QUALITY OF LIFE OF ELDERLY PEOPLE WHO CARE FOR THE ELDERLY AT HOME

ABSTRACT

Objective: recognizing the self-assessment of quality of life (QOL) of older people caring for elderly from the WHOQOL-BREF tool. Method: a descriptive, exploratory, cross-sectional study, of quantitative nature carried out from February to April 2013 in Fortaleza (CE) with 151 older people caring for elderly. It was used as a research tool the World Health Organization Quality of Life instrument-bref (WHOQOL-bref). The research project was approved by the Research Ethics Committee, Protocol. 208.923. Results: self-assessment of QOL of the elderly caregiver was satisfactory. The average of the domain social relationships brought greater contribution to the quality of life. Already the domain environment presented the lowest values in the evaluation of QOL; therefore, it is the area that needs further intervention. Conclusion: the study showed the impact of care tasks on QoL of individuals who are already old and there are still caregivers who perform the function. Descriptors: Elderly; Caregivers; Quality of Life.

RESUMO

Objetivo: conhecer a autoavaliação da qualidade de vida (QV) de idosos que cuidam de idosos a partir do instrumento WHOQOL-bref. Método: estudo descritivo, exploratório, transversal, de natureza quantitativa realizado no período de fevereiro a abril de 2013 em Fortaleza (CE) com 151 idosos que cuidam de idosos. Utilizou-se como instrumento de pesquisa o World Health Organization Quality of Life instrument-bref (WHOQOL-bref). O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, protocolo n. 208.923. Resultados: a autoavaliação da QV do idoso cuidador foi satisfatória. A média do domínio relações sociais trouxe maior contribuição para a QV. Já o domínio meio ambiente apresentou os piores valores na avaliação da QV, portanto, é o domínio que necessita de maior intervenção. Conclusão: o estudo mostrou o impacto das tarefas do cuidado sobre a QV de indivíduos que já são idosos e ainda exercem função de cuidadores. Descripitores: Idoso; Cuidadores; Qualidade de Vida.

RESUMEN

Objetivo: conocer la autoevaluación de la calidad de vida (CV) de las personas mayores que cuidan a los ancianos del instrumento WHOQOL-bref. Método: es un estudio descriptivo, exploratorio, transversal, de naturaleza cuantitativa realizado entre febrero y abril de 2013 en Fortaleza (CE) con 151 personas mayores que cuidan de ancianos. Fue utilizada como una herramienta de investigación el World Health Organization Quality of Life instrument-bref (WHOQOL-bref). El proyecto de investigación fue aprobado por el Comité de Ética en la Investigación, Protocolo. 208.923. Resultados: la autoevaluación de la calidad de vida del cuidador de ancianos fue satisfactoria. El dominio promedio relaciones sociales trajo una mayor contribución a la calidad de vida. Tener el dominio del medio ambiente tuvo los peores valores en la evaluación de la calidad de vida; por lo tanto, es el área que necesita de más intervención. Conclusión: el estudio mostró el impacto de las tareas de cuidado en la calidad de vida de las personas ya idosas y que todavía tienen la función de cuidadores. Descriptores: Ancianos; Los Cuidadores; Calidad de Vida.
INTRODUCTION

The increased life expectancy is already a reality in Brazilian society. However, the improvement in quality of life does not follow the increase in longevity. The current scenario of research with elderly documents the importance of knowing the issues that concern the welfare of the elderly, showing that longevity without quality is not a victory, but rather a concern.¹

In Brazil, in recent years, it has gone from a mortality scenario own a young population to a picture of complex and burdensome illnesses typical of developed countries, characterized by multiple chronic diseases that last for years, demanding constant care, continuous medication and periodic examinations.² Thus, the aging of the diseases themselves come to have greater expression throughout society. This situation gave rise to a new character in the scenery of care for the elderly: the informal caregiver, usually a family that cares more closely, longer and collaborating within its means with the activities of life in the elderly is dependent, an unpaid, and independent of its basic training or life experience.³

The population consists of caregivers, mostly in children or spouse, female, middle-aged, who care for an extended period of time and do not receive help from other family members for care work.⁴ What has been observed in recent years is the increasing number of elderly people who present themselves as caregivers for other elderly people, both the national and international scene.⁵-⁶

There is a significant number of studies related to deterioration of health and illness of caregiver overload due to the care given for a long time, especially when the caregiver is solely responsible, there is no division of labor⁷-⁸-⁹-¹⁰; whereas the aging process brings a physiological reduction in the functional capacity of the individual, the elderly acting as the caregiver may become even more painful.¹⁰

Considering that the elderly holding caregiver role is something rarely addressed in the literature, it is not known which likely impacts the care task can bring to the quality of life of seniors. The term quality of life, a subjective assessment, necessarily linked to the impact of health status on an individual's ability to fully live.¹¹

The interest of measuring the quality of life did initially conjured up such gigantic and unsatisfactory instruments until the WHO Quality of Life Group developed from the WHOQL-100, a shortened version that requires little time for its completion, but with satisfactory psychometric characteristics, the WHOQL-bref. The short version is composed of four domains: physical, psychological, social relationships and environmental.¹²

The scientific literature has revealed, from the use of this tool that, the greater caregiver burden, the lower the quality of life.¹² Moreover, there is a negative correlation between the age of the caregiver and elderly care with the physical domain. Caregivers older than 60 have a worse perception of quality of life, especially in the field physical aspect.⁸

Knowing how the elderly caregiver realizes their quality of life means allowing the very elderly assessing how the caregiving activities interfere with their well-being and consequently in their ability to live fully. With this acquired knowledge, intervention strategies can be formulated specifically for the elderly caregiver, in order to reducing the losses of this task, if any.

Given the above, this study aimed to evaluating the quality of life of elderly caregivers, playing the role of other seniors from the use of the WHOQL-bref tool.

METHOD

This is a descriptive, exploratory, cross-sectional study with a quantitative approach to the area of six neighborhoods located on the outskirts of the city of Fortaleza/CE, Brazil; randomly elected by simple draw.

The study population consisted of older adults, caregivers of other seniors. The sample of 151 elderly was calculated from sample calculation for finite populations, considering a 95% significance level, a maximum error of 5% and prevalence of proportional value of caregivers of 22%, as noted in previous research, still in submission process.

The inclusion criteria in the study were: to be aged less than 60 years old; performing the informal caregiver function of another old, for a minimum of 60 days; residing in neighborhoods drawn to the study and accepting freely to participate in the study, after clarification and signing the Informed Consent. Seniors who had some cognitive impairment (self-reported) were excluded.

Access to members of the sample was given through home visits. Since there is no official registration of elderly caregivers, their identification and initial contact occurred through professionals of the Family Health Strategy (FHS) of the Family Health Centers located in elected neighborhoods to the study.
The sampling technique was employed snowball. In places that were at high risk of violence, community health agents of the FHS teams followed those responsible for data collection visits.

The data were collected from February to April 2013, using form for sociodemographic and clinical characterization of the elderly and the generic questionnaire for subjective assessment of quality of life (QoL) World Health Organization Quality of Life instrument-BREF (WHOQOL-bref), developed by the World Health Organization (WHO).\textsuperscript{11} The WHOQOL-bref tool consists of adopting a multidimensional concept of QoL, and is internationally referenced and used in research. It contains 26 items goals, two of which relate to personal perception of QoL and satisfaction with health, and other items are distributed among four distinct domains: physical, psychological, social relationships and environmental. The choices of answers to the items are in Likert scale format of five points (the closer to five, the better the quality of life assessment).\textsuperscript{13}

Data were double entered and stored in Microsoft Office Excel 2010 program and the software Statistical Package for Social Sciences (SPSS), version 18.0.

Information concerning the sociodemographic characteristics and clinical elderly and percentage results for the individual items of the WHOQOL-bref were organized with SPSS in charts and tables with absolute and relative frequencies. For descriptive statistical analysis of the instrument, we used specific tool, proposed in the literature, compatible with Microsoft Office Excel 2010.\textsuperscript{14} This tool allowed the calculations of WHOQOL-bref scores in a simple and automated way.

There was obtained the mean scores for each of the instrument areas and standard deviations, coefficients of variation and values of raw scores of the areas corresponding to the scale of zero to 100 (score used in the WHOQOL-100, extensive version, which gave the WHOQOL-bref).\textsuperscript{13}

The study followed the ethical recommendations for research involving human subjects, under Resolution 196/96 and complementary, the National Health Council/Ministry of Health. The research project was previously submitted to the Ethics Committee of the Federal University Ceara, obtaining assent, under Protocol 208.923.

**RESULTS**

The sociodemographic profile of elderly caregivers, as shown in Table 1, revealed that there was a predominance of women (86%), aged between 60 and 69 years old (54%), married or in a consensual union (78%), literate (74%), retired (62%), with monthly personal income equal to or less than the minimum wage (79%).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>130</td>
<td>86%</td>
</tr>
<tr>
<td>Male</td>
<td>21</td>
<td>14%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 - 69</td>
<td>81</td>
<td>54%</td>
</tr>
<tr>
<td>70 - 79</td>
<td>60</td>
<td>39%</td>
</tr>
<tr>
<td>80 or older</td>
<td>10</td>
<td>7%</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/Consensual union</td>
<td>117</td>
<td>78%</td>
</tr>
<tr>
<td>Single</td>
<td>15</td>
<td>10%</td>
</tr>
<tr>
<td>Widower</td>
<td>17</td>
<td>11%</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Schooling (in years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than four years</td>
<td>39</td>
<td>26%</td>
</tr>
<tr>
<td>From four to six years</td>
<td>79</td>
<td>52%</td>
</tr>
<tr>
<td>Seven to ten years</td>
<td>24</td>
<td>16%</td>
</tr>
<tr>
<td>Over ten years</td>
<td>23</td>
<td>9%</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>93</td>
<td>62%</td>
</tr>
<tr>
<td>Pensioner</td>
<td>11</td>
<td>7%</td>
</tr>
<tr>
<td>Beneficiary of the Government</td>
<td>16</td>
<td>11%</td>
</tr>
<tr>
<td>Formal/Informal work</td>
<td>17</td>
<td>11%</td>
</tr>
<tr>
<td>Only housework</td>
<td>14</td>
<td>9%</td>
</tr>
<tr>
<td>Personal income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One minimum wage (SM)* or less</td>
<td>119</td>
<td>79%</td>
</tr>
<tr>
<td>Two to three</td>
<td>13</td>
<td>9%</td>
</tr>
<tr>
<td>Four or more</td>
<td>20</td>
<td>9%</td>
</tr>
<tr>
<td>Without income</td>
<td>14</td>
<td>9%</td>
</tr>
</tbody>
</table>

*One minimum wage (SM) = 678, 00.
With respect to aspects related to offering care, it was observed that most of the elderly takes care of the spouse (67%). When asked about the time of care, 37% reported exercising care for a period from one to five years; 34% cared for over ten years. In addition, 60% reported receiving some help to take care of, but in eventual/temporary basis (28%).

As regards clinical characteristics investigated, had those most elderly caregivers mentioned porting from one to four chronic diseases (91%). From these, 13% still presented diagnose of depression. Only 9% denied chronic diseases. Among these diseases, the most common were: Hypertension, diabetes mellitus, osteoporosis and rheumatoid arthritis.

There were investigated yet the feelings arising from the exercise of professional experience. It was found that 68% of seniors reported having positive feelings regarding caregiving tasks, among which, the most common were: well-being, happiness, feeling useful and love. The other elderly (32%) reported negative feelings such as fatigue, sadness, anger and stress.

Table 2 shows the results by domains obtained to descriptive statistical analysis of the WHOQOL-brief results given to older caregivers of elderly patients to evaluate their QoL.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Average</th>
<th>Standard deviation</th>
<th>Coefficient of variation</th>
<th>Corresponding value scale zero-100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>13,53</td>
<td>2,85</td>
<td>21,04</td>
<td>59,58</td>
</tr>
<tr>
<td>Psychological</td>
<td>14,52</td>
<td>2,34</td>
<td>16,11</td>
<td>65,73</td>
</tr>
<tr>
<td>Social Relationships</td>
<td>15,69</td>
<td>2,70</td>
<td>17,20</td>
<td>73,07</td>
</tr>
<tr>
<td>Environment</td>
<td>12,58</td>
<td>1,93</td>
<td>15,33</td>
<td>53,62</td>
</tr>
<tr>
<td>Personal perception of QoL and satisfaction with health</td>
<td>13,54</td>
<td>3,82</td>
<td>28,21</td>
<td>59,60</td>
</tr>
<tr>
<td>Total</td>
<td>13,72</td>
<td>1,81</td>
<td>13,22</td>
<td>62,32</td>
</tr>
</tbody>
</table>

The social relationships domain showed the highest average in amounts corresponding to the zero-100 scale (73,07), suggesting that was the area that most contributed to the positive assessment of QoL (values closer to 100 indicate better QoL). The environment field, in turn, demonstrated the lowest average (53,6).

The personal perception of QoL and satisfaction with health had higher standard deviation among the others, it means that there was a higher score variation on these items (28,21), both for more and for less, relative to the average obtained (13,54).

The 26 objective items of WHOQOL-brief, also called facets, were analyzed individually in the range of 0-100, as seen in Chart 1.
The elderly had higher QoL scores on self-esteem (82.45) and spirituality/religion (80.43), both are the psychological domain. The lower QoL scores were: dependence on medication/treatment (40.56) the physical domain, health care (37.75) of the Environment domain, and especially, recreation/leisure (24.34) also the field of Environment.

The facet health care was assessed using the following question: “How satisfied are you with your access to health services” Fifty-seven percent said they were dissatisfied or very dissatisfied, among the complaints cited by the elderly there, lack of medicines, lack of medical and difficulty in scheduling appointments.

Regarding the dependence on medication or treatments, 54% said extremely or quite depend on treatments for their daily life, 27% more or less, and 19% little or nothing.

There was evaluated the facet recreation/leisure through the question: “To what extent do you have recreational opportunities?” (74%) said little or nothing, and explain the lack of leisure by the need to care for others.

The facet positive feelings, represented by the question: How much do you enjoy life? Was closely associated with the elderly leisure opportunities or have fun, and why, as well as recreation and leisure facet, also presented average low with only 41% satisfaction. On the other hand, the facet negative feelings whose question was: How often do you have negative feelings such as blue mood, despair, anxiety or depression? Showed satisfactory average (62.58), in which 57% report that they never or sometimes have these feelings, 26% have these feelings often and only 17% have very often or always.

Regarding the level of satisfaction with sexual life of the elderly in the study, 70% say they are satisfied or very satisfied with their sexual relationships, 24% neither satisfied nor dissatisfied and only 6% report dissatisfaction. The acceptance of body image also showed high levels of satisfaction, 66% of seniors say they are very or completely satisfied with their physical appearance.
When inquired about the ability to perform activities of their daily lives, 71% of seniors were satisfied, 15% neither satisfied nor dissatisfied and, and 15% dissatisfied. Thus we can consider that the functional capacity of older people who exercise activity as a caregiver was preserved. The same was observed when assessing satisfaction with work ability, in that 66% of seniors say they are satisfied or very satisfied.

Regarding the ability to get around, 71% report being good or very good, 9% either bad or good and 20% bad or very bad. In relation to the means of transport, 64% reported being satisfied or very satisfied. It is noteworthy that the majority of older people use public transport, yet only 26% have shown some level of dissatisfaction among the complaints can cite: disrespect of the younger that also use public transport and do not give priority seating for the elderly; and disrespect of some drivers who do not stop the bus for the elderly to board.

When evaluating the financial resources facet, asked the elderly if the money they have is sufficient to meet their needs, 54% said little or nothing, 30% medium and 16% responded very or completely. This information is related to the low value attributed to the minimum wage in Brazil, and as we have seen in the elderly study, in general, are retired and receive a single minimum wage.

Regarding the ability to concentrate, 41% said good, 33% neither good nor bad, and 26% very little. The ability to concentrate is evaluated in the field Psychological, which generally showed a good level of satisfaction (65,7%).

With regard to satisfaction with sleep, the majority (45%) reported dissatisfaction, 11% refers neither satisfied nor dissatisfied, 19% and 25% satisfied very satisfied. It is believed that dissatisfaction with sleep may be related to dependence on medication, or with the concerns of caring tasks.

In evaluating the physical pain, ask the elderly if the pain prevents them from performing daily activities, 50% seniors answered little or nothing, 15% more or less, and 35% said very or extremely.

**DISCUSSION**

Most caregivers are women, and this is already something confirmed in several studies. In the present study considered only the caregiver who is also old, and once again the female population predominates.

Regarding age, it was found, the prevalence of younger elderly, aged 60-69 (54%). Whereas increasing age brings with it an increase in functional limitations and caregiver capacity, it is expected that most oldest old, have greater difficulty in carrying out this function, and therefore, the number of caregivers in this age group is naturally low.

About the schooling of elderly caregivers, the majority had four to six years of study, indicating that concluded on average the 3rd or 4th grade of elementary school, thus acquiring the ability to read, write and do simple calculations. Thus, it can be considered that have a satisfactory level of education. The relationship between schooling and the care activities are also addressed in the scientific literature, the better the level of education the better the performance in care tasks.

In a study conducted in the city of São Paulo an analysis of variance of the means of the SF-36 by number of morbidities. The data demonstrate that increasing the number of chronic diseases impacting several domains of quality of life and also highlights the greater commitment of quality of life as related to limitations in physical aspects. In the present study there was a high percentage of morbidity among the elderly (91%), mainly due to systemic arterial hypertension.

Overall assessment of the quality of life and overall assessment of elderly caregiver quality of life was satisfactory. Similar results were obtained in a study of elderly in the city of Uberaba, Minas Gerais, which showed the difference in satisfaction with QoL and elderly in the urban areas (67,3%) and rural (60,5%).

In this overall assessment of QoL two questions were used: How do you rate your quality of life? And how satisfied are you with your health? The level of satisfaction with the quality of life was 59% and the satisfaction with health was 52%. Thus, we observed that health is fundamental in the perception of the elderly in the evaluation of quality of life, but even dissatisfied with health, some elderly, still consider as good or very good quality of life.

Data from a study conducted in Porto Alegre suggests that, when defining quality of life, the elderly often bring aspects related to health, but also show that health is not understood by them merely the absence of disease and there is more to quality of life than health. Being healthy marks the importance of distancing the notion of quality of life of biological reductionism, because, for the elderly, have a controlled disease or taking drugs does not perceive themselves as a being sick.
Also in this study it was found that to have QoL, and health, the elderly need positive feelings, like having joy and live in peace; family and social life; old age more quiet on the financial conditions; leisure; have food to eat and have a healthy diet.¹⁹

The higher QOL scores in the social relationships domain corroborates other studies to evaluate quality of life in aging.¹⁸,²⁰

The average was 73,07% indicating that studies subjects are “satisfied” or “very satisfied” with their personal relationships with their sex life and the support received from friends. The facet sexual activity contributed 73,18% of the average of the scores on quality of life. It is assumed that this result is related to the fact that most elderly care for their spouses and still maintain sexual relationship, expressed in many ways, not only with the sexual act itself.

Social networks are formed by friends, relatives and neighbors, religious groups, trade unions, neighborhood associations and recreational clubs, which enable groups of people to establish relationships of trust and solidarity that characterize the capital. For many people, especially the elderly, the networks are the only resource available to ease the burdens of everyday life and those that come from the illness.²¹ As we are dealing with older people caring for elderly loads and concerns are even greater, and that require more intensive social care.

In integrative review, comprising the databases Lilacs and Scielo, for the publications of 2010, 50% of the research emphasized the “Coexistence and social interaction” as very important factors for life and the best levels of satisfaction of the elderly.²² This is because social interaction protects the elderly from functional loss, especially with work and leisure activities that should be focused throughout life, especially in the elderly, as well as the relationship with friends and a special attention to maintaining a healthy lifestyle.²²

A study with 480 elderly enrolled in Care Program for the Elderly in Recife/PE indicates that unrepresentative proportion of elderly participate in culture and leisure groups and/or sports groups and physical activity. It also emphasizes that not all seniors have the opportunity and/or knowledge of the existence of specific groups of physical activity and leisure.²³

In assessing the emotional aspect of the caregiver, a study conducted in São Paulo revealed that the average this domain varied according to the caregiver's relationship with the elderly. Spouses had the lowest scores as the children had the best.⁸ Unlike the present study, in which most caregivers are spouses, and yet, the emotional aspect evaluated by the psychological domain had high average and higher than the physical domain.

Regarding the physical domain, in this same study, it appears that caregivers older than 60 had a lower score on the physical domain when compared to younger caregivers. Elderly caregivers have functional losses that impact a reduction of its global potential, which may explain the relationship between the reduction in functional capacity and the upper age 60 years old.⁸

On the other hand, when comparing the results, we obtained in the physical domain with other studies that evaluate quality of life in old age¹⁷,²⁴ we see that the average of the physical domain of an elderly caregiver holding function are superior to older people who exercise this function. We conclude that elderly people who are caregivers have better physical performance are more willing and stronger and so are able to care for other dependent elderly.

In a study conducted in Porto Alegre, it was found that the better the quality of life of older people in the physical domain, the better their performance on tasks of executive function, attention, language and cognitive functioning.²⁴ A possible explanation for this result could lie in the fact that the better physical health and the ability of the locomotor and elderly performance for activities of daily living, the better their performance on cognitive tasks. Probably the best physical state influences on autonomy and self-care ability, leading the elderly to feel safer to live independently and therefore this type of active aging results in improved cognitive functioning.

According to study with elderly patients with type II diabetes, having quality of life is to live with autonomy.²⁵ Elderly value the ability to take hands control of their own decisions and wills and that this fact contributes to live with more quality. The preservation of physical and cognitive autonomy, for the elderly, the power of movement, to make decisions, ensure them a successful aging, guaranteeing them an active attitude towards life and the society.²⁵

Regarding the environment, the average was 53,62 configured as the lowest average of the four areas and therefore the least contribution to the quality scores life.¹⁸ It is assumed that this result is related to precarious recreational opportunities in the community and also to the difficulties encountered by the elderly to seek entertainment opportunities because they are busy with caring tasks.
With regard to the health service, it was evident dissatisfaction of the elderly population studied (57%). The health system is a powerful determinant intermediary in the social production of health chain, especially for universal access, which can deal directly exposure differences and vulnerabilities, preventing individuals, especially the elderly with chronic diseases, are forced into poverty by high costs of health care.21

Many advances have been made with programs such as Basic Assistance Floor, the National Immunization Program, the Food and Nutritional Security Program and the Family Health Strategy. However, social inequalities in access to and use of health services still persist.21 It is worth noting that older people who exercise caregiver role, often forget their own health to take care of each other, and there is no program in public health that meets caregiver needs.

Aging with QoL depends on the balance between the limitations and potential of the elderly. The probability of age with good QoL increases due to the adequate performance of health services. In the process of preparation and adaptation of society to this demographic reality must include the training of professionals who will have the task of caring for the health of the elderly, because, currently, there is a significant shortage of professionals with this skill.26

Health professionals should participate effectively in the conduct of a better quality of life for those people, acting as educational agents, intervening through guidance on disease prevention, referral to health services, stimulating physical activity and food appropriate. These measures allow the people walk in the aging process with more health and wellness.

**CONCLUSION**

The study showed the impact of care tasks on QoL of individuals who are already old and that still have caregivers function. It was also possible to evaluating in detail the facets of more and less influence on the averages in each domain that is the WHOQOL-bref.

The self-assessment of elderly caregiver QoL was satisfactory. This means that older people caring for other seniors are satisfied with the lives they lead and their health they have. However, satisfaction with life was present even among the elderly, having from 1 to 4 chronic diseases or having shown some dissatisfaction with health. Therefore, according to the perception of the elderly, being healthy does not mean that you have QoL and quality of life for much more than health. An old, same patient may instead have QoL, depending on the mode in which it controls and faces his illness.

The average social relationships domain brought greater contribution to QoL, thus it is concluded that it is essential, according to the elderly caregiver, social participation, family support, friends and neighbors and maintain active sex, even when there is no sexual act itself, in order to provide satisfaction with the quality of life.

The physical domain had higher values in seniors who are caregivers compared to seniors who do not perform this function. This is because the elderly caregiver has better performance and physical strength than other seniors, and so are able to exercise that function; less dependent elderly caring for more elderly dependents.

The environmental domain presented itself with the lowest values in the assessment of QoL; therefore, is the area that needs further assistance, both with regard to the lack of leisure, as dissatisfaction with health services.

It aims with this study encouraging scholars in gerontology area to caring about theme and to promoting measures of attention to this population in the Family Health Strategy. Carers in general, are overloaded and not properly take care of their own health.

When the elderly is the caregiver, considering the aging process, difficulties in caring tasks only increase. The overhead of this function is added the aging limitations, making this feature even more painful.

It is known also that there is no program aimed at well-being and health of the caregiver. The attention of health services focuses only on the individual is taken care of. The nurse practitioner is a member of the family health team whose function mainly concentrated in the health education activities. Through these educational activities, it is believed that nurses could contribute more effectively to the elderly who are caregivers to perform their tasks about care with better quality and lower damage to their own health.

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