Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

SOCIODEMOGRAPHIC AND CLINICAL PROFILE OF INSTITUTIONALIZED ELDERLY PEOPLE

PERFIL SOCIODEMOGRÁFICO E CLÍNICO DE IDOSOS INSTITUCIONALIZADOS

PERFIL SOCIODEMOGRÁFICO Y CLÍNICO DE LOS ANCIANOS INSTITUCIONALIZADOS

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ABSTRACT

Objective: to identify the sociodemographic and clinical profile of elderly residents in long-stay institutions for the elderly. ***Method:*** a quantitative approach, epidemiological cohort study conducted at two institutions João Pessoa / Paraíba / Brazil. Data collection was conducted with 81 elderly through form. For analysis, was used for descriptive analysis. The research project was approved by the Ethics Committee under the Protocol. n. 0305/11. ***Results:*** population predominantly female, with age, illiterate, single, white race, with children, income 1-3 minimum wages, with some physical limitation, institutionalized for over 10 years, mostly by relatives, hypertensive and using the unique system health and primary health care. ***Conclusion:*** the elderly are growing up in institutions for long stay and prove multidimensional characteristics of these health, helps to identify the major needs facing the aging process and can guide the skilled assistance. ***Descriptors:*** Nursing, Elderly; Institutionalization.

RESUMO

Objetivo*:** identificar o perfil sociodemográfico e clínico de idosos residentes em Instituições de longa permanência para idosos. ***Método: estudo de abordagem quantitativa, epidemiológico de coorte, realizado em duas instituições de João Pessoa/Paraíba/Brasil. A coleta de dados com 81 idosos foi realizada por meio de formulário. Para a análise, utilizou-se de análise descritiva. O projeto de pesquisa foi aprovado pelo Comitê de Ética com o protocolo n. 0305/11. ***Resultados***: população predominantemente feminina, com idade avançada, analfabetos, solteiros, raça branca, com filhos, renda de 1 a 3 salários mínimos, com alguma limitação física, institucionalizados há mais de 10 anos, majoritariamente por familiares, hipertensos e utilizando o Sistema Único de Saúde como principal serviço de saúde. ***Conclusão***: os idosos se fazem crescente em Instituições de longa permanência e ao se revelar características multidimensionais de saúde destes, contribui-se para identificar as principais necessidades frente ao processo de envelhecimento, podendo guiar a assistência qualificada. ***Descritores:*** Enfermagem; Idosos; Institucionalização.

RESUMEN

Objetivo: identificar el perfil sociodemográfico y clínico de ancianos residentes en instituciones de larga estadía para ancianos. ***Método***: estudio de enfoque cuantitativo, epidemiológico de corte, realizado en dos instituciones João Pessoa/Paraíba/Brasil. La recolección de datos se llevó a cabo con 81 ancianos a través de forma. Para el análisis, se utilizó el análisis descriptivo. El proyecto de investigación fue aprobado por el Comité de Ética com el Protocolo n. 0305/11. ***Resultados***: la población predominantemente femenina, con la edad avanzada, analfabetas, solas, raza blanca, con los niños, los ingresos salariales mínimos 1-3, con alguna limitación física, institucionalizadas hace más de 10 años, en su mayoría por familiares, hipertensos y con el uso del Sistema Único de la Salud como principal servicio de salud. ***Conclusión***: las personas mayores están creciendo en las instituciones de larga estancia y a probar las características multidimensionales de la salud de éstos, ayuda a identificar las principales necesidades al proceso de envejecimiento y puede guiar la asistencia especializada. ***Descriptores***: Enfermería; Ancianos; Institucionalización.

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INTRODUCTION

In Brazil registers the time of demographic transition. It is a young country that due to the decline in fertility, mortality and increased life expectancy is resulting in a country of old.[1] The 2010 census recorded 190,755.799 inhabitants, representing 7.4% of the total age group of 65 years or more was 4.8% in 1991 and rose to 5.9% in 2000.2 This growth was 1, 1% from 1991 to 2000 and 1.4% from 2000 to 2010, growth of 0.3%. It is estimated that in 2025, Brazil will become the sixth country with the largest number of individuals aged 60 years or more, representing 13% of the population.[3]

During the aging process, there are many psychological and biological changes due to the change of lifestyle, due to new phase and it requires attention because such modifications, combined with the demographic transition of the global population leads to increased demand for health services, social security and social assistance. Soon, the elderly will have new needs of society which demanded an adaptation to living with quality of life, with that health professionals have a duty and responsibility to promote health for this population reach longevity with quality of life.[4]

Caring for seniors is a process of everyday health professionals and increasingly requires knowledge beyond the basics such as anatomy and physiology, more complex behaviors to adopt in the treatment through systematic evaluation. There are several types of diseases that the elderly face is subject to specific stemming from the aging process. Between injury stands out: The weakening in the aging process constitutes a syndrome of multifactorial origin multidimensional and causing changes in the elderly that lead elderly people to a state of increased vulnerability and increased risk of functional decline.[5]

The nurse is committed to helping and caring for elderly according to the possibilities of technical and scientific knowledge of his profession and available resources, is committed also to respect and ensure respect for each senior, watching them in their uniqueness and way to express the meaning of old age and aging for each of the elderly. That way, you can introduce activities to promote health and autonomy.[6]

The care of the elderly is not only played by health professionals, but also for the family. The care for the elderly was held by the family, especially for the female figure, ie, spouse, daughter or daughter in law. Changes in family structure such as separation, widowhood, decline in the number of children out of women to the labor market situation of low income often contributes to preclude the family from exercising elderly care.[3] Thus, these situations together with diseases that compromise the autonomy and independence of the elderly, contributing to an increase in the number of individuals in long-stay institutions. Therefore, institutions for elderly emerge as an alternative to reduce the responsibility of the family by the elderly.

Institutions for the elderly emerged at the time of Christianity. The elderly in nursing homes were kept together with other marginalized by society (the poor, homeless, abandoned and orphaned children) beyond the term asylum came home, shelter, nursing home care to define idoso.7 Thus, the Brazilian Society of geriatrics and Gerontology suggested the appointment of long permanence institution for the elderly (LTCF).

Therefore, the ILPI institutions for the aged, play a significant role as an alternative care, however there are few studies related to these institutions, especially with regard to its definition and consequently their role in society.8 However is important to note that with the changing age profile of the population, where we have in addition the growing number of elderly people perceive an increase of very old elderly (above 80 years), it is the reduction of physical, cognitive and mental. Given the above it is clear that these institutions need to be part of the network of health care, not leaving but to exercise their social role, ie offer something more than a shelter.

National studies indicate that 0.8% of the elderly population is living in long-stay institutions for the elderly (LTCF). For scholars institutionalization is not a common practice in Brazil. The indicators do not reveal the high visibility of the issue to the national stage, the institutionalization are on the rise, so there is a growing trend in the near future.[5]

Thus, this research aims to identify the sociodemographic and clinical profile of institutionalized elderly people in long-stay institutions for the elderly.

METHOD

Study of quantitative approach, epidemiological cohort, conducted in two institutions Long Term elderly located in the city of João Pessoa / Paraíba / Brazil. Philanthropic institutions are meeting the region's elderly with and without family ties,

from families unable to house them or provide proper care.

The first ILP is divided into six accommodation blocks of the elderly, among them one does not work, is under renovation, and the administrative block and laundry, kitchen, chapel and nuns. These blocks have flat type accommodation and collective housing. The elderly care is not covered by the Family Health Unit (FHU), however, has the support of the health district as the medications of primary and marking of examinations.

The second ILPI is divided into four accommodation blocks of the elderly, two male and two female, and an administrative block and a hall for events and food court. The accommodations are apartment-style accommodation and collective. It is covered by the Family Health Unit, and has visiting medical staff.

The research sample consisted of 81 elderly, 45 and 36 of the first institution of the second institution, all of whom participated in the study by signing the consent form.

Inclusion criteria: aged over 60 years, being a resident of the institution and take part in the research. It is noted that people who have cognitive information gathering was held responsible for a (family), or caregiver of the institution. The term caregiver is related here to the institution officials, providers of assistance to seniors who are trained caregiver or nursing technician and caregiver training with individual nursing technician designated by a family.

The data collection instrument was a form composed of objective questions, applied to the elderly, caregiver, or both, in the period April to September 2012. The instrument variables approach sociodemographic characteristics, health status and degree of dependency to physical limitations. Evaluated by the elderly: lies, posing, sitting and walking with their own autonomy? Aid of person(s)? Use tools to walk or bedridden?.

The results were entered into an Excel 2010 spreadsheet program was used descriptive data analysis both in absolute and percentage terms. The results were organized in tables and graphs and discussed in the light of relevant literature or relevance.

The project was approved by the Ethics Committee in Research of the Center for Health Sciences, under Protocol nº 0305/11, according to Resolution 196/96 National health.[9] Is part of a larger study entitled "Evaluation of risk for developing pressure ulcers by institutionalized elderly." Which is linked to the Group of Studies and Research in Wound Management, Federal University of Paraíba - (GEPEFE / UFPB), as well as the programs of Undergraduate Research and Graduate Nursing at that institution.

RESULTS

Of the 81 subjects interviewed 66 (67%) completed the data collection instrument, 12 (14.8%) were answered by the caregiver, and 3 (3.7%) had the senior caregiver assistance to answer questions.

The data presented in Table 1 shows some characteristics related to socio-demographic variables of the sample, which found that there was a predominance of elderly females 50 (61.7%) and 31 (38.2%) were male. The most prevalent age group was 80 to 94 years with 42 (51.9%), followed by 60-79 years and 7 (8.7) were older than 95 years. Regarding education, 20 (25%) were illiterate.

Table 1. Distribution of elderly according to gender, age and education, João Pessoa, PB, 2012.

Variable		n	%
Gender	Male	31	38,2
	Female	50	61,7
Age	60-79	32	39,5
	80-94	42	51,9
	Over 95	07	8,7
Schooling	Illiterate	20	25
	Literate	18	22,2
	Complete Basic School	11	13,5
	Incomplete Basic School	13	16
	Complete High School	06	7,4
	Incomplete High School	02	2,5
	Degree	07	8,7
	NS/NR*	04	05

*NR / NS: Data that older people do not remember or do not know answer

In Table 2, we observe variables such as skin color featuring 43 seniors (53%) were white, 28 (34.5%) mixed and with regard to marital status, only 37 (46%) were single and 38 (47 %) had children.

Table 2. Distribution of elderly according to race, marital status and children, João Pessoa, PB, 2012.

Variable		n	%
Color	White	43	53
	Black	10	12,3
	Brown	28	34,5
Marital Status	Single	37	46
	Married	02	2,5
	Widower	29	36
	Stable Unio	01	1,2
	Divorced	05	6,2
	Separated	05	6,2
	NS/NR	02	2,5
Children	Yes	38	47
	No	31	38
	NS/NR*	12	15

*NR / NS: Data that older people do not remember or do not know answer

When questioned in relation to income, 93% reported having income and 7% said they did not own it or did not know whether it had or not. Of those with income, 58 (71.6%), 1-3 corresponds minimum salaries, due to retirement pension or Social Security, 6 (7.4%) corresponds to 1 minimum wage and 17 (21%) did not know the answer value.

In Table 3, it was observed that the time of institutionalization is predominantly in the range from ≤ 1 to 66 and 10 years old (82%), which for establishing the routing was mainly due to family 38 (47%) and the health services they use most is SUS 45 (56%) followed by the Covenant health 13 (16%).

Table 3. Distribution of elderly according to length of stay, who referred to the institution and type of health service use. João Pessoa, 2012.

Variable		n	%
Time at the institution	≤ 1 to 10	66	82
	11 to 20	12	15
	> 20	03	3,7
Who has indicated to the institution	Family	38	47
	Own initiative	27	33,3
	Other	06	7,4
	NS/NR*	10	12,3
Health service used	SUS	45	56
	Insurance	13	16
	Particular	11	13,5
	Other	01	1,2
	NS/NR	11	13,5

*NR / NS: Data that older people do not remember or do not know answer

When assessing the health situation, Table 4, comorbidities diagnosed in the records of the study participants were: hypertension 49 (60.5%) neurological diseases 19 (24%), osteoarticular 19 (24%), diabetes 16 (19.8%), psychiatric disorders 9 (11.1%), Stroke 6 (7.4%), cancer, 4 (4.9%) and heart disease 4 (3.7%).

Table 4. Distribution of elderly according to the presence of comorbidities, João Pessoa, PB, 2012.

Chronic diseases
Hipertension
Neurological diseases
Osteoarticular diseases
Diabetes
Vascular encephalic accident
Psiquiatric
Cancer
Hearth disease

Limitation of physical activity for 81 elderly participants 33 (41%) had some limitation. Of this total, 18 (54.5%) seniors throws, lifts, sitting and walking with the aid of a person; 1 (3%) seniors throws, lifts, sitting and walking with the aid of two people and 14 (42, 4%) seniors lies down, sits up and with the aid of a tool support (cane, andajar).

Compared to caregivers of the elderly in institutions, were investigated activities that they played. 10 caregivers participated in this process, among which two were individual

caregivers who had training as a nurse technician and were paid by the family to care for a single elderly. The other eight were caretakers of the institution, with 02 technically trained nursing and six with caregiver course, without any nursing training.

The activities performed by caregivers were: food, clothing, bathing, grooming and walking. Showed no differences in the activities of the two types of caregivers, however, caregivers institutions caring for up to 10 elderly for every caregiver.

DISCUSSION

The sociodemographic and clinical overview of institutionalized elderly in two long-stay institutions for the elderly in the city of João Pessoa had the highest percentage of females. Studies have found that women are the ones that have longevity, also cites the feminization of old age due to longer life expectancy of women.[4,8,10-4]; Also, the prevalence of older women is due to greater self-care that women have about their health, as they do not have the habit to care for themselves, whereas for men, in general, seek a health service is weakness, vulnerability and fragility, these criteria that fall into the feminine characteristics that imply a distrust of masculinity embedded in the social imaginary.[15]

According to age and education, the majority of elderly illiterate or low education were in the age group 80-94 years old. In a study of elderly in a long-stay institution in Curitiba / PR also showed a higher percentage of elderly in the same age group, illiterate or low escolaridade.16 During childhood education of the elderly had an important context reflecting today in the elderly with low education.[11]

Studies reveal that factors such as age and low education are strongly associated with impaired functional capacity which implies the involvement of activities of daily living.[10,17] Functional capacity is related to the ability of the elderly to perform activities of daily living with autonomy and independence.[18]

The sample was predominantly white elderly, unmarried with children. This result is also observed in a survey of institutionalized elderly in Juiz de Fora - MG and Pindamonhangaba-São Paulo, most also was white, unmarried with children.[19-20]

The fact shows that having children is not a factor for older people in care are family environment, so the decision to take care of the elderly will depend possibly structural conditions and human family. The LTCF has become an option for those families of seniors who can not afford to provide care as a result of work activities and this difficulty increases as you increase the dependence of the elderly.[20]

With respect to income, receive no benefit is justified by the lack of personal documents. Do not forget that in our country all the seniors who prove to have no source of income is entitled to a minimum wage paid by the Federal Government on the Law of Benefit Provision Continuous.[19]

Regarding the length of stay in the institution found that most are in the institution from one to ten years. In research on adaptation of institutionalized elderly was not possible to confirm that the longer the institution greater the level of compliance of the elderly that environment. In the research it was also observed that the entry of the elderly in the institution of the family departed, this fact is evidenced in many studies.[19, 21]

Family institutionalize the elderly is to provide it better care, life care and comfort needed in demanding their limitations.[11] The health service most used by the elderly is the SUS (Unified Health System) showing the lack of the elderly in economic terms. It was also found that only one of the institutions had coverage of the Family Health Unit for the care of the elderly.

In relation to chronic diseases listed, hypertension is what is present in a higher percentage. Published studies have also shown that hypertension as the leading chronic illness of the elderly.[16,18-20] It is estimated that chronic diseases that are considered characteristic of old age, will be steadier in the elderly 80 years or more, which will contribute to the emergence of difficulties in activities of daily living interference with its independence and autonomy.[10]

Diseases such as hypertension, neurological and musculoskeletal lead the elderly to develop co-morbidities that may prevent or limit the elderly in their daily activities, which was evidenced by the significant number of people who had limitations in walking alone. Although the majority consist of elderly who had no physical limitations, the senile and chronic diseases that have some physical limitations, need greater attention in care that may delay or minimize the maximum possible time for a partial or total dependence. However, of those with limited physical activity for the most needed help human caregiver to get around, corroborating

the study developed in ILPS of Ribeirão Preto.[22]

CONCLUSION

The objectives were achieved once the clinical profile of older institutions surveyed revealed a predominantly female population aged 80-94 years, with a high proportion of illiterate, single, white race, with children, income, limiting physical activity dependent on one person to get around, institutionalized over 10 years mostly by family members with chronic diseases, and using the NHS as the main health service.

The results show that the number of elderly people is increasing in long-stay institutions and disclose health multidimensional characteristics contribute to identify their main needs facing the aging process and can guide a qualified assistance. Considering these aspects, the nurse holding the knowledge of the peculiarities of the process of aging can plan an effective assistance, geared to the needs of this audience.

With respect to institutions surveyed, one was perceived caregiver burden, since they take care of many seniors at the same time, thus hampering the care of this population. Another aspect to be considered is the fact that the need for a support network for the elderly by the Family Health Strategy, as it is risk groups, care to these elderly people are neglected.

We stress the need to increase knowledge on the conditions of institutionalized elderly, to the development of research in all aspects of institutionalization, so that later the actions and goals of this research can contribute to more effective health policies in our country, especially to improve the practices of nursing care in NHs.

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Submission: 2013/03/24
Accepted: 2013/04/21
Publishing: 2013/10/01

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