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ORIGINALES

Validation of activities developed in day-care centers for elderly: subsidies for assessing the quality

Validação das atividades desenvolvidas em centros dia para idosos: subsídios para avaliação da qualidade

Validación de las actividades desarrolladas en centros de día para ancianos: contribuciones para la evaluación de la calidad

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ABSTRACT:

Objective: Validate the content of care activities for elderly developed in day-care centers.
Methods: Methodological study, with content validation carried out by nine specialists, based on the attributes relevance, clearness, pertinence and simplicity. The established consensus rate was at 80%. The data collection period was between September and November 2014.
Results: Eight activities were validated and two included. In the health dimension, the activities were: functional capacity and frailty, food and nutrition, hygiene and comfort, drugs of continuous use, handling and cognitive stimulation; concerning participation: the socio-cultural activities, acceptance and monitoring, spiritual/religious support; concerning safety: accessibility and control of risk factors in falls; and concerning education: educational activities. Among 82 items assessed, 100% were considered relevant; 91,4% were considered clear; 97,5% were considered pertinent; and 92,6% were considered simple.
Conclusion: We believe that validation and systematization of activities contribute to support the assessment of quality in this type of attention.

Keywords: Aging; Day care; Comprehensive health care; Health services evaluation; Validation studies.

RESUMO:

Objetivo: Validar o conteúdo das atividades de atenção ao idoso desenvolvidas em centros dia.
Métodos: Estudo metodológico, com validação de conteúdo realizada por nove especialistas, segundo os atributos relevância, clareza, pertinência e simplicidade. O índice de consenso estabelecido correspondeu a 80%. A coleta de dados ocorreu entre setembro e novembro de 2014.

Resultados: Oito atividades foram validadas e duas incluídas. Na dimensão saúde, foram: capacidade funcional e fragilidade, alimentação e nutrição, higiene e conforto, medicamentos de uso contínuo, manejo e estímulo cognitivo; na participação as atividades socioculturais, acolhimento e monitoramento, apoio espiritual/religioso; na segurança, acessibilidade e controle dos fatores de risco para queda e na educação, as atividades educativas. Dentre 82 itens avaliados, 100% atingiram o consenso quanto à relevância; 91,4% à clareza; 97,5% à pertinência; 92,6% à simplicidade. **Conclusão:** Acreditamos que a validação e a sistematização das atividades contribuirão para subsidiar a avaliação da qualidade nessa modalidade de atenção.

Palavras-chave: Envelhecimento; Assistência diurna; Atenção integral ao idoso; Avaliação de serviços de saúde; Estudos de validação.

RESUMEN:

Objetivo: Validar el contenido de las actividades de atención al anciano desarrolladas en los centros de día.
Métodos: Estudio metodológico con validez de contenido realizada por nueve especialistas, según los atributos relevancia, claridad, pertinencia y simplicidad. El índice de consenso establecido correspondió al 80%. La recopilación de datos se llevó a cabo entre septiembre y noviembre de 2014.
Resultados: Ocho actividades fueron validadas y dos incluidas. En la dimensión salud fueron: capacidad funcional y fragilidad, alimentación y nutrición, higiene y confort, medicación continuada, manejo y estímulo cognitivo; en participación: actividades culturales, acogida y supervisión, apoyo espiritual/religioso; en seguridad, accesibilidad y control de factores de riesgo de caída y en educación, actividades educativas. De los 82 ítems evaluados, el 100% alcanzaron el consenso respecto a la relevancia; el 91,4% respecto a la claridad; el 97,5% respecto a la pertinencia, el 92,6% respecto a la simplicidad.
Conclusión: Creemos que la validez y la sistematización de las actividades contribuirán en el proceso de evaluación de la calidad en esta modalidad de atención.

Descriptores: Envejecimiento; Atención diurna; Atención integral al adulto mayor; Evaluación de servicios de salud; Estudios de validez.

INTRODUCTION

The appropriate management of elderly care should emphasize the functional capacity maintenance and/or improvement, including actions to promote healthy and active aging, injuries prevention, health recovery and physical and cognitive rehabilitation[1].

The Active Aging refers to the process of optimizing health, participation, safety/protection and long life learning opportunities. The aim is to act on these four pillars to improve the aging quality of life and enable aging be a positive experience[1].

In this conception, the health is understood as the possibility of access to services to meet physical and cognitive needs of the elderly, ensuring the best quality of life, longest healthy life and independence; the participation involves intersectoral actions promotion that provide the integration of people into recreational, cultural, social and spiritual activities; the safety/protection can be achieved through the policies development and programs that favor physical, social and economic aspects; and the long life learning refers to the training of specialized human resources and educational actions for the elderly[1,2].

Thus, the day-care center has been described as a promising opportunity for elderly care, based on health promotion, disease prevention, rehabilitation and recovery. It is a formal social support device for the elderly and their families and caregivers, intended for the daytime stay of elderly people with partial dependence to perform activities of daily living and that provides reception, protection and coexistence[3].

The frequency of the person in this service favors the maintenance of family ties, ensures the better quality of life as possible and allows the interpersonal relationships

development, the socialization promotion and the functional capacity and autonomy maintenance/improvement[4].

However, in Brazil, the profile data of the population attending in the day-care centers and the results in elderly's physical and mental health are still scarce. Furthermore, there isn't consensus concern to the day-care centers concept, activities, professional staff, way of works, structure, work processes, evaluation measures and good practices that must be performed in this care model.

Therefore, day-care centers professionals face a challenge in the search for quality services. This attribute refers to the set characteristics that includes professional excellence, resources efficient use and minimum risk to the user, and its evaluation is essential for planning, organizing, conducting and evaluating the activities developed in these services[5].

Thus, this research aimed to validate the content of the activities developed in elderly day-care centers, in the health, participation, safety/protection and long life learning dimensions, to subsidize the quality of services evaluation.

METHOD

It was a methodological study, developed in three phases: identification of the activities of elderly's attention developed in day-care centers; activities selection; and content validation.

The study was conducted in accordance with Resolution number 466/12 of the National Health Council of the Ministry of Health (CNS/MS), registered in the Brazil Platform and approved by the Research Ethics Committee of the São Paulo University, Nursing School (CEP/EE-USP) on October 4th, 2014, under protocol number 612.317 (CAAE 29147914.0.0000.5392).

The first phase, activities identification, was carried out from a literature review in databases: MEDLINE via PubMed, LILACS and IBECS. The gray literature was searched through Google Scholar, the WHO website and government websites.

The search strategy and descriptors used in MEDLINE were: ("Day Care"[MeSH]) AND "Health Services for the Aged"[MeSH] and (("Aged"[MeSH]) AND "Community Health Services"[MeSH]) AND "Day Care"[MeSH]. In this database, the search was carried out through two different strategies, with broad literature results. When the two strategies were associated, the search did not result in production destined to the object of this research. In the databases LILACS and IBECS, it was used the subject descriptor DeCS "day care". The gray literature search was conducted using the following words: "day-care center for the elderly", "community health services", "day care", "geriatric day care", "adult day services" and "day care units".

The second phase, of activities selection, took place through the categorization of those that were identified in the literature review, according to the health, participation, safety/protection and long life learning dimensions, giving rise to the material to be validated[1].

The content validation of the activities developed in geriatric day-care centers, corresponding to the third phase of the study, was based on the four pillars of active aging, considering the scope of care[1]. This validation was carried out by nine specialists, using the Delphi technique[6]. The first contact with the professionals to explain the study goals and method was carried out by phone, e-mail or in person, followed by the sending of: an invitation letter, the validation material and the filling

instructions, in the most convenient way for the specialist - in person or by electronic means. At that time, it was agreed the deadline of 30 days for the material to be returned.

In order to compose the specialists group, we have established the following criteria: professionals and/or researchers with experience working in day-care center or with knowledge in the themes: aging, elderly care activities, instruments validation, services quality and evaluation, and health promotion and disease prevention.

The experts received a questionnaire and each one delivered their individual judgment, aiming at the content analysis. After the judges return the material, the data was organized in a spreadsheet, and the answers analysis, to verify the consensus index (CI), which in this study was established in ≥ 80%[7].

The validation instrument was built based on the one developed for validation of the activities performed by the nursing team in Material and Sterilization Centers (CME)[8]. This choice was made due to the methodological similarity of the present study and the one conducted to validate the activities in CME.

The questionnaire used in this study had two parts. The first one with the variables for the specialists characterization, namely: age, sex, work place, institution legal nature, position occupied and occupation time, work area, graduation and graduation time, last academic degree and area.

The second part consisted of validation content items and was composed of a table describing the dimensions - health, participation, safety/protection and long life learning, the corresponding activities and their descriptions.

Subsequently, assertions were made that allowed affirmative or negative responses, as well as spaces destined to the possible specialists comments and/or suggestions. The judges were also expected to analyze each activity and its descriptions regarding: definition, inclusion and/or exclusion of descriptions and whether the set of descriptions represented actions aimed at that activity to elderly's care in day-care centers. We asked the experts to consider whether the set of activities contemplated each dimension and whether to include another activity or not.

For the health dimension, the activities were *food and nutrition* and *hygiene and comfort*; for participation, *mental capacity optimization*, *socio-cultural activities*, *acceptance and monitoring* and *spiritual support*; for the safety/protection dimension, *accessibility and mobility*; and for the long life learning, *socio-educational activities*.

The activities and their descriptions were represented by letters and numbers, and the letters corresponded to the initial of each dimension (Health - H, Participation - P, Safety/Protection - SP and Long Life Learning - L) and the numbers corresponded to the order of presentation in the text.

The evaluation of dimensions, activities and descriptions was carried out through four attributes: *relevance* (it is significant for the elderly's quality of care in day-care centers); *clarity* (the expressions are objective and intelligible); *pertinence* (reproduces what is advocated for health promotion and prevention of aggravations in the aging area); and *simplicity* (it expresses a single idea, without possibilities of other interpretations).

The data were stored in a spreadsheet and analyzed by descriptive statistics, in absolute and relative frequencies and in measures of central tendency. The concordance analysis among the judges who composed the committee was calculated

by the Consensus Index (CI), represented by the ratio between the number of concurrent experts and the total number of specialists, multiplied by one hundred[9].

RESULTS

The specialists group was composed of nine professionals, all female, with five (55%) nurses, two (22%) gerontologists, one (11%) social scientist and one (11%) nutritionist. Among them, three (33%) had experience in day-care centers.

The age ranged from 28 to 66 years, with an average of 40,2 years (dp±10,1) and a median of 42,5 years. As for training time, the mean was 15,3 years (dp±11,2) and the median was 12 years, with a minimum of 3 and a maximum of 29 years. The average time in the current position was 4,1 years (dp±2,6) and the median was 3 years, ranging from 1 to 8 years.

Most of the specialists (55%) worked in a public institution, holding the position of professor (33%) and worked in the area of teaching/research (33%), with the predominance of specialists with *stricto senso* postgraduate (44,4%), followed by those with specialization *lato senso* (33,3%).

In the experts' consensus analysis regarding the definition of activities in each of the dimensions, the value obtained was ≥ 80% in all activities, and the lowest values were 88%. The simplicity attribute obtained 100% agreement regarding the definition in all activities. The definitions of activities *food and nutrition*, *socio-cultural activities* and *socio-educational activities* had 100% consensus for the four attributes evaluated.

In the health dimension, of the total 32 descriptions, only four (12,5%) had CI lower than 80%. In the *food and nutrition* activity, all the descriptions reached 100% agreement for the relevance and pertinence attributes; among the nine existing descriptions, six (H1.3, H1.4, H1.5, H1.6, H1.7 and H1.8) presented 100% consensus among the experts regarding relevance, clarity, pertinence and simplicity. The worst percentages involved activities H1.1 (77%) and H1.9 (66%), in attributes clarity and simplicity.

In the *hygiene and comfort* activity, there was a 100% consensus for relevance and simplicity. The descriptions H2.4 to H2.14 showed 100% agreement for the four attributes analyzed. Two descriptions (H2.18 and H2.21) obtained a CI of 77%, close to the estimated, in the relevance attribute.

In the participation dimension, of the total 35 propositions, 33 (94,2%) reached consensus ≥ 80%. The worst results (77%) were verified in the activities *acceptance and monitoring* (P3.1) and *spiritual support* (P4.2 and P4.3), in the attributes clarity and simplicity.

In the activity *mental capacity optimization*, 100% of the descriptions obtained CI ≥ 80%. The lowest CI (88%) was verified in item P1.2, in the attribute relevance.

In the descriptions of *socio-cultural activities*, the lowest consensus value (88%) was obtained in items P2.1, P2.2, P2.3, P2.7 and P2.9 for clarity and simplicity. For the relevance and pertinence attributes, there was 100% consensus for all descriptions.

The agreement between the judges regarding relevance was also 100% for all descriptions of *acceptance and monitoring* activity. In this activity, the majority (68,8%) of the descriptions (P3.3 to P3.7 and P3.11 to P3.16) reached a consensus of 100% in the four aspects analyzed. Only the description P3.1 didn't reach the estimated consensus for clarity and simplicity (77%).

For the descriptions of the *spiritual support* activity, the highest CI was 88%. The agreement percentage for the descriptions P4.2 and P4.3 was 77%, also in the clarity and simplicity aspects.

In the safety/protection dimension, of the total descriptions related to the *accessibility and mobility* activity, two (22,2%) (SP1.5 and SP1.6) didn't reach a consensus ≥ 80%, the first being in clarity and simplicity attributes (77 %) and the second in the clarity attribute (77%).

In the long life learning dimension, in terms of relevance and pertinence, the agreement among the judges was 100% for all descriptions of *socio-educational activities*. The lowest CI observed were 88% in items L1.5 and L1.6, in clarity and simplicity aspects. The other four descriptions reached 100% consensus on the four attributes. Thus, in this dimension, all the descriptions obtained the established CI.

In the health dimension, for 88% of the specialists, the descriptions contained in *food and nutrition* and *hygiene and comfort* represented these activities as a whole. For the participation dimension, this percentage was 100% for activities *mental capacity optimization* and *socio-cultural activities*, and 88% for activities *acceptance and monitoring* and *spiritual support*. In the safety/protection dimension, 88% of the judges mentioned that the proposed descriptions comprised, as a whole, the activity *accessibility and mobility*, and in the long life learning dimension, this percentage was 100% for *socio-educational activities*.

Regarding the need to include or exclude descriptions in each of the activities, the answers indicated that in the health dimension, 44% of the judges would include descriptions in the *food and nutrition* activity and 23% in the *hygiene and comfort* activity; 23% would exclude some description in *food and nutrition* activity and 44% in *hygiene and comfort*. In the participation dimension, the percentages for descriptions inclusion were 44% for *acceptance and monitoring*, 33% for *spiritual support* and 23% for *mental capacity optimization* and for *socio-cultural activities*. In this dimension, the *acceptance and monitoring* activity received the highest percentage of opinions to exclude some description (55%), followed by *spiritual support* (33%). For the other activities, the percentage was 12%.

The *accessibility and mobility* activity, from the safety/protection dimension, was the one which most of the experts pointed out the need to include descriptions (77%). As for the exclusion, the percentage was 12%. In the long life learning dimension, the percentages for descriptions inclusion and exclusion for *socio-educational activities* were 33% and 12%.

When analyzing whether the activities with their descriptions represented, in their whole, the dimension in which they were, the judges positively opined for the four dimensions, being 88% for the health and safety/protection dimensions, 77% for participation and 100% for long life learning.

Thus, when questioned about the need to include activities in the four dimensions, 77% of specialists would not do so in the health dimension and 100% in participation and long life learning. In the safety/protection dimension, 55% of judges would include some activity.

Within the four dimensions, eight activities were described, of which 100% reached the CI established for the four attributes, relevance, clarity, pertinence and simplicity.

The total of items described, considering the eight activities, was 82. Of these, 100% reached the CI established in the relevance attribute, 91,4% (N=75) in the clarity, 97,5% (N=80) in the pertinence and 92,6% (N=76) in simplicity.

Most of the specialists suggestions and comments for the eight activities were to improve the descriptions' clarity and simplicity.

Regarding the activities definition, in the health dimension there were two suggestions to include *functional capacity and frailty* activities and *continuous use medications*. In the participation dimension, there was a suggestion to change the *mental capacity optimization* activity for *handling and cognitive stimulation* and reallocate this to the health dimension. One judge suggested modifying the *acceptance and monitoring* for *social-assistance activities* and one suggest excluding *monitoring*. There was also a suggestion to exclude the *spiritual support* activity and one to put it into the health dimension. In the safety/protection dimension, a specialist commented on redefining the *accessibility and mobility* activity for *accessibility and control of falls risk factors*. In the long life learning dimension, the suggestion was to name the activities as *educational*, rather than *socio-educational*.

The specialists evaluation and their suggestions/comments allowed the activities and their descriptors readjustment, with the incorporation of the knowledge shared by the judges, and it wasn't necessary the return of the instrument for a new evaluation.

The validated content allowed the construction of an instrument to subsidize the evaluation of the day-care centers quality, which is structured in four dimensions: health, participation, safety/protection and long life learning. Each dimension has activities with descriptions, totaling ten activities and 102 descriptions. The tables listed from I to IV indicate the activities evaluated and validated by the specialists for each dimensions.

Table I: Activities and descriptions, evaluated and validated by specialists, in the health dimension, São Paulo – 2015

HEALTH DIMENSION (H)	
Food and nutrition (H1)	
Evaluated Activities	**Validated Activities**
H1.1 Support the elderly during the meal. **H1.2** Evaluate food consistency according to the elderly's needs. **H1.3** Evaluate the elderly's preferences for food. **H1.4** Evaluate dysphagia, choking, nausea and vomiting, intestinal constipation. **H1.5** Evaluate the elderly's nutritional status. **H1.6** Stimulate the water intake. **H1.7** Stimulate, assist and supervise the elderly's feeding. **H1.8** Re-educate the elderly's eating habits. **H1.9** Serve the elderly or help them serve themselves.	- Evaluate the elderly's nutritional status. - Evaluate deglutition, chewing, diet acceptance and bowel behavior. - Evaluate the elderly's preferences for food. - Identify food restrictions, according to the elderly's health condition. - Adapt food consistency according to the elderly's needs. - Assist the elderly during the meal, when necessary. - Stimulate, assist and supervise the elderly's feeding. - Stimulate the water intake. - Re-educate the elderly's eating habits. - Guide the family about food and nutrition for the elderly. - Promote culinary activities with the elderly.
Hygiene and comfort (H2)	
H2.1 Just do what the elderly can't do alone. **H2.2** Assist the elderly with clothing. **H2.3** Take care of fingernails and toenails.	- Perform only what the elderly can't do alone. - Observe the preferences and habits of the elderly. - Stimulate, guide, supervise and assist the

H2.4 Stimulate, guide and assist the elderly to perform oral hygiene. **H2.5** Stimulate, guide and assist the elderly in the dental prostheses' hygiene. **H2.6** Stimulate, guide and assist the elderly in handwashing. **H2.7** Stimulate, guide, supervise and assist the elderly to make their hygiene, aiming at self-care. **H2.8** Maintain the privacy of the elderly. **H2.9** Observe the preferences and habits of the elderly. **H2.10** Perform intimate hygiene on each diaper change. **H2.11** Carry out changing diapers periodically. **H2.12** Separate the materials necessary for oral hygiene. **H2.13** Make sure clothes are adequate and comfortable. **H2.14** Check that the shoes are suitable and are safe. **H2.15** After bathing, help the elderly to wipe. **H2.16** Put the elderly in the bath and supervise him/her to avoid falling. **H2.17** Wash the hair of the elderly at least three times a week. **H2.18** During bathing, keep doors and windows closed to prevent drafts. **H2.19** Observe the need of use a hygienic chair. **H2.20** Prepare the bathroom and place objects needed for bathing in an easily accessible place. **H2.21** After bathing, thoroughly dry intimate parts, knee bends, elbows, under the breasts, underarms and between the toes. **H2.22** Separate personal clothing in advance for bathing. **H2.23** Check the water temperature for the bath.	elderly to make their hygiene, aiming at self-care. - Maintain the privacy of the elderly. - Stimulate, guide and assist the elderly in handwashing. - Keep nails short and clean. - Assist the elderly with clothing. - Make sure clothes are adequate and comfortable. - Check that the shoes are suitable and are safe. - Stimulate, guide and assist the elderly to perform oral hygiene, including dental prostheses. - Separate the materials necessary for oral hygiene. - Carry out changing diapers periodically. - Perform intimate hygiene on each diaper change. - Put the elderly in the bath and supervise him/her to avoid falling. - Separate personal clothing in advance for bathing. - Prepare the bathroom and place objects needed for bathing in an easily accessible place. - Observe the need of use a hygienic chair. - Check the water temperature for the bath. - keep doors and windows closed to prevent drafts during bathing. - Wash the hair of the elderly at least three times a week. - After bathing, if necessary, help the elderly to wipe. - Adopt safety measures during bathing, such as: - Observe the presence of carpets and steps that may cause falls. - Keep the soap in a container (for example, nylon stocking) to prevent the elderly person from lowering if they are knocked over. - Keep a plastic chair next to the bathroom stall, to be used in case the elderly's needs.
Functional capacity and frailty	
This activity was included after content validation by the experts.	- Evaluate the elderly's functional capacity. - Promote rehabilitation activities for the elderly with functional decline. - Evaluate and monitor the clinical criteria related to the diagnosis of frailty. - Provide and stimulate physical activities. - Provide strength and balance training exercises.

	- Identify the intrinsic factors related to the fall risk.
Continuous use medications	
This activity was included after content validation by the experts.	- Administer the medication according to the medical prescription. - Administer the medication correctly, considering: patient, medication, dose, route and time. - Evaluate polypharmacy. - Evaluate adverse events risks. - Provide qualified professional for the medication administer. - Promote educational actions aimed to the medications' rational use.
Handling and cognitive stimulation	
This activity corresponds to the activity **Mental capacity optimization (P1)**, which was included in the **participation** dimension and was changed to the **health** dimension after content validation by the specialists. **P1.1** Evaluate the cognitive function. **P1.2** Evaluate the presence of psychological changes. **P1.3** Stimulate reading. **P1.4** Stimulate the autobiographical memory. **P1.5** Encourage the elderly's participation in cognitive stimulation games. **P1.6** Promote the elderly's self-esteem. **P1.7** Promote stimulation and cognitive rehabilitation activities.	- Evaluate changes in mood/behavior (psychological). - Evaluate the cognitive function. - Promote stimulation and cognitive rehabilitation activities. - Encourage the elderly's participation in cognitive stimulation games. - Stimulate reading. - Stimulate the autobiographical memory. - Stimulate the family to participate in activities with the elderly.

Table II: Activities and descriptions, evaluated and validated by specialists, in the participation dimension, São Paulo – 2015

PARTICIPATION DIMENSION (P)	
Socio-cultural activities (P2)	
Evaluated Activities	**Validated Activities**
P2.1 Accompany the elderly in internal or external activities. **P2.2** Promote socio-cultural activities. **P2.3** Evaluate the preferences of the elderly for leisure activities. **P2.4** Encourage the elderly to participate in activities. **P2.5** Promote intergenerational integration. **P2.6** Promote the participation of the elderly in community activities. **P2.7** Promote leisure activities, according	- Promote socio-cultural activities, respecting the physical and cognitive limitations of the elderly. - Encourage the elderly to participate in socio-cultural activities. - Accompany the elderly in internal or external socio-cultural activities. - Map the preferences of the elderly for leisure activities. - Promote leisure activities, according to the preferences of the elderly. - Promote integration among the elderly.

to the preferences of the elderly. **P2.8** Promote and encourage family's participation in activities. **P2.9** Promote commemorative celebrations and collective outings.	- Promote intergenerational integration. - Promote the participation of the elderly in community activities. - Promote commemorative celebrations and collective outings. - Perform periodic cultural exhibitions of the activities developed by the elderly. - Promote and encourage family's participation in socio-cultural activities.
Acceptance and monitoring (P3)	
P3.1 Support the family in the care of the elderly. **P3.2** Evaluate the adaptation of the elderly within a maximum of 30 (thirty) days. **P3.3** Assess the initial expectations of the elderly and the family. **P3.4** Assess the biopsychosocial needs of the elderly and the family. **P3.5** Evaluate the reactions/behaviors of the elderly. **P3.6** Establish partnership with family. **P3.7** Demonstrate the importance of the participation of people close to the elderly. **P3.8** Monitor the health of the elderly. **P3.9** Monitor and periodically evaluate the individual care plan, designing a new plan according to personal need. **P3.10** Provide clarification if necessary. **P3.11** Carry out multidimensional evaluation of the elderly. **P3.12** Carry out a survey of the material provided by the elderly (eg, hygiene items, medicines and others). **P3.13** Hold a meeting with the family and the elderly to present the plan of care. **P3.14** Hold a meeting with the family and the elderly to provide information on the reception process. **P3.15** Remember, where necessary, the rules of operation of the day-care center, the rights and duties of both parties and the responsibilities of all persons involved in the provision of the service. **P3.16** Record the information on the seniors card.	- Identify the initial expectations of the elderly and the family. - Perform multidimensional evaluation of the elderly. - Identify the biopsychosocial needs of the elderly. - Evaluate the reactions/behaviors of the elderly. - Evaluate the adaptation of the elderly in the day-care center, within a maximum period of 30 (thirty) days. - Periodically monitor and evaluate the plan of individual attention, elaborating a new planning, according to the need raised. - Hold a meeting with the family and the elderly to present the plan of care. - Hold a meeting with all persons involved in the provision of the service. - Establish partnership with family. - Guide the family in the care of the elderly at home. - Provide clarification to the elderly/family, whenever necessary. - Show the importance of the participation of people close to the elderly. - Carry out the survey of the material provided by the elderly (eg, hygiene items, medicines and others). - Record the information in the file of the elderly. - Remember, where necessary, the rules of operation of the day-care center, the rights and duties of both parties and the responsibilities of all persons involved in the provision of the service.
Spiritual support (P4) (Activity changed to: **Spiritual/religious support)**	
P4.1 Identify the spiritual belief. **P4.2** Promote the spiritual support. **P4.3** Promote moments of spiritual activities.	- Promote spiritual/religious activities in the day-care center. - Define religious and/or spiritual activities that promote the well-being of the elderly and preserve healthy coexistence in the day-care center.

	- Identify the religion declared by the elderly. - Identify the importance of religion/spirituality for the elderly. - Respect the choices and individuality of each elderly person. - Stimulate the coexistence and respect between different beliefs.

Table III: Activities and descriptions, evaluated and validated by specialists, in the safety/protection dimension, São Paulo – 2015

SAFETY/PROTECTION DIMENSION (SP)	
Accessibility and mobility (SP1) (Activity changed to: **Accessibility and control of falls risk factors)**	
Evaluated Activities	**Validated Activities**
SP1.1 Assist and supervise the elderly in physical activities and rehabilitation. **SP1.2** Assist the elderly to sit or stand. **SP1.3** Assist the elderly in locomotion. **SP1.4** Assess the mobility of the elderly. **SP1.5** Assess the need for the use of assistive technology. **SP1.6** Instruct and support the elderly in the use of assistive technology. **SP1.7** Maintain adequate and correct positioning of the elderly. **SP1.8** Prevent accidents. **SP1.9** Promote physical activities and rehabilitation.	- Perform the appropriate ergonomic and environmental adaptation to the elderly. - Evaluate the accessibility of day-care center environments. - Monitor, continuously, the physical area of the day-care center in order to prevent accidents. - Map possible causes of accidents in the day-care center. - Assist the elderly to sit or stand. - Assist the elderly in locomotion. - Assess the mobility of the elderly. - Assess the need for the use of assistive technology. - Instruct and support the elderly in the use of assistive technology. - Maintain adequate and correct positioning of the elderly. - Prevent falls, by means of measures such as: - Ensure adequate lighting in environments. - Keep vigil light in places of low luminosity. - Don't use carpets, rugs and mats. - Keep the floor covering in perfect condition. - Don't use wax on floors. - Indicate the presence of unevenness in the floors. - Don't use low, unstable or sliding furniture. - Don't leave objects on the floor. - Keep handrails in circulation areas. - Provide support bars in the bathrooms.

Table IV: Activities and descriptions, evaluated and validated by specialists, in the long life learning dimension, São Paulo – 2015

LONG LIFE LEARNING DIMENSION (L)	
Socio-educational activities (L1) (Activity changed to: **Educational activities)**	
Evaluated Activities	**Validated Activities**
L1.1 Promote educational programs for the elderly and the family. **L1.2** Promote lectures, workshops and community events about themes related to aging.	- Identify the educational needs of the elderly. - Stimulate the elderly's constant individual development. - Promote educational programs for the elderly and the family.

L1.3 Promote meetings for the guidance of family members and caregivers. **L1.4** Promote community events and activities, such as gatherings, rides and theme parties. **L1.5** Promote educational and preventive campaigns. **L1.6** Promote permanent education activities for professionals.	- Promote meetings for the guidance of family members and caregivers. - Promote educational and preventive campaigns. - Promote lectures, workshops and community events about themes related to aging. - Promote permanent education activities for professionals who work in the day-care center.

DISCUSSION

The elderly monitoring in the day-care center is an important feature to maximize their functionality and maintain their skills. In countries such as Portugal, Spain, Sweden, Japan, Denmark, Finland, Ireland, the Netherlands, the United Kingdom, Canada and Norway, day-care centers belong to integrated and long-term care networks, aimed to providing health care and social support, recovery, autonomy promotion and the community services provision[10].

The day-care centers provide family assistance and care for the frail elderly as an alternative to institutionalization, through multiprofessional care, and avoid elderly exposure to risk situations, such as: accidents and violence at home, depression, sedentary lifestyle and social isolation[2].

In this study, the specialists participation was essential to better adapt and improve the activities and to point out pertinence involving the dimensions, activities and descriptions. The judges' training, experience and different areas contributed to enrich their judgments, seeking the best quality of validated content.

The specialists comments and suggestions were aimed at identifying more appropriate terms/words to the daily practice of day-care centers, allowing both public and private institutions to use this tool as a reference in their services, and handled by professionals with different backgrounds. Therefore, items considered unclear, non-pertinent or difficult to understand, as suggested by the judges committee were eliminated or replaced.

In the active aging perspective, validated activities in the **health dimension** - *food and nutrition*, *hygiene and comfort*, *functional capacity and frailty*, *continuous use medications* and *handling and cognitive stimulation* - indicated the importance of relating physical, mental and social health, since all three are interrelated and their adequate and timely management minimize losses and benefits the elderly in preserving autonomy, functionality and quality of life[1].

Considering the importance of acting in elderly support to perform the basic activities of daily living, studies have shown that the prevalence of elderly people who needed some assistance with *food and nutrition* was 1,5% and in *hygiene and comfort*, 6,9% of them presented difficulties with bathing[11,12].

Regarding the *functional capacity and frailty* activity, the World Health Organization indicated that the possibility of maintaining functional capacity allows the well-being of aging and, according to the National Policy of Elderly Person Health, the main problem that can affect people aged 60 years or over is loss of functional capacity[13,14]. Thus, we highlight the need for services such as the day-care center, intended to intervene

in maintaining or improving the functional capacity of fragile or frail elderly individuals[4].

In Brazil, the *continuous use medications* is present in 72,3% of the elderly in the South, 67,6% in the Northeast and 81,1% in the Southeast[15,16,17]. Therefore, professionals who work with the elderly should pay attention to practices such as polypharmacy, self-medication and the use of inappropriate medications, promoting awareness of the rational use of these substances[18].

The *handling and cognitive stimulation* are associated with greater autonomy and reduced risk of cognitive decline, dementia and depressive symptoms[19,20]. This activity in the day-care center is an important factor, considering that the presence of cognitive decline is associated with greater difficulty in performing the instrumental activities of daily living[21].

In relation to the **participation dimension**, the activities described - *socio-cultural activities*, *acceptance and monitoring* and *spiritual/religious support* - allow social, cultural, recreational and spiritual engagement, which awakens in the elderly the self-esteem, emotional balance, citizenship exercise, strengthening of ties, autonomy and social protagonism[1,22].

The elderly participation in *socio-cultural activities* has a positive impact on mortality, functional capacity, cognition and well-being[23]. The *acceptance and monitoring* allow the elderly integration in the service and the evaluation of the answers of the day-care center to their needs[10,24]. The *spiritual/religious support* is significant for the best satisfaction with life, health and ability to carry out the productive and instrumental activities of daily life[25].

When considering the **safety/protection dimension**, we emphasize that the environment should be safe and friendly to the elderly, adjusted to their limitations and preferences, allowing a sense of control, self-efficacy, autonomy and self-esteem. Friendly environments favor independence and reduce apathy, lack of interest, a sense of incompetence and health complaints[26].

The day-care center is a service that favors *accessibility and mobility*, emphasizing that the elderly attending this model of care have a reduction of falls risk[27].

In the **education dimension**, the *educational activities* are an opportunity for updating and acquiring new knowledge that enables learning in relation to different aspects of life, such as motivation for change, sense of competence and improvement in communication with others, and contribute to the understanding of the aging process[28].

In this way, day-care centers play an important role in promoting autonomy and in representing opportunities for active aging[29]. Therefore, the development of new day-care center units in Brazil is recommended, since the elderly frequency in these places avoids isolation, sadness and depression and allows the experience of an active aging[30].

CONCLUSIONS

The accomplishment of this study evidenced the literature scarcity about the activities developed in the day-care centers for the elderly, as well as the management and care models implemented in these equipments. Thus, we consider that the systematization of activities in the four dimensions constitutes an initial step, in order to overcome the innumerable challenges that involve the management and assistance aspects in this context, based on active aging.

In addition, it was possible to verify that the day-care center privileges aspects of the elderly person's quality of life, preventing family disintegration, is a resource that supports health promotion, prevention of injuries and improvement of functionality, as well as providing autonomy of the elderly and social interaction.

We believe that the final product of this research can be used both in public and private day-care centers in Brazil and contribute to structuring elements to evaluate the quality of these services, supporting the planning of activities, the organization of the service and decision making by the managers. However, we indicate as limitations of the proposal the facts that the day-care center isn't yet a consolidated modality in our country and that not all existing services have Active Aging as a reference framework, which may make it difficult to use the instrument.

Also, we emphasize the need for new investigations, in order to implement the instrument validated in the daily services and involve the management components that can measure the quality in the day-care centers. In this sense, we propose the pursuit of research aiming at the construction and validation of structure, process and result indicators, so that the Donabedian model can be used in the evaluation of the quality of the day-care centers.

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