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SOCIODEMOGRAPHIC AND HEALTH PROFILE OF INSTITUTIONALIZED ELDERLY PEOPLE

PERFIL SOCIODEMOGRÁFICO E DE SAÚDE DE IDOSOS INSTITUCIONALIZADOS

PERFIL SOCIODEMOGRÁFICO Y DE SALUD DE ADULTOS MAYORES INSTITUCIONALIZADOS

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ABSTRACT

Objective: to describe the sociodemographic and health profile of institutionalized elderly people. ***Method:*** This is a quantitative, descriptive, cross-sectional study based on the evaluation of 219 medical records of the elderly, using a semi-structured instrument. Data were analyzed with the help of the SPSS, version 20.0, and presented in tables. ***Results:*** there was a predominance of elderly women, mean age of 77 years, schooling from 4 to 15 years, single marital status, Catholics, coming from their own domicile, with institutionalization time of less than 5 years, retired, and elderly people who received visits. Regarding clinical characteristics, 44.7% had 3 to 4 comorbidities and 49.3% used 0 to 4 medicines. As for the degree of dependence, it was observed that 35.6% of the elderly presented grade III. ***Conclusion:*** it is noteworthy that the data described stimulate a reflection on issues that directly influence the process of adaptation of the elderly to institutionalization, as well as the need for the multiprofessional team to provide individualized care based on knowledge of the profile of the institutionalized elderly. ***Keywords:*** Elderly; Long Stay Institutions for the Elderly; Institutionalization; Health of Institutionalized Elderly; Health Profile; Aging.

RESUMO

Objetivo: buscou-se descrever o perfil sociodemográfico e de saúde de idosos institucionalizados. ***Método:*** trata-se de um estudo quantitativo, descritivo, transversal, realizado a partir da avaliação de 219 prontuários de idosos, mediante a aplicação de um instrumento semiestruturado. Analisaram-se os dados com o auxílio do SPSS, versão 20.0, e os apresentaram em tabelas. ***Resultados:*** obteve-se predomínio de idosos do sexo feminino, média de idade de 77 anos, escolaridade de 4 a 15 anos de estudo, solteiros, católicos, provenientes de domicílio próprio com tempo de institucionalização menor que 5 anos, aposentados e que recebiam visitas. Viu-se acerca das características clínicas que 44,7% tinham de 3 a 4 comorbidades e 49,3% faziam uso de 0 a 4 medicações. Observou-se sobre o grau de dependência que 35,6% dos idosos apresentavam grau III. ***Conclusão:*** ressalta-se que os dados descritos estimulam a reflexão sobre questões que influenciam diretamente o processo de adaptação do idoso à institucionalização, bem como a necessidade de a equipe multiprofissional prestar uma assistência individualizada a partir do conhecimento do perfil dos idosos institucionalizados. ***Descritores:*** Idoso; Instituição de Longa Permanência para Idosos; Institucionalização; Saúde do Idoso Institucionalizado; Perfil de Saúde; Envelhecimento.

RESUMO

Objetivo: se buscó describir el perfil sociodemográfico y de salud de adultos mayores institucionalizados. ***Método:*** se trata de un estudio cuantitativo, descriptivo, transversal, realizado a partir de la evaluación de 219 prontuarios de adultos mayores, mediante la aplicación de un instrumento semi-estructurado. Se analizaron los datos con el auxilio del SPSS, versión 20.0, y los presentaron en tablas. ***Resultados:*** se obtuvo un predominio de adultos mayores del sexo femenino, media de edad de 77 años, escolaridad de 4 a 15 años de estudio, solteros, católicos, provenientes de domicilio propio con tiempo de institucionalización menor que 5 años, jubilados y que recibían visitas. Se observó en las características clínicas que 44,7% tenían de 3 a 4 comorbilidades y 49,3% usaban de 0 a 4 medicamentos. Se observó el grado de dependencia en que 35,6% de los adultos mayores presentaban grado III. ***Conclusión:*** se resalta que los datos descriptos estimulan la reflexión sobre cuestiones que influyen directamente el proceso de adaptación del adulto mayor a la institucionalización, así como la necesidad del equipo multi-profesional prestar una asistencia individualizada a partir del conocimiento del perfil de los adultos mayores institucionalizados. ***Descriptores:*** Adulto mayor; Institución de Larga Permanencia para Adultos Mayores; Institucionalización; Salud del Adulto Mayor Institucionalizado; Perfil de Salud; Envejecimiento.

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INTRODUCTION

It is known that in Brazil the number of elderly people is increasing, especially due to the introduction of new technologies, the decrease of fecundity, and of mortality, and the increase of life expectancy. It should be noted that, according to the Economic Commission for Latin American and the Caribbean countries, 12% of the Brazilian population is composed of elderly people.[1]

It is understood that, although aging is a natural process, it has repercussions on health conditions, making the elderly persons more prone to frailty to the point of impairing their quality of life. It is perceived that population aging causes relevant socioeconomic changes such as increased demand and restructuring of health services and professionals able to assist this population.[1] It should be emphasized that attention should be intensified because these changes cause greater demand in health, social security and social services. There is a need for professional follow-up, and also referrals to Long Stay Institutions for the Elderly (LSIE).

It is noteworthy that LSIE are collective residences that serve elderly people who resort to them, either due to family and/or income needs, or due to need for long-term care.[2] It is noted that these characteristics present changes, since elderly people also seek to maintain their independence and manage their daily lives.[3] It is assumed that LSIE residents are people who have never had or lost close family members, who experience family conflicts, and/or who are not physically or mentally qualified to manage their daily life, nor to guarantee their livelihood.[3]

It is considered that the services provided by LSIE need to be responsive to the needs of the elderly in order to reduce the risks related to institutionalization.[4] It should be noted that many of the existing Brazilian institutions have poor infrastructure conditions and face many financial difficulties. It is reported that this problem implies inability to provide better assistance. It is evidenced that LSIE should be a place of protection, care and comprehensive attention, especially for elderly people in the condition of social vulnerability.

OBJECTIVE

- To describe the sociodemographic and health profile of institutionalized elderly.

MÉTHOD

This is a quantitative, descriptive, cross-sectional study carried out in a philanthropic LSIE in the Northeast of Brazil, in which 219 elderly people of both sexes lived. The elderly were from different social classes, and were mainly people who had been abandoned, victims of violence, or had been in some other situations of social vulnerability.

Data were collected during the period from November to December 2015. Data were obtained from the analysis of the 219 medical records of the elderly through the application of a semi-structured form approaching information about sex, age, schooling, marital status, occupation, time, reason for institutionalization, and reception of visits. In the clinic of the sample, variables on chronic diseases, use of medicines, and degree of dependence were collected. It is reported that with respect to issues of institutionalization, the data collected were the time the elderly person had lived in the institution, whether or not they were visited, and with whom they resided before entering the institution.

Elderly people were classified as grade I (independent), grade II (difficulty in up to three activities of daily living) and grade III (difficulty in more than three activities of daily living and severe cognitive impairment) , according to the Resolution of the Collegiate Board 266/2005, of the National Sanitary Surveillance Agency, which regulates the operation of LSIE.[5]

The Microsoft Excel 2010 and the SPSS, version 20.0, were used for the analyses. Tables were drawn with relative and absolute frequencies and measures of central tendency as means and standard deviations.

The research was carried out in accordance with the ethical principles established in Resolution nº 466/12, of the National Health Council, and was approved by the Research Ethics Committee of the State University of Ceará under Opinion number: 1,206,457, CAAE: 12390513.8.0000.5534.

RESULTS

The results obtained in the research are shown in Tables 1 and 2.

Table 1. Social profile and institutionalization of institutionalized elderly. Fortaleza (CE), Brazil, 2015.

Variables	n	%
Age	*	*
Mean: 77 (±0.55); minimum: 60; maximum: 101		
Sex		
Female	122	55.7
Male	97	44.3
Marital status		
Single	113	51.6
Married/stable union	10	4.6
Divorced	22	10
Widower	43	19.6
Separated	31	14.2
Schooling		
0 to 3 years of study	105	48
4 to 15 years of study	114	52
Retirement		
Yes	197	90
No	22	10
Religion		
Catholic	182	83.1
Evangelical	21	9.6
Spiritist	2	1.0
None	5	2.3
Other	9	4.0
With whom he/she resided before institutionalization		
Other relatives/friends	75	34.2
Alone	60	27.4
Partner and children	50	22.8
Others	34	15.6
Time of institutionalization		
Mean: 92.7 (± 106.9); Minimum: 1 month; Maximum: 756 months		
1 to 59 months	99	45.2
60 to 119 months	60	27.4
120 to 756 months	60	27.4
Receive visits		
Yes	130	59.4
No	89	40.6

Table 2. Health profile of the institutionalized elderly. Fortaleza (CE), Brazil, 2015.

Variables	n	%
Comorbidities		
Mean: 3.6 (±1.8); minimum: 0; maximum: 11		
0 to 2	62	28.3
3 to 4	98	44.7
5 to 11	59	27
Medicines		
Mean: 4.7 (±2.5); minimum: 0; maximum: 11		
0 to 4	108	49.3
5 to 6	56	25.6
7 to11	55	25.1
Level of dependence		
Grade 1	75	34.2
Grade 2	66	30.2
Grade 3	78	35.6

DISCUSSION

In this study, the majority of the elderly were female, aged over 70 years, corroborating other research already done.[6-7] It is reported that the greater probability of women to live in long stay institutions may be due to the fact that they are older, have poorer health and functional capacity, and have a disadvantaged position in family arrangements. The literature has pointed out that men have a greater chance than women

to be cared for by their respective spouses and, consequently, to stay longer with the family.[3]

The study shows that most of the elderly were single (51.6%) and had zero to three years of schooling (48%). It should be noted that the data is in line with another study that found a higher prevalence of unmarried elderly people (46.3%), illiterate (46.3%) or low schooling (22.2%).[6] Low schooling is a very frequent finding when philanthropic institutions are evaluated.[8] This is a result of the previous reality of discrimination of educational opportunities for these elderly people. The association between socioeconomic conditions, completion of primary and secondary education, and access to higher education is reflected in Brazil.[9]

In terms of institutionalization variables, the information about receiving visits is worrying, since 40.6% of the elderly did not receive visits from family or friends. In another study carried out in Natal, 100% of the elderly in a for-profit institution received visits, while 14.7% at the non-profit institution did not receive them.[9] It is noted that the absolute frequency of elderly people who received visits is much higher when compared to the present study.

It is noteworthy that in the process of institutionalization, the support network is essential, as it helps the elderly to adapt to this situation, improving their well-being and quality of life. It is perceived that the great challenge is to help the institutionalized elderly to establish social relations, mainly with the other residents of the institution. It is evidenced that studies indicate that institutionalized elderly people have low motivation to develop friendships with other peers, besides presenting prejudiced and despising attitudes toward them.[10]

Interpersonal communication is often hampered in the LSIE environment, and social and affective life is limited. In institutional life, it is necessary for the elderly people to establish new relationships and demarcate their space, having their old lifestyle as reference.[11]

It is inferred that, before this situation, the multiprofessional team inserted in this scenario has the responsibility to support these elderly in their process of institutionalization and have to provide social, emotional, physical and mental support. It is recommended that the links and reintegration in the family context be stimulated and strenghened, giving to the family the responsability to care the elderly.

It was verified, on the clinical characteristics, that 44.7% of the elderly had at least three or four comorbidities. These findings are similar to those of other studies carried out with elderly people living in LSIE.[12] It is indicated that the presence of comorbidities is a risk factor for disability, which in turn is the result of the frailty syndrome. It is evident that when all these factors overlap, they lead to impairment of quality of life and functional status, resulting in incapacity, hospitalization, institutionalization and death.[13] Moreover, it is known that the prevalence of chronic diseases is doubled in female elderly,[14] and also that fragile individuals with more than one comorbidity are at higher risk of mortality.[15]

Thus, the daily activities of institutionalized elderly people are hampered by comorbidities. They require more careful care from the multiprofessional team. It should be stressed that the promotion and maintenance of health should always be considered as priorities in the planning of health care in LSIE.

It was also observed the consumption of a high number of medicines by the elderly. The practice of polypharmacy is associated with an increased risk and severity of adverse reactions, drug interactions, cumulative toxicity, medication errors, reduction of adherence to treatment, and elevation of morbidity and mortality.[16] Thus, the prescription of multiple medications to the elderly should be considered, as well as the observation of the occurrence of adverse events.[17]

Thus, the importance of detecting health needs/problems that indicate the real need for medication is evident. Being attentive to feeding schedules and interactions with medications for chronic use is also important, as well as the inclusion of medications, such as antibiotics and anti-inflammatories, and possible interactions.[6]

In the evaluation of the degree of dependence, 65.8% of the elderly had grade II or grade III. Another study carried out in Montes Claros-MG showed that almost 60% of the institutionalized elderly had some degree of dependence.[18] The importance of the evaluation of the degree of dependence of institutionalized elderly as a means of subsidizing planning and execution of actions within the institutional framework is highlighted.[18]

It is also considered the evaluation of activities of daily living and the knowledge of the main characteristics of this group of activities, because they reflect levels of social

participation and quality of life in aging.[19] It should be noted that the modifications in these activities are often not perceived without the application of a specific functional evaluation, which reiterates the relevance of this theme for the early identification of small changes in performance.[19]

It is pointed out that, in view of these situations, the multiprofessional team should devote careful attention to the limitations and should plan, along with the specialized team, specific and effective care and rehabilitation so that the elderly can carry out, with the maximum autonomy and independence, their activities of daily life by encouraging they to overcome certain obstacles to their better adaptation to the new living environment in LSIE.

It is believed that one of the major challenges in the care to the elderly is the perception of the multiprofessional team regarding all the factors that influence their lives. It is understood that care must happen in a holistic and comprehensive way based on all the possibilities that may affect, in a negative way, their quality of life.

It should be noted that socioeconomic aspects are also related to the health situation and the morbidity and mortality pattern of the population. They should be considered in the health monitoring and care planning by health professionals, subsidizing health actions directed to the needs of institutionalized elderly.[6]

CONCLUSION

It was observed a predominance of female adults, mean age of 77 years, literate people, single, Catholic, coming from their own home, with institutionalization time of less than five years, retirees, who received visits, had three to four comorbidities, used zero to four medicines, and presented grade III of dependence.

It is believed that, despite the limitations of this study, which has an academic nature and was restricted to the survey of some variables of the profile of institutionalized elderly living in one long stay institution, the results obtained stimulate reflection on issues that directly influence the process of adaptation of the elderly to this new situation.

Another concern is related to the multiprofessional team. Care should be provided to maintain the LSIE prepared to receive this population well and in a dignified manner. The focus should be to maintain a pleasant environment for the promotion, rehabilitation and recovery of the general health of the elderly. Emphasis is given to individualized and humanized care, based on the knowledge of the profile of the institutionalized elderly, promoting a dignified aging.

It is suggested that future studies allow the continuity of research on the characteristics that influence the longevity and quality of life of institutionalized elderly. Themes related to institutionalization, Gerontology and Nursing/Health must be studied and improved so as to plan actions for a more effective care that encompasses the real needs of these elderly people, thus improving their biopsychosocial well-being.

REFERENCES

1. Comissão Econômica para a América Latina e o Caribe. La nueva era demográfica en América Latina y el Caribe: la hora de la igualdad según el reloj poblacional. Primera Reunión de la Mesa Directiva de la Conferencia Regional sobre Población y Desarrollo de América Latina y el Caribe. Documento de referencia DDR/24 [Internet]. Santiago: CEPAL; 2014 [cited 2018 July 10]. Available from: https://repositorio.cepal.org/bitstream/handle/11362/37252/1/MPD_ddr2_esp.pdf

2. Bentes ACOB, Pedroso JS, Falcão DVS. Experiences of non-dependent elderly in long-term care institutions. Psicol estud. 2015;20(4):563-73. Doi: http://dx.doi.org/10.4025/psicolestud.v20i4.27668

3. Alcântara AO, Camarano AA, Giacomin KC. Política nacional do idoso: velhas e novas questões [Internet]. Rio de Janeiro: Ipea; 2016 [cited 2018 July 04. Available from: http://www.en.ipea.gov.br/agencia/images/stories/PDFs/livros/livros/161006_livro_politica_nacional_idosos.PDF

4. Alves MB, Menezes MR, Felzemburg RDM, Silva VA, Amaral JB. Long-stay institutions for the elderly: physical-structural and organizational aspects. Esc Anna Nery Rev Enferm. 2017;21(4):e20160337. Doi: http://dx.doi.org/10.1590/2177-9465-EAN-2016-0337

5. Ministério da Saúde (BR), Agência Nacional de Vigilância Sanitária. RDC Nº 283, de 26 de setembro de 2005 [Internet]. Brasília: Ministério da Saúde; 2005 [cited 2018 July 02]. Available from: http://portal.anvisa.gov.br/documents/10181/2718376/RDC_283_2005_COMP.pdf/a38f2055-c23a-4eca-94ed-76fa43acb1df

6. Borges CL, Silva MJ, Clares JWB, Nogueira JM, Maria Célia de Freitas. Sociodemographic and clinical characteristics of institutionalized older adults: contributions to nursing care. Rev enferm UERJ. 2015; 23(3):381-7. Doi: https://doi.org/10.12957/reuerj.2015.4214

7. Oliveira MPF, Novaes MRCG. The socio-economic, epidemiological and pharmaco-therapeutic profile of institutionalized elderly individuals in Brasilia, Brazil. Ciênc Saúde Coletiva. 2013 Apr;18(4):1069-78. Doi: http://dx.doi.org/10.1590/S1413-81232013000400020

8. Cordeiro LM, Paulino JL, Bessa MEP, Borges CL, Leite SFP. Quality of life of frail and institutionalized elderly. Acta Paul Enferm. 2015 July/Aug;28(4):361-6. Doi: http://dx.doi.org/10.1590/1982-0194201500061

9. Pinheiro NCG, Holanda VCD, Melo LA, Medeiros AKB, Lima KC. Inequality in the characteristics of the institutionalized elderly in the city of Natal, Brazil. Ciênc Saúde Coletiva. 2016 Nov;21(11):3399-405. Doi: http://dx.doi.org/10.1590/1413-812320152111.19472015

10. Rodrigues AG, Silva AA. The social network and types of support received by the institutionalized elderly. Rev Bras Geriatr Gerontol. 2013 Jan/Mar;16(1):159-70. Doi: http://dx.doi.org/10.1590/S1809-98232013000100016

11. Bessa MEP, Silva MJ, Borges CL, Moraes GLA, Freitas CASL. Elderly residents in long-term institutions: the use of spaces in the construction of everyday life. Acta Paul Enferm. 2012;25(2):177-82. Doi: http://dx.doi.org/10.1590/S0103-21002012000200004

12. Polaro SHI, Fideralino JCT, Nunes PAO, Feitosa ES, Gonçalves LHT. Elderly living in long-term institutionsinthemetropolitan areaof Belém city, state of Pará, Brazil. Rev Bras Geriatr Gerontol. 2012 Oct/Dec; 15(4):777-84. Doi: http://dx.doi.org/10.1590/S1809-98232012000400016

13. Murad K, Kitzman DW. Frailty and multiple comorbidities in the elderly patient whit heart failure: implications for management. Heart Fail Rev. 2012 Sept;17(4-5):581-8. Doi: 10.1007/s10741-011-9258-y

14. Weiss CO. Frailty and chronic diseases in older adults. Clin Geriatr Med. 2011 Feb; 27(1):39-52. Doi: 10.1016/j.cger.2010.08.003

15. Wilhelm-Leen ER, Hall YN, Horwitz RI, Chertow GM. Phase Angle, Fraily and Mortality in Older Adults. J Gen Intern Med. 2014 Jan;29(1):147-54. Doi: 10.1007/s11606-013-2585-z

16. Secoli SR. Polypharmacy: interaction and adverse reactions in the use of drugs by elderly people. Rev Bras Enferm. 2010 Jan/Feb; 63(1):136-140. Doi: http://dx.doi.org/10.1590/S0034-71672010000100023

17. Borges CL, Silva MJ, Clares JWB, Bessa MEP, Freitas MC. Frailty assessment of institutionalized elderly. Acta Paul Enferm. 2013; 26(4):318-22. Doi: http://dx.doi.org/10.1590/S0103-21002013000400004

18. Marinho LM, Vieira MA, Costa SM, Andrade JMO. Degree of dependence of elderly residents in geriatric long-term care facilities in Montes Claros, MG. Rev Gaúcha Enferm. 2013 Mar; 34(1):104-10. Doi: http://dx.doi.org/10.1590/S1983-14472013000100013

19. Dias EG, Duarte YAO, Almeida MHM, Lebrão ML. The advanced activities of daily living at component of the functional assessment in elderly people. Rev Ter Ocup Univ São Paulo. 2014 Sept/Dec;25(3):225-32. Doi: http://dx.doi.org/10.11606/issn.2238-6149.v25i3p225-232

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