

Quality of life among elderly people receiving home care services*

Avaliação da qualidade de vida de idosos que recebem cuidados domiciliares

Evaluación de la calidad de vida de los ancianos que reciben cuidados en el hogar

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ABSTRACT

Objective: To assess and describe the quality of life of elderly people receiving home health care services. **Methods:** This was a cross-sectional study. A random sample of 50 elderly people who were registered in the Family Health Program of four Healthcare Units participated in the study. Data were collected with the WHOQOL-100 questionnaire. Data were analyzed with the Epiinfo software and consisted of descriptive statistics such as frequencies, percentages, means, and Chi-square tests using a 95% confidence interval and p level < 0.05. **Results:** The mean age of participants was 69.84 years. They were having difficulties to perform activities of daily living and needing assistance with medication use, environment safety, and access to healthcare. The participants also had difficulty with their sexuality and financial resources. **Conclusion:** The findings of the study suggest that the sample of elderly people had good quality of life despite of having co-morbidities conditions.

Keywords: Quality of life; Old age assistance; Home nursing

RESUMO

Objetivo: Avaliar por meio da aplicação do WHOQOL-100, a qualidade de vida de idosos que recebem cuidados domiciliares em saúde. **Métodos:** Estudo transversal com abordagem quantitativa. Foram selecionados aleatoriamente 50 idosos cadastrados no Programa de Saúde da Família de quatro Unidades Locais de Saúde. A coleta de dados foi realizada por meio da aplicação do questionário WHOQOL-100. Os dados foram compilados e analisados com o auxílio do *software* Epiinfo®. As variáveis foram sumarizadas como percentagem ou média, conforme indicado. Os grupos de interesse foram submetidos ao teste do qui-quadrado em um nível de significância estatística de 95% (p<0,05). **Resultados:** Os resultados mostraram idosos com média de idade de 69,84 anos, apresentando dificuldades para exercer atividades diárias, necessidade do uso de medicação contínua, prejuízo na sexualidade, vivendo em ambiente seguro, com alguma dificuldade financeira e bom acesso aos cuidados de saúde. **Conclusão:** Neste estudo, constatou-se que é possível ter boa qualidade de vida mesmo na presença de co-morbididades.

Descritores: Qualidade de vida; Assistência a idosos; Assistência domiciliar

RESUMEN

Objetivo: Evaluar por medio de la aplicación del WHOQOL-100, la calidad de vida de ancianos que reciben cuidados domiciliarios en salud. **Métodos:** Se trata de un estudio transversal con abordaje cuantitativo. Fueron seleccionados aleatoriamente 50 ancianos registrados en el Programa de Salud de la Familia de cuatro Unidades Locales de Salud. La recolección de los datos fue realizada por medio de la aplicación del cuestionario WHOQOL-100. Los datos fueron compilados y analizados con el auxilio del *software* Epiinfo®. Las variables fueron sumadas como porcentaje o media, conforme indicado. Los grupos de interés fueron sometidos al test del Chi-cuadrado en un nivel de significancia estadística del 95% (p<0,05). **Resultados:** Los resultados mostraron a ancianos con un promedio de edad de 69,84 años, que presentaban dificultades para ejercer actividades diarias, con necesidad del uso de medicamentos continuo, perjuicio en la sexualidad, viviendo en un ambiente seguro, con alguna dificultad financiera y buen acceso a los cuidados de salud. **Conclusión:** En este estudio, se constató que es posible tener buena calidad de vida aun en presencia de co-morbididades.

Descriptores: Calidad de vida; Asistencia a los ancianos; Atención domiciliar de salud

* Study developed in the city of São José in Santa Catarina (SC), Brazil.

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INTRODUCTION

In almost all the countries in the world, estimated life expectancy has increased, causing a significant rise in the proportion of elderly citizens in society and, as a result, an important social change⁽¹⁾. In Brazil, life expectancy has risen from 66 years, in 1991, to 68.6 years, in 2000, representing an increase of 2.6 years during this period⁽²⁾.

Old age, considered a natural phenomenon and experienced by some, is currently a social, cultural and economic phenomenon known as population aging. The ramifications and consequences of such phenomenon are yet unknown. Studies show perspectives of old age and point to the rapid increase of this scale^(1,3-4).

In old age, to have a healthy life means to maintain or restore autonomy and independence. Autonomy is defined as decision-making ability, and independence as one's ability to do something by oneself. Thus, to measure an elderly person's level of autonomy, as well as the level of independence when performing routine activities, is a way to assess their health and quality of life⁽⁵⁾.

Many limitations resulting from aging are organic and functional changes that can certainly be overcome or adapted to each person's lifestyle. "In other words, the person does not need their complete functional reserve to live well and with quality"⁽⁶⁾.

Promoting healthy aging is a task that involves achieving quality of life and great access to services that enable aging issues to be dealt with, based on knowledge available. It is also essential to increase awareness of the aging process and health, while strengthening and providing tools to the elderly population in their fight for citizenship and social justice. Health and aging are indicative of quality of life.

The concept of quality of life is oriented towards more subjective elements. The World Health Organization (WHO) defines quality of life as "the individual's perception of their position in life in the context of the value system and culture in which they live and in relation to their goals, expectations, standards and concerns"⁽⁷⁾. Quality of life in old age can be understood as the maintenance of life in all human life aspects: physical, social, psychological and spiritual. The multidimensionality of a person does not always show the ideal balance and needs to be perceived according to each individual's actual possibilities. The meaning of health and disease processes varies among people.

Assessment of quality of life of an elderly person implies the adoption of multiple criteria of a biological, psychological, cultural, spiritual, and socio-structural nature, as well as ways of coping, because several elements are pointed out as determinants or indicative

of well-being in old age: longevity, biological health, mental health, satisfaction, cognitive control, social competence, productivity, activity, cognitive efficacy, social status, income, continuance of family and occupational roles, and continuance of informal relationships with friends⁽⁸⁾.

Some criteria currently in vogue to assess quality of life in old age are part of the agenda of several scientific disciplines. In Social Gerontology, associations among quality of life in old age, satisfaction and activity predominate. In Psychology, the most commonly investigated aspects are self-beliefs in control, self-efficacy and meaning, as well as social and cognitive competence, and subjective well-being. In Medicine, the main criteria are longevity, health and functional capacity. In Bioethics, assessments of the possibilities of autonomy and respect for the dignity, given to the elderly by the social system and its micro-systems, predominate.

Health professionals usually focus their elderly care actions on morbidity and mortality control. A change in paradigm has been recently observed, with the attempt to direct the focus of action to the assessment of disease impact and its compromising quality of life in old age⁽⁹⁾.

Chronic-degenerative diseases may appear with aging. Such condition can influence quality of life, once health care, especially home care, may be necessary, due to these morbidities.

As the duration of overall survival increases, it is essential to rethink measures that guarantee that not only will elderly people live longer or longevity be extended, but also how to live with quality, satisfaction and happiness⁽¹⁰⁾. It is known that the way to assess one's way of living and satisfaction with life is associated with subjective questions and individually defined criteria, which are intertwined with existing conditions (housing, health, relationships) and individual expectations.

In this sense, the present study aimed to assess quality of life in elderly people who receive home care, by applying the WHOQOL-100 questionnaire.

METHODS

This was a cross-sectional study with a quantitative approach. In this type of study, only data analysis enables groups of interest, those exposed, those not exposed, those with diseases, and those who are healthy to be identified.

Sample was selected by surveying elderly people, who required home care, in four *Unidades Locais de Saúde* (ULS – Local Health Units), in a city of the greater Florianópolis area. A total of ten family health teams work at these ULSs. According to data provided by these units, 80 elderly people were registered because they required home care. With this information, families

were contacted and 50 elderly people were randomly selected to apply the research instrument. Exclusion criteria adopted were data collection instrument incompletely filled out and refusal to participate in the study. This sample was considered satisfactory to detect an occurrence of the event analyzed – good or bad quality of life, estimated at 50% with a $\pm 10\%$ sample error, and a 95% statistical confidence level ($p < 0.05$).

Data was collected with the application of the WHOQOL-100 questionnaire⁽¹⁾, validated by the World Health Organization (WHO), which provides information to measure an individual's quality of life. This quality of life assessment instrument is comprised by 100 questions that cover six domains: physical, independence, psychological, social, environmental, and spiritual. It is necessary to answer all questions for data to be representative and for actions to be directed. The questions are simple, direct and self-explanatory, referring to the participant's last 15 days of life. They can be answered using four types of scales, which vary according to their content: intensity, capacity, frequency and assessment⁽⁹⁾. The first 39 questions of the WHOQOL-100 questionnaire were used for this article. Data were compiled and analyzed with the Epi Info® software, variables summarized as percentage or mean accordingly, and groups of interest submitted to the chi-square test with a 95% statistical significance level ($p < 0.05$).

This research project is in accordance with Resolution n° 196/96, which deals with human research. It was assessed by the *Comitê de Ética em Pesquisa da Universidade do Sul de Santa Catarina* (UFSC Research Ethics Committee) and approved by the official opinion n° 06.155.4.04 III. All participants were informed about the research and signed an Informed Consent Form.

RESULTS

A total of 50 elderly people, registered in four ULSs of a city located in the Greater Florianópolis area, were assessed. One participant was excluded from this study due to the data collection instrument being incompletely filled out. The final sample was thus comprised by 49 individuals.

Participants' mean age was 69.84 years ($SD \pm 7.5$), varying from 60 to 91 years, of which 28 (57.1%) were female and 21 (42.9%) male. In terms of marital status, 31 (63.3%) individuals were married, 12 (24.5%) were widowed, 4 (8.2%) were single and 2 (4%) were separated.

When asked about the extent to which they found it difficult to perform routine tasks, the majority of participants 17 (34.7%) responded they had some difficulty, 12 (24.5%) had much difficulty, 10 (20.4%)

had little difficulty, 7 (14.3%) had no difficulty, and 3 (6.1%) had extreme difficulty.

As regards their feeling uncomfortable due to the difficulty in performing routine tasks, 21 (42.9%) individuals stated they felt very uncomfortable, 14 (28.6%) felt somewhat uncomfortable, 6 (12.2%) felt a little uncomfortable, 5 (10.2%) felt extremely uncomfortable, and 3 (6.1%) felt no discomfort at all.

The majority of participants reported they needed a certain amount of medication to live their daily life; 22 (44.9%) quantified it as very high, and 9 (18.4%) as extremely high. Only 4 individuals (8.2%) affirmed they needed no medical treatment to live their routine life and 14 (28.5%) used medication sporadically.

When asked about the extent to which their quality of life depended on the use of medication or medical care, 22 (44.9%) participants reported they were highly dependent, 10 (20.4%) were somewhat dependent, 8 (16.3%) were extremely dependent, 5 (10.2%) were little dependent, and 4 (8.2%) stated their quality of life did not depend on the use of medication or medical care.

As regards the question about their feeling lonely in life, 20 (40.8%) individuals reported they were somewhat lonely, 15 (30.6%) were a little lonely, 9 (18.4%) were very lonely, 3 (6.1%) did not consider the question to be important, and 2 (4.1%) were extremely concerned about loneliness. All responses are shown on Table 1.

Table 1 – Elderly participants, according to their response to the question, “How lonely do you feel in your life?”, São José, SC, Brazil, 2007

Response	Nº	%
Somewhat	20	40.8
A little	15	30.6
Very	9	18.4
Not at all	3	6.1
Extremely	2	4.1
Total	49	100

When asked about how difficult it was to deal with some pain or discomfort, 23 (46.9%) individuals reported it was very difficult.

The majority of participants, 25 (51%), reported that physical pain prevented them from doing what they needed and 24 (49%) informed that the pain was bearable, not preventing them from performing their activities. A total of 40 (81.6%) individuals reported they were very or extremely worried about their pain or physical discomfort and 9 (18.4%) stated they worried a little about the pain.

As regards sexual needs, 16 (32.7%) participants reported that their needs were somewhat satisfied, 15 (30.6%) were very little satisfied, 14 (28.6%) were not satisfied at all, and 4 (8.2%) reported they were very

satisfied.

When asked about how safe they felt in their daily life, 21 (42.9%) individuals stated they felt very safe, 19 (38.8%) felt somewhat safe, 5 (10.2%) felt extremely safe, and 4 (8.2%) felt a little safe. In terms of how safe the environment where they lived was, 23 (46.9%) found their environment somewhat safe, 20 (40.8%) found it very safe, 4 (8.2%) found it safe, and 2 (4.1%) found it little safe.

The majority of participants, 30 (61.2%), felt concerned about their safety, 16 (32.7%) felt somewhat concerned, 2 (4.1%) felt extremely concerned, and 1 (2.0%) felt little concern, as shown on Table 2.

Table 2 – Elderly participants, according to their response to the question, “How concerned do you feel about safety?”, São José, SC, Brazil, 2007

Response	Nº	%
Very	30	61.2
Somewhat	16	32.7
Extremely	2	4.1
A little	1	2.0
Total	49	100

In terms of housing, 27 (55.1%) elderly people considered the place where they lived to be very comfortable, 21 (42.9%) found it somewhat comfortable, and only one of them (2%) found it a little comfortable. When asked about how they liked the place where they lived, 28 (57.1%) stated they liked it very much, 11 (22.4%) somewhat liked it, and 10 (20.4%) were extremely fond of it.

As regards financial difficulties, 28 (57.1%) reported their financial situation was somewhat difficult, 13 (26.5%) found it very difficult, and 8 (16.3%) found it a little difficult or not difficult at all.

When asked about how concerned about money they were, 18 (36.7%) individuals reported they felt very concerned, 17 (34.7%) were somewhat concerned, 8 (16.3%) were extremely concerned, 4 (8.2%) were not concerned at all, and 2 (4.1%) were a little concerned.

Assessment of participants' ease of access to quality health care was almost 50% positive, of which 24 (49%) individuals found this aspect satisfactory, 17 (34.7%) found it somewhat satisfactory, 5 (10.2%) found it extremely satisfactory, 2 (4.1%) found it little satisfactory, and 1 (2.0%) found it not satisfactory at all, as shown on Table 3.

When asked about how they enjoyed their free time, 22 (44.9%) participants said somewhat, 18 (36.7%) said very much, 5 (10.2%) said a little, 3 (6.1%) said extremely, and 1 (2%) participant stated they did not enjoy their free time at all.

Table 3 – Elderly participants, according to their response to the question, “How easy an access do you have to quality medical care?”, São José, SC, Brazil, 2007

Response	Nº	%
Very	24	49.0
Somewhat	17	34.7
Extremely	5	10.2
A little	2	4.1
Not at all	1	2.0
Total	49	100

The majority of individuals, 28 (57.1%), considered their physical environment (climate, noise, pollution, and convenient location) quite healthy, and 21 (42.9%) considered it somewhat satisfactory.

As regards the question “How tired do you feel?”, 22 (44.9%) individuals reported they felt very tired, 17 (34.7%) felt somewhat tired, 6 (12.2%) felt a little tired, and 4 (8.2%) felt extremely tired.

When asked about the extent to which they had transportation problems, 19 (38.8%) reported transportation was somewhat difficult, 13 (26.5%) said it was a little difficult, 12 (24.5%) said very difficult, 3 (6.1%) said not difficult at all, and 2 (4.1%) said extremely difficult. Difficulties in transportation were reported to interfere with their life very much by only 15 (30.6%) elderly people, whereas 34 (69.4%) stated it interfered a little with their life.

Some difficulty in sleeping was reported by 21 (42.9%) individuals, while 11 (22.4%) said it was a little difficult to sleep, 7 (14.3%) said very difficult, 5 (10.2%) said extremely difficult, and 5 (10.2%) said they had no difficulty in sleeping.

When asked about how they enjoyed life, 23 (46.9%) said they somewhat enjoyed it, 19 (38.8%) said very much, 4 (8.2%) said a little, 2 (4.1%) said not at all, and 1 (2%) said extremely.

A total of 21 (42.9%) participants reported they were extremely or very optimistic about the future. The same proportion of elderly people (42.9%) reported they experienced frequent feelings of optimism in their lives. A total of 7 (14.2%) stated they were somewhat uncertain about the future.

In terms of capacity of concentration, the majority of participants, 22 (44.9%), reported they were somewhat able to concentrate, 11 (22.4%) said very much, 13 (26.5%) said a little, and 3 (6.1%) said extremely. When asked about self-worth, 17 (34.7%) reported they somewhat valued themselves, 16 (32.7%) said very much, 13 (26.5%) said a little, and 3 (6.1%) said extremely. High self-esteem was reported by 21 (42.9%) participants, and low self-esteem by 28 (57.1%).

In terms of feelings of inhibition due to their appearance, the majority of elderly people, 22 (44.9%),

reported they were somewhat inhibited, 13 (26.5%) said very much, 11 (22.4%) said a little, 2 (4.1%) said not at all, and 1 (2%) said extremely. Responses with the same percentages were obtained when participants were asked whether there was something in their appearance that made them feel uncomfortable.

Finally, 24 (49%) elderly people reported they felt somewhat sad or depressed in their daily life, while 25 (51%) reported they felt this a little. There was no significant statistical difference in responses obtained when stratified by sex, age or marital status ($p > 0.05$).

DISCUSSION

As regards participants' age, this study evidenced elderly people who were in their late 60s and many who had an advanced age, which could increase the need for home care, due to their health condition worsening or the onset of pathological changes.

In terms of sex, female participants predominated, which could be associated with women's greater life expectancy. It should also be emphasized that the absolute number of elderly women in Brazil has been higher, when compared to that of men aged 65 or older. "This could occur due to sex differential mortality, which has long prevailed in the Brazilian population"⁽¹²⁾.

Because of the substantial number of elderly women in the population, some action should be implemented to promote health with quality of life for them, as they have greater life expectancy than men⁽¹³⁾. In Brazil, as in the majority of countries, the increase in life expectancy at birth has been more significant among females, which explains the high number of elderly women, especially those who have an advanced age and, as a consequence, are exposed to chronic-degenerative co-morbidities that result in hospitalizations or the need for continuous home care.

Marital status of the elderly people studied does not reflect demographic findings in Brazil and the Americas, where age reflects their marital status, i.e. widowhood. In this study, only 24.5% of elderly people are widows/widowers and the great majority, 63.3%, are married. Only 8.2% are single, a condition that can contribute to coming into old age without the support from a husband or wife, sons and daughters, should they become dependent for some reason⁽¹⁴⁾.

By assessing aspects associated with performance of routine activities, 42.9% stated they felt bothered by the fact that they cannot perform simple tasks. This situation can be directly related to the need, found by this study, to use medication continuously to treat chronic diseases and also to the fact that physical pain is a constant obstacle to perform certain activities.

These findings emphasize the fact that the elderly

frequently have non-communicable, chronic diseases that may result in complications, leading to hospitalization and continuous home care, and justifying multiplicity of diagnoses.

In general, diseases in the elderly are chronic and multiple, last several years and require constant follow-up, permanent care, continuous medication and complementary exams (laboratorial or imaging diagnosis)⁽¹⁴⁾. Associated with changes resulting from aging, the use of multiple medications that influence food ingestion, digestion, absorption and use of several nutrients is frequent, which could further compromise and elderly person's health status and nutritional needs⁽¹⁴⁾.

The presence of co-morbidities in the elderly is very common. Proportionately, an elderly person tends to have more episodes of diseases, usually chronic ones, resulting in higher health expenses, once the cost with the elderly tends to be higher than that with people of other age groups. In the elderly, chronic diseases and their complications predominate, resulting in decades of health service use⁽¹⁵⁾. The incidence of such diseases, in addition to incurring expenses for their prevention, treatment and recovery, also brings the connotation of impairment. As a result, to have a chronic disease can cause isolation and/or one's distancing oneself from social contact⁽⁴⁾.

Loneliness, manifested by many elderly people, may be associated with the presence of physical limitations caused by the disease and the difficulty in performing routine activities, such as walking. It should be emphasized that some factors can contribute to an elderly person's social distancing and consequent feeling of loneliness, once the individual becomes a recluse in their home. Access to transportation and concern about personal safety can be listed as examples of architectural and social barriers faced by an elderly person, which may increase their loneliness. These changes cause substantial reduction in functional capacity and may become worse in the face of inadequate environmental and social conditions.

As regards sexuality, sexual response time should be taken into account, as it increases considerably in the elderly. It is important to emphasize that, if an elderly person's health is in good condition, nothing will prevent them from being sexually active. Restrictions due to one's falling ill can trigger new learning about caressing, companionship and sexuality.

Sexuality in old age, as well as in other age groups, does not refer to sexual intercourse alone, but to the exchange of affection, caressing, companionship, concern for one's appearance and body care. It can be perceived and experienced by individuals in different ways, such as: moments of expression of one's affection; affirmation of the body with its functionality; perception of oneself and one's identity; protection of one's intimacy against anxiety and identity confirmation; and manifestation of

pleasure through physical contact⁽¹²⁾.

One study, aiming at sexuality in old age, showed evidence that 70% of elderly people believed that a couple could live without sex; 100% believed there were other ways to express affection but those of a sexual nature, and these could be ways to show one's feelings, including sexuality; 80% had sexual intercourse with their partner and this same percentage reveals that, when aging, desire only changes, it does not end, and that they feel desire for their partner associated with emotions, feelings and sex⁽¹²⁾.

The belief that old age weakens the capacity to feel and/or the presence of desire for someone is unfounded, because feelings do not grow old. What matters is that both man and woman are aware of what may change in sexual response. What happens is that, due to cultural conditioning and prejudice, the woman ends up repressing her sexuality⁽¹³⁾. It is worth remembering that inhibition associated with physical appearance is high, as it reaches 71.4% of cases when all "somewhat" and "very much" responses are added.

Acceptance of one's own body is an inner, personal process and media-oriented stereotypes must be discarded. Thus, every human being, at a mature age or already aging, needs to develop expressions of sexuality, because this is a basic human need and can be felt/experienced/satisfied by all.

Longevity, ever more present in the human life cycle, results in an ambiguous situation, i.e. the desire to live longer and longer and, at the same time, the fear of living a life of dependence and with disabilities. In fact, as one grows older, the chances of diseases and physical, psychological and social function impairment occurring increase. Many years of life may mean years marked by diseases with sequelae, functional decline, increase in dependence, loss of autonomy, social isolation and depression. In addition to these factors, financial difficulties were experienced by the elderly people in this study, as it usually is the greatest obstacle, the turning point which is significantly associated with health and life conditions.

It should be emphasized that the majority of elderly people have access to health services and that these are of quality, a fact that directly influences quality of life, especially that of elderly people with diseases.

When individuals grow older with autonomy and independence, with good physical condition, performing

social roles, remaining active and taking advantage of the sense of personal meaning, their quality of life can be very good or, at least, maintained.

FINAL CONSIDERATIONS

Application of the WHOQOL-100 instrument and related data analysis enabled researchers to assess quality of life in the elderly who receive health care at home. Despite the limitations and difficulties identified by individuals in this research, in some way, satisfaction with the life process of elderly people has been preserved in this community. To know these individuals' quality of life may enable a unique and adequate approach to home care. Among the questions that deserve special attention are drug prescription, physical safety, restrictions to perform routine activities, and repressed demand for psychological care concerning sexuality and self-esteem issues.

The *Estratégia de Saúde da Família* (Family Health Strategy) plays a key role in this context, especially when developing care, educational, and health promotion and recovery practices. From the moment quality of life in the elderly is revealed, this will enable subsidies to think about/rethink the health care they are provided. It should be emphasized that the sample showed the majority of them are couples, a fact that increases the challenge, in addition to pointing to the gender issue as a differential factor to approach health.

Another factor to be emphasized is that the application of this instrument enables health care and health care services to be assessed. Thus, results can help both health professionals and managers to assess services and rethink elderly-oriented health strategies, especially those that require home care.

The major challenge health professionals face is to care for human beings as a whole, performing an action aimed at their pain and suffering, in the physical, psychological, social and spiritual spheres, with human and technical-scientific competence.

When elderly people realize they are respected and understood, when they are welcomed in a humanized way, and when all information pertaining their health-disease status is offered to them, it is believed that a relationship of trust is formed, receptivity is established, and the required health care, imbued with concern for quality of life, is benefited.

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