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CHARACTERISTICS OF THE ELDERLY AND THEIR FAMILY CAREGIVERS

CARACTERÍSTICAS DE IDOSOS E DE SEUS CUIDADORES FAMILIARES

CARACTERÍSTICAS DE LAS PERSONAS MAYORES Y SUS CUIDADORES FAMILIARES

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ABSTRACT

Objective: to describe characteristics of the elderly and their family caregivers at home. ***Method:*** descriptive study, carried out with 71 elderly and their family caregivers, enrolled in Family Health Strategy. Data was collected from Katz, Mental State Mini Exam, sociodemographic, Zarit and WHOQOL-bref and analyzed using descriptive statistics. ***Results:*** of the elderly women who were cared for, prevailed those that had diseases and were dependents. Among the caregivers, there was a predominance of women, with advanced age, reduced education, unfavorable economic conditions and cohabiting with the elderly. Overload and lower quality of life were more pronounced in caregivers of dependent elderly. ***Conclusion:*** It was noticed that independent elderly people need caregivers to support them in the execution of their activities. And, among caregivers, formal support is non-existent, which makes it essential for health professionals to adopt preventive measures for health and care-related burdens, with a focus on the family. ***Descriptors*:** Elderly; Caregivers; Family; Quality of Life; Social Support.

RESUMO

***Objetivo*:** descrever características de idosos e seus cuidadores familiares no domicílio. ***Método*:** estudo descritivo, realizado com 71 idosos e seus cuidadores familiares, cadastrados em Estratégia Saúde da Família. Os dados foram coletados a partir do Katz, Mini Exame do Estado Mental, sociodemográfico, *Zarit* e *WHOQOL-bref e* analisados por meio da estatística descritiva. ***Resultados*:** dos idosos cuidados, prevaleceram mulheres, acometidas por doenças e dependentes. Entre os cuidadores, houve predominância de mulheres, com idade avançada, reduzida escolaridade, condições econômicas desfavoráveis e coabitando com o idoso. A sobrecarga e a menor qualidade de vida foram mais acentuadas em cuidadores de idosos dependentes. ***Conclusão*:** notou-se que idosos independentes necessitam de cuidadores para apoiá-los na execução de suas atividades. E, entre os cuidadores, o apoio formal é inexistente, o que torna fundamental profissionais de saúde adotarem medidas preventivas de agravos à saúde e de sobrecarga relacionadas ao cuidado, com enfoque na família. ***Descritores*:** Idoso; Cuidadores; Família; Qualidade de Vida; Apoio Social.

RESUMEN

Objetivo: describir las características de las personas mayores y sus cuidadores familiares en el hogar. ***Método:*** estudio descriptivo, realizado con 71 adultos mayores y sus cuidadores familiares, inscritos en la Estrategia de Salud de la Familia. Los datos se recolectaron a partir del Katz, Mini Examen del Estado Mental, socio-demográfico *Zarit* y *WHOQOL-bref* y analizados mediante estadística descriptiva. ***Resultados:*** de los ancianos cuidados, prevaleció las mujeres, afectadas por enfermedades y dependientes. Entre los cuidadores, hubo predominio de las mujeres, con edad avanzada, bajo nivel educativo, condiciones económicas desfavorables y cohabitando con el anciano. La sobrecarga y la menor calidad de vida fueron más acentuadas en los cuidadores de ancianos dependientes. ***Conclusión:*** se observó que las personas mayores independientes requieren cuidadores para apoyarlos en la ejecución de sus actividades. Y, entre los cuidadores, el apoyo formal es inexistente, lo que hace fundamental profesionales de salud adoptaren medidas preventivas de los daños a la salud y sobrecarga relacionadas con la atención, con enfoque en la familia. ***Descriptores*:** Anciano; Cuidadores; Familia; Calidad de Vida; Apoyo Social.

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INTRODUCTION

Demographic and epidemiological transitions have given rise to a number of discussions about the challenges of seeking care alternatives to the growing number of older people, which deserves attention, especially in developing countries, where the rapid aging of the population does not accompany social and economic development.[1]

Chronic degenerative diseases are the ones that most affect the elderly and can lead to changes in their functional capacity, [2] making them need permanent care of the family and/or caregiver, as well as continuous and specific attention of the health team.[3] In this perspective, it is verified that care for the elderly is mostly provided at home, and the family is primarily responsible for supporting them. This is reinforced by public policies aimed at the elderly.

Dependence on daily life activities, often associated with comorbidities, tends to increase by about 5%, in the 60-year age group, to 50% among the elderly with 90 or more years of age.[4] Thus, caring for elderly dependents by chronic or acute diseases, is a frequent condition among families.[5]

The informal caregiver emerges as a fundamental partnership with the Brazilian health system, and the promotion of elderly health and support to caregivers represents new challenges to the system, and it is indispensable to implement actions directed to the needs of this age structure.[3]

When the caregiver assumes care for the elderly, they begin to experience family (re) organization due to the demands that arise.[6] Thus, the caregiver modifies the way of living as a result of caring for the elderly. This change does not always occur by the caregiver's will, but by circumstances. And when this happens, the likelihood of overloading is higher,[2] this can interfere with lifestyle, social well-being, and have negative consequences for the elderly, caregiver, and family.[6]

Health professionals, for the most part, focus their attention on health only for the elderly, not addressing the needs and particularities of the family and caregivers, which is important for the success of approaches developed by health teams.[7] This is a problematic, therefore, some caregivers are also elderly, present bio-psychosocial changes, as a result of the aging process, and are affected by diseases.

This study aimed to describe characteristics of the elderly and their family caregivers at home.

METHOD

A descriptive study, was carried out in the municipality of Manoel Vitorino, in the southwest region of the State of Bahia, with a Municipal Human Development Index (IDHM) (between 0.5 and 0.599).[8] The population with low schooling, low economic conditions and high Informal occupation of the municipality was the determining factor for their choice.[8] Data collection was carried out from January to February 2013.

The population of this municipality is composed of 14,387 individuals, and, in the urban area, there are 7,359 (51.1%) of people. Of these, 871 (11.8%) are elderly.[9] Its IDHM occupies the 4,921th position in relation to the 5,565 municipalities of Brazil. And in relation to the 417 municipalities in Bahia, it occupies 312st position.[8] Average per capita income has grown in the last decades, from R$ 80.63, in 1991, to R$136.09, in 2000, and R$ 226.95, in 2010. The Extreme poverty, measured by the proportion of people with per capita household income of less than R$ 70.00, in reais in August 2010, went from 60.74%, in 1991, to 38.67%, in 2000, and to 26.47%, in 2010, characterizing the improvement of the financial conditions of the population. Despite this, inequality increased, with the Gini Index rising from 0.49, in 1991, to 0.51, in 2010.[8]

The participants of this study were 71 elderly and 71 family caregivers residing in the urban area, included in two Family Health Strategies (FHS). These FHSs together comprise two teams, 14 microareas and 871 elders, aged 60 and over, registered. To identify those elderly who had caregivers, home visits were carried out, with the support of the Community Health Agents. The inclusion criteria were: the elderly have a family caregiver and cohabit in the same household; The caregiver is 18 years of age or older; be the primary caregiver and be enrolled in one of two FHS.

The Mini-Mental State Examination (MMSE) was designed to evaluate the cognitive function of the elderly.[10] This instrument was translated with modifications for Brazil and contains questions related to the sections: orientation, immediate memory, attention and calculation, memory of evocation and language.[11] Their scores vary from one to 30 points. As the total score reduces, increases the cognitive impairment. For this study, the

adopted scores were: illiterates- 20; For the age of one to four years- 25; from five to eight years- 26.5; From nine to 11 years-28; and for persons over 11 years-29 points.[12]

Next, the socio-demographic form was then applied to identify the characteristics of the elderly and, later, the Independence Scale in Daily Life Activities (EIAVD) or Katz Scale[13], with a cross-cultural adaptation to Brazil, used to evaluate the functional independence of the elderly. This scale evaluates the following operating areas: bathing, dressing, toilet, transfer, salute and feeding.[14]

The classification adopted for this study was: 0) Independent in all six functions; 1) Independent in five functions and dependent on one; 2) Independent in four functions and dependent in two; 3) Independent in three functions and dependent in three; 4) Independent in two functions and dependent on four; 5) Independent in one function and dependent on five functions; 6) Dependent on all six functions.[15] Part of the elderly responded to the instruments on their own; others were assisted by caregivers.

The socio-demographic, economic and health characteristics of the caregiver were identified through a semi-structured form. Subsequently, to measure the overload, the Zarit Burden Interview scale was applied. This instrument is composed of 22 items that assess the condition of health, psychological well-being, finances and social life. The Zarit scale is scored from zero to four, which measures the presence or intensity of a response (0 = never, 1 = rare, 2 = sometimes, 3 = frequent, and 4 = always). The last item asks if the participant is feeling overwhelmed when performing the caregiver function (0 = nothing, 1 = little, 2 = quite, 3 = quite, 4 = extremely). The scale score ranges from 0 to 88 points. The greater the numbering, the greater the overload of people.[16]

Caregivers' quality of life (QoL) was assessed by the World Health Organization Quality of Life (WHOQOL-bref) questionnaire containing 26 questions, two general (overall QoL and health satisfaction) and 24 questions in four domains: physical, Psychological, social relations and environment, composed of points scored on a Likert scale, from one to five. The two general questions are calculated together to generate a single score, independent of the other scores of domains, called the General Index of Quality of Life (IGQV). 17 The WHOQOL-bref author does not suggest a cut-off point for the classification of quality of life as "good" or "poor". However, the higher the score, which ranges from 0 to 100, better the QoL of the people.

Statistical Package for the Social Sciences (SPSS), version 18.0, was used for the statistical treatment of the data. The data was explored from the descriptive statistics, using median and standard deviation.

The research project was approved by the Research Ethics Committee of the State University of Southwest of Bahia, Campus of Jequié, Bahia, under the substantiated opinion nº 128.580 / 2012 and CAAE: 08643612.6.0000.0055. Participants signed the Informed Consent Term.

RESULTS

Of the 71 elderly, 18.3% were independent and 81.7%, were dependent, according to Katz scale; (61.5% and 27.6%) in the age group of 70 to 79 years, respectively; predominance of females; affected by any disease; were found to be cognitively deficient and hospitalized between 2012 and 2013 (Table 1).

Table 1. Sociodemographic characteristics of the elderly, n = (71). Manoel Vitorino (BA), Brazil, 2014.

Characteristics	Independent Elderly (Katz) N=13 (%)	Dependent Elderly (Katz) N=58 (%)
Age group (years)		
60-69	-	13 (22.4)
70-79	8 (61.5)	16 (27.6)
80-89	5 (38.5)	16 (27.6)
90 -99	-	10 (17.2)
100 or more	-	3 (5.2)
Gender		
Female	10 (76.9)	38 (65.5)
Male	3 (23.1)	20 (34.5)
Income		
Retired	13 (100)	56 (96.6)
No income	-	2 (3.4)
Presence of diseases		
Yes	13 (100)	58 (100)
Hospitalized		
Yes	4 (30.8)	18 (31)
No	9 (69.2)	40 (69)
Cognition (MMSE)		
Preserved	4 (30.8)	3 (5.2)
Committed	9 (69.2)	55 (94.8)

Of the dependent elderly, 53.2% were affected by two or three diseases and 46.8%, by one, four or five. Among the elderly, 84.6% had two to four diseases and 15.4%, one. When analyzing all dependent and independent elderly, 22.5% had one; 36.6%, two; 19.7%, three and 21.2%, four or five diseases, with a median of 2.0 (± 1.2). Among the main self-reported comorbidities were hypertension (58.8%), heart problems (15.4%), diabetes (12.6%) and respiratory problems (12.6%).

Regarding the evaluation of the degree of independence for ABVD, 13 (18.3%) elderly were independent and, of these, eight (11.4%) were between 70 and 79 years old. And among the 58 (81.7%) elderly dependent, 22 (30.8%) were dependent in five or six functions, with the age groups of 70 to 79 and 80 to 89 being the ones that presented the most dependent elderly people (Table 2).

Table 2. Distribution of the Katz Index of the elderly according to age and gender, n = 71. Manoel Vitorino (BA), Brazil, 2014.

	Classification of the Katz Index								
Age Group (in years)	Independent n (%)		Dependent in one or two functions n (%)		Dependent in three or four functions n (%)		Dependent in fove or six functions n (%)		Total n (%)
	M*	F†	M*	F†	M*	F†	M*	F†	M* F†
60 to 69	-	-	1 (1.4)	4 (5.7)	1 (1.4)	3 (4.2)	-	4 (5.6)	13 (18.3)
70 to 79	2 (2.8)	6 (8.6)	2 (2.8)	4 (5.7)	2 (2.8)	1 (1.4)	5 (7.0)	2 (2.8)	24 (33.9)
80 to 89	1 (1.4)	4 (5.8)	3 (4.2)	2 (2.8)	2 (2.8)	5 (7.0)	2 (2.8)	2 (2.8)	21 (29.6)
90 to 99	-	-	1 (1.4)	3 (4.2)	-	1 (1.4)	-	5 (7.0)	10 (14.0)
100 or more	-	-	-	1 (1.4)	-	-	-	2 (2.8)	3 (4.2)
Total	3 (4.2)	10 (14.4)	7 (9.8)	14 (19.8)	5 (7.0)	10 (14.0)	7 (9.8)	15 (21.0)	71 (100)

(*) Male
(†) Female

In the sample of caregivers of independent and dependent elderly, women (92.3% and 84.5%) predominated; race / brown color (69.2% and 65.5%); the age group of 31 to 40 years (23.1% and 22.4%); married (69.2% and 60.3%); with children (69.2% and 56.9%); cohabiting with three to four people (53.9% and 39.7%), respectively. Among the caregivers, 26.7% were elderly caregivers and 46.2% used daily medications (Table 3).

Table 3. Sociodemographic characteristics of caregivers of the elderly, n = (71). Manoel Vitorino (BA), Brazil, 2014.

Characteristics	Caregivers of independent elderly N=13 (%)	Caregivers of dependent elderly N=58 (%)
Gender		
Female	12 (92.3)	49 (84.5)
Male	1 (7.7)	9 (15.5)
Race / color		
White	3 (23.1)	15 (25.9)
Brown	9 (69.2)	38 (65.5)
Black	1 (7.7)	5 (8.6)
Age group (years)		
18-30	2 (15.4)	10 (17.2)
31 to 40	3 (23.1)	13 (22.4)
41-50	5 (38.4)	8 (13.7)
51-59	1 (7.7)	10 (17.4)
60 to 70	2 (15.4)	13 (22.4)
71 or more	-	4 (6.9)
Marital status		
Married	9 (69.2)	35 (60.3)
Not married	4 (30.8)	19 (32.8)
Divorced / separated	-	1 (1.7)
Widower	-	3 (5.2)
Relationship to the elderly		
Spouse	2 (15.4)	12 (20.6)
Child	9 (69.2)	33 (56.9)
Grandchild	1 (7.7)	6 (10.4)
Brother	-	3 (5.2)
Niece	1 (7.7)	1 (1.7)
Daughter in law	-	3 (5.2)
How many residents per dwelling		
1 to 2 people	5 (38.4)	17 (29.3)
For 3 to 4 people	7 (53.9)	23 (39.7)
From 5 to 6 people	1 (7.7)	13 (22.4)
More than 6 people	-	5 (8.6)
Use of some daily mediation		
Yes	3 (23.1)	30 (51.7)
No	10 (76.9)	28 (48.3)

Among caregivers, 39.2% had incomplete elementary education and 25.2% were illiterate. Regarding the occupation, 78.4% did not have paid work, 75.6% worked out of home before taking over care, 32.2% declared they did not have an income and 44.8% received up to a minimum wage, with a median of R $ 172, 00 (± 653). Of these, 29.5% received only Bolsa Família (welfare) as a source of income (Table 4).

Table 4. Socioeconomic characteristics of family caregivers of the elderly, n = (71). Manoel Vitorino (BA), Brazil, 2014.

Characteristics	Caregivers of independent elderly N=13 (%)	Caregivers of dependent elderly N=58 (%)
Schooling		
Illiterate	5 (38.4)	13 (22.4)
Incomplete Elementary	2 (15.4)	26 (44.9)
Complete Elementary	-	5 (8.6)
Incomplete high school	-	3 (5.2)
Complete High School	6 (46.2)	7 (12.1)
Complete/incomplete higher education	-	2 (3.4)
Specialist	-	2 (3.4)
Current professional situation		
With other gainful activity	5 (38.5)	10 (17.2)
No gainful activity	8 (61.5)	48 (82.8)
Professional situation before care		
Worked out of home	12 (92.3)	42 (72.4)
Never worked	1 (7.7)	16 (27.6)
Individual income in SM *		
No income	2 (15.3)	21 (36.2)
Up to 1/2 SM	5 (38.5)	16 (27.6)
Up to 1 SM	5 (38.5)	16 (27.6)
Up to 2 SM	1 (7.7)	2 (3.4)
Greater than 2 SM	-	3 (5.2)

* Minimum wage (MW) of R($) 620,00.

In terms of time, 32.7% of the caregivers of dependent elderly people spent 15 years in care and 8.6% in time over 16 years, 89.6% of whom were full-time caregivers. Overload is higher among caregivers of dependent elderly, since 70.7% present overload with scores ranging from 41 to 88 points (Table 5).

Caregivers have never participated in any course and/or counseling groups to help them care for the elderly, receive informal support

especially from the family and report that they do not receive formal support. The lowest QoL assessed by the *WHOQOL*-bref was demonstrated among caregivers of dependent elderly (50.15%), the environment domain (41.43%), which presented the lowest percentage, followed by social relationships (50.43%), as shown in Table 5.

Table 5. Characteristics of family caregivers of the elderly according to time / hours of care, social support, presence of diseases, overload and quality of life. Manoel Vitorino (BA), Brazil, 2014.

Characteristics	Caregivers of independent elderly N=13 (%)	Caregivers of dependent elderly N=58 (%)
Caregiver time in years		
Up to 1 year	2 (15.4)	6 (10.3)
1 to 2 years	2 (15.4)	4 (6.9)
3 to 5 years	4 (30.7)	17 (29.4)
6 to 16 years	2 (15.4)	27 (46.5)
Greater than 16 years	3 (23.1)	4 (6.9)
Daily hours dedicated to caring		
Up to 8	4 (30.8)	3 (5.2)
9 to 24	9 (69.2)	55 (94.8)
Has help caring for the elderly		
Yes	7 (53.8)	35 (60.3)
No	6 (46.2)	23 (39.7)
Who the get help from		
Son (a)	2 (28.6)	8 (23.1)
Maid	1 (14.2)	8 (23.1)
Husband	2 (28.6)	12 (33.7)
Others*	2 (28.6)	7 (20.1)
Presence of diseases		
Yes	3 (23.1)	7 (12.1)
No	10 (76.9)	51(87.9)
Levels of overload (Zarit)		
Up to 21 points	5 (38.5)	-
From 21 to 40 points	7 (53.8)	17 (29.3)
From 41 to 60 points	1 (7.7)	30 (51.7)
60 to 88 points	-	11 (19.0)
WHOQOL-bref Domains		
General QV	54.66	50.15
Physical	64.01	54.80
Psychological	61.86	54.53
Social relationships	60.23	50.43
Environment	38.22	41.43

Concerning the sister, nephew, daughter-in-law, grandson, mother, brother and brother-in-law of the caregiver.

Caregivers of the elderly are compromised by their health. The most comorbidities were low back pain (62.2%), lower limb varicose veins (36.4%), hypertension (36.4%) and diabetes (9.8%).

DISCUSSION

Study shows that, among the elderly, the majority were women, married, with an average age of 70.4 years. The occurrence of functional disability for the ABVD was 26.8%, with a prevalence of care of 49.5% .[1] The results of this study show that the elderly, although not dependent on care, according to the Katz scale, need a caregiver to help them perform their daily activities.

In the life stage of people after 60 years of age, physiological changes occur that can interfere with the functional capacity and the ABVD of the elderly, especially when there is a chronic illness associated with it.3 A study showed that all the elderly had some kind of disease, among them, hypertension, diabetes, osteoporosis, osteoarthritis and depression. In spite of this, as well as needing caregivers, they exercise their autonomy, deliberating and making decisions related to their lives.[18] In this study, all independent and dependent elderly were affected by illness. Among the most cited, are hypertension or heart problems.

National and international studies show that most of the caregivers are women, married, [5,19-21] with a mean age of 55 to 66 years, [5,20,22] and a low level of education (until elementary school) .[19-20] In this study, (95.9%), confirming that care continues to be attributed to women, which can lead to biopsychosocial wasting due to daily demands, especially when they are elderly caregivers as seen (26.7%) and assume responsibilities, often without guidelines.

The profile of caregivers has changed over the years, and what is observed is the presence of the caregiver, elderly spouse, nieces, granddaughters, and sisters.[5] Most live in the same household as the elderly, [5.19] motivated, often because of the ease of

caregiving and, above all, the unfavorable economic conditions of the families.[5] In this study, all the caregivers lived with the elderly, there was a reduced participation of the caretaker, as well as the independent elderly caring for dependent elderly.

A study carried out in the region of Porto, Portugal, identified that 34% of the caregivers did not have an income, 40% received a minimum wage and 83% did not work outside the home.[20] This fact has added to this responsibility, the function of caring for other dependents, the family and the mother.[5,19-20] This study is supported in part by the fact that 36.2% of caregivers of dependent elderly people were without income, 55.2% received up to a minimum wage and 82.8 % were unemployed.

Taking care of the elderly can be reversed in the economic restructuring facility for the family. Generally, a member must move away from work to act as caregiver, because the "structured" solidarity network is not enough to meet the growing demands of families, even though it acts as a support. Thus, depending on the caregiver's income, such an arrangement may be economically disadvantageous to the families.[6] In this study, it was observed that taking care of elderly care may have financial implications, such as reducing the caregiver's income due to this, move away from some renumbered activity.

In many situations, the family shifts responsibility for care to a single person who sometimes does not have the support of others. In this sense, the caregiver modifies and reconciles his family life, plans his activities to depend on the needs of the other, and also has to deal with the coexistence of not having time for rest and leisure, [7] especially when care is integral, [1] which can cause the caregiver emotional, physical, and isolation.

Studies carried out in Brazil and the Netherlands showed the presence of diseases or injuries among caregivers, such as hypertension, diabetes, [19,22] depression[22] and algia.[23] and in some cases, they needed treatment, mainly for anxiety and depression .[7,22] Regarding the current state of health, caregivers perceive it as regular.[5,23] However, when comparing this state five years ago, almost half reported having worsened[23] and showed concern, since they needed to take care of themselves to care for the other.[2] This worsening of the health status of the caregivers may be related to the demands of specific care performed for the elderly and that have happened with reduced social support.

Caring for care can mean social recognition and personal fulfillment.[6] However, the caregiver's lack of preparation to meet the needs of the elderly can generate anxiety and lead to risky situations for both of them.[3,23] Strategies must therefore be created that provide comprehensive and balanced care for the health team, the elderly and the caregiver.[3] Thus, health professionals need to offer caregivers support, based on the development of effective actions that favor responsible care for the family.

The family caregiver needs to obtain information about the disease and its progression, manifestations, complications and treatment of the elderly. There are programs for caregivers that are meant to guide them. These are critical because they provide insight into what happens to your family member and get care guidelines. When receiving the guidelines, they disseminate to others who are in the same situation and these influence the quality of care provided to the elderly and the self-care of their health.[24]

As for the caregivers' overload, it is associated with functional independence.[25] And when the caregiver is elderly or has restrictions on their health, the burden increases, even so, they continue to care, considering that the limitations of their relatives are greater than theirs19 and feel satisfaction in care, even if they change their daily routine of life.[23]

A study carried out in Mexico revealed that 91.5% of the caregivers presented some type of overload.[21] Although a variant, 46.2% presented moderate overload and 26% moderate to severe, which indicates a strong probability of these developing to severe overload, 2 especially when they do not receive support for care.[19] Thus, the need for social support to caregivers is evident in order to prevent overload and negative effects on the bio-psychosocial dimensions.[25]

A Mexican study evidenced an inverse relationship between QoL and overload among caregivers.[21] One of the difficulties faced is the deprivation of social life, [2,23] although there have been advances in technological communication resources such as telephone, internet, television and radios, since these actions occur in the home, the environment where the care is carried out, [2] which does not favor the caregiver's exit for extra-domestic social activities.

The prevalence of home care and overload caused to caregivers is an important indicator for the planning of health actions.[1] In this context, health professionals must direct their attention not only to the elderly, but also to

family members, especially those who experience situations of stress, since these can affect the physical and psychological health of the caregivers, as these are responsible for the continuity of the care to the elderly in the home.

A study showed that there is a shortage of health care, monitoring and actions directed to the family caregiver by the health team. The lack of support and information to understand and face the disease of the elderly was also evident. Because caregivers perform caregiving, they need support and training to take responsibility for safety. The Nursing activity, through guidelines and care for the relatives and caregivers of the elderly, with interventions directed to their specificities, becomes indispensable, as well as demand that the public and private sectors direct their attention to the health of the caregiver, being that the partnership between health professionals and family caregivers can minimize difficulties experienced by them.[26]

CONCLUSION

It was evidenced that, among the elderly care, there was a prevalence of women, elderly, affected by diseases, who had cognitive deficits and are dependent. It was evident that the elderly, although considered independent for ABVD, needed caregivers to support them in their daily activities. Among the caregivers, women, married, older or elderly, with low levels of education, living in unfavorable economic conditions, and who dedicate care to the elderly in an integral way for several years predominated.

The overload and the lower perception of QoL were more pronounced among caregivers of dependent elderly, with an inverse relationship between the variables. It was seen that most caregivers presented overload, with high scores, and the environmental domains and social relationships of QoL were the most compromised.

Informal caregiver support has been demonstrated, however, and it has been found that formal support has not been achieved. Therefore, health professionals, particularly those working in FHS, because they are closer to the reality of caregivers of the elderly living in the home, need to adopt preventive measures of health problems and of care-related overload, focusing on the elderly, caregivers and family.

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