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HEALTH CHARACTERIZATION OF ELDERLY PATIENTS FROM A FAMILY HEALTH UNIT

CARACTERIZAÇÃO DA SAÚDE DE IDOSOS CADASTRADOS EM UMA UNIDADE DE SAÚDE DA FAMÍLIA

CARACTERIZACIÓN DE LA SALUD DE ANCIANOS REGISTRADOS EN UNA UNIDAD DE SALUD DE LA FAMILIA

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Objective: to characterize the health of elderly patients registered in a family health unit. Method: this is a cross-sectional descriptive quantitative study conducted with 159 participants between 2016 and 2017. Validated instruments were used in data collection. Data were tabulated and analyzed in SPSS version 21.0 using descriptive statistics. Results: most participants were young, female, literate, with an income of up to one minimum wage, and they considered their health as good. Hypertension was the most prevalent pathology. They presented good functional capacity and good quality of life, but at risk for malnutrition, without cognitive impairment or depression symptoms. Most of them access public health services and use some chronic medication. Conclusion: elderly patients registered in the health center had no cognitive or psycho-emotional problems and considered themselves as healthy individuals, although most of them had hypertension and risks of malnutrition were detected.

Descriptors: Health of the Elderly. Family Health. Public Health. Aging. Geriatric Nursing.

Objetivo: caracterizar a saúde de idosos cadastrados em uma Unidade de Saúde da Família. Método: estudo quantitativo descritivo, transversal, realizado entre 2016 e 2017, com 159 participantes. Para a coleta de dados, foram utilizados instrumentos já validados. Os dados foram tabulados e analisados no SPSS versão 21.0 por meio de estatística descritiva. Resultados: houve predomínio de idosos jovens, do sexo feminino, alfabetizados e com renda de até um salário mínimo, que consideravam boa a sua saúde. A hipertensão foi a patologia mais prevalente. Apresentaram boa capacidade funcional e boa qualidade de vida, ainda em risco para desnutrição, sem déficit cognitivo e sintomas depressivos. A maioria acessa os serviços públicos de saúde e utiliza algum medicamento em

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caráter crônico. Conclusão: os idosos cadastrados na unidade de saúde não apresentavam problemas de ordem cognitiva, nem psicoemocional e consideravam-se saudáveis, apesar de a maioria ter hipertensão arterial e terem sido detectados riscos para desnutrição.

Descritores: Saúde do Idoso. Saúde da Família. Saúde Pública. Envelhecimento. Enfermagem Geriátrica.

Objetivo: caracterizar la salud de ancianos registrados en una Unidad de Salud de la Familia. Método: estudio cuantitativo, descriptivo, transversal, realizado entre 2016 y 2017 con 159 participantes. Datos recolectados mediante instrumentos validados, luego tabulados y analizados en SPSS versión 21.0 por estadística descriptiva. Resultados: existió predominio de mayores jóvenes, de sexo femenino, alfabetizados, con ingresos de hasta un salario mínimo, que consideraban tener buena salud. La patología más prevalente fue la hipertensión. Mostraron buena capacidad funcional y buena calidad de vida, incluso en riesgo de desnutrición, sin déficit cognitivo ni síntomas depresivos. La mayoría accede a los servicios públicos de salud y utiliza algún medicamento en carácter de crónico. Conclusión: los ancianos registrados en la unidad sanitaria no presentaban problemas de orden cognitivo ni psicoemocional, y se consideraban saludables, aunque la mayoría sufría de hipertensión arterial y se les había detectado riesgo de desnutrición.

Descriptores: Salud del Anciano. Salud de la Familia. Salud Pública. Envejecimiento. Enfermería Geriátrica.

Introduction

Population aging in Brazil has increased in the last decades due to reduced total fertility rates and increased life expectancy. This situation has resulted in changes in the population pyramid and important challenges to the health care of elderly patients, requiring the development of public policies and planning for health promotion and disease prevention among this population[1].

Changes in the human body due to aging are recurrently perceived as unique and may cause natural losses that make the elderly vulnerable to the process of illness[2]. This process cannot be considered a pathology, and aging does not mean fragility and morbidities; however, this population presents more health-related demands, considering today aging is characterized by the onset of chronic non-communicable diseases (NCDs) and, consequently, dependent elderly[2].

In order to meet the new demands of this growing population group, the Ministry of Health created in 2006 the National Health Policy for the Elderly (PNPI, as per its acronym in Portuguese) to promote, prevent and recover health, based on the National Unified Health System (SUS, as per its acronym in Portuguese) guidelines, with basic health units (BHU) providing health services through the Family Health Strategy (FHS) program[3].

A recent study showed that 75.3% of elderly patients in Brazil depend exclusively on SUS services[4], which highlights the crucial role of Family Health Units (FHUs) in the effectiveness of elderly policies, through comprehensive care, with a focus on promoting healthy habits, educational practices that can control and prevent NCDs and inabilities, and care for the elderly and their families, thus favoring active and participatory aging[5].

Nurses have become essential professionals in the FHU teams and in providing care to elderly patients, as they act in care provision and planning of educational activities and actions for the promotion, prevention, and recovery of health. In order to improve their actions, the professionals who comprise the FHU should know the characteristics of the elderly patients assisted to understand the real needs of this group and set effective care-related goals for them[6].

When the characteristics of a given population group are identified, actions can be developed to improve the quality of life of these individuals, favoring the direction of health care actions and defining the needs for adequacy of the study place and its practices[6], as well as actions to prevent aggravations.

Given this context, this study aimed to characterize the health of elderly patients from a family health unit.

Method

This is a cross-sectional descriptive quantitative study conducted in the municipality of Recife, Pernambuco, Brazil, between 2016 and 2017. The study population consisted of all 1,209 elderly patients registered in FHU Sítio Wanderley. The sample was calculated using the finite population formula for epidemiological studies, using a 95% confidence level and a 5% margin of error. The resulting sample consisted of 159 elderly patients.

The study sample included people aged 60 years or over registered in the FHU described above. Exclusion criteria were: elderly patients in terminal stage, with severe hearing or vision deficits and with severe cognitive impairment. These exclusion criteria were identified by the researcher through observation or information provided by those in charge of the patients.

Data were collected at the homes of the elderly patients, when explanations were provided about the study objective and data confidentiality and when they showed willingness to participate in the study and signed an informed consent form. Each interview lasted two hours on average.

A pilot study was conducted with 25 elderly patients to test the data collection protocol seeking to identify failures and evaluate its viability.

The following instruments were used for data collection: Brazil Old Age Schedule (BOAS) for characterization of sociodemographic and health information[7]; a questionnaire on self-reported diseases (DAR – *Doenças Autorrelatadas*) with questions about the existence of chronic diseases; the Mini-Mental State Examination (MMSE) for cognitive assessment[8]; the Geriatric Depression Scale (GDS-15) to check for depression symptoms[9]; the Mini Nutritional Assessment (MNA) to evaluate their nutritional status[10]; the Katz Index of Independence in Activities of Daily Living (ADL)[11]; the Lawton Instrumental Activities of Daily Living Scale (IADL)[12]; questions adapted to the Advanced Activities of Daily Living (AADL)[13]; the resilience scale to assess the level of resilience[14]; the WHOQOL-OLD to assess quality of life[15]; the social support scale[16]; and the Inventory of Stressful Events[17].

Data were tabulated and analyzed in SPSS version 21.0 using descriptive statistics (absolute and relative frequency, mean, median, standard deviation, minimum and maximum values).

This project is linked to an umbrella study titled "*Impacto de Intervenções Multidimensionais em Idosos Cadastrados na Atenção Primária à Saúde e seus Cuidadores*" (Impact of multidimensional interventions on elderly patients registered in a basic health care center and their caregivers) approved by the Research Ethics Committee (REC) of the Health Sciences Center (HSC) of the Federal University of Pernambuco (UFPE) under nº. 51557415.9.0000.5208. The project observed Resolution 466/12 of the National Health Council, always respecting the dignity, freedom and autonomy of human subjects involved in the study, ensuring data confidentiality and privacy of individuals.

Results

Younger female literate elderly patients with no spouse and with high social support prevailed in this study. Retired elderly patients with a monthly income of one minimum wage were more frequent. Regarding the homes of the elderly, they shared their home with 1 to 4 people, predominantly their children. Most of them owned the home (77.4%; n=123). Regarding the source of the income (the participant could provide more than one answer), 106 (66.7%) of all 159 interviewees answered that it was retirement income, 38 (23.9%) answered the spouse's retirement income, and 26 (16.4%) had a job (Table 1).

Table 1 – Frequency of sociodemographic and economic variables of elderly patients registered in a family health unit. Recife, Pernambuco, Brazil – 2016-2017 (N=159)

Variables	n	%
Age		
60-70	85	53.5
71-80	46	25.8
over 80	27	20.1
No answer	1	0.6
Sex		
Male	37	23.3
Female	122	76.7
Literate		
Yes	106	66.7
No	53	33.3
Marital status		
Married/living with a partner	54	34
Widowed/divorced/separated/never married	105	66
Monthly income of the elderly patient		
Up to 1 minimum wage	113	71.1
More than 1 – up to 3 minimum wages	38	23.9
More than 3 minimum wages	8	5.0
Source of income		
Job	26	16.4
Retirement	106	66.7
Investments	5	3.1
Support from relatives or friends	14	8.8
Spouse's retirement	38	23.9
Other	11	6.9
People who live on this income		
The elderly patient only	32	20.1
2-4 people	93	58.5
5-8 people	34	21.4
The house where the elderly patient lives is		
His/hers	123	77.4
Rented	15	9.4
Granted at no cost	14	8.8
No answer	7	4.4
Number of people at home		
Lives alone	22	13.8
1-4 people	112	70.4
5-8 people	25	15.7
Social support		
Low social support	5	3.1
High social support	152	95.6
No answer	2	1.3

Source: Created by the authors.

Table 2 shows the critical aspects in the participant's health assessment, categorized in dimensions for an easy understanding. Most elderly patients evaluated their health as good or excellent, despite having reported a health problem. When questioned about the health problem, they could answer more than one problem, if necessary. Joint problems and urinary incontinence were more common, in 72 (45.3%) participants. Regarding the presence of any disease, they could answer 'yes' to more than one option if they had more than one disease. Hypertension was the most frequent pathology, reported by 117 (73.6%) participants, followed by arthritis or rheumatism, reported by 55 (34.8%) elderly patients. The use of public health services and the regular medications for chronic diseases were frequently reported by the study population.

Table 2 – Frequency of health assessment of elderly patients registered in a family health unit. Recife, Pernambuco, Brazil – 2016-2017 (N=159) (continued)

Dimensions	Assessment	n	%
Self-perceived health	**How do you assess your health today?**		
	Excellent	27	17.0
	Good	84	52.8
	Not good	36	22.6
	Terrible	10	6.3
	No answer	2	1.3
	Do you have any health problem?		
	Yes	129	81.1
	No	30	18.9
	What is your health problem?		
	In the feet, affecting mobility	48	30.4
	In articulations	72	45.3
	In teeth, affecting proper chewing	54	34.2
	Urinary incontinence	72	45.3
	Self-reported diseases		
	Angina or heart attack	19	12.1
	Stroke or CVA	15	9.4
	Cancer	10	6.3
	Arthritis or rheumatism	55	34.8
	Pneumonia, bronchitis	23	14.5
	Depression	38	24.2
	Osteoporosis	40	25.6
	Hypertension	117	73.6
	Diabetes	46	29.5
Access to health services	**What kind of health service do you use when you need medical care?**		
	No service, or the interviewee has not seen a physician for a long time.	6	3.8
	Medical service provided by a free public institution.	130	81.8

Table 2 – Frequency of health assessment of elderly patients registered in a family health unit. Recife, Pernambuco, Brazil – 2016-2017 (N=159) (conclusion)

Dimensions	Assessment	n	%
	Medical service from the participant's medical plan.	17	10.7
	Private physicians/clinics	6	3.8
	Do you take any medication?		
	Yes	141	88.7
	No	18	11.3
	How many medications do you take daily?		
	None	22	13.8
	1-3	77	48.4
	4 or more	60	37.7

Source: Created by the authors.

Table 3 shows other dimensions about the health assessment of the elderly patients. The individuals did not present any cognitive impairment or depression symptom, but resilience was high. Regarding their functional capacity and nutritional status, most of them showed good functional capacity and risk of malnutrition, respectively. When assessing the occurrence of stressful events, if necessary, the participants could report more than one event. The predominance of a friend's death was reported by 102 (64.2%) interviewees, followed by a disease of the elderly patient himself/herself, reported by 90 (54.6%) participants, and a decrease in activities they liked to perform, reported by 89 (55.7%) interviewees.

Table 3 – Frequency of variables related to the health of elderly patients registered in a family health unit. Recife, Pernambuco, Brazil – 2016-2017 (N=159) (continued)

Dimensions	Variables	n	%
Cognitive and mental dimension	**Mental status**		
	Without cognitive impairment	109	68.6
	With cognitive impairment	50	31.4
	Depression		
	Without symptoms	83	52.2
	With symptoms	76	47.8
	Resilience		
	Low resilience	51	32.1
	High resilience	108	67.9
	Stressful events		
	Death of a friend	102	64.2
	Death of a close relative	86	53.8
	Spouse got sick	64	35.4
	The elderly himself/herself got sick	90	54.6
	Taking care of sick wife	44	22.3
	Decrease in purchasing power	57	35.4
	Decrease in activities they liked	89	55.7
Physical and functional dimension	**Nutritional status**		

Table 3 – Frequency of variables related to the health of elderly patients registered in a family health unit. Recife, Pernambuco, Brazil – 2016-2017 (N=159) (conclusion)

Dimensions	Variables	n	%
	Normal	51	32.1
	Risk of malnutrition	82	51.6
	Malnourished	18	11.3
	No answer	8	5.0
	Activities of daily living		
	Advanced		
	More active	84	52.8
	Less active	75	47.2
	Instrumental activities		
	Independent	73	45.9
	Partially dependent	48	30.2
	Fully dependent	38	23.9
	Basic activities		
	Independent	131	82.4
	Partially dependent	19	11.9
	Fully dependent	9	5.7

Source: Created by the authors.

Table 4 shows data related to the descriptive analysis of quality of life, its total score and the individual score obtained for each facet. In this comparison a better performance was observed in sensory functioning, death and dying, and social participation.

Table 4 – Quality of life scores of elderly patients registered in a family health unit. Recife, Pernambuco, Brazil – 2016-2017 (N=159)

Quality of life	Mean	Median	Mode	Standard Deviation	Minimum	Maximum
Total score						
Total score	84.76	85.50	92	13.031	52	114
Facets						
Sensory functioning	15.91	18.00	19	3.910	4	20
Autonomy	13.09	13.00	11(a)	2.974	6	20
Past, present and future activities	14.02	14.00	14(a)	3.065	5	20
Social participation	14.25	15.00	16	3.079	6	20
Death and dying	14.64	16.00	16	4.203	4	20
Intimacy	13.48	15.00	16	4.020	4	20

Source: Created by the authors.

(a) Multiple modes exist; the table shows the lowest mode.

Discussion

Regarding sociodemographic characterization, the study data agree with the profile of elderly participants found in other studies[18-19], showing a predominance of female elderly patients aged 60 to 70 years, widowed, separated or who never married, literate, with a monthly income of up to one minimum wage.

Regarding the people who share the home with the elderly participants, most are their children, followed by a spouse and grandchildren. The existence of close affective bonds, especially in marriage, can contribute to a successful aging process. However, widowhood is the most frequent occurrence among women, due to their increased longevity, contributing to a higher percentage of elderly people living alone[20].

The bond between grandparents and grandchildren makes the elderly feel valued, transferring tradition and knowledge during the child's growth. However, the interaction between these generations is considered a challenge, since the adaptation of the elderly to the family reality requires efforts from everyone involved[20].

Given this context, the health assessment of elderly patients should consider the effects of social support networks on the health-disease process, psychological well-being, and satisfaction with life. Therefore, the role of family arrangement is essential as a protective effect to avoid stress and/or support the elderly in situations of adversity they face in the aging process[21].

Among the health problems reported in this study, urinary incontinence prevailed. This result agrees with those of a study conducted in Goiás, in which 38.76% of the elderly patients reported urinary incontinence. The aging process is considered a factor that predisposes to urinary incontinence, but when related to sex, the prevalence is even higher in women due to anatomical, hormonal and childbirth issues[22].

The presence of one or more diseases in elderly patients may increase the chance of dependence when performing activities of daily living and negatively influence their well-being[23]. Regarding this topic, hypertension was the most reported disease, followed by osteoarticular disorders and diabetes. Such evidence is supported by findings in the literature[24].

It is essential to have a situation health diagnosis of the assisted population in order to plan actions that promote health, prevent disorders and noncommunicable diseases[25], and develop more effective actions and public policies to fight and/or minimize the onset of such disorders[2].

Regarding the use of medication, most of the elderly participants of this study (88.7%) were in medical therapy. When asked about quantity, a great percentage took 1 to 3 (48.4%) medications daily, followed by 4 or more (37.7%), a result confirmed in the literature[15] and that calls for measures towards the adoption of alternative solutions to avoid such use whenever possible.

Regarding functional capacity, most of the elderly participants were independent for basic and instrumental activities. However, when analyzing the difference between the numbers of partially and fully dependent elderly, it increased considerably from the basic to the instrumental activities. This result confirms the hierarchical decline found in other studies, in which the loss of capacity to perform activities occurred from the most complex to the most basic, while simpler and less complex functions remained for a longer period[26].

Functional dependence is a barrier for the elderly patients and their families, considering that, throughout their life, they take care of themselves and their families, but in this period of life the roles are reversed. Such dependence causes unwanted feelings, such as disability, fear, and shame[2].

Regarding the physical dimension, a nutritional assessment of elderly patients requires attention, since the prevalent classification was the risk of malnutrition, which added to the classification of malnutrition, corresponds to almost two-thirds of all studied patients. Low weight identified among the elderly participants has a proportional relation with malnutrition, that is, long-lived elderly patients showed greater chances of nutritional deficiency. This factor is related to morbidity and mortality, since the impact of this condition causes a worse prognosis due to health problems[24].

Cognitive impairment is frequent in old age, so the elderly must participate in activities of the environment where they live[2]. In this study, most individuals did not present cognitive impairment.

In the mental dimension, the results regarding the presence of depression symptoms were similar between those who presented them and those who did not. Then, care for the elderly with mental problems that require continuous attention

is not limited to medication, since the problem of depression symptoms in the FHU is not restricted to diagnosis. Dedicating more attention to this problem will allow health professionals to perform an active search, early detection, continuous follow-up, and conduct therapeutic workshops to ensure improvements in health care to this group of mentally ill people[21].

Regarding the level of resilience among the elderly, most of the interviewees presented high resilience, in agreement with a study that evaluated this factor in elderly people of low and high economic level, with all of them presenting positive results after negative facts in life, according to the distinct groups[1].

When evaluating the mean values between the facets of the quality of life assessment instrument, the elderly presented better results in the facets of sensory functioning, death and dying, and social participation, in agreement with the results of a study that evaluated institutionalized elderly people, which indicated higher mean values in the facets of death and dying, sensory functioning, and intimacy.

Also regarding the quality of life assessment instrument, this study sample indicated a lower mean in the fact of autonomy. Health condition can be considered a factor that influences the autonomy of the elderly, given that, over the years, physical and psychological problems may appear and influence their health status[24].

In this health scenario that presents fragile elderly people with compromised longevity due to several harmful factors, such as the onset of diseases, functional incapacity and cognitive impairment, the care provided by the FHU should be committed to ensuring healthy and active aging to the population[2].

The creation of groups in the FHU is an option that allows the elderly to remain social and active and build friendships, encouraging them to participate in different activities of the daily life, avoiding social isolation and several complications related to this factor[2].

Characterizing the health of the community that will receive care will enable nurses to better adjust their professional practice and develop actions to meet the real needs of this population[25].

The study limitations refer to the small study site and its cross-sectional design, since it did not allow generalization and real demonstrations of the health condition of the elderly.

Conclusion

Most participants of this study were younger elderly people, female, literate, without a spouse, retired, and with incomes of up to one minimum wage. They presented good health condition, good functional capacity and quality of life, without cognitive impairment or depression symptoms. The most prevalent pathology was hypertension, and the elderly showed risk of malnutrition, joint problems, and urinary incontinence.

In addition, the results showed the implementation of services focused on chronic diseases is a critical measure to maintain the functional capacity of the elderly for as long as possible, valuing self-care, autonomy, and independence of these individuals to increase their quality of life.

The nursing team, when assisting the elderly population, especially considering the gradual expansion of this group, should perform a situation health diagnosis to ensure proper health care.

Collaborations:

1. conception, design, analysis and interpretation of data: Gleicy Karine Nascimento de Araújo and Rafaella Queiroga Souto;

2. writing of the article and relevant critical review of the intellectual content: Gleicy Karine Nascimento de Araújo, Rafaella Queiroga Souto, Fábia Alexandra Pottes Alves and Rute Costa Régis de Sousa;

3. final approval of the version to be published: Gleicy Karine Nascimento de Araújo, Rafaella Queiroga Souto, Fábia Alexandra Pottes Alves, Renata Clemente dos Santos and Karla Alexsandra de Albuquerque.

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