



HEALTH PROFESSIONALS' PERCEPTIONS OF CARE FOR OLDER ADULTS WITH NEUROPSYCHIATRIC EMERGENCIES: A QUALITATIVE STUDY*

PERCEPÇÃO DE PROFISSIONAIS DE SAÚDE SOBRE O ATENDIMENTO À PESSOA IDOSA COM URGÊNCIAS NEUROPSIQUIÁTRICAS: ESTUDO QUALITATIVO

PERCEPCIÓN DE LOS PROFESIONALES DE SALUD SOBRE LA ATENCIÓN A LA PERSONA MAYOR CON URGENCIAS NEUROPSIQUIÁTRICAS: ESTUDIO CUALITATIVO

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RESUMO

Objetivo: Compreender as percepções de profissionais de saúde sobre os desafios e potencialidades no atendimento à pessoa idosa com urgência neuropsiquiátrica em uma Unidade de Pronto Atendimento. **Método:** Estudo qualitativo, exploratório e descritivo, realizado com 15 profissionais de saúde em uma Unidade de Pronto Atendimento de João Pessoa, Paraíba, no período de março a junho de 2024. Os dados foram obtidos por meio de entrevistas individuais semiestruturadas, gravadas e transcritas na íntegra, e analisados pelo software IRAMUTEQ com base na Classificação Hierárquica Descendente, ancorada na análise de conteúdo temático-categorial de Bardin. **Resultados:** Emergiram quatro categorias temáticas: (1) Dificuldade no manejo clínico; (2) Ausência de protocolos e lacunas formativas; (3) Abertura para tecnologias educativas; e (4) Propostas de qualificação da assistência, como capacitações regulares e integração com a Rede de Atenção Psicossocial. **Conclusão:** Evidenciam-se desafios assistenciais e o "vazio normativo" no atendimento neuropsiquiátrico. A insegurança clínica e a desarticulação da rede exigem protocolos e formação continuada. O engajamento profissional e a reestruturação organizacional são fundamentais para garantir a segurança da pessoa idosa.

Descritores: Saúde Mental; Saúde do Idoso; Serviços Médicos de Emergência; Serviços de Emergência Psiquiátrica.

ABSTRACT

Objective: To understand health professionals' perceptions regarding the challenges and potential in caring for older adults with neuropsychiatric emergencies in an Emergency Care Unit. **Method:** A qualitative, exploratory, and descriptive study conducted with 15 health professionals at an Emergency Care Unit in João Pessoa, Paraíba, from March to June 2024. Data were gathered through individual semi-structured interviews, recorded and transcribed in full, and analyzed using the IRAMUTEQ software based on Descending Hierarchical Classification, anchored in Bardin's thematic-categorical content analysis. **Results:** Four thematic categories emerged: (1) Difficulty in clinical management; (2) Absence of protocols and educational gaps; (3) Openness to educational technologies; and (4) Proposals for care qualification, such as regular training and integration with the Psychosocial Care Network. **Conclusion:** Care challenges and a "normative vacuum" in neuropsychiatric care are evident. Clinical insecurity and network fragmentation demand protocols and continuing education. Professional engagement and organizational restructuring are essential to ensure older adults' safety.

Descriptors: Mental Health; Health of the Elderly; Emergency Medical Services; Psychiatric Emergency Services.

RESUMEN

Objetivo: Comprender las percepciones de los profesionales de salud sobre los desafíos y potencialidades en la atención a la persona mayor con urgencia neuropsiquiátrica en una Unidad de Pronta Atención. **Método:** Estudio cualitativo, exploratorio y descriptivo, realizado con 15 profesionales de salud en una Unidad de Pronta Atención de João Pessoa, Paraíba, en el período de marzo a junio de 2024. Los datos se obtuvieron mediante entrevistas individuales semiestruturadas, grabadas y transcritas en su totalidad, y se analizaron con el software IRAMUTEQ a partir de la Clasificación Jerárquica Descendente, anclada en el análisis de contenido temático-categorial de Bardin. **Resultados:** Emergieron cuatro categorías temáticas: (1) Dificultad en el manejo clínico; (2) Ausencia de protocolos y brechas formativas; (3) Apertura a tecnologías educativas; y (4) Propuestas de cualificación de la asistencia, como capacitaciones regulares e integración con la Red de Atención Psicossocial. **Conclusión:** Se evidencian desafíos asistenciales y el "vacío normativo" en la atención neuropsiquiátrica. La inseguridad clínica y la desarticulación de la red exigen protocolos y formación continuada. El compromiso profesional y la reestructuración organizacional son fundamentales para garantizar la seguridad de la persona mayor.

Descriptores: Salud Mental; Salud del Anciano; Servicios Médicos de Urgencia; Servicios de Urgencia Psiquiátrica.

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What is already known:

- Population aging increases the demand for mental health care, making Emergency Care Units (ECUs) strategic entry points for older adults experiencing neuropsychiatric emergencies.
- Emergency care professionals experience clinical insecurity in geriatric management due to the absence of systematic care protocols and clear institutional guidelines.
- Gaps in academic training and the lack of articulation with the Psychosocial Care Network (RAPS) hinder the continuity and comprehensiveness of care.

What this study adds:

- It maps real-world barriers, such as the "normative vacuum", where care relies exclusively on individual experience, creating a risk of errors and fragmented management.
- It identifies high staff engagement and receptivity toward digital educational technologies as strategic tools for immediate support in safe clinical decision-making.
- It provides practical foundations for developing operational flowcharts that reduce diagnostic iatrogenesis and enhance older adult safety in emergency settings.

INTRODUCTION

Population aging is one of the most significant demographic transformations of the 21st century, generating profound impacts on global health systems. In Brazil, this transition is accelerated: IBGE projections indicate that by 2050, the number of people aged 60 years or older will exceed 58 million, accounting for approximately 26% of the country's total population. This scenario demands care models capable of responding to the clinical complexity inherent to this age group⁽¹⁾.

Currently, older adults account for more than 30% of visits to Emergency Care Units (ECUs) in Brazil⁽²⁾. Among the main reasons for seeking these services, neuropsychiatric disorders stand out—such as dementias, delirium, and acute psychotic episodes—affecting about 20% of this population and representing a significant share of emergency and urgent care admissions^(3,4).

Although ECUs are strategic entry points, the literature indicates that healthcare professionals experience difficulties in the early recognition of symptoms and insecurity in clinical management. Such vulnerabilities are exacerbated by the absence of systematic care protocols and gaps in academic training, given that less than 30% of undergraduate health curricula include structured content on geriatric mental health^(4,5).

In the context of public policies, the Psychosocial Care Network (RAPS) organizes mental health care, positioning ECUs as essential components for reception and crisis stabilization⁽⁶⁾. However, fragmentation between emergency units and other network points, such as Psychosocial Care Centers (CAPS), compromises the continuity of care. This lack of articulation highlights the pressing need for continuing education strategies for frontline teams^(6,7).

High professional turnover and a lack of time for in-person training make contextualized continuing education strategies emerge as promising tools. Resources such as digital guides and flowcharts can offer real-time technical and scientific support, facilitating safe clinical decision-making. However, the development of these solutions requires a thorough understanding of the real challenges experienced by workers⁽⁷⁻⁹⁾.

This study is grounded in the importance of enhancing geriatric care within the scope of the Unified Health System (SUS), aligning with Sustainable Development Goal (SDG) 3 — Good Health and Well-being, of the 2030 Agenda, which advocates for the promotion of mental health and

well-being at all ages. Furthermore, the research meets the National Agenda of Priorities in Health Research (ANPPS) of the Ministry of Health, fitting specifically into the thematic axis of Older Adult Health and, cross-sectionally, into Mental Health, which seeks evidence to address the challenges of population aging^(10,11).

Given the need to evaluate the care scenario for neuropsychiatric emergencies in older adults and considering the essential role of frontline health professionals in this process, this study aimed to understand the perceptions of health professionals regarding the challenges and potential in caring for older adults with neuropsychiatric emergencies in an ECU.

METHODS

This is a qualitative, analytical study representing an excerpt from a master's thesis developed within the Graduate Program in Gerontology at the Federal University of Paraíba (UFPB). The study focuses on the diagnostic dimension of professional perceptions regarding the care scenario and was conducted and reported in accordance with the recommendations of the COnsolidated criteria for REporting Qualitative research (COREQ) checklist⁽¹²⁾.

The research was conducted in a Type II Emergency Care Unit (ECU), operating 24 hours a day, located in João Pessoa, Paraíba. The unit serves a population of approximately 200,000 inhabitants, with an average of 600 daily visits. Its physical structure includes risk classification rooms, medical offices, observation areas, a red room, yellow room, green room, and a pediatric ward, in addition to a laboratory, radiology, and a pharmacy. The multidisciplinary team comprises approximately 400 healthcare professionals.

Participants were selected through purposive convenience sampling, adopting the following inclusion criteria: being a healthcare professional (physician, nurse, or nursing technician); having been regularly active at the ECU for at least six months; and directly engaging in the clinical care of older adults. Professionals on medical leave or vacation during the data collection period were excluded, as well as those working exclusively in the pediatric sector. The number of participants was determined by the criterion of theoretical data saturation^(13,14), understood as the point at which subsequent interviews cease to add new thematic elements to the analysis corpus, rendering further data collection analytically redundant. Applying this criterion,

the final sample comprised 15 healthcare professionals.

Data collection took place between March and June 2024 via individual in-depth interviews, previously scheduled and conducted by the principal researcher (a master's student). A semi-structured guide containing open-ended questions was used regarding: care practices addressing neuropsychiatric emergencies in older adults; difficulties and facilitators in clinical management; perceptions of professional training for this type of care; suggestions for care qualification; and perceptions of demands for technical-scientific support and clinical decision support strategies in the emergency context. Prior to the interview, a sociodemographic and professional questionnaire was administered to characterize the participants, covering the following variables: sex, age group, marital status, family income, professional category, educational level, length of service at the ECU, work schedule, and type of employment bond.

The interviews were conducted in person in a private room within the unit itself, with an average duration of 35 minutes. They were audio-recorded with the participants' authorization, formalized through the Informed Consent Form (ICF). The recordings were transcribed in full, totaling 138 pages of text, and subjected to an exhaustive reading to verify the reliability between the audio and the transcribed text.

To analyze the material, the IRAMUTEQ software (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) was used as a supporting tool for qualitative analysis to identify cores of meaning, contextual elements, and thematic categories. The findings were subsequently interpreted in light of Bardin's thematic-categorical content analysis⁽²⁰⁾, allowing an in-depth understanding of the emerging meanings. To preserve the participants' identity, excerpts were identified with the letter "P" followed by sequential numbers (P1, P2... P15).

The study was approved by the Ethics Committee of the Federal University of Paraíba (UFPB), under CAAE no. 79796524.1.0000.5188 and Opinion no. 6,869,487, in accordance with the guidelines of Resolution no. 466/2012 of the National Health Council (CNS). All participants signed the ICF before the interviews began.

RESULTS

A total of 15 healthcare professionals participated in the study. Regarding the sociodemographic profile, there was a predominance of females (n=10; 66.7%). As for team composition, the sample comprised seven nurses (46.7%), five physicians (33.3%), and three nursing technicians (20.0%). Regarding professional experience in the study setting, six professionals (40.0%) had worked at the ECU for between one and three years, five (33.3%) had more than three years of service, and four (26.7%) had been at the unit for less than a year. The majority worked on a shift basis (80.0%) and held a temporary employment contract (53.3%).

The lexicometric analysis processed 159 text segments, retaining 78.74% of the material for the Descending Hierarchical Classification (DHC), which revealed that care is permeated by critical barriers, such as the absence of clinical protocols (n=13), lack of specific training (n=12), and insecurity in management (n=11). Other factors, such

as work overload and lack of coordination with the RAPS, also emerged as obstacles to the fluidity of care. Based on the DHC, the discourses were organized into four thematic categories that reflect the meanings constructed regarding care.

Insecurity and challenges in clinical management

Professionals' understanding of the management of neuropsychiatric emergencies reveals a practice permeated by diagnostic uncertainties. Identifying conditions such as anxiety disorder, depression, and delirium is hindered by atypical clinical presentations in older adults, in which psychological symptoms are frequently masked by physical complaints or somatizations. This "invisibility" of mental disorders requires qualified listening that the team struggles to exercise within the dynamic flow of emergency care.

Often, the caregiver does not directly report problems like depression, but rather complaints like 'they are not eating' or 'they are sleeping too much.' (P7)

Physical symptoms are frequently reflections of untreated emotional issues. (P10)

Additionally, high care demand and work overload in ECUs emerge as critical barriers to a detailed evaluation. The cognitive impairment of many older adults, as in cases of Alzheimer's disease or acute mental confusion, makes the medical history-taking a complex process, requiring time and screening tools that are not always available on duty.

Sometimes we don't know if it's a psychotic episode, dementia, anxiety. . . We feel insecure. (P3)

Diagnosis is hindered by a lack of time and the absence of specific tools to quickly identify the problem. (P11)

The number of patients we see in a single shift is enormous. This forces us to be quick, and we cannot always give the necessary attention to more complex cases. (P12)

Training gaps and the absence of guidelines

The accounts highlight a scenario of institutional helplessness, where the absence of systematic clinical protocols for geriatric mental health forces professionals to act based on individual experiences. This "normative vacuum" results in heterogeneous conducts and generates a constant fear of committing iatrogenic errors or performing inadequate interventions, such as excessive medicalization without diagnostic support.

There is no protocol; everyone acts as they see fit. We just keep trying! (P1)

Many of us did not receive in-depth training in mental health during undergraduate studies, which leaves us insecure in complex situations such as managing delirium. (P4)

The lack of continuing education and the lack of real-time specialized support worsen the frontline teams' sense of limitation. Professionals perceive that the training of-

ferred is rarely contextualized to the dynamic reality of ECUs, focusing on models that do not consider the turnover and pressure for rapid resolvability inherent to emergency services.

The available training sessions are sporadic and not always focused on our ECU reality. (P6)

Our greatest challenge is dealing with situations involving behavioral changes in older adults without relying on specialized support. (P9)

Without resources such as assessment scales or defined protocols, we often have to act based on our perceptions and experience, which can lead to errors. (P10)

Demands for technical support and support strategies

The need for tools that offer objectivity and speed in decision-making is a point of convergence among the discourses. Given the scarcity of time, professionals demonstrate high receptivity to digital technologies that translate scientific evidence into flowcharts and practical, easily accessible guidelines at the bedside.

Digital guides have been a good tool for providing quick guidance during care, especially when we don't have much time. (P2)

Often, speed in decision-making makes all the difference in caring for patients with neuropsychiatric symptoms. (P5)

The integration of resources such as e-books, applications, and rapid decision algorithms is seen as a strategy capable of mitigating professional insecurity. These tools are perceived not only as consultation media, but as essential supports to underpin clinical conducts and ensure patient safety in high-pressure care environments.

With the use of technological tools, we are able to ensure that the decisions made are faster and more grounded. (P8)

The use of applications in our daily routine has greatly facilitated symptom identification and management... We can quickly access updated protocols. (P11)

An e-book with a flowchart would help a lot. We need something simple and practical. (P15)

Proposals for care qualification

Participants suggest that improving care quality depends on structuring multidisciplinary teams that include mental health support in the daily routine of the ECU. The inclusion of psychology professionals, combined with regular training in gerontology, is pointed out as essential to transform patient reception and case resolvability.

With training, support, and materials, it would be possible to provide better care. (P7)

Training the team in geriatrics and geriatric mental health would significantly contribute to the quality of care provided. (P11)

The inclusion of a psychology service in the unit is essential to improve care for this patient profile. (P13)

Finally, the organization of care flows and effective integration with RAPS emerge as proposals to overcome care fragmentation. The creation of clear referral protocols and assessment scores that consider the physical and emotional complexity of older adults constitutes an essential path to ensure more humanized and continuous care.

Developing a score to assess older adult distress, considering physical and emotional aspects, could improve care. (P9)

It would be ideal to have clear protocols to identify, manage, and refer patients with neuropsychiatric emergencies. (P15)

DISCUSSION

Rapid population aging in Brazil imposes the challenge on ECUs to act as a strategic gateway for neuropsychiatric crises, although these units were designed for general clinical emergencies. The findings of this study reveal a complex care scenario, where professionals' perceptions converge on a state of vulnerability for both older adults and the healthcare team^(2,3). This fragility is fueled by a growing demand that lacks support from specific institutional protocols, resulting in care that is frequently fragmented and reactive⁽⁷⁾.

Professional insecurity in clinical management emerged as the densest thematic core, being justified, in part, by the participants' length of experience in the study setting. It was observed that 40% of the sample had between one and three years of service at the unit, suggesting that limited experience in high-turnover and high-complexity care services negatively impacts confidence in clinical decision-making. In gerontology, insecurity is a risk factor for diagnostic error, especially in cases requiring discernment beyond traditional physical symptoms⁽²³⁾.

One of the most critical points discussed by professionals is what can be termed a "normative vacuum", characterized by the absence of systematized clinical protocols for geriatric mental health in ECUs. The non-existence of guidelines forces professionals to act based on individual perception or prior experience, which favors heterogeneous and potentially unsafe practices⁽⁶⁾. Studies indicate that the lack of standardization is associated with higher rates of excessive medicalization, improper physical restraint, and early readmissions, impairing older adults' autonomy⁽²²⁾.

In the field of cognitive disorders, delirium stands out as a frequently overlooked emergency, remaining underdiagnosed in more than 60% of cases treated in emergency settings⁽¹⁶⁾. Reports indicate that the absence of rapid and validated screening tools, such as the Confusion Assessment Method (CAM), hinders the early identification of this syndrome, which is frequently precipitated by reversible organic causes, such as infections. The underdiagnosis of delirium is alarming, as it is directly linked to accelerated functional decline and high in-hospital mortality^(16,17).

Simultaneously, anxiety disorders in older adults represent a unique diagnostic challenge as they often manifest

through somatic complaints such as dyspnea, palpitations, dizziness, and chest pain. This "physical mask" leads the team to prioritize extensive cardiological or neurological investigations, often disregarding underlying psychological distress^(17,18). Furthermore, a study⁽¹⁹⁾ highlights that incorporating instruments such as the Geriatric Anxiety Inventory (GAI) into ECU workflows would facilitate differentiation between anxious crises and acute organic events, optimizing resource use and care time.

This gap in symptom identification reflects a historical deficit in academic training, where less than 30% of undergraduate health curricula include structured content on geriatric mental health⁽⁴⁾. Academic unpreparedness perpetuates the stigma that neuropsychiatric symptoms are natural consequences of aging, which delays crucial interventions and compromises the humanization of care. Continuing education thus emerges not only as a need for technical updating, but as a strategy to reformulate attitudes and prejudices toward older adults in crisis⁽¹⁷⁾.

An innovative element brought by the qualitative analysis was the duality of the companion's role in the care process. If, on one hand, they are the main source of clinical history for older adults with cognitive deficit, on the other hand, they can act as a communication barrier by omitting information or inhibiting the patient's voice. In contexts of suspected interpersonal violence, the presence of the companion may mask abuse, requiring the healthcare team to develop qualified listening and non-verbal observation skills to ensure the safety and integrity of older adults⁽²³⁾.

The lack of coordination with RAPS was also pointed out as a barrier to continuity of care. Although ECUs formally integrate the network, fragmentation in communication with CAPS causes emergency care to often be an isolated event, without the necessary outpatient follow-up after discharge. Strengthening referral flows is essential to reduce the revolving door of emergency services and ensure that older adults receive appropriate multidisciplinary support within their territory⁽⁶⁾.

Given the high turnover of professionals and the scarcity of time for in-person training, digital educational technologies emerge as viable solutions well-accepted by the frontline⁽⁷⁾. Receptivity to resources such as e-books and rapid decision algorithms signals a desire for tools that offer technical-scientific support at the bedside in a simple and practical manner⁽¹⁶⁾. Such technologies have the potential to mitigate professional insecurity, transforming the ECU routine into a space for continuous learning grounded in evidence.

Care qualification depends on an integrated approach combining standardized conducts, supportive technologies, and team sensitization to the particularities of aging. Only through an articulated network and technically supported teams will it be possible to ensure dignity and resolvability in older adult care within Brazilian emergency services. Studies on hospital services have demonstrated that investments in structured continuing education present better patient safety indicators, lower diagnostic error rates, and greater professional satisfaction⁽⁷⁾.

Digital clinical decision support tools, when developed based on the real needs of professionals, present high potential for adherence and effectiveness, especially in contexts

of high turnover and care overload, characteristics inherent to ECUs^(7,8).

A systematic review conducted in the international scenario identified that educational interventions based on digital technology for healthcare professionals working with older adults in emergency care resulted in significant improvement in the early recognition of geriatric syndromes—including delirium, dementia, and acute anxious states—with a positive impact on patient clinical outcomes⁽¹⁶⁾.

The systematic proposals put forward by participants for improving care were regular training, construction of institutional guidelines, and effective integration with RAPS. This evidences that professionals not only recognize system fragilities but possess clarity regarding the interventions needed to overcome them. This propositive repertoire of professionals is a high-value qualitative data, as it signals engagement and willingness for change, indispensable conditions for the success of any continuing education strategy⁽⁷⁾.

Integration with RAPS deserves special attention. The National Mental Health Policy, established by Law No. 10,216/2001 and operationalized by Ordinance GM/MS No. 3,088/2011, institutes the mental health care network, positioning ECUs as a strategic component in crisis care. However, participant reports indicate that this integration remains fragile in practice, with difficulties in proper case referral, communication between services, and ensuring continuity of care after emergency visits^(5,6).

Ultimately, the propositive engagement identified among frontline professionals signals that the transformation of practices is viable, provided it is sustained by joint efforts between management and workers to institute continuing education processes and clear operational flowcharts. Only through an articulated network and institutionally supported teams will it be possible to mitigate underdiagnosis and ensure the safety and dignity of older adults experiencing acute psychological distress^(3-4,19).

Study limitations

The limitations of this study involve its cross-sectional qualitative design, which captures perceptions subject to temporal variations due to the high turnover and dynamics of emergency services. The single-center setting in a capital city in Northeastern Brazil restricts the immediate transferability of the findings to regions with different network flows. Furthermore, the exclusive focus on the direct care team and the limited time for interviews may have constrained interdisciplinary perspectives, reinforcing the need for future multicenter studies to validate the efficacy of educational technologies in diverse care contexts.

CONCLUSION

The findings revealed that the care provided to older adults with neuropsychiatric emergencies is marked by significant care challenges and the need for organizational structuring. The qualitative investigation identified that care is permeated by critical barriers that directly impact older adult safety and the frontline team's confidence in

clinical decision-making.

The results demonstrated a diversity of experiences, highlighting as main challenges the absence of systematized clinical protocols and the historical deficit in academic training regarding geriatric mental health. Work overload, high patient turnover, and lack of coordination with the RAPS also emerged as obstacles that hinder the continuity of care and favor fragmented conducts.

The contributions of this study lie fundamentally in mapping the real barriers faced in clinical practice and identifying the "normative vacuum" that generates clinical insecurity. Furthermore, the work offers a strategic contribution by highlighting professionals' high receptivity to the use of digital educational technologies as rapid support for safe decision-making, providing practical foundations for service qualification.

Despite these difficulties, professionals' proactive engagement was observed toward overcoming the identified

fragilities. The recognition of the ECU's strategic role signals the potential for implementing more humanized and resolute practices, provided they are supported by multidisciplinary assistance and clear operational flowcharts. The improvement of practices requires joint efforts in continuing education and the creation of environments that foster effective communication among professionals, management, and the other points of the care network.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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All authors are responsible for the drafting and critical revision of the intellectual content, the final published version, and all ethical, legal, and scientific aspects related to the accuracy and integrity of the study.



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