



THE HEALTH CONDITIONS OF ELDERLY INDIVIDUALS AND CAREGIVERS IN A LONG-TERM CARE FACILITY

CONDIÇÕES DE SAÚDE DE IDOSOS E CUIDADORES EM UMA INSTITUIÇÃO DE LONGA PERMANÊNCIA PARA IDOSOS

CONDICIONES DE SALUD DE ANCIANOS Y CUIDADORES EN UNA INSTITUCIÓN DE LARGA PERMANENCIA PARA ANCIANOS

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ABSTRACT

Objective: to assess the health statuses of elderly individuals and formal caregivers from an Long-Term Care Facility. **Method:** study with quantitative approach, epidemiologic, descriptive and cross-sectional study with 37 elderly people and 15 formal caregivers, applying the questionnaire about address demographic, social and health characteristics: the Katz and Lawton Scale, the Mini-Mental State Exam, Geriatric Depression Scale, and one specific question from the Zarit Caregiver Burden Interview was asked of caregivers along with the Self-Reporting Questionnaire (SRQ). SPSS 20.0 was used for data analysis. The project was approved by the Institutional Review Board, CAAE 21522513.8.0000.5504. **Results:** in regard to functionality, totally dependent individuals were found both for performing BADLs (51.4%) and IADLs (62.2%), while 100% presented cognitive deficits (MEMS = 6.6). Most caregivers were women (86.7%), married (46.7%), and reported poor sleep, tension and tiredness. **Conclusion:** data reveal elderly individuals with significant physical and cognitive impairment and fatigued caregivers, which indicates the need to plan actions to better assist both elderly individuals and caregivers. **Descriptors:** Aged; Caregiver; Homes for the Aged

RESUMO

Objetivo: avaliar as condições de saúde de idosos e cuidadores formais em uma Instituição de Longa Permanência para Idosos. **Método:** estudo de caráter quantitativo, epidemiológico, descritivo e transversal, com 37 idosos e 15 cuidadores formais, aplicando-se instrumento de caracterização demográfica, socioeconômica e de saúde, Escala de Katz e Lawton, Mini Exame do Estado Mental, Escala de Depressão Geriátrica, uma questão específica de sobrecarga da Escala de Zarit e o Self Reporting Questionnaire (SRQ) para o cuidador. Para análise dos dados utilizou-se o SPSS 20.0. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE 21522513.8.0000.5504. **Resultados:** quanto à funcionalidade, revelaram-se idosos totalmente dependentes, tanto para ABVDs (51,4%), para AIVDs (62,2%) e 100% apresentaram déficit cognitivo (MEEM = 6,6). Os cuidadores, mulheres (86,7%), casados (46,7%), revelaram má qualidade de sono, sentimento de tensão e cansaço. **Conclusão:** há idosos com importante comprometimento físico e cognitivo e cuidadores cansados o que direciona o planejamento de ações para melhor assistência a esses idosos e cuidadores. **Descritores:** Idoso; Cuidadores; Instituição de Longa Permanência para Idosos.

RESUMEN

Objetivo: Evaluar las condiciones de salud de ancianos y los cuidadores y formales en una Institución de Larga Permanencia para Ancianos. **Método:** carácter cuantitativo epidemiológico, descriptivo y transversal, con 37 ancianos y 15 cuidadores formales, instrumento de aplicación de la caracterización demográfica, socioeconómica y la salud, Escala de Actividades Escala de Actividades Básicas de la Vida Diaria de Katz y Instrumentales de la Vida Diaria de Lawton, Mini Examen del Estado Mental, Escala de Depresión Geriátrica, un tema específico de la sobrecarga de la Escala de Zarit y Self Reporting Questionnaire (SRQ) para el cuidador. El análisis de datos utiliza el programa SPSS 20.0. El proyecto de investigación fue aprobado por el Comité Ético de Investigación, CAAE 21522513.8.0000.5504. **Resultados:** concernientes a la funcionalidad, resultó ser totalmente dependiente de edad avanzada, tanto ABVD (51,4%), para las AIVD (62,2%) y 100% tienen deterioro cognitivo (MMSE = 6,6). Los cuidadores, mujeres (86,7%), casados (46,7%) revelaron la falta de sueño, sentimientos de tensión y fatiga. **Conclusión:** hay personas mayores con deterioro físico y cognitivo importante y cuidadores cansados que dirige la planificación de acciones para ayudar mejor a estos adultos mayores y cuidadores. **Descriptores:** Ancianos; Cuidadores; Institución para la Tercera Edad.

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INTRODUCTION

The number of individuals 60 years old or older went from 14.8 million in 1999, to approximately 20.6 million (11% of the population) in 2009. The number of older individuals is even higher. In 1999, Brazil had 6.4 million individuals older than 70 years old (3.9% of the total population), while in 2010 individuals this age range reached 9.3 million, which corresponds to 5.1% of Brazilians.¹

This panorama helps to explain changes in the epidemiological profile of the Brazilian population, which shows a high prevalence of non-transmissible chronic diseases, cognitive loss, sensory decline, accidents, and social isolation, which characterize an elderly population and may culminate in functional impairment of elderly individuals who become dependent on others to provide daily care.²

The greatest concern with aging is individuals achieving old age and being affected by one or more diseases that limit daily life and make them dependent on others. In general, even when affected by one or more diseases acquired over the course of life, most Brazilian elderly individuals are capable of self-determination and organization, maintaining their independence and autonomy. Often, however, there is a need for caregivers to help physically or mentally impaired individuals to perform activities of daily living and self-care.³

A caregiver is an individual responsible for providing care to an ill or dependent individual, facilitating activities of daily living, such as feeding, grooming, administering medication, and accompanying individuals to healthcare facilities or other places in their routine.⁴

There are two types of caregivers: formal and informal caregivers. The first is a professional with formal education qualifying them to provide care at home, while the latter can be either a family member or someone from the community informally providing care to dependent individuals. Both caregivers are required to attend to the specific needs of patients.²

One’s educational level impacts the care process and a lack of qualification is a difficult problem to solve in the short term. In order to provide a more qualified level of care, one needs to identify the profile of caregivers since these individuals face different problems related to socio-economic and cultural conditions so that guidance and/or orientation need to be coherent with the context of each caregiver and patient.⁴

An excess of activities may harm the health of caregivers, lead to psychiatric symptoms, fatigue, and poor sleep, consequently impeding these individuals from properly caring for elderly individuals.⁵In some cases, overload is a result of caregivers feeling responsible for providing and performing all care actions, even when such actions are not under their responsibility.²

Lack of knowledge concerning individuals residing in long-term care facilities located in São Carlos, SP, Brazil, as well as an excessive number or amount of activities performed in these facilities, justify this study and show its relevance. Both nurses and gerontologists play an essential role in diagnosing the health of this population, using consistent instruments and proposing care strategies in accordance with healthcare policies direct to the elderly. This study contributes to evidence-based practice supporting the improvement of competencies of nurses and gerontologists, who deal daily with the elderly population and their respective caregivers, consolidating scientific knowledge in the field of gerontology.

OBJECTIVES

- To assess the health conditions of elderly individuals and formal caregivers working in a Long-Term Care Facility (LTCF).

METHOD

This paper was extracted from the project “Warning Integral Elderly Health and Caregivers from the Municipality of San Carlos, Brazil” supported by the Brazilian Council for Scientific and Technological Development - CNPq (grant number 484864/2012-2).

This quantitative, epidemiological, descriptive and cross-sectional study’s aim was to identify data concerning sociodemographic, health status, functionality, and cognitive function of elderly individuals, 60 years old or older, living in an LTCF located in São Carlos, SP, Brazil and also to assess the sociodemographic profiles, health statuses, caregiver burden, and emotional discomfort of formal caregivers working in the same facility.

A total of 38 elderly individuals and 15 caregivers were initially included in the study, but one elderly individual died, so 37 individuals were interviewed.

The coordinator of the undergraduate Gerontology program together with previously trained undergraduate students from the program applied the assessment instruments.

The elderly individuals were assessed in regard to personal, functional, emotional, cognitive, and health aspects. Cognitive performance was assessed using the Mini-Mental State Exam (MMSE); the Katz and Lawton scales were used to assess the functional performance of these individuals, i.e., to objectively assess the levels of dependence or independence of these individuals in the performance of Activities of Daily Living (ADVs); emotional aspects were verified using a geriatric depression scale; and health status was verified through physical assessment, identification of diseases and lifestyle. The instruments are described as follow:

The instrument of Sociodemographic and Personal information addresses age, marital status, place of birth, with whom the individual lives and whether there is a caregiver; social profile such as schooling, elderly individual's income, and family income; lifestyle; and health status.

The Mini-Mental State Exam (MMSE) was validated⁶ and adapted⁷ for Brazil. The MMSE is a cognitive screening test with scores ranging from 0 to 30 and is widely used. Scores⁷ consider the sample's different educational levels: 17 for illiterate individuals; 22 for those with 1 to 4 years of schooling; 24 for individuals with 5 to 8 years of schooling; and 26 for those with 9 or more years of schooling.

Katz's scale measures one's level of independence in performing six self-care activities and classifies individuals either as independent or dependent.⁸ This is a useful scale to show the role played by impairment in the aging process, for establishing prognoses, assessing care demands, determining the effectiveness of treatment, and contributing to the meaning of "help" in the context of rehabilitation. Its results are given in letters that represent the number of activities the individual is capable of performing by themselves: A for no loss; B up to G, in which G indicates loss in six basic activities of daily living, i.e., total dependency.⁸

Lawton's scale assesses the functional performance of elderly individuals in regard to instrumental activities of daily living, i.e., activities that enable one to lead an independent life.⁸ Its maximum score is 21, which characterizes an independent individual; lower scores refer to levels of dependence.⁹

The Geriatric Depression Scale is composed of 15 questions with objective answers (yes or no) addressing how the individual has felt in

the last week. It is a tool that enables rapidly assessing depression among elderly individuals. Each affirmative answer is computed as one point. Scores between zero and five indicate no depression, while scores from six to 10 indicate mild depression, and between 11 and 15 indicate the individual may present severe depression.^{8,10}

Demographic data, caregiver burden, and emotional discomfort were identified using Self-Reporting Questionnaire (SRQ) and by asking one question from Zarit Caregiver Burden Scale.

The Zarit Caregiver Burden Scale was translated and validated for the Brazilian culture.¹¹ Its 22 items are designed to assess the perceived impact of providing care on one's physical and emotional health, social activities and financial status. Nonetheless, because this scale was validated for family caregivers, only the last question was applied to identify how burdened the caregivers felt.

The Self Reporting Questionnaire (SRQ-20), validated in Brazil¹², was designed to detect emotional discomfort in the population in general. The 20 questions composing the scale are answered with yes or no and address emotional and physical symptoms associated with psychiatric conditions (frequent headaches, insomnia, changes in appetite, worsening concentration, nervousness, fatigue, stomach complaints, decreased interest in daily activities, suicidal thoughts, sadness and hopelessness). The highest the frequency of affirmative answers the highest the level of emotional stress.

Data were analyzed with descriptive, univariate (frequency tables) and bivariate statistics (contingency tables for qualitative variables) using the Statistical Package for the Social Science (SPSS), version 20.0. Person's correlation was also used for quantitative variables. The level of significance considered in all tests was $\alpha = 0.05$. It is worth noting that p-values were interpreted considering a simple random sample of a population with similar characteristics.

In accordance with Resolutions No. 466 from December 12, 2012 and No. 251 from August 7, 1997 of the Brazilian Council of Health, the project was submitted to and approved by the Institutional Review Board at the Federal University of São Carlos (No, CAAE 21522513.8.0000.5504). Free and informed consent forms were read and signed by both elderly individuals and caregivers, in accordance with guidelines regulating research involving human subjects.

RESULTS

◆ Elderly individuals’ health statuses and sociodemographic characteristics

The study was conducted with 37 elderly individuals living in an LTCF in the city of São Carlos, SP, Brazil. Most individuals (43.2%) were aged from 70 to 79 years old (minimum 52 years old and maximum 95 years old) and were men (54.1%); 74.4 years old (+9.8 years) on average. Women (78.1 years old) were older than men (71.2 years old) on average. In terms of marital status, most were single (67.6%): 80% among men and 52.9% among women.

The most incident disease was hypertension (32.4%) followed by Diabetes Mellitus (18.9%), while diseases classified as “others”, mainly represented by psychiatric disorders and sequelae of (21.6%), and Alzheimer’s (16.2%), were very frequently found (78.4%).

In regard to gender-related lifestyles: most (66.7%) individuals (57.9% of men and 76.5% of

women) reported no smoking and most (66.7%) also reported no physical exercise.

Most individuals were totally dependent on others to perform activities of daily living: both for BADLs (51.4%) and for IADLs (62.2%). The average score obtained on the MMSE, concerning cognitive performance, was 6.6; women performed worse than men (6.0 and 7.2, respectively).

Table 1 presents education data, and performance obtained in regard to BADLs and the MMSE related to categorical variables concerning the IADL performance of the 37 elderly individuals interviewed. Statistically significant differences ($p<0.001$) were found between the means concerning BADLs and the MMSE. A higher mean was found in the performance of BADLs and the MMSE for partially-dependent individuals, revealing that individuals with worse performance in IADLs also present greater impairment in regard to BADLs and worse cognitive performance.

Table 1. Distribution of means and standard deviations concerning education, performance in BADLs and cognitive performance, related to IADLs’ categorical variables. São Carlos, SP, Brazil 2014.

Avaliação do idoso	Escolaridade	BADL	MMSE
IADLs	Mean(SD)	Mean(SD)	Mean(SD)
Partial Dependence	1,44(1,6)	3,72(2,2)	12,28(6,6)
Total Dependence	1,05(1,8)	1,05(1,3)	1,26(3,9)
Test t (p-value)	0,501	<0,001	<0,001

In the Table 2, the scores presented by Brucki *et al.* (2003) were considered in the assessment of the elderly individuals’ cognitive performances according to the different cutoff points: 17 for illiterate individuals; 22 for those with 1 to 4 years of education; 24 for those with 5 to 8 years, and 26 points for those with 9 or more years of education (Table 2). According to the total mean found on the MMSE (6.2 points), 100% of the individuals presented cognitive deficit. A low mean (4.43) was found for illiterate individuals while those who attended from 1

to 4 years of school obtained a higher mean (10.2), showing statistically significant differences ($p<0.001$) when the categorical variables were related with the MMSE means. Note that the highest number of years of school in the sample was four years. According to Pearson’s coefficient, the correlation between education (complete years) and the MMSE raw score was moderate and statistically significant ($r = 0.403$, $p< 0.001$), showing that fewer years of formal education negatively influenced the performance of the elderly individuals on the MMSE.

Table 2. Distribution of the MMSE’s means according to the educational level of elderly individuals living in the Catinho Fraterno LTCF and the MMSE’s cutoff points according to Brucki *et al.* (2003). São Carlos, SP, Brazil 2014.

Schooling	Mean MMSE (SD)	Score MMSE Brucki <i>et al.</i> (2003)	Test t (p-value)
Illiterate	4,43(6,08)	20	<0,001
1 a 4 years	10,21(8,9)	25	<0,001
Cognitive Deficit?	-	100%	

$r = 0,403$, $p<0,001$

◆ Caregivers health statuses and sociodemographic characteristics

A total of 15 formal caregivers, represented by the nursing staff, one physical therapist, and one social worker, were interviewed. 13 (86.7%) were women and 02

(13.3%) were men. The caregivers were 36.7 (± 8.5) years old on average; female caregivers were older (37.5; ± 8.7) than male caregivers (31; ± 4.2) on average.

Married caregivers and those in stable relationships were classified in the item “have

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a partner”. The item “no partner” included single, widowed, and divorced individuals. Statistically significant ($p<0.05$) differences were found in this item: most female caregivers reported a partner (61.5%), while the male caregivers (100%) reported having no partners.

Statistically significant differences ($p<0.05$) were found in terms of education: 100% of the caregivers had more than nine years of schooling, with $13.7(\pm 2.9)$ years on average, while men had more years of schooling ($15; \pm 2.8$) than their female counterparts ($13.4; \pm 4.1$) on average.

Important differences were found between women and men in regard to salary and the number of daily working hours: men reported higher salaries (R\$ 1,600.00) compared to women (R\$1,269,90) and also worked less hours (5.5h) than the female caregivers (7.5h).

In regard to social support used by caregivers to minimize burden, most female

caregivers (76.9%) reported only religiosity, while men did not report any social support.

In regard to health-related aspects, caregivers self-reported the following diseases: only one female caregiver reported hypertension; back problems were reported by one male caregiver and five (38.5%) female caregivers. Diseases such as dyslipidemia, diabetes, heart disease, osteoporosis, artrite/artrose, and others were not reported.

Emotional discomfort was assessed through the SRQ 20. Data presented in Table 3 reveal that “poor sleep” was more frequently reported (53.3%), followed by “feeling tense, nervous, or worried” (40%) and “feeling tired” (40%). Note that one caregiver reported “the thought of ending his life had been on his mind”, showing the urgent need to provide immediate psychological care to this individual.

Table 3: Distribution of answers provided to the SRQ 20 by caregivers working in Cantinho Fraterno LTCF. São Carlos, SP, Brazil 2014.

Questions from the SRQ 20	No (0) n(%)	Yes (1) n(%)
Do you often have headaches?	12(80)	3(20)
Is your appetite poor?	12(80)	3(20)
Do you sleep badly?	7(46,7)	8(53,3)
Are you easily frightened?	12(80)	3(20)
Do your hands shake?	13(86,7)	2(13,3)
Do you feel nervous, tense or worried?	9(60)	6(40)
Is your digestion poor?	12(80)	3(20)
Do you have trouble thinking clearly?	12(80)	3(20)
Do you feel unhappy?	12(80)	3(20)
Do you cry more often than usual?	11(73,3)	4(26,7)
Do you find it difficult to enjoy your daily activities?	12(80)	3(20)
Do you find it difficult to make decisions?	13(86,7)	2(13,3)
Is your work suffering?	10(66,7)	5(33,3)
Are you unable to play a useful role in life?	14(93,3)	1(6,7)
Have you lost interest in things?	13(86,7)	2(13,3)
Do you feel that you are a worthless person?	14(93,3)	1(6,7)
Has the thought of ending your life been on your mind?	14(93,3)	1(6,7)
Do you feel tired all the time?	9(60)	6(40)
Do you have uncomfortable feelings in your stomach?	11(73,3)	4(26,7)
Do you tire easily?	11(73,3)	4(26,7)

Self Reporting Questionnaire (SRQ-20)/ (Hardin, Arango, Baltazar, 1980; translation to Portuguese by Mari e Willians, 1986).

Caregiver burden was assessed using the last question in the Zarit Burden Interview: “Overall, how burdened do you feel?” The scale presents four alternative answers: never (0), rarely (1), sometimes (2), quite frequently (3) and always (4), though the options for this specific question in the present study are: not at all (0), a little (1), somewhat (2), very much (3), and extremely (4). The higher the answer, the higher the score for burden. In this context, the caregivers who were interviewed more frequently reported “a little burdened” (40%) and “somewhat burdened” (26.7%).

Table 4 presents the distribution of answers (yes/no) concerning BADLs caregivers helped individuals to perform. Only physical exercise is seldom encouraged in the context of the LTCF; only 33.3% of the caregivers assist elderly individuals in performing this activity. Only two caregivers reported that they do not assist elderly individuals in the performance of the remaining activities, especially those concerning BADLs (hygiene, eliminations, feeding, medication, sleep/rest), possibly because two professionals included in the sample were not from the nursing staff (one physical therapist and one social worker).

Table 4: Distribution of caregivers' answers concerning assistance provided to elderly individuals in performing BADLs. São Carlos, SP, Brazil 2014.

Activities performed by caregivers	Yes (%)	No (%)
Bodily hygiene	13(86,7)	2(13,3)
Oral hygiene	13(86,7)	2(13,3)
Eliminations	13(86,7)	2(13,3)
Skin care	14(93,3)	1(6,7)
Feeding	13(86,7)	2(13,3)
Medication	13(86,7)	2(13,3)
Sleep/rest	13(86,7)	2(13,3)
Phisical exercise	5(33,3)	10(66,7)
Leisure	12(80)	3(20)

DISCUSSION

♦ Elderly individuals' health statuses and sociodemograohic characteristics

Aging is a differentiated phenomenon for men and women since women live longer than men. This study's findings show longevity in women (54.1%), which corroborates most Brazilian studies.¹³⁻⁷ The fact that women live longer than men may be due to differential mortality by sex that has prevailed for a long time; since 1950, women have had a higher life expectancy at birth, six years more than men.¹⁸

Another important aspect reveals a strong relationship between sex, marital status and being cared for in an LTCF. Most individuals living in the facility were male and single.

A predominance of elderly male individuals was found in three studies assessing institutionalized individuals. One of the studies investigated the elderly individuals' levels of functional capacity, the professionals responsible for providing care, and the profile of an LTCF in Ribeirão Preto, SP, Brazil. Another study was conducted in Caldas Novas, Go, Brazil and addressed the socio-demographic, mental and functional profiles of institutionalized individuals. Both studies report similar data concerning the number of male individuals cared for in these facilities.^{13,17,18} Other studies, though, provide contradictory data reporting a larger number of women living in LTCFs.^{14,19}

In terms of the individuals' marital statuses, the high number of single elderly individuals may indicate a marginalization of elderly individuals without families. There is also a possibility that the individual him/herself prefers to be isolated from society because they believe they are a burden for the family, or even because the family itself considers the individual to be a burden.¹⁷

Brazilian families in general opt to institutionalize their elderly members in nursing homes when they have exhausted their ability to provide the necessary care.¹⁵

These facilities are also seen by the elderly individuals themselves as the last resort. Some may seek nursing homes on their own initiative, influenced by situations such as the death of a spouse, economic reasons, family rejection, the need to receive care from a place where they do not have to pay, or a place where they have company and a structure that gives them peace of mind and safety.²⁰

In regard to the elderly individuals' health statuses, important results were found. A significant tendency to chronic diseases is perceived among the most frequent diseases such as hypertension and Diabetes Mellitus, diseases that can be avoided if preventive medical follow-up is implemented to preserve the health of these individuals. Another study reports similar chronic diseases, in addition to osteoarthritis, vascular dementia, congestive heart failure and depression.¹⁷

In regard to schooling, most individuals were illiterate (62.2%), which showed a strong relationship between education and cognition: the less educated the individual, the worse the performance on screening tests such as the MMSE and the clock-drawing test. Schooling has been indicated as a direct risk factor for cognitive decline measured by the MMSE. Illiterate individuals obtained a low mean (4.43) on the MMSE, while those who attended up to four years of school obtained a higher mean (10,2 pontos).

According to the study conducted by Ana Beatriz Fonseca in the Psychiatric Institute of the Federal University of Rio de Janeiro, not having access to education in early childhood should be seen as a factor that possibly leads to health problems over the course of life. She states that education contributes to cognitive reserve and prevents dementia among elderly individuals.²¹

These characteristics were expected, considering the vulnerable social context of the individuals under study; however, quality education should be encouraged among people of all ages because it is a predictive factor for preserved cognitive capacity.

Another study reports that schooling was a strong negative factor, independently associated with caregivers' needs, while a higher educational level was associated with better functional status and a lower risk for cognitive impairment among elderly individuals.²

The context previously discussed indicated the need for public policies intended to protect and strengthen educational practices, not only with basic educational development in mind, but also considering the relationship between quality elementary school and the preservation of cognitive reserves in old age.

In regard to the elderly individuals' functional capacities, most were dependent on others' assistance both to perform BADLs and IADLs. A direct relationship was found in the application of the MMSE between worse performance regarding BADLs and greater cognitive impairment.

Functional activity comprises one's ability to perform daily tasks, including physical, psychological and social aspects. These activities reveal one's ability to perform self-care, roles and basic and social tasks. The loss of adaptive functioning in many institutionalized individuals is not only a result of decline or negative biological changes, but also a consequence of an environment that establishes and defines occasions for deficient behavior and reinforces inefficacious and dependent behavior.¹⁶

Impaired functional capacity may be directly linked to the fact that most individuals interviewed did not exercise. The literature shows that the practice of exercise can help to preserve physical and cognitive conditions and delay frailty and dementia.¹⁸ The activities provided in this facility should be reconsidered and changes could be proposed to encourage greater adherence on the part of the elderly individuals. The possibility of involving the caregivers themselves in these activities should be examined. Another aspect to consider is whether involving caregivers in these activities would impose more burden, since increased burden may be the reason they have not assisted elderly individuals in the performance of exercises.²

Therefore, it is important to identify how the facility structures itself to meet such needs and which sectors require theoretical and methodological support to encourage health actions.²²

♦ Caregivers' health statuses and sociodemographic characteristics

Data concerning caregivers show that most were women. There were only two male caregivers, which corroborates extensive Brazilian literature and confirms the concept of care feminization.¹³⁻¹⁸ Understanding the reasons that lead women to seek jobs of this nature and how they relate to such activities is essential to take into account specificities of gender and to propose actions. Most women reported having a partner, while both male caregivers reported they had no partners.

All the caregivers reported more than nine years of formal education and background in the field of elderly care, showing the institution's concern to hire qualified personnel and provide a service that is in accordance with legislation regarding LTCFs. This is a very positive aspect; however, continuing education should be provided to staff along with a participatory and multidisciplinary management style that encourages dialogue and makes these individuals feel essential to the therapeutic processes.²²

Another factor to be highlighted is the relationship between gender and remuneration. This aspect has been widely discussed in different fields and, once more, the tendency to pay men better than women who perform the same job is revealed. There is a need to investigate the factors leading to this fact and to identify how to address this issue in the sphere of management and fight for the rights of these women who equally dedicate themselves to the job providing care of similar quality.²³

Still in regard to the female gender, it is interesting to note that only women reported religious support in their lives. A better understanding of how these women relate to the world through their faith and spirituality is also essential to understanding the reasons they choose this modality of work and to think in regard to future practices that take into account these aspects on their personal characteristics.¹⁶

Caregivers have their health compromised and experience injuries as direct results of their work process, such as hypertension and back problems, which shows the need to follow-up on these cases in order to preserve the functional health of these caregivers through implementing exercise at work and adapting the workload to workers' health characteristics. If the staff is integrated and willing to seek solutions, this is an aspect that has great potential for exploration because

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the facility already has the necessary professionals, equipment and physical space to provide such assistance.

This study also contributed to improving knowledge regarding burden symptoms experienced by the caregivers of elderly individuals living in an LTCF. The caregivers participating in the study more frequently reported that they felt “a little burdened” (40%) and “somewhat burdened” (26.7%). The instruments used to assess burden were important for this population but great attention should be paid to the interpretation of the burden scale’s questions when applied to formal caregivers, because we could only use the last question regarding level of burden.

Complementary to the investigation concerning burden, we used the SRQ, which addresses physical and psychological problems that characterize the caregiver’s emotional distress in order to better understand the fatigue experienced by caregivers. A total of 26.7% of the caregivers were diagnosed with emotional distress, considering the cutoff point of 7/8. They also frequently reported poor sleep, tension and tiredness. This report shows the specificities of the work distributed in work schedules and also the stress to which these workers are subjected. Some feelings, such as worry and tension, are common among caregivers, and many aspects may be involved with these feelings, such as how severe the patient’s disease is, while daily and continuous delivery of care to elderly individuals and their dependence on caregivers also contributes to affect the sleep quality of caregivers.^{2, 24, 25}

There are some limitations to this study, especially in regard to the inclusion of professionals, such as the service’s management (social worker) and the physical therapist. These individuals chose to participate in the study because they feel they have the responsibility of a caregiver. This choice may have compromised the homogeneity of responses, since the context of their work is different from the remaining caregivers and the instruments applied did not address their experiences in the sphere of care delivery.

CONCLUSION

The institutionalization of frail elderly individuals brings up the emergent need to rethink and adapt the service provided by long-term care facilities in order to improve and facilitate the work performed by caregivers and other healthcare providers.

The context observed in this study revealed there is an urgent need to implement actions directed to the leisure of institutionalized elderly individuals and to consider the specificities and characteristics of these actions in the therapeutic process. There is also a need to encourage a healthy workplace for caregivers to avoid harming the health of these workers over time. The study’s general objective was to identify the health profiles of these elderly individuals and their respective caregivers, but the implementation of this study unfolded a map to track aspects requiring attention and interventions that can improve the quality of the service provided.

Knowledge acquired from validated instruments is necessary to implementing and assessing actions intended to improve assistance provided to elderly individuals and caregivers, considering that the latter require emotional and psychological support.

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