



Family insufficiency and the condition and the physical frailty's components of elderly in ambulatorial care^a

Insuficiência familiar e a condição e os marcadores de fragilidade física de idosos em assistência ambulatorial

Insuficiencia familiar y la condición y los marcadores de fragilidad física de ancianos en asistencia ambulatorial

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ABSTRACT

Objective: to analyze the relationship between family insufficiency and the condition and the markers of physical frailty of elderly people followed up in a Geriatrics and Gerontology outpatient clinic. **Method:** a quantitative and cross-sectional study conducted with 384 elderly (≥ 60 years) selected by pre-established inclusion and exclusion criteria. Physical frailty was assessed according to the frailty phenotype and family insufficiency by the Family APGAR. Data was analyzed using descriptive statistics and univariate analysis using the chi-square test with a statistical significance level of $p \leq 0.05$. **Results:** there was no association between family insufficiency and physical frailty ($p=0.344$), however, it was observed a percentage of frail elderlies with high Family Dysfunction (22.2%) and moderate Family Dysfunction (19.4%), higher than that observed among the elderly with good family functioning (12.2%). Among the frail elderly for the marker "fatigue/exhaustion", there was a direct proportionality to the degree of Family Dysfunction and a statistically significant relation to the total score of the Family APGAR ($p=0.001$). **Conclusion and implications for the practice:** family frailty in the elderly is related to other intra-family factors and not exclusively to physical frailty, however, it can be stated that the degree of physical frailty among the elderly is directly proportional to the level of Family Dysfunction.

Keywords: Ambulatory Care; Family; Family Relations; Frail Elderly; Geriatric Nursing.

RESUMO

Objetivo: analisar a relação entre insuficiência familiar e a condição e os marcadores de fragilidade física de idosos acompanhados em ambulatório de Geriatria e Gerontologia. **Método:** estudo quantitativo e transversal realizado com 384 idosos (≥ 60 anos) selecionados por critérios pré-estabelecidos de inclusão e exclusão. Avaliaram-se a fragilidade física segundo o fenótipo da fragilidade e a insuficiência familiar pelo APGAR de Família. Analisaram-se os dados mediante a estatística descritiva e a análise univariada mediante o teste de qui-quadrado com nível de significância estatístico de $p \leq 0,05$. **Resultados:** não houve associação entre insuficiência familiar e fragilidade física ($p=0,344$), entretanto, observou-se percentual de idosos frágeis com elevada Disfunção Familiar (22,2%) e moderada Disfunção Familiar (19,4%), maior que o observado entre os idosos com boa funcionalidade familiar (12,2%). Entre os idosos frágeis para o marcador "fadiga/exaustão", houve proporcionalidade direta ao grau de Disfunção Familiar e relação estatisticamente significativa ao escore total do APGAR de Família ($p=0,001$). **Conclusão e implicações para a prática:** a insuficiência familiar no idoso está relacionada a outros fatores intrafamiliares e não exclusivamente à fragilidade física, no entanto, pode-se afirmar que o grau de fragilidade física entre os idosos é diretamente proporcional ao nível de Disfunção Familiar.

Palavras-chave: Assistência Ambulatorial; Enfermagem Geriátrica; Família; Idoso Fragilizado; Relações Familiares.

RESUMEN

Objetivo: analizar la relación entre insuficiencia familiar y la condición y los marcadores de fragilidad física de ancianos acompañados en ambulatorio de Geriatria y Gerontología. **Método:** estudio cuantitativo y transversal realizado con 384 ancianos (≥ 60 años) seleccionados por criterios preestablecidos de inclusión y exclusión. La fragilidad física fue evaluada de acuerdo el fenotipo de la fragilidad y la insuficiencia familiar según el APGAR de Familia. Los datos fueron analizados por estadística descriptiva y el análisis univariada por prueba de chi-cuadrado con nivel de significancia estadístico de $p \leq 0,05$. **Resultados:** no hubo asociación entre insuficiencia familiar y fragilidad física ($p=0,344$), sin embargo, han sido observados ancianos frágiles con elevada Disfunción Familiar (22,2%) y moderada Disfunción Familiar (19,4%), mayor que lo observado entre los ancianos con buena funcionalidad familiar (12,2%). Entre los ancianos frágiles para el marcador "fatiga/agotamiento" hubo proporcionalidad directa al grado de Disfunción Familiar y relación estadísticamente significativa a la puntuación total del APGAR de Familia ($p=0,001$). **Conclusión e implicaciones para la práctica:** la insuficiencia familiar en el anciano está relacionada a otros factores intrafamiliares y no exclusivamente a la fragilidad física, sin embargo, se puede afirmar que el grado de fragilidad física entre los ancianos es directamente proporcional al nivel de Disfunción Familiar.

Palabras clave: Atención de ambulatorio; Enfermería geriátrica; Familia; Anciano fragilizado Relaciones familiares.

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Submitted on 10/01/2021.

Accepted on 05/06/2022.

DOI: <https://doi.org/10.1590/2177-9465-EAN-2021-0375en>

INTRODUCTION

The family plays an important role in the care of the elderly, and is often the primary source of care.¹ Relying on family care is a significant determinant of an elderly person's well-being. This support generates personalized care and, in a broad sense, brings more quality of life.² For the World Health Organization³, the home is a privileged space for care as long as the family participates and provides the necessary support to these individuals.

Family insufficiency syndrome is defined as the "loss of the family's ability to provide care, support and support for the elderly due to absence of family or lack of conditions".^{4:13}

The physical frailty syndrome has been defined as the "clinical state characterized by increased vulnerability in the individual when exposed to internal and external stressors, and is a major contributor to functional decline and early mortality in the elderly".^{5:773} The phenotype of this syndrome is made up of the following markers: unintentional weight loss; self-reported fatigue/exhaustion; low level of physical activity; reduced walking speed (WS) and reduced hand grip strength (HGS). The elderly who present three or more markers are classified as frail, pre-frail with one or two and non-frail in the absence of markers.⁶

The physical frailty syndrome is not synonymous with comorbidities or dependence, although it is predictive of these conditions resulting from decreased strength, endurance and performance.⁶ Frailty can worsen due to the absence of social support, since the lack of it can affect the body's defense systems, making the individual more susceptible to disease⁷, since family support promotes better health conditions for the elderly, favoring resilience in cases of stressful situations.⁸

The relevance of this study stands out when considering that family insufficiency in the context of the elderly, besides negatively impacting the relationships between family members, brings even greater harm to the health of the frail elderly, since conflicting relationships make care deficient.⁹ Furthermore, an increasing number of frail elderly people who have the family as the main, or only, source of informal support for their health demands is observed. By elucidating the relationship between these syndromes, the study provides directions for the care practices of Geriatric Nursing.

Thus, the objective of this study was to analyze the relationship between family insufficiency and the condition and markers of physical frailty of elderly people followed up in a Geriatrics and Gerontology outpatient clinic.

METHOD

Quantitative and cross-sectional study conducted with elderly people (≥60 years) at the Geriatrics and Gerontology Outpatient Clinic (GGOC) in the municipality of São José dos Pinhais, metropolitan region of Curitiba, Paraná (Brazil). The study was approved by the Ethics Committee on Human Research under Opinion CEP/SD No. 1.755.394.

The target population was the elderly scheduled for consultation at the GGOC, and the recruitment to participate in the study

occurred through posters posted on the service premises and when the elderly were waiting in the waiting room for consultation at the GGOC. The ethical principles of voluntary and consented participation were observed by signing the Free and Informed Consent Term for each participant. Participants were identified by numbers to ensure anonymity.

A sample size calculation was performed in order to obtain a representative sample of the elderly population of the municipality of São José dos Pinhais (Paraná). The total elderly population of the municipality of São José dos Pinhais (36,648) in 2015 was considered, according to the latest census of the Brazilian Institute of Geography and Statistics¹⁰ with 95% confidence interval (95% CI), 5% significance level ($\alpha=0.05$) and sample error of five percentage points. The sample size included an 8% margin for possible losses or refusals, resulting in a calculated sample of 411 elderly. After inclusion and exclusion criteria, a final sample of 384 elderly was obtained.

For the selection of participants, the following inclusion criteria were established: a) age ≥ 60 years; b) be in the waiting room for scheduled consultation at the GGOC; c) present cognitive ability according to the result of the cognitive screening performed by means of the Mini Mental State Examination (MMSE).^{11,12} The cut-off points by education were used.¹² Exclusion criteria were: a) presenting severe sequels of stroke with localized loss of muscle strength and aphasia; b) having neurological diseases that prevented them from performing the tests; c) having severe hearing or vision deficits that markedly hindered communication; d) being physically unable to perform the proposed tests and/or presenting upper or lower limb amputations.

Data collection occurred in the period from October 2016 to March 2017. In this phase, sociodemographic and clinical questionnaires were applied in which the variables of interest were: sex; age; marital status; race; monthly family income; diseases; continuous use medications; falls in the last 12 months; and hospitalization.

The condition and markers of physical frailty were assessed by phenotype⁶ comprising the five components: HGS, WS, self-reports of weight loss and fatigue/exhaustion, and level of physical activity. The team of examiners was composed of four researchers, previously trained examiners, with experience in the assessment of physical frailty.

The HGS was measured in kilogram/force (Kgf) in the dominant hand using a Jamar® hydraulic dynamometer. The average of the three measurements was adjusted according to gender and Body Mass Index (BMI). The HGS values, which included the lower quintile, were considered markers of frailty for this study.⁶

To evaluate the WS, we considered the average speed of three journeys (round trip) in a course of six meters and sixty centimeters (6.6 m), and the first and last meter of the walk were not timed in order to reduce acceleration and deceleration effects. At this stage, the use of walking aids (cane, crutch, and walker) was allowed. After adjusting for sex and height, the WS values of the lowest quintile were markers of frailty for this component.⁶

The unintentional weight loss was verified by self-report. The elderly who declared a loss of body weight greater than or equal to 4.5 kg in the last twelve months in an unintentional manner (without diet or exercise) was considered frail for this component.⁶

Fatigue/exhaustion was assessed by self-report according to the participant's response to items 7 and 20 of the Center for Epidemiological Scale - Depression (CES-D).¹³ Answering "2" or "3" to any of the questions categorized the elderly person as frail for this component.⁶

For the level of physical activity, the Minnesota Leisure Activity Questionnaire was applied,^{14,15} which addresses the frequency and time of activities (physical activities and household chores) performed in the last year. The energy expenditure for each activity followed the recommendations of the Compendium of Physical Activities.¹⁶ After adjusting for sex, the lowest quintile values were markers of frailty for this study.⁶

Family insufficiency syndrome was assessed by the Family APGAR,^{17,18} instrument that assesses family functioning from a family member's perspective in five domains: adjustment, companionship, development, affectivity, and resolution.

The APGAR domains were addressed by structured questions: 1) Adaptation-"Am I satisfied with the attention I receive from my family when something is bothering me?"; 2) Companionship-"Am I satisfied with the way my family discusses issues of common interest and shares problem solving with me?"; 3) Development - "Does my family accept my desires to start new activities or to make changes in my lifestyle?"; 4) Affection - "Am I satisfied with the way my family expresses affection and reacts toward my feelings of anger, sadness, and love?" and 5) Resolution - "Am I satisfied with the way my family and I spend time together?".^{17,18}

For each question, the answer is categorized as: rarely (0), sometimes (1), and almost always (2). Good family functioning is considered to be scores between seven and ten points, moderate Family Dysfunction (FD) between five and six points, and high FD scores between zero and four points.^{17,18}

The data was analyzed in the Statistical PacKage for Social Sciences (SPSS) program, version 22.0. Descriptive statistical analyses were performed as means, standard deviation, absolute and relative frequencies. Univariate analysis was performed using the chi-square test with statistical significance level of $p \leq 0.05$.

RESULTS

Table 1 shows the frequency distributions of the total sample (n=384) referring to the sociodemographic and clinical characteristics of the elderly.

The sample was homogeneous regarding the gender variable. There was a predominance of the 65 to 69 age group (n=84; 21.9%), with a mean age of 70.7 (± 7.44) years. More than half of the elderly were married (n=253; 65.9%), followed by the widowed elderly (n=70; 18.2%). White people (n=313; 81.5%), monthly family income of one to two minimum wages (n=331; 86.2%) and elderly with one to four years of schooling (n=208; 54.2%) predominated (Table 1).

Table 1 shows that about the totality of the sample had one or more diseases (n=356; 92.7%) and a significant percentage used medication (n=344; 89.6%). Hospitalization in the last twelve months was reported by 89 (23.2%) elderly individuals and 132 (34.4%) reported a fall episode in the last year (Table 1).

Table 1. Shows the frequency distributions of the total sample (n=384) referring to the sociodemographic and clinical characteristics of the elderly.

Characteristics	Classification	n (%)
Sex	Male	195 (50.8)
	Female	189 (49.2)
Age group	60-64	84 (21.9)
	65-69	105 (27.3)
	70-74	84 (21.9)
	75-79	58 (15.1)
	≥ 80	53 (13.8)
Marital status	Married	253 (65.9)
	Divorced	44 (11.5)
	Widower	70 (18.2)
	Single	17 (4.4)
Race	White	313 (81.5)
	Black	32 (8.3)
	Brown*	38 (9.9)
	Yellow	1 (0.3)
Monthly family income	1 to 2 minimum wages	331 (86.2)
	2 to 4 minimum wages	42 (10.9)
	≥ 5 minimum wages	11 (2.9)
Education	Illiterate	65 (16.9)
	Functional illiterate	10 (2.6)
	1 to 4 years of schooling	208 (54.2)
	5 to 8 years of schooling	54 (14.1)
	>8 years of schooling	47 (12.2)
Diseases	Yes	356 (92.7)
	No	28 (7.3)
Use of medication	Yes	344 (89.6)
	No	40 (10.4)
Hospitalization**	Yes	89 (23.2)
	No	295 (76.8)
Fall episode **	Yes	132 (34.4)
	No	252 (65.6)

SOURCE: the authors (2018).

KEY: * Included, in this category, the elderly who declared race mulatto, cabocla, cafuza, mameluca or mixed black. No senior citizen declared himself to be indigenous. ** In the last twelve months.

Family insufficiency and physical frailty of the elderly

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Among the 384 elderly, 212 (55.2%) were classified as pre-frail, 118 (30.7%), non-frail and 54 (14.1%) were frail. As for the Family APGAR assessment, 286 (74.5%) had good family functionality, 62 (16.1%), high FD and 36 (9.1%), moderate FD.

Table 2 shows the association between physical frailty and family functioning.

The physical frailty condition was not associated with family functioning ($p=0.344$). However, it is observed that the percentage of frail among the elderly with high FD (22.2%) and moderate FD (19.4%) is higher than that observed among the elderly with good family functioning (12.2%). Thus, it can be stated that the

degree of physical frailty among the elderly is directly proportional to the level of FD (Table 2).

In table 3, the associations between family functioning and markers of physical frailty are presented.

The percentage of frail elderly for the marker “fatigue/exhaustion” showed direct proportionality to the degree of FD and presented a statistically significant relation to the total score of the Family APGAR ($p=0.001$) (Table 3).

The homogeneous distribution of the percentage of frail elderly in all classifications of the Family APGAR for the components “unintentional weight loss”, “WS” and “HGS” suggests no direct

Table 2. Association between physical frailty and family functionality, São José dos Pinhais, 2018.

Physically frail condition	Family APGAR			Value of p^*
	Good functionality n (%)**	Moderate disfunction n (%)**	Elevated disfunction n (%)**	
Frail	35 (12.2)	7 (19.4)	12 (22.2)	0.344
Pre-frail	157 (54.9)	21(58.3)	34 (54.8)	
Non-frail	94 (32.9)	8 (22.2)	16 (25.8)	
Total	286 (100)	36 (100)	62 (100)	

SOURCE: the authors (2018).

KEY: * chi-square test; ** percentage calculated by Family APGAR classification

Table 3. Association between family functionality and markers of physical frailty, São José dos Pinhais, 2018.

Markers of physical frailty	Family APGAR			Value of p^*
	Good functionality n (%)**	Moderate disfunction n (%)**	Elevated disfunction n (%)**	
Unintentional weight loss				
Yes	39 (13.6)	7 (19.4)	8 (12.9)	0.614
No	247 (86.4)	29 (80.6)	54 (87.1)	
Reduced Waking Speed				
Yes	55 (19.2)	8 (22.2)	14 (22.6)	0.789
No	231 (80.8)	28 (77.8)	48 (77.4)	
Reduced handgrip strength				
Yes	58 (20.3)	8 (22.2)	14 (22.6)	0.900
No	228 (79.7)	28 (77.8)	48 (77.4)	
Decreased level of physical activity				
Yes	108 (37.8)	18 (50.0)	25 (40.3)	0.361
No	178 (62.2)	18 (50.0)	37 (59.7)	
Fatigue/exhaustion				
Yes	60 (21.0)	14 (38.9)	25 (40.3)	0.001
No	226 (79,0)	22 (61,1)	37(59.7)	

SOURCE: the authors (2018).

KEY: * chi-square test; ** percentage calculated by physical frailty marker

relation of these components with family functionality. On the other hand, frailty marked by the component “level of physical activity” ($p=0.361$) shows a value of relationship closer to family functioning (Table 3).

DISCUSSION

Pre-frail elderly people predominated ($n=212$; 55.2%), followed by the non-frail ones ($n=118$; 30.7%) and, finally, the frail ones ($n=54$; 14.1%). In other national contexts, the number of pre-frail elderly people also takes significant proportions. In the municipality of Porto Alegre, Rio Grande do Sul (Brazil), with a sample consisting of 521 elderly (≥ 60 years), the Multidimensional Study of the Elderly of the Family Health Strategy (EMI-UHS) aimed to describe the association between frailty and geriatric syndromes. Prevalences of 51.1% pre-frail and 21.5% frail were observed.¹⁹

In the international context, in a survey of 8,804 community-dwelling Australian older adults (≥ 65 years of age), 21% were identified as frail, with the highest percentage being pre-frail (48%).²⁰ A systematic review with meta-analysis aimed to search the literature since 2000 for evidence of the prevalence of frailty (Fried’s criterion) among Japanese community-dwelling elderly (≥ 65 years). The search was conducted in 11 databases, and 1,529 studies were found of which five made up the corpus of the review. The pooled prevalence ($n=11,940$) of frail, pre-frail, and non-frail elderly was 7.4%, 48.1%, and 44.4%, respectively.²¹

In another systematic review with meta-analysis, 1,078 studies were identified in seven databases and 12 studies were selected for analysis. The studies were conducted in nine countries (Spain, Brazil, France, South Korea, Israel, United States, Ireland, China, and United Arab Emirates). Of the pooled sample ($n=26,935$), 11,265 older adults (41.82%) were classified as pre-frail and 2,460 (9.13%) as frail.²²

Thus, when comparing these results to the findings of this study, one must consider the socioeconomic differences between the contexts and countries where the research was conducted. Studies conducted in developed countries, which have a high Human Development Index, showed lower rates of frail elderly when compared to developing countries, such as Brazil.

The condition of physical frailty is influenced by factors such as the low level of education and income of the investigated samples,^{6,23} however, the observed variations can also be the result of genetic and environmental characteristics that change in countries.²⁴

The high prevalence of the pre-frailty condition reinforces the importance of identifying it early among the elderly. Moreover, pre-frailty responds better to care interventions and recommended treatments.⁵ For this, it is necessary to develop the practice of frailty assessment during the nursing consultation with the elderly population and, when identifying it, it is essential to implement integrated care in a multiprofessional team.²⁵ The recommended interventions are aerobic and resistance exercise, reduction of polypharmacy, vitamin D supplementation, caloric and protein support.⁵

In this study, 16.1% ($n=62$) of the elderly had high FD; 9.4% ($n=36$) moderate FD and 74.5% ($n=286$), good family functioning. These data may be underestimated, since this is a very delicate issue for the elderly.

A study carried out with a sample consisting of 2,052 elderly (≥ 60 years old), in the municipality of Sete Lagoas, Minas Gerais (Brazil), aimed to evaluate the family functionality of Brazilian elderly and test the influence of determining factors. The researchers found a prevalence of 8.62% ($n=177$) of high and 15.11% ($n=310$) of moderate FD, totaling 23.73% of FD.²⁶ This distribution of total FD converges with the data from this study. In Porto Alegre, Rio Grande do Sul (Brazil), the result of the study was considerably lower. In 227 elderly nonagenarians and centenarians, the FD (high and moderate) was identified in 9.69% ($n=22$) of them.²⁷

In this study, there was no significant relationship between physical frailty and family dysfunctionality ($p=0.344$), however, it was observed that the percentage of frail among the elderly with high (22.2%) and moderate FD (19.4%) is higher than that observed among the elderly with good family functionality (12.2%). Studies have pointed out that family dysfunctionality is present among the elderly in the process of frailty, with multiple diseases and limitations to perform activities of daily living.²⁸

All these conditions place the elderly in greater demand for care. When the family, the main provider of this assistance to the elderly, is not able to adapt to this restructuring, conflicts of coexistence among members often occur, causing tensions in the care process.²⁹

A longitudinal observational study of the Health, Well-Being and Aging Network (SABE) conducted in São Paulo, São Paulo (Brazil), aimed to analyze whether family functionality acts as a moderator of the association between frailty and health-related quality of life (HRQoL). The 2,143 elderly (≥ 60 years) were followed in three assessment waves (2006, 2010, and 2015). Family functionality was related to physical frailty at the last assessment wave ($p=0.008$ in 2015) and was indicated as a protective factor for the mental component of the SF-12.³⁰

Study in China assessed the relationship between sarcopenia and family functionality in 834 community-dwelling elderly (≥ 60 years).³¹ Family functioning was operationalized by means of the Family APGAR and sarcopenia was evaluated according to the following criteria: muscle mass measured by means of the Bioelectrical Impedance Analysis (BIA); muscle strength measured by means of the HGS and physical performance evaluated according to the WS (six meters). The results showed that the sarcopenic elderly had lower scores on the Family APGAR. There was a significant association of family functioning with sarcopenia in men ($p=0.003$) and in women ($p=0.013$).

The study cited above³¹ did not employ the physical frailty phenotype,⁶ however, it investigated two variables that make up the phenotype: WS and HGS. The performance of physical activities was evaluated as a parameter of the elderly “lifestyle” and the researchers used the International Physical Activity Questionnaire.

The researchers³¹ also evidenced the association between sarcopenia and family functionality. On this aspect, it is worth noting that the percentage of Chinese elderly who reported performing physical activities very often was high among both the sarcopenic (n=48; 54.5%) and non-sarcopenic (n=494; 66.2%) elderly. The latter data differs from that found in this study in which decreased physical activity was the component that showed the highest frequency among frail elderly (n=151; 39.2%) (Table 3).

Sedentary lifestyle is considered a predictor of physical frailty in the elderly. In turn, physical activity and exercise are highlighted as effective interventions, which prevent the development and or progression of the syndrome, in the care management of frailty.^{5,32}

Social isolation, psychosocial factors, and even depression can interfere with the elderly's performance of physical activities, as well as the report of "feeling tired/exhausted." Furthermore, research shows that depressive symptoms in the elderly are related to the presence of frailty.³³ The statistical relationship between the marker "fatigue and exhaustion" and the Family APGAR can be justified, since the assessment of this marker of the phenotype is performed through two questions of the Depression Scale (CES-D).

A research developed with the objective of investigating physical, psychological and social predictors of frailty used data from the second wave of evaluations of the English Longitudinal Study of Aging with a sample composed of 4,638 elderly aged between 65 and 69 years. The findings indicated that the presence of chronic diseases, decreased physical activities, depressive symptoms, cognitive impairment and poor social support are all predictors of physical frailty (p<0.005).³⁴ Depression and anxiety are the most common psychiatric conditions in old age, associated with the perception of social support as insufficient or negative, with a lesser degree of closeness to other people and with less satisfaction with social and/or family relationships.³⁵

CONCLUSION AND IMPLICATIONS FOR PRACTICE

The predominance of pre-frail elderly is an alert for the need of Gerontological Nursing care in order to prevent the progression of this condition to the physical frailty syndrome through interventions of physical frailty management, which should be practiced with the multiprofessional health team.

The expressive quantity of elderly with family insufficiency (high and moderate dysfunction), despite the no significant association with the physical frailty syndrome, showed that the percentage of frail elderly with high and moderate FD was higher than that observed among those with good family functionality.

In the context of elderly health, conditions of (pre)physical frailty and family insufficiency should be identified concomitantly. The simultaneous presence of the syndromes indicates an alert for the evolution or worsening of physical frailty and, consequently, the exacerbation of family insufficiency.

It is essential to implement the evaluation of physical frailty in Nursing consultations with the elderly in order to prevent its evolution, since it leads the elderly to the condition of dependence. The dependent elderly are more subject to family insufficiency and, when already installed in the family, the tendency is to exacerbate it.

Thus, Nursing professionals should pay attention to the elderly at risk of becoming frail, especially when it comes to considering and valuing the notes of the elderly referring to family relationships, since the quality of these directly impacts their health status.

This study presents limitations regarding the absence of studies on the theme that associates family insufficiency and physical frailty. A significant deficit of studies developed with elderly in outpatient care was verified, which limited the comparison and discussion of results.

The analysis of the level of physical activity, using the Minnesota Leisure Time Activities, presented restrictions because it included physical activities not performed by Brazilian elderly and did not value domestic activities with significant energy expenditure. Furthermore, the use of instruments with self-report questions for the assessment of physical frailty was considered a limiting factor. Thus, it is suggested that future research could investigate the family insufficiency also from the point of view of the family of the elderly in a condition of physical frailty.

FINANCIAL SUPPORT

This study was financed in part by the *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior - Brazil (CAPES) - Finance Code 001*.

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^a Article extracted from the master's dissertation "Family insufficiency and physical frailty in the elderly" presented to the Postgraduate Program in Nursing at the Federal University of Paraná on November 30, 2018. Author: Larissa Sayuri Setoguchi. Advisor: Maria Helena Lenardt.