revista de pesquisa ISSN 2175-5361

CUIDADO É FUNDAMENTAL

Escola de Enfermagem Alfredo Pinto – UNIRIO

RESEARCH DOI: 10.9789/2175-5361.rpcfo.v14.11865

QUALITY OF LIFE IN ELDERLY RESIDENTS OF A COMMUNITY CENTER

Qualidade de vida em idosos integrantes de um centro de convivência

Calidad de vida en ancianos atendidos de un centro social

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ABSTRACT

Objective: to analyze the quality of life of elderly residents of a senior community center by applying the World Health Organization Quality of Life (WHOQOL) -bref and WHOQOL-OLD scales. **Method:** This is a descriptive and inferential study, with quantitative approach, with 58 elderly people from a senior community center assisted by a multiprofessional team. Sociodemographic data and the WHOQOL-bref and WHOQOL-OLD scales were used to obtain the data. **Results:** the highest mean obtained in the instruments was WHOQOL-bref domain "environment" (26.9%) and WHOQOL-OLD domain "social participation" (15.5%). The age variable showed significant correlation with death and dying domain of the WHOQOL-OLD and the social relations domain of WHOQOL-bref. **Conclusion:** elderly who are assisted at the senior community center had a good perception of quality of life. Demonstrating the importance of qualifying teams for better attention in gerontological care and management.

DESCRIPTORS: Geriatric nursing; Health of the elderly; Quality of life; Senior centers; Monitoring ambulatory.

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Received: 04/18/2022; Accepted: 05/11/2022; Published online: 10/04/2022

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How cited: Madeira E, Machado JR, Alfradique P, Macedo EC, Carvalho CM, Koike RY. Quality of life in elderly residents of a community center. *R Pesq Cuid Fundam* [Internet]. 2022 [cited year mouth day];14:e11865. Available from: https://doi.org/10.9789/2175-5361.rpcfo.v14.11865

RESUMO

Objetivo: analisar a qualidade de vida de idosos integrantes de um centro de convivência mediante a aplicação das escalas *World Health Organization Quality of Life* (WHOQOL) -bref e WHOQOL-OLD. **Método:** trata-se de um estudo descritivo e inferencial, de abordagem quantitativa, com 58 idosos de um centro de convivência com atendimento pela equipe multiprofissional. Para a obtenção dos dados foram utilizados dados sociodemográficos e as escalas WHOQOL-bref e WHOQOL-OLD. **Resultados:** a maior média obtida nos instrumentos foi WHOQOL-bref domínio "meio ambiente" (26,9%) e WHOQOL-OLD domínio "participação social" (15,5%). A variável idade apresentou correlação significante com o domínio morte e morrer do WHOQOL-OLD e o domínio relações sociais do WHOQOL-bref. **Conclusão:** idosos que são acompanhados no centro de convivência apresentaram boa percepção da qualidade de vida. Demonstrando a importância de capacitar equipes para melhor atenção no cuidado e manejo gerontológico.

DESCRITORES: Enfermagem geriátrica; Saúde do idoso; Qualidade de vida; Centros comunitários para idosos; Monitoramento de pacientes externos.

RESUMEN

Objetivo: analizar la calidad de vida de ancianos de un centro social mediante aplicación de las escalas *World Health Organization Quality of Life* (WHOQOL) -bref y WHOQOL-OLD. **Método:** estudio descriptivo e inferencial, con abordaje cuantitativo, con 58 ancianos de un centro social con la atención del equipo multidisciplinario. Para obtención de los datos se utilizó datos sociodemográficos las escalas WHOQOL-bref y WHOQOL-OLD. **Resultado**s: la media más alta obtenida en los instrumentos fue el dominio "medio ambiente" del WHOQOL-bref (26,9%) y el dominio "participación social" del WHOQOL-OLD (15,5%). La variable edad se correlacionó significativamente con el dominio de muerte y morir del WHOQOL-OLD y el dominio de relaciones sociales del WHOQOL-bref. **Conclusiones:** los ancianos que son seguidos en el centro social mostraron una buena percepción de calidad de vida. Demostrar la importancia de formar equipos para una mejor atención en el cuidado y manejo geriátrico.

DESCRIPTORES: Enfermería geriátrica; Salud del anciano; Calidad de vida; Centros para personas mayores; Monitoreo ambulatorio.

INTRODUCTION

The longevity of the elderly population is constantly growing every year. Relationships with quality of life and health of this population have been an important issue mainly observed in autonomous seniors.

Global functionality is what underlies the concept of elderly health; it is the concept that defines the elderly with the ability to manage their own lives and take care of themselves. Based on the identification of the autonomy or frailty level or risk of the same, a plan of health actions was outlined, in order to define goals and what needs to be prioritized in the care.[1]

There is a progressive increase of elderly at advanced ages observed both nationally and abroad in life expectancy due to improved health conditions, as well as the issue of fertility rate, since the average number of children per woman has been falling.[2]

In Brazil, Law No. 10.741 from October 1st 2003, which addresses the Elderly Statute, defines elder as any person aged 60 years or older and is intended to ensure all the rights to them.[3] Law No.10,741 also emphasizes that it is an obligation of the family, community, society and government to ensure the elderly, with absolute priority, the realization of the rights for life, health, food, education, culture, sport, leisure, work, citizenship, freedom, dignity, respect and family and community life.[1]

The aging process requires improvements in politics, economics, and health care for this population.

Therefore, it is necessary to promote healthy and dignified practices for this population. Public health policies are crucial factors to promote healthy aging. It is important that health professionals keep themselves in constant improvement on the aspects that longevity can bring to the elderly population, stimulating and emphasizing the importance of good health practices in order to have healthier years of life. Quality of life, according to the population, physical and social conditions, may present different responses.[4] Therefore it is relevant to understand the aspects that promote the autonomy of these elderly people.

There is an instrument that has been validated in Brazil to assess quality of life, with a primary focus on the elderly population.[4] The instrument, known as the World Health Organization Quality of Life (WHOQOL), "is a final version consisting of 26 questions". The questions are divided into physical, psychological, social relations, and environment domains.[4] In addition to its cross-cultural character, the WHOQOL values individual perception, assessing quality of life (QOL) in various groups and situations.[5] However, this assessment has been little performed in elderly residents of senior community centers.

This study aims to analyze the quality of life (QoL) of elderly residents of a senior community center by applying the WHOQOL-bref and WHOQOL-OLD scales. The specific objectives were to describe the epidemiological profile of the elderly, compare their quality of life according to age and chronic diseases and correlate the domains and total scores between Whoqol-old and Whoqol-bref.

METHOD

This is a descriptive and inferential study, of quantitative approach, carried out in a community center for the care of elderly people by a multiprofessional team, consisting of physicians, nurses, psychologists, nutritionists, social workers, occupational therapists, and physical educators. The community center is located in a university hospital in the city of Rio de Janeiro.

Fifty-eight independent elderlies participated in the study, who were accompanied in a senior community center. The inclusion criteria were: older than 60 years of age, who were able to answer the questionnaire independently, and who were duly registered in the senior center where the research was carried out. As exclusion criteria, we considered elderly people who had some degree of dependence and/or cognitive impairment. The data collection was randomly selected, simply, and of the participant's free will.

The data collection was conducted between August and November 2019. For data collection, three instruments were used, divided into two parts, the first part referring to sociodemographic data; and the second to the scales that assessed the quality of life of the elderly, Whoqol-old and Whoqol-bref.

The QL assessment was performed by the World Health Organization Quality of Life Bref, (Whoqol-bref), which has 26 questions, two general questions, related to global QL and global health and 24 that compose the four domains: physical, psychological, social relations and environment[3]. The World Health organization Quality of Life old module (Whoqol-old), validated for the Brazilian elderly population, was also used. It consists of 24 questions and its answers follow a Likert scale (from 1 to 5) assigned to six facets, which are: "Sensory Functioning" (FS), "Autonomy" (AUT), "Past, Present and Future Activities" (PPF), "Social Participation" (PSO), "Death and Dying" (MEM) and "Intimacy" (INT). Each of the facets has 4 questions; the answers can range from 4 to 204.

The Microsoft Office Excel 2016 software was used to analyze the data and they were also analyzed in R 3.4.3. The existence of a relationship between Whoqol-Old and Whoqol-Bref was also verified.

Thus, a univariate analysis was performed in order to describe the profile of the elderly who attend the community center and outpatient consultations. Besides mapping the quality of life of these elderly through the analysis of Whoqol-old and Whoqol-Brief.

After that, a bivariate analysis was performed to analyze the existing relationships between the age of the elderly with the respective Whoqol-Old and Whoqol-Brief categories, besides the relationship between the Whoqol-Old and Whoqol-Brief categories. Thus, Spearman's correlation was applied, a non-parametric statistical method in order to obtain the association degree between the quantitative variables of the study.

The study was submitted to and approved by the Research Ethics Committee of the Federal University of the State of Rio de Janeiro, protocol number 3.410.345, in accordance with Resolution 466/12 of the National Health Council. The study complied with the formal requirements contained in national and international norms regulating research with human beings, authorization was requested for study's participation, participants were informed how the study would proceed, and each participant signed the TCLE (Free and Informed Consent Form).

RESULTS

Fifty-eight elderly people registered at the studied community center participated in the research. Table 1 shows the sociodemographic characteristics and Table 2 shows the health conditions of the overall participating population. The sample was predominantly female with (81%), with the prevalence of age ranging from 75 to 84 years. Most individuals were widowed (46.6%), had complete elementary school education (34.5%), and had their own income (retirement 77.6%).

Table 1 – Sociodemographic profile: total elderly participants (n=58). Rio de Janeiro, RJ, 2019

Sociodemographic profile	n (%)	Sociodemographic profile	n (%)
Sex		Education	
Female	52 (89,7)	Incomplete elementary school	10 (17,2)
Male	6 (10,3)	Complete elementary school	20 (36,2)
Age group		Complete high school	20 (32,8)
60 to 74 years old	23 (39,6)	Complete college degree	7 (12,1)
75 to 84 years old	24 (41.4)	Post-graduation	1 (1,7)
85 years old or more	11 (19,0)	Income	
Marital status		Retirement	45 (77,6)
Widower	27 (46,6)	Pension	4 (6,9)
Single	14 (24,1)	elderly aid	3 (5,2)
Married	11 (19)	Salary	1 (1,7)
Separated/divorced	6 (10,3)	Other sources of income	5 (8,6)

Source: Research data, 2019.

In this population, 91% had some previous serious health problem that generated one or more hospitalizations throughout their lives (Table 2). This caused some chronic diseases that have accompanied these elderly over the years.

Hospital admissions were common among the elderly, 84.5% of them had hospitalizations throughout their lives, the main cause being surgeries with 94.8% (Table 2). Comorbidities were present in 91.4% of the elderly, the highest incidence was hypertension (62.1%), followed by diabetes (32.8%) and depression (24.1%).

Depression was the comorbidity that most affected the routine of the elderly. This disease directly interferes with the individual's willingness to seek or not to seek an improvement in their quality of life, which makes it difficult to look for medical assistance. 96.6% of the elderly use medication and 17.2% need help to move around.

In the evaluation of quality of life proposed by Whoqol-old, the average total score presented "very good" (Table 3). The domains 'social participation' showed the highest results (15.5%), followed by the domains 'past, present, and future activities' (15.4%), 'death and dying' (15.3%), 'sensory functioning' (15.1%), 'intimacy' (14.9%), and lastly the domain 'autonomy' (14.2%) (Table 3).

The domains autonomy and intimacy showed the lowest scores, being classified as good by the elderly participants. The lowest score was autonomy and the highest was social participation (Table 3).

These results represent that social participation is an important aspect for the elderly because they continue to have feelings of belonging to a society that is "active", in other words, there is a closeness of the younger adults with the elderly population.

However, for some elderly people, there is a feeling of loss of autonomy due to their age. This phenomenon occurs in greater incidence with the elderly who live with a family member, usually their children.

The Whoqol-bref mean score was "good" at the end of the total scores (Table 4). Containing the results of the domains 'physical' (23.7%), 'psychological' (22.6%), 'social relations' (11%) and 'environment' (26.9%) (Table 4).

Elderly participants in the research have full control of their activities of daily living, that is, their age does not prevent them from performing simple actions in their daily lives (Table 4).

The correlation between age and the Whoqol-old and Whoqol-bref categories showed significant results for death and dying, social relations, and environment domains (Table 5).

The environment domain, was the lowest result found, which can be inferred those aspects such as physical safety and protection, opportunities to acquire new information and skills, opportunity to participate in recreation/leisure activities, as well as pollution, traffic and means of transportation, were considered as essential components for, in some cases, hindering the improvement of health-related quality of life (Table 5).

Table 2 – Elderly Health Conditions (n=58). Rio de Janeiro, RJ, 2019

Clinical profile of the elderly	n (%)	Clinical profile of the elderly	n (%)
Previous hospital admissions	49 (84,5)	Chronically ill	53 (91,4)
Year that started attending the community center		Hypertension	36 (62,1)
1995 - 2005	13 (22,4)	Depression	14 (24,1)
2006 - 2015	20 (34,5)	Diabetes	19 (32,8)
2016 - 2019	25 (43,1)	Other	25 (43,1)
Previous surgical intervention	55 (94,8)	Regularly takes medication	56 (96,6)
Needs help to walk	10 (17,2)		

Source: Research data, 2019.

Table 3 – Distribution of the Whoqol-old health-related quality of life scores. Rio de Janeiro, RJ, 2019

Domains	Mean (SD)	Minimum	Median (q25; q75)	Maximum
Sensory functioning	15,1 (SD = 3,679)	6	15,5 (13,0;18,0)	20
Autonomy	14,2 (SD = 3,288)	4	14,0 (12,0;16,0)	20
Past, present, and future activities	15,4 (SD = 2,930)	7	16,0 (13,2;17,0)	20
Social participation	15,5 (SD = 3,230)	7	16,0 (15,0;18,0)	20
Death and dying	15,3 (SD = 4,063)	4	16,0 (13,0;18,0)	20
Intimacy	14,9 (SD = 3,652)	4	16,0 (13,0;18,0)	20
Total	**89,8 (SD =13,656)**	**55**	**90,0 (82,0;98,8)**	**112**

Source: Research data, 2019.

Table 4 – Distribution of health-related quality of life scores from the Whoqol-bref. Rio de Janeiro, RJ, 2019

Domains	Mean (SD)	Minimum	Median (q25; q75)	Maximum
Physical	23,7 (SD = 5,214)	7	24,0 (21,0;27,0)	35
Psychological	22,6 (SD = 4,284)	10	23,0 (20,0;25,0)	29
Social relations	11,0 (SD = 2,675)	3	11,0 (10,0;13,0)	15
Environment	26,9 (SD = 5,537)	8	27,0 (24,0;30,0)	38
Total	84,2 (SD = 14,069)	38	86,0 (76,2;92,8)	111

Source: Research data, 2019.

Table 5 - Correlation between age and the respective categories of the Whoqol-old and Whoqol-bref. Rio de Janeiro, RJ, 2019

WHOQOL DOMAINS	AGE	
	CORRELATION	P-VALUE
Sensory Functioning	-0,020	0,869
Autonomy	-0,150	0,268
Past, present, and future activities	-0,090	0,500
Social participation	0,150	0,252
Death and dying	0,340	0,008***
Intimacy	-0,060	0,663
Total Whoqol-old	**0,060**	**0,676**
Physical	0,010	0,923
Psychological	0,030	0,835
Social Relationships	0,280	0,033**
Environment	0,250	0,062*
Total Whoqol-bref	**0,160**	**0,228**

*** The correlation is significant at the 0.01 level (2 ends).
** The correlation is significant at the 0.05 level (2 ends).
* The correlation is significant at the level 0,10 (2 ends).
Source: Research data, 2019.

DISCUSSION

Sociodemographic data regarding gender, age and low education of the elderly in this study corroborate the study carried out in the city of Foz de Iguaçú - PR and the study conducted in a countryside city of Minas Gerais, where the quality of life and self-esteem of the elderly were evaluated. The later one showed a predominance of women and low education levels; however, a higher incidence of widowed elderly people was found. In Foz do Iguaçú the highest incidence is of married elderly.[5,6]

Health conditions, the findings were divergent from the study conducted in a countryside city of Minas Gerais, where the percentage of participants with comorbidities was 53.9%, while this study identified that 91.4% had some comorbidity.[5] In this manner, it is observed that although the elderly are considered independent, there is a high prevalence of associated comorbidities, which can directly influence the perspective of health-related quality of life.

Research highlights that stressful situations, risky behaviors and frequent experiences of negative emotions can determine the onset of depressive symptoms in old age, as well as activities, resilience characteristics and self-efficacy can maintain mental balance.[7]

The age was also observed as a significant factor and of correlation with domains of both tests in an assessment study of institutionalized elderly people.[4] As for QL measured by Whoqol-old and Whoqol-bref, there was similarity of scores in social relationships and death and dying domains.[8] Demonstrating that although the elderly has advanced age, it does not mean that the finitude of life should be fearful and that therefore social contact and social relationships should be extinguished. On the contrary, the elderly throughout the interview demonstrated an immeasurable value to their social relationships and how important these are for their well-being.

Social relationships were also evaluated as positive points in institutionalized Brazilian elderly, demonstrating the importance of socialization independent of the affective and/or family degree.[4] Similar to previous studies, this domain showed better evaluation by the elderly, demonstrating the importance of socialization in aging.[9]

Social and psychological relationships are also related to each other and corroborate the importance that the elderly give to family relationships and friendships, thus influencing their positive feelings, thinking, learning, memory and concentration, self-esteem, body image, appearance, spirituality, religion and personal beliefs.[8]

Similar to this study, another research conducted with community-dwelling elderly people showed higher scores in the social relations domain, which can be attributed to the fact that they are related to the elderly's greater opportunities to experience and participate in daily activities, especially in the community.[5]

In the research conducted to measure the quality of life of the elderly in a community center, the scores found in death and dying domain presented the highest results. The same result is found in this study. This implies in the perception of QL, where one can conclude through these results that death does not influence it. The elderly have the understanding that the facet death and dying is the process of finitude of life, so for this population, death is just another stage of their journey through life.[10]

Since this study was conducted with elderly individuals who were not in nursing homes or hospitalized, i.e., in a senior community center, one can infer about the preservation of autonomy and independence, which will interfere in the functional capacity, resulting in a better quality of life. In addition, the movement to and from the clinic can reinforce social support and interpersonal relationships. A comparative study of the quality of life of elderly people in nursing homes and those who attend a day care center considers that, although institutionalization is not a determining factor, the search for institutionalization can negatively influence the perception of the elderly. The study also shows that the elderly who receive assistance at the Day Care Center have a better quality of life and highlight the outpatient setting as a promising alternative for the health of the elderly.[11]

Therefore, this study becomes relevant to the practice and understanding of health professionals. Especially for nurses in contact with this elderly population, as it will help in the improvement of the longevity process of the population, bringing more clarity about what are the best and possible actions to obtain a good quality of life related to health, even more so in the case of active and independent elderly, in which the objective is preventive health care strategies.

The study has the limitation of being restricted to a single scenario with active seniors, with the need to assess the quality of life of the elderly in other scenarios.

CONCLUSION

It is concluded that the health-related quality of life for the elderly in outpatient care is considered very good and good, when assessed respectively for the whoqol-old and the whoqol-bref. This fact shows that for the population of this study, the quality of life and how it has impacted the health-disease process has shown a positive response, since the elderly participants of the community center remain independent and active. Thus, this is an important aspect for the elderly in outpatient care.

We hope to contribute to the knowledge of gerontological care in outpatient follow-up. Longitudinal studies to evaluate the quality of life of the independent elderly are suggested.

Therefore, we suggest studies that address the issues related to thanatology and professional training are essential for a quality gerontological care in all stages of life, especially in the coming years.

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