional, and social needs through a multidimensional approach[15].

The context surrounding the disease should also be considered, as it may constitute or determine part of the reported problem. Authors further note an increasing technologization and a shift toward ambulatory, protocol-driven clinical practice—a topic widely discussed—particularly because, in some service settings, humanized care has been inadequate, thereby excluding aspects tied to patients' expectations, desires, and lived experiences, which may help explain the reality observed[15].

Another important point raised by participants concerns the SOAP method and the International Classification of Primary Care, which are used as reference frameworks for geriatric nursing consultations in PHC, guiding the Nursing Process[16]. However, these instruments are oriented toward clinical disease analysis and tend to overlook the broader, multidimensional approach required for geriatric assessment.

The classification method embedded in the citizen's electronic health record helps clarify issues associated with the illness experience of the person seeking care, enabling classification of the reason for encounter rather than a presumptive diagnosis. It classifies people, not diseases, and it generates a systematized model — the SOAP method — that addresses both the subjective aspects of the consultation (the reason for seeking care) and the objective component (findings from the physical examination

and complementary tests). The model enables professionals to document an assessment of the clinical situation and overall findings during the consultation, ultimately devising a patient-centered care plan following the visit[17].

Accordingly, care for each population group must be individualized and encompass its particularities, given the unique context surrounding the health–illness process. Thus, care provided to older adults, when delivered in a generalized manner and with emphasis only on their reported complaints, as observed in the participants' statements, results in a deficit in the provision of qualified care, constituting a weakness in the healthcare process. This occurs because the subjective aspects of each individualare not adequately observed or addressed by healthcare professionals[18].

Conversely, a potential enabler highlighted by participants is the use of the electronic health record for guiding and documenting consultations, since applying the International Classification of Primary Care through the SOAP method enables nurses to guide care more efficiently and facilitates recording older adults' general health conditions in the information system. In this regard, using the citizen's electronic health record in conjunction with a multidimensional assessment of older adults can strengthen the care delivered and provide a more comprehensive view of the aspects involved in the health–illness process[19].

Another critical factor identified was the absence of specific planning for geriatric nursing consultations in the Basic Health Units under study. Care was delivered alongside chronic disease consultations, perpetuating the traditional biomedical model. This practice runs counter to the principles of the Statute of Older Adults (*Estatuto da Pessoa Idosa*), which calls for specialized, individualized care for this population[20].

Moreover, care for older adults living with comorbidities must be differentiated since, in addition to common health needs, they require closer monitoring that ranges from medication management and laboratory test results to quality-of-life aspects such as diet and physical activity, aiming to prevent complications and clinical decompensation[21].

In care for older adults, nurses are responsible for implementing a multidimensional approach focused on the particularities of the aging process. Multidimensional care is considered a priority care technology because it enables early identification of conditions that compromise autonomy and independence. However, implementation remains challenging, owing to technical and operational issues that limit its applicability in routine services and to limited policy investment in geriatric care, as the older adult population is still not viewed as a priority in primary health care activities[22].

The identified gap in implementing the multidimensional assessment of older adults has direct implications for public policy, reinforcing the need for structural investments in health care for an aging population. The Statute of Older Adults and the National Health Policy for Older Adults already mandate individualized actions; thus, there is a clear need to strengthen policies that encourage the use of standardized protocols and to include more specific indicators of the quality of geriatric care in performance evaluations of healthcare teams[22].

As reported by participants in this study, many nurses indicated that they did not use specific geriatric assessment instruments, whether due to work overload or gaps in the technical skills required to carry out this practice. Similarly, we observed a lack of systematic implementation of the stages of the Nursing Process, revealing weaknesses in the structuring of the care provided. Such limitations often stem from a lack of care systematization and a guiding theory to underpin nursing actions[23].

The use of geriatric assessment instruments aims to systematize the data collection across clinical, functional, social, cognitive, affective, nutritional, gait, and balance domains. Incorporating these tools into nursing consultations enables more effective and personalized care, allowing the actual needs of older

adults to be identified and addressed appropriately[24].

However, studies indicate that many professionals still perceive an unfavorable cost–benefit ratio for using these instruments. The most frequently cited reasons include limited consultation time and the perception that applying them may slow care delivery and disrupt service routines[25]. Nevertheless, most instruments are generally easy to administer and contribute to both improving the quality of care and enhancing health indicators among older adults[26].

Another challenge observed is the tendency to prioritize physical aspects — such as mobility and chronic diseases — over equally relevant domains, including mental health, social support, and cognition. This reductionist view compromises the development of effective, personalized care plans and hinders holistic, preventive interventions, particularly when adequate resources for more comprehensive assessments are lacking[27].

This scenario highlights the negative impact of competency gaps in the appropriate use of these instruments during care. Many nurses feel uncertain about the technical application of these tools, which can lead to inefficient or even incorrect use of the available instruments[27]. Compounding this is a lack of in-depth theoretical knowledge, which fosters reliance on generic routines and undermines the personalization of care — an essential component of the longitudinal care of older adults[28].

To ensure person-centered, high-quality care, nurses must develop a critical understanding of their competencies, recognizing their central role in promoting the well-being of older adults[24]. In addition, they should continuously analyze their practice context, identifying opportunities to implement strategies centered on individuals' needs, preferences, and values, thereby strengthening the quality of care[28]. More effective coordination can improve the quality of consultations for older adults, strengthen therapeutic relationships, and enable different modalities of multidimensional care[26-27].

Beyond structural improvements and professional training, incorporating innovative approaches is crucial. Telehealth can serve as a complementary strategy to monitor older adults with mobility limitations or those living in rural areas. Likewise, digital tools for geriatric assessment — such as applications integrated with the citizen's electronic health record—can facilitate the application of multidimensional assessment scales, automate documentation, and generate alerts for high-risk conditions. Such resources save time, improve diagnostic accuracy, and contribute to more personalized care[29].

Additionally, implementing digital transdisciplinary protocols that integrate information from the various health professionals involved can foster a shared view of older adults' health, thereby strengthening coordination and the longitudinal nature of care. Another promising avenue is the use of artificial intelligence for risk stratification, enabling the early identification of frailty and supporting clinical decisionmaking[30].

Study limitations

Among this study's limitations is its limited geographical scope—restricted to a single small municipality—which may limit the generalizability of the findings to settings with different sociodemographic or structural characteristics. Another consideration is response bias, since data were collected through interviews, which may have led participants to omit weaknesses or emphasize institutionally expected practices.

In addition, there was no triangulation of data (e.g., direct observation or document analysis), which could have enriched understanding of the phenomenon under investigation and enhanced the credibility of the results. This absence may limit interpretive depth, restricting the analysis to participants' selfreported perceptions.

Despite these limitations, the study provides evidence to inform understanding of the reality of geriatric nursing consultations in primary health care

and supports reflection and improvements in professional practice.

Contributions to practice

Practical actions informed by these findings include implementing protocols for the multidimensional assessment of older adults; systematically using the older adult health record booklet as a follow-up tool; promoting continuing professional development aimed at developing gerontological competencies; and expanding transdisciplinary integration to foster a shared, problem-solving approach. In addition, the results reinforce the importance of effective use of the Nursing Process as a structuring tool for care, enabling greater standardization and quality in care delivery. These strategies can strengthen longitudinal care, enhance nurses' clinical capacity, and increase the problem-solving capacity of primary health care.

Conclusion

Consultations were predominantly guided by the biomedical model — centered on main complaints and chronic conditions — at the expense of a comprehensive approach. There was limited use of multidimensional assessment tools, a lack of specific planning for older adults, and insufficient professional training. As a potential enabler, the use of the electronic health record stood out, supporting systematized documentation and more humanized care.

Authors' contributions

Conception and design or data analysis and interpretation; drafting of the manuscript or critical revision for important intellectual content; agreement to be accountable for the accuracy and integrity of any part of the manuscript: Menezes VV. Drafting of the manuscript or critical revision for important intellectual content; final approval of the version to be published: Costa PA, Silva ATH, Oliveira CBS, Barbosa MPR. Drafting of the manuscript or critical revision for important intellectual content: Silva BJQ. Drafting of the manuscript or critical revision for important intellectual content; final approval of the version to be published; agreement to be accountable for the accuracy and integrity of any part of the manuscript: Nogueira MF.

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