

ORIGINAL ARTICLE

SOCIODEMOGRAPHIC ASPECTS, QUALITY OF LIFE AND HEALTH OF THE
INSTITUTIONALIZED ELDERLY*

ASPECTOS SOCIODEMOGRÁFICOS, QUALIDADE DE VIDA E SAÚDE DO IDOSO INSTITUCIONALIZADO
ASPECTOS SOCIODEMOGRÁFICOS, CALIDAD DE VIDA Y SALUD DE LOS ANCIANOS INSTITUCIONALIZADOS

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ABSTRACT

Objective: to analyze the characteristics of the institutionalized elderly by pointing out correlations. **Method:** this is a quantitative, descriptive, analytical, exploratory study with elderly people living in long-term care facilities for the elderly. The following questionnaires were used: sociodemographic; Mini Mental; Barthel index; self-reported assessment of frailty in the elderly; Family Apgar and Nottingham Health Profile. **Results:** it is revealed that the six institutions evaluated were philanthropic; 135 elderly people were studied; the average age was 76.4 years and the average institutionalization time was four years; According to the questionnaires, most had scores that suggest cognitive decline and frailty, were independent for basic activities of daily living, had marked family dysfunction and showed a noticeable loss of quality of life sensation; Most respondents moved to the institution without their own will. It was found that the preservation of cognition and the higher level of education correlate with lower satisfaction and perception of quality of life. **Conclusion:** this study presented some aspects of the institutionalized elderly and their perception of health. **Descriptors:** Elderly Health; Elderly; Socioeconomic Factors; Life Conditions; Health Conditions; Quality of Life.

RESUMO

Objetivo: analisar as características do idoso institucionalizado apontando correlações. **Método:** trata-se de um estudo quantitativo, descritivo, analítico, tipo exploratório, com idosos que vivem em instituições de longa permanência para idosos. Empregaram-se questionários: sociodemográfico; Mini Mental; índice de Barthel; avaliação autorreferida de fragilidade em idosos; *Family Apgar* e Perfil de Saúde de Nottingham. **Resultados:** revela-se que as seis instituições avaliadas eram de caráter filantrópico; foram estudados 135 idosos; a média de idade foi de 76,4 anos e o tempo médio de institucionalização, de quatro anos; de acordo com os questionários, a maioria apresentou pontuação que sugere declínio cognitivo e fragilidade, era independente para as atividades básicas de vida diária, possuía acentuada disfunção familiar e apresentou perceptível perda da sensação da qualidade de vida; a maior parte dos entrevistados mudou para a instituição sem vontade própria. Constatou-se que a preservação da cognição e o maior grau de instrução se correlacionam a uma menor satisfação e percepção de qualidade de vida. **Conclusão:** apresentaram-se, por este estudo, alguns aspectos próprios do idoso institucionalizado e sua percepção de saúde. **Descritores:** Saúde do Idoso; Idoso; Fatores Socioeconômicos; Condições de Vida; Condições de Saúde; Qualidade de Vida.

RESUMEN

Objetivo: analizar las características de los ancianos institucionalizados señalando correlaciones. **Método:** este es un estudio cuantitativo, descriptivo, analítico y exploratorio con personas mayores que viven en centros de atención a largo plazo para personas mayores. Se utilizaron cuestionarios: sociodemográficos; Mini Mental; Índice de Barthel; evaluación autoinformada de fragilidad en ancianos; Perfil de salud de la familia Apgar y Nottingham. **Resultados:** se revela que las seis instituciones evaluadas eran filantrópicas; se estudiaron 135 personas mayores; la edad promedio fue de 76.4 años y el tiempo promedio de institucionalización fue de cuatro años; según los cuestionarios, la mayoría tenía puntuaciones que sugerían deterioro cognitivo y fragilidad, eran independientes para las actividades básicas de la vida diaria, tenían una disfunción familiar marcada y mostraban una pérdida notable de la sensación de calidad de vida; la mayoría de los encuestados se mudaron a la institución sin su propia voluntad. Se comprobó que la preservación de la cognición y el mayor nivel de educación se correlacionan con una menor satisfacción y percepción de la calidad de vida. **Conclusión:** este estudio presenta algunos aspectos de los ancianos institucionalizados y su percepción de la salud. **Descriptor:** Salud de los Ancianos; Ancianos; Factores Socioeconómicos; Condiciones de Vida; Condiciones de Salud; Calidad de Vida.

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INTRODUCTION

Contrary to what happened in many developed countries, Brazil is aging very fast and does not appear to be prepared to respond to the needs generated by this aging population, unlike many developed nations that have made significant progress in adapting their public, health and law policies. Estimates point to 34 million elderly people in 2025, bringing, as a perspective, that from 1985 to 2060 the number of institutionalized elderly will increase from 1.3 to 4.5 million, most of them elderly. In confronting this reality, Brazil needs not only to reorganize the levels of care and public policies to meet the needs, but also to innovate and build on the experiences of other countries that have experienced the aging process.¹⁻³

The profile of morbidity and mortality changes with demographic transition. Acute conditions are replaced by chronic processes of attrition and illness, producing impacts on the health system and population. It is understood that this process, associated with the poor inclusion of the elderly in society, inefficient public policies, low financial condition and failure of family capacity to provide the necessary care, may explain the increased demand for long-term care facilities for older people (LTCFs). Due to this phenomenon of population aging and the consequent search for LTCFs, a new reality is emerging, resulting in the need to redefine this form of care for the elderly, generating significant care practices that consider the individual aging process not only by the professionals involved, but also for family, senior and community.^{2,4}

The process of institutionalization tends to occur in two different ways: the first when the process of institutionalization occurs against the will of the elderly, resulting from the rupture in the family process. This process is due to family insufficiency in face of the imitations evidenced in the aging process, making the care process difficult. In this sense, the lack of time is presented as an important factor that leads families to choose institutionalization.¹ On the other hand, changes in family arrangements, such as smaller families and excessive workload, reduce the prospect of aging in a safe family environment, especially when this process is accompanied by a high degree of dependence and families. Many times, they are unable to meet the needs of the elderly or do not have one of their members to follow up on them. In this perspective, LTCFs are emerging as a safe and low cost alternative outside the family, providing care and shelter to those who live alone and who do not have support from the family network.⁵⁻⁷

It is explained that the LTCFs are a modality of health care of low complexity aimed at the

collective housing of individuals aged 60 years and over, with or without family support. It is explained that in the past these institutions were called asylum and were intended only for the wretched and the abandoned. Then, the term asylum, strongly marked by prejudice, was replaced by LTCF, proposed by the Brazilian Society of Geriatrics and Gerontology. The institution was then offered, in addition to social support, health care services. The residents of the LSIE show great heterogeneity in their health conditions, considering that their admission can be determined by issues related to the loss of autonomy, dependence and lack of family support, as well as those related to social work.⁸⁻¹⁰

It is noted that, in Brazil, most LTCFs are philanthropic in nature, and the advanced decline in health of residents makes medical services prevail over the provision of leisure and social activities.¹¹⁻²

Several authors have shown that, within the LTCFs, the elderly tend to experience a monotonous routine and low autonomy in activities, as well as limited social life, attributing the lack of learning and growth to the aging process in the institution. LTCF are considered for some elderly as a home, but many consider it only as a place of residence intended mainly to care for sick individuals, thus revealing the lack of a sense of belonging and identification in relation to place and thus generating lack of expectation regarding the institution and desire for changes in personal life; Another factor mentioned is the condition imposed on daily life to have to live with very different people, with disabling, mental and psychiatric diseases, which makes the environment uncomfortable and ends up influencing their self-image.^{5,7,13}

The aging process and its consequences are seen, showing growing reflection and concern for the population. It is, by him, a particular experience of each individual: it is the circumstances experienced in different ways by the elderly, in functionality, changes or not, in personality, in social and productive life, that affect, in some way, autonomy. and independence for daily living and, consequently, quality of life. Society should understand this process as dynamic and progressive, which occurs throughout life differently in each individual. Positivity depends on increasing longevity of a key factor: health.¹³⁻⁴

It is added that, within this perspective, the understanding of the concept of quality of life as subjective, multidimensional and influenced by various factors related to education, economics, sociocultural aspects and directly interconnected to the point of view of the individual in relation to his own disease, being the health process of prime importance. In addition, its assessment should be contemplated under the physical, social,

psychological and spiritual domains, seeking to capture the personal experience of each individual.¹⁴

Given the above, it is evident that there is a growing need to redefine the vision attributed to the LTCF, not only by society, but also by the professionals involved and the population served, in order to change the stereotype associated historically with the term asylum and to promote policies that act in health promotion and health conditions of these individuals.⁴

A small number of researches have been found for institutionalized elderly, although there is a growing interest in health and aging in the scientific literature. It is allowed, by assessing the physical, psychological, social and cultural conditions of this group, to broaden the understanding of their health needs.

OBJECTIVE

- To analyze the characteristics of the institutionalized elderly by pointing out correlations.

METHOD

This is a quantitative, descriptive, analytical, exploratory study. The convenience sample was used to define the number of participants, and the inclusion and exclusion criteria were applied to all individuals living in the institutions. Participants are elderly people living in six different LTCFs in the interior of the state of São Paulo. Data were collected from September 2017 to February 2018, and all institutions are philanthropic and receive government assistance.

Inclusion criteria were: elderly over 60 years old, capable of communicating verbally and with preserved cognitive ability. Exclusion criteria were: elderly unable to communicate verbally, bedridden and those with a Mini Mental score (MMSE) of less than 12, as it is suggestive of significant cognitive deficit and consequent impossibility to answer the questionnaires. It is described that such exclusion criteria may represent a possible weakness of the study because they do not allow the representation of all the elderly. To participate in the research, the elderly were oriented to sign the Informed Consent Form (FICT).

The elderly were interviewed individually, all interviews being conducted by the same interviewer and following the same systematization. For this, a room made available by the responsible of the institution was used. For the collection of data related to health (diseases and medication in use), information extracted from the medical records of the elderly in order to identify it and to characterize their sociodemographic aspects, a questionnaire was

applied, elaborated by the authors, which evaluated the following independent variables: gender; age; religion; marital status; schooling; previous profession; monthly income; number of children cause / time of institutionalization; type of accommodation; practice of leisure and playful activities; degree of satisfaction with the institution (good, fair and bad); decision of institutionalization (of their own accord and intervention by others) and acceptance (good or not accepted).

In each institution, a survey was conducted with the responsible professional, nurse and / or social worker in which data were collected for the characterization of the institution, as well as the list of the sheltered elderly and which met the criteria for the research, with the general identification questionnaire prepared by the author.

The Mini Mental (MMSE) provides information on different cognitive parameters, and when analyzing the scores obtained, these are related to the level of education, considering the following median scores: for illiterate, 20; for one to four years of study, 25; from five to eight years old, 26; from nine to 11 years old, 28 and, for individuals with more than 11 years of schooling, 29 points. For the analysis of the results obtained, the elderly with scores below the medians were considered as suggestive of cognitive decline and those with indices equal or higher than the medians as normal.¹⁵

The use of MMSE as inclusion / exclusion criteria was included in the research after extensive discussion with specialists, since it is understood that the instrument has been described for the use of detection of possible cognitive losses and that different profiles will exist depending on the subject's baseline, however. , by decision of the researcher, it was adopted, as exclusion criteria of the research, the score below 12.

The Barthel index assesses activities of daily living (ADLs) and functional independence. Respondents are classified as dependent, with score lower than 60, or independent, with score equal to or greater than 60.¹⁶

The self-reported assessment of frailty in the elderly is composed of questions related directly to each component of the frailty phenotype. For the final classification, the following were considered: non-fragile (no components identified); pre-fragile (presence of one or two components) and fragile (presence of three or more components).¹⁷

Family Apgar has five questions that evaluate family functionality. The family is classified by the value of the score obtained into three types: highly functional (seven to ten points), moderately

functional (four to six points) and marked dysfunctionality (zero to three points).¹⁸

It is detailed that PSN evaluates quality of life and consists of 38 items with answers in the “yes / no” format, with the answers obtaining a score ranging from zero to 38: the higher the score, the worse the perception of quality of life.¹⁹⁻²⁰

For statistical analysis, the Excel program, Windows 2010 version, and the SPSS (Statistical Package for the Social Sciences), version 19 program were used. The results were expressed in absolute numbers and proportions for categorical variables and in measures of central tendency (medians and medians) and dispersion (Standard Deviation - SD) for continuous variables. The symmetry of the data distribution was evaluated by the Smirnov-Kolmogorov test. Kruskal Wallis and Spearman correlation tests were used to analyze the results. Results with $p \leq 0.05$ were considered statistically significant.

The research was approved by the Research Ethics Committee of the Marília Medical School under the opinion of number 2,283,923.

RESULTS

According to data provided by the heads of the institutions, the total number of elderly was 337; Of these, 146 met the inclusion criteria and could participate in the research, however, six did not obtain the MMSE score 12 and one was under 60 years old. Therefore, 139 elderly people were considered eligible to participate in the study and, of these, four refused; Therefore, 135 elderly were evaluated, making up 97.12% of the eligible sample. All LTCFs studied are reported to be philanthropic, nonprofit-managed, and to sustain themselves receive 70% of retirement from sheltered seniors, donations, and government aid. Regarding the physical structure of the institutions evaluated, two are organized by individual houses or with two or three bedrooms, which share the same bathroom, and the other four are organized in pavilions, with bedrooms and shared bathrooms. For all, there is a collective kitchen and dining room to offer meals (Table 1).

Table 1. General characteristics of the six institutions evaluated. Marília (SP), Brazil, 2018.

Evaluated variable	Characteristics
Total number of elderly living in LTCF	Total number of tenants: 337
	Average number per institution: 56.1 ±10.1
	Average number studied per institution: 22.5 ±6.3
	Total number studied: 135
Technical team	Social worker: 1 per institution
	Nurse: 1 per institution
	Physiotherapist 0.66 (± 0.66)
	Doctor 0.66 (± 0.44)
	Nutritionist 0.33 (± 0.44)
	Psychologist 0.16 (± 0.27)
	Nursing Technician 10.5 (± 2.8)
Occupational therapist 0.16 (± 0.27)	
Amount of people per room in the evaluated LTCFs.	Individual 17 (12.6 %)
	Two people 83 (61.5 %)
	Three people 30 (22.2%)
	Four people 5 (4.7%)
Practice of physical and leisure activities in the evaluated LTCFs.	Leisure activity 42 (31.1 %)
	Physical activity 42 (31.1 %)

Key: LTCF: Long term care facilities.

Most respondents were male, white or brown, and widow or single, with a mean age of 76.5 years. Most were reported to have children, ranging from one to ten. In the practice variant of physical and leisure activities, the number of respondents was equal, as 42 (31.1%) answered

that they practice leisure and physical activities. It is observed that respondents consider as physical activity those developed by physical therapists and leisure activities are developed by voluntary groups (Table 2).

Table 2. Descriptive statistics of the studied population. Marília (SP), Brazil, 2018.

Variable	Minimum	Maximum	Median	Average	Standard deviation
Age in years	60	101	77	76.43	9.69
Amount of children	0	10	2	1.80	1.95
Duration of institutionalization (months)	0,16	276	24	41.72	51.05
Weekly frequency of practice of physical activity	0	7	0	0.85	1.48
Weekly frequency of practice of leisure/fun activity	0	7	0	0.69	1.63
Mini Mental	12	30	20	19.9	4.99
Barthel's Index	10	100	95	82.88	23.43
Frailty Index	0	6	3	2.92	2.06
Apgar	0	10	5	4.57	3.93
Nottingham (total)	0	38	13	14.80	9.14

Regarding the diseases, the most prevalent ones were heart diseases, 83 (61.5%), followed by endocrine diseases, which affected 49 (36.3%) of the population studied; mental / emotional diseases appeared in 43 (31.9%) and the incidence of neurological diseases in 24 (11.9%), also being quite significant; of the studied population, only nine (6.7%) elderly had no comorbidity.

Regarding the medications in use, it was investigated that 86 (63.7%) of the respondents were using cardiovascular medications, 35 (25.9%) were using neurological medications and 79 (58.5%), psychiatric medications. ; medications to the digestive system were also frequent, as 41 (30.4%) elderly people were using it; Platelet antiaggregants and statins were also frequent, with 26 (19.3%) and 28 (20.7%), respectively. In

addition, nine (6.7%) of the respondents did not use any medication and 36 (26.7%) concomitantly used five or more medications, configuring polypharmacy.

According to the applied questionnaires, the population profile of each institution could be described. When considering MMSE, 96 (71.2%) had scores that suggest a cognitive decline. It was noted with the Barthel questionnaire that most of the population studied was classified as independent; Regarding the result of the frailty questionnaire, most respondents were classified as fragile. Most of the population presented marked family dysfunction, according to the family Apgar score, and the average Nottingham score was 14.8, which corresponds to a perceived loss of 38.9% of quality of life (Table 3).

Table 3. Result of the applied questionnaire. Marília (SP), Brazil, 2018.

Evaluated questionair	Classification	%	Average Express score M±SD	S.D.
Mini Mental ¹	Normal	39 (28.8)	19.9	4,2
	Suggestive of cognitive deficit	96 (71.2)		
Barthel ²	Independent	108 (80)	82.9	23,4
	Dependent	27 (20.0)		
Apgar Familiar ³	Enhanced dysfunctionality	53 (36.3)	4.6	3,9
	Moderate dysfunctionality	40 (29.6)		
Frailty Index ⁴	Functional	42 (31.1)	2.9	2,06
	Non frail	24 (17.8)		
	Pre frail	37 (27.4)		
Nottingham ⁵	Frail	74 (54.8)	14.8	9.1

SD = standard deviation. 1: Analysis according to schooling-related scores: illiterate, 20; for one to four years of study, 25; from five to eight years old, 26; from 9 to 11 years old, 28 and for individuals with more than 11 years of schooling, 29 points; equal to or above normal, below suggestive of deficit. 2: Dependent, with score less than 60, or independent, with score equal to or greater than 60. 3: Highly functional (seven to ten points), moderately functional (four to six points) and marked dysfunctionality (zero to three points). 4: Not fragile (no components identified); pre-fragile (presence of one or two components) and fragile (presence of three or more components). 5: 38 items with yes / no answers. The higher the score, the worse the perception of quality of life.

Most respondents showed a good acceptance of institutionalization and a good degree of satisfaction with the LTCF (Table 4).

Table 4. Degree of acceptance of institutionalization and satisfaction with the institution. Marilia (SP), Brazil, 2018.

Analyzed variable	Índex	Total: Gross Number (%)	Average±SD
Acceptance of Institutionalization	Good acceptance	86 (63.7 %)	14.3 (± 5.1)
	Did not accept	49 (36.3 %)	8.16 (± 1.5)
Satisfaction in relation to the institution	Good	90 (66.6 %)	15 (± 5)
	Regular	39 (28.8 %)	6.5 (± 2)
	Bad	6 (4.4 %)	1 (± 1.3)

SD.: Standard deviation.

When the variables studied in the different institutions were submitted to descriptive statistics, the variables - concerning leisure and leisure activities, monthly income, room type,

amount of meals, degree of satisfaction, weekly frequency of leisure activity / playful, Mini Mental and Barthel indexes - showed differences between the LTCFs, as described in table 5.

Table 5. Differences between the variables studied in relation to the institutions analyzed regarding the level of statistical significance (P value <0.05). Marilia (SP), Brazil, 2018.

Variable	p
Sex	0.26
Color	0.80
Marital Status	0.40
Religion	0.73
Progress profession	0.42
Is or is not retired	0.69
Has their own home or not	0.14
Has children or not	0.52
Acceptance of institutionalization	0.74
Practice of physical activity	0.40
Has leisure or fun activities	< 0.001*
Education	0.36
Monthly income	< 0.001*
Type of room	< 0.001*
Amount of meals	< 0.001*
Degree of satisfaction	< 0.001*
Age in years	0.23
Duration of institutionalization (Months)	0.24
Weekly frequency of practice of physical activities	0.47
Weekly frequency of practice of leisure and fun activities	< 0.001*
Mini Mental	< 0.001*
Barthel's index	0.02
Frailty index	0.65
Apgar	0.16
Nottingham	0.26
Barthel's Index (classification)	< 0.001*
Frailty Index	0.41

There was a strong positive correlation with statistical significance between the number of meals and the degree of satisfaction; There was also a moderate positive correlation between the degree of satisfaction and the amount of people in the room. On the other hand, the degree of satisfaction with schooling presented a negative correlation, and the relationship between the degree of satisfaction and monthly income followed the same trend. When the relationship

between the degree of satisfaction and the decision on institutionalization was analyzed, a positive correlation was obtained, while the relationship between the Nottingham questionnaire result and the degree of satisfaction was negative; The same occurred with the Mini Mental, that is, the higher the score on these questionnaires, the lower the satisfaction of the elderly (Table 6).

Table 6. Correlation analysis between the various variables. Marília (SP), Brazil, 2018.

Correlational variables	Correlation coefficient	P
Degree of satisfaction in relation to education	- 0.24	0.005*
Degree of satisfaction in relation to monthly income	- 0.24	0.004*
Degree of satisfaction and Apgar Index	- 0.004	0.96
Degree of satisfaction and frailty index	0.03	0.67
Degree of satisfaction and Nottingham (total)	- 0.57	0.5
Degree of satisfaction and Mini Mental	- 0.22	0.01
Degree of satisfaction and Barthel's index	- 0.11	0.19
Decision on hospitalization regarding acceptance of institutionalization	0.38	< 0.001*
Degree of satisfaction with the decision on hospitalization	0.007	0.93
Degree of satisfaction regarding the number of individuals per room	0.17	0.04
Degree of satisfaction regarding the amount of meals	0.46	<0.001*
Degree of satisfaction with physical activity	- 0.01	0.89

DISCUSSION

This study allowed the characterization of the health conditions of elderly people living in LTCFs, as well as their sociodemographic aspects, being all institutions with philanthropic character. The literature points to the importance of training professionals who work in the care of the elderly, considering the relevance of interdisciplinary work. It was considered that multiprofessional and interdisciplinary action, with principles in health promotion and integrated with knowledge about the individualized aging process, generates a more effective and effective care, favoring the autonomy and independence of the institutionalized elderly.²¹

The authors also pointed to the need for specific care, ranging from the encouragement of group life to the appropriate prescription of drugs and resources appropriate to each one's needs. It is noteworthy in this research, when considering the technical team of health care, that all the LTCF had a nursing team constituted and the nurse presented as the technical responsible. However, it was noticed that the multidisciplinary and interdisciplinary characteristic was not reality in the studied LTCFs.

In Brazil, residential LTCFs are considered, taking into account the elderly population who can or cannot live in the family environment and, in this context, interdisciplinary action, comprehensive health care and maintenance of the elderly's autonomy are foreseen. in legislation; In contrast, most institutions only provide the demand for health care due to the degree of dependence and distinct health / disease characteristics of elderly residents.^{4,9-10}

The majority of the study population consisted of widowed or single elderly, with children and income of one minimum wage, without a home, with up to four years of study, and the average time of living in the LTCF was four years. It was pointed out by a study that 76% of the elderly interviewed had the decision to move to the institution by intervention of other people and

without their own will. It was shown that the decision to change to the LTCF itself and the possibility of choosing the institution were a protective factor for cognitive deficit, since the elderly living in LTCF are more susceptible to physical inactivity and loss of functional and cognitive capacity.²²

Added to the increase in the number of elderly in the population added to a growing dependency, socioeconomic and cultural changes in modern society, low income, and changes in family constitution. Some factors in the literature are predisposing to the institutionalization process of the elderly, such as the absence of children, a partner, cognitive impairment and dependence on activities of daily living.²³⁻⁴ In this research, the absence of children as a determining factor for institutionalization is not evident, since 61.5% of respondents reported having children. However, this research demonstrates the absence of a partner as a predisposing factor, since 95% of respondents report being widowed / separated or single.

In addition, the 135 elderly who participated in this study corresponded to 40% of the elderly living in these institutions. Considering that, as exclusion criteria, the impossibility of verbal communication, bedridden, presence of severe cognitive disability and refusal to participate were used, the majority of the elderly living in these LTCF presented severe cognitive decline and marked degree of dependence. It was evidenced by the majority, still among the elderly participants, when analyzing the result of the questionnaire, relating it with the educational level, result of the Mini Mental suggestive of cognitive deficit. The literature corroborates this characteristic, which points out, as an important predisposing factor for cognitive loss, the loss of autonomy and social life, factors present in most LTCFs, and such factors end up having direct consequences on the quality of life may lead to functional decline and decreased perception of quality of life.^{22,25} It is noteworthy that cognitive impairment and functional capacity is a factor of

great incidence in the institutionalized population, besides being a factor that leads to the institutionalization process, since the deterioration of health conditions is a significant reason for institutionalization.^{23,26}

In terms of functionality, most respondents show independence, but with a high degree of frailty. Frailty in the elderly is shown by a decline in physiological and functional reserves, providing lower physiological and psychological tolerance to stressors and consequent risk of adverse health events. It was pointed out that the prevalence of frailty syndrome among the elderly living in institutions is a major health problem and is related to cognitive loss.²⁷

In a study conducted in Spain about the importance of assistance in LTCF, which is increasingly being presented as an essential element in the care of frail and cognitive elderly, which, as witnessed in this research, frail elderly and cognitive decline constitute the majority of the population living in the institution, which poses a major challenge as to the proper health care plan and medication approach.²⁸

Most of the elderly in this study stated that they are satisfied with the institution where they live, showing good acceptance of the institutionalization process; In contrast, when applying the questionnaires to verify family dynamics, most respondents showed marked family dysfunction and average perception of quality of life, according to the Nottingham questionnaire, which had an average score of 14.8, ie the perception of loss of quality of life of the studied population is 38.9%. It was concluded, by applying the same questionnaire to the elderly attended at the primary health care network, that the population had a 25.4% loss of quality of life, with an average score of 9.16.²⁰ The literature confirms these data regarding the adaptive process of institutionalization, which generates resistance and sadness, while the feeling of acceptance is accompanied by melancholy, perspective of loss of autonomy, isolation and feeling of worthlessness.^{24,29}

Good family support is a protective and protective mechanism against stressful situations, fulfilling a social function and having beneficial effects in adulthood and the elderly, as it enables the management of stressful situations and acts as a protective element. In a study conducted in institutional residential centers for the elderly in three Spanish cities, it was pointed out that individuals with intellectual disabilities with a higher degree of personal autonomy, associated with the received and perceived family and institutional support, reported health, well-being and significantly higher perceptions of quality of life than more dependent and less supportive individuals.³⁰

Better life conditions lead to a better quality of life, that is, the higher the personal satisfaction, the higher the quality of life.³⁰ The experience of loneliness, institutionalization and the adaptive process are presented, linked to events such as grief, the difficulty of establishing interpersonal relationships and the lack of social and family support, as the main risk factors for depression.^{21,24,31}

In the study population, 31.9% of the elderly had a diagnosis of emotional / mental illness, but in this same population, 58.5% were using psychiatric medication. The significant prevalence of affective and psychiatric disorders in the elderly is shown in the literature, and a high prescription of psychotropic drugs can be observed as evidence of this.³² It was clear from this study that there is a difference between diagnosis and prescription. This may reflect a lack of knowledge about their own health by the elderly or even unpreparedness of professionals who deal with them in knowing how to recognize the signs of depression and the drug aspects. It is noteworthy that, for the collection of data related to medication and morbidity, a review of the medical records was performed, a fact that also makes it difficult to present these data, since most institutions did not present updated organization and records.

It is inferred, when comparing some variables, that are inversely proportional the degree of satisfaction with education, monthly income and Nottingham and Mini Mental questionnaire; In other words, the higher the income and education among the elderly interviewed, the lower the degree of satisfaction with the institutionalization, as well as the higher Mini Mental scores, suggesting that the preserved cognitive capacity leads to less satisfaction with the institutionalization process. The same happens with the Nottingham questionnaire, which shows that the higher the score, which means lower perception of quality of life, the lower the satisfaction. This data corroborates the literature, considering that it is observed that the impact of institutionalization contributes to the prevalence of feelings of anxiety, anguish and distress. The elderly are influenced by changes in their daily routine, absence of family and difficulty in creating bonds, repetitive routine, loss of autonomy, loss of privacy, daily living with sick individuals, presence of rules, obedience to employees and compulsory activities, which has repercussions for the elderly, both emotional and physical.^{24,29}

It was found in the research involving 699 elderly residents of LTCFs in Spain, an important association between higher mortality and living in a nursing home, pointing out that house

characteristics and contextual factors are important for residents.³³

When comparing the variables related to the amount of food and decision on hospitalization, these factors were positively correlated with the degree of satisfaction with the institution, and the elderly also showed greater satisfaction when sharing a room with a partner.

CONCLUSION

In this research, it was observed that the studied LTCFs tend to be unprepared to meet this growing demand. It is pointed out that the degree of autonomy, the relevant rate of cognitive deficit, the involuntary process of institutionalization and social isolation end up directly affecting the quality of life of this population, generating cognitive and functional decline. It is noted that the preservation of cognition and the higher level of education favor a lower degree of satisfaction with life in the institution and, consequently, a lower perception of quality of life.

Most of the studied LTCFs present a population with a significant cognitive deficit and a high dependency rate, which creates a greater need for specific health care and contributes to a lower offer of activities that promote quality of life. This fact is associated with living with people who have different health needs that may favor a lower degree of satisfaction, when correlated with the preservation of cognition.

It is believed that it is far from achieving adequate care for the elderly and institutionalized population, and such reality demands urgency in the proposal of solutions to promote quality of life and satisfaction, predisposing factors for a healthy aging.

It is noteworthy that studies that present the characterization of the residents of the LTCFs, profiling them and relating them to the quality of life and the satisfaction of the elderly, in this process, are of great relevance, since we are facing a population in significant growth, and the evaluation of the physical, psychological, social and cultural conditions of these elderly people becomes important because it allows to broaden the understanding of their health needs. However, studies of this nature are scarce in the literature. Some of these aspects were presented in this research, not only bringing factors related to sociodemographic conditions, but also relating them to factors that bring satisfaction and quality of life to these elderly people.

This study was limited by the fact that it was a regional study conducted in a limited number of LTCFs, which could compromise the external validity of the finding and the exclusion of bedridden elderly with significant cognitive

deficit, as it does not allow the representation of all seniors. Therefore, the need for further studies in other regions addressing the institutionalized elderly is considered paramount.

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