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Original Article

Quality of life of an institution hypertensive older women long stay

Qualidade de vida de mulheres idosas hipertensas em uma instituição de longa permanência

Calidad de vida de ancianas hipertensas de una institución de larga permanencia

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Objective: to identifying the quality of life of hypertensive elderly women´s residents in a long-stay institution. **Method:** it was conducted a case study, cross-sectional quantitative study. The research began in held in an institution of long stay in the city of Curitiba and data were collected a validated instrument. The study included 12 hypertensive elderly. **Results:** Showed that, for the elderly, even with intercurrent illness, quality of life remained at average rates when analyzed the different areas. That most contributes in the results was the Social, followed by the Psychological and of the Physical Environment. The majority of older women is satisfied with their quality of life as being cited as well with their body image. **Conclusion:** nursing work is identifying the factors that interfere conditions of quality of life of older and proposing interventions in institutions.
Descriptors: Quality of Life; Aged; Homes for the Aged; Hypertension.

Objetivo: identificar a qualidade de vida das mulheres idosas hipertensas em uma instituição de longa permanência. **Método:** foi realizado um estudo de caso quantitativo transversal em uma instituição de longa permanência na cidade de Curitiba e os dados foram coletados usando-se um instrumento validado. O estudo incluiu 12 idosas hipertensas. **Resultados:** mostrou que, para as idosas, mesmo com doenças intercorrentes, a qualidade de vida permaneceu em taxas médias quando analisadas as diferentes áreas. O que mais contribui nos resultados foram os fatores sociais, seguido do psicológico e do meio físico. A maioria das idosas está satisfeita com a sua qualidade de vida como mencionado e com sua imagem corporal **Conclusão:** o trabalho da enfermagem é identificar os fatores que interferem nas condições de qualidade de vida das idosas propondo intervenções nas instituições.
Descritores: Qualidade de Vida, Idoso; Instituição de Longa Permanência para Idosos; Hipertensão.

Objetivo: identificar la calidad de vida de mujeres ancianas hipertensas residentes en hogares para ancianos. **Método:** estudio de caso, cuantitativo, transversal. Datos recogidos en un hogar para ancianos de Curitiba, Brasil, a través de un instrumento validado. Participaron 12 ancianas hipertensas. **Resultados:** para las ancianas, a pesar de las enfermedades intercurrentes, la calidad de vida se mantuvo en tasas medias cuando se analizaron diferentes dominios. Lo que más ha contribuido en los resultados fue el Social, seguido del Psicológico, Físico y Medio Ambiente. La mayoría de las ancianas se consideraron satisfechas con la calidad de vida y su imagen corporal. **Conclusión:** el trabajo de enfermería es identificar los factores que afectan la calidad de vida de ancianas y proponer estrategias de intervenciones en las instituciones.
Descriptores: Calidad de Vida; Anciano; Hogares para Ancianos; Hipertensión.

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Introduction

The United Nations established in 1985 the age of 65 years old to defining elderly in developed countries. However, for developing countries where life expectancy is shorter, adopts 60 years old. In 2000, the elderly population (> 60) in the world was of 600 million people, and this number may increase to 1.2 billion in 2025, and two billion in 2050[1].

One of the cases of aging are chronic diseases. With them there is a great demand of care and costs. In the context of public health the aim is to reduce the impact of these diseases in general with health promotion, prevention and the reduction of complications, which can lead to loss of functionality[2].

The aging generates consequences, which can lead to increased risk of disorders and diseases. The prevalence of chronic diseases contributes to the reduction of physical and biological capacity thus reduces the independence and autonomy of the elderly, compromising their quality of life[3].

Morphofunctional changes inherent to the process of human aging, when associated with chronic diseases, can lead to reduced independence of the elderly. The prevention and control of chronic diseases, including hypertension, can assist in the maintenance of cognition and functional capacity[4].

The universal phenomenon today both in developed countries as in developing. In institutionalized elderly or not, several elements point to as indicators of well-being and quality of life in old age, such as longevity, productivity, relationships with friends and family, biological and mental health, social competence, cognitive efficacy, leisure etc[5].

According to the World Health Organization, quality of life is the perception of the individual, of their position in life, in the context of culture and value system in which he lives and in relation to your goals, expectations, standards and concerns[6].

Quality of life for older people is related to well-being, happiness and personal fulfillment. The best of this quality assessment involves physical and cognitive functionality, values, feelings, expectations. In order to evaluate the quality of life of elderly people, the World Health Organization Quality Group developed the questionnaire of WHOQOL-100. With the need for a shorter instrument, and that short time to fill their demand, WHOQOL-bref was developed, this includes 26 questions, being two general quality of life and other 24 representatives from each of the facets that composes the original instrument[7-8].

The changes of cognitive state and not before activities carried out are among the main reasons for the institutionalization of the elderly. This change of environment leads, in most cases, people have lower performance in physical and psychological skills, as most of these institutions of long permanence lacks financial and human resources to offer the elderly an integral attention[9].

Clearly, the increase in the number of elderly Brazilians in institution of long permanence and that population tends to grow further due to several factors, among them, longevity, fragility, development of chronic degenerative diseases, impairment of autonomy and fragile family structure, which may compromise the quality of life[10].

The institution of Long permanence is a place of integral care for residents, dependent or independent, that do not have conditions to live with family or in your home. The a long-stay institution must provide services in the areas of social, medical, psychology, nursing, physiotherapy, occupational therapy, dentistry and others, as the need of the elderly[11].

It is necessary that the changes in the elderly are accompanied by physical exams and assessments of cognitive state employees, in order to distinguish the senescence of senility, allowing in this way the development of activities specific to different processes of aging, whether they are healthy or not[9].

We know that the leading cause of mortality

and morbidity are chronic diseases, they have slow development. Chronic conditions are linked to an aging society, but not only that, are lifestyle choices, such as smoking, alcohol consumption, inadequate diet, physical inactivity and genetic predisposition. Older people have a greater chance of developing illnesses and disabilities, so the functional capacity arises as a concept of health to the health care of the elderly[2].

Among the elderly, hypertension is a disease highly prevalent, affecting about 50% to 70% of people in this age group. Is a determinant of morbidity and mortality, but, when properly controlled, significantly reduces the functional limitations and disability in the elderly. Hypertension should not be considered a normal consequence of aging[12].

Living in long-stay institutions alone can result in changes in the indicators of quality of life. Literature data corroborating with such factors that indicate this population is prevalent in comorbidities as hypertension. To identify the interference of comorbidities as hypertension in the quality of life of elderly residents of an institution of long permanence enables nursing care and this Living in long term care facilities alone can result in changes in quality of life indicators. Literature data confirming these factors indicate that this population is prevalent co-morbidities such as hypertension. To identify the interference of co-morbidities such as hypertension quality of life of elderly residents in a long term care facility enables nursing care and was proposed as strategies to minimize the content pointed to by the study. strategies to minimize the as a result of that.In this context it searches to know which the quality of life of hypertensive elderly womens´s residing in an institution of long permanence?

The aim of this study is to identify the quality of life of hypertensive elderly women's residing in an institution of long permanence.

Method

It was a case study, prospective and quantitative. The research began in September 2013, held in an institution of long stay in the city of Curitiba-PR, with 153 elderly women. This is a uniquely female institution. The sample was composed of all the elderly with 12 diagnosis of hypertension with record in institutional records and in medical treatment for more than 6 months, aged less than 60 years, literate, being cognitively able to sign an informed consent-FICS and replying to the questionnaire proposed by the study. There were excluded the elderly who find themselves at the time of data collection in the hospital.

This research was developed in two steps. The first consisted in the analysis of medical records to verify the inclusion and exclusion criteria for the study. For measuring the general and socio-demographic characteristics, as well as inter-current diseases of participants, general variables were used: sex, middle ages, marital status and education.

The second stage, was performed using the WHOQOL-bref instrument (World Health Organization Quality of Life)[12]. The questionnaire was developed to specifically measure the quality of life of the elderly. The WHOQOL-bref includes 26 questions, two of which are general quality of life and the rest represent each one of the 24 facets that composes the original instrument. The data were collected by means of interview, conducted by researchers with approximate duration of 20 minutes each.

The data have been inserted and tabulated in Excel 2010 program. The evaluation occurred as advocated by instructions of the following questionnaire: WHOQOL-bref, the question's, the answers follow a scale of 1 to 5, the higher the score the better the quality of life. Has 24 facets which comprise 4 areas: physical, psychological, social and environmental relations.

Data analysis is presented in absolute form, descriptive, and which presents numerical variations calculated in measures of mean values and standard deviation.

To maintain the anonymity of the respondents were identified as: E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11 and E12, on presentation of the table 4. The study followed the ethical precepts of Brazilian legislation and was approved by the Research Ethics Committee to the number 17418113.0.0000.0095.

Results

Participated in the research 12 elderly of an average age of 77 years old, being all old ladies who had incomplete elementary education. Among those interviewed are 4 singles, 2 are married, 1 is separated, and 5 are widows.

Table 1 - General characteristics of the elderly female (n=12)

Variables	Results
Age: average	77
Marital status	
Single	4
Married	2
Separated	1
Widow	5
Schooling	
Incomplete elementary school	12
Intercurrent disease	
Cerebral Vascular Accident	3
Osteoporosis	3
Hypothyroidism	3
Chronic Renal Failure	2
Chronic Cough	2
Diabetes	3
Vitamin D deficiency	10
Gait instability	5
Dyslipidemia	3
Depressive Disorder	4

Table 2 has been prepared by the authors and separated by issues and domains, initially without using standardization planned for 100 scale analysis of the WHOQOL-bref, thus there was the direct search for the answer of the purpose of the study.

Table 2 - Average values of the different issues and domains of the WHOQOL-bref

Domains	Variables	Weighted Average	Simple Average
Global QOL	QOL	3.75	3.37
	Health	3.0	
Physical	Pain and discomfort	3.9	3.47
	Energy and fatigue	3.16	
	Sleep and rest	3.16	
	Mobility	3.66	
	Activities of everyday life	3.5	
	Medical treatment	3.41	
	Ability to work	3.54	
Psychological	Positive feelings	3.33	3.43
	Concentration	4.0	
	Self-esteem	3.63	
	Body image and appearance	3.75	
	Negative feelings	2.66	
	Spirituality/religion	3.25	
Social relations	Personal relationships	4.33	4.29
	Support (aid) social	4.25	
Environment	Physical security and protection	3.91	3.48
	Home environment	4.0	
	Financial resources	3.0	
	Access to health services	4.25	
	Information	3.4	
	Leisure	2.8	
	Physical environment	2.5	
	Transport	4.0	

In the physical domain in general have been as mean 63.16. Since this can be confirmed in table 2, with the simple average 3.47. Within these results, the variable related to energy and fatigue, of 9 participants have considered the average willingness to completely develop the activities of everyday life, which may explain seven of them have responded are satisfied with their ability to work. The standardized values are presented in table 3.

Through table 4 there are average indices of quality of life by analyzing the different areas as recommended by the instructions of the WHOQOL-bref questionnaire. Among them the contributor in the quality of life is the Social Domain, followed by the psychological, physical and environment.

Table 3 - Distribution of descriptive measures of issues 1 and 2 of the WHOQOL-bref (n=12)

Questions	n
1. How would you rate your quality of life?	
Very bad	0
Bad	0
Neither good nor bad	5
Good	5
Very good	2
2. How satisfied are you with your health?	
Very unsatisfied	1
Unsatisfied	1
Neither satisfied nor dissatisfied	3
Satisfied	7
Very satisfied	0

Table 4 - Following the syntax for the calculation of the WHOQOL-bref (n=12)

	Physical Domain	Psychological Domain	Social Domain	Domain Environment
Interviewed	Average: 63.16	Average: 68.83	Average: 82.29	Average: 60.64
	SD: 20.31	SD: 10.85	SD: 12.45	SD: 11.99
E1	92.75	62.5	75	81.25
E2	64.25	80	62.5	60.5
E3	82	75	100	75
E4	53.5	66.5	75	68.75
E5	25	54	87.5	45.75
E6	60.5	62.5	75	56.25
E7	62.5	90	87.5	54
	Physical Domain	Psychological Domain	Social Domain	Domain Environment
E8	64.25	62.5	100	65.5
E9	89.25	83.25	100	71.75
E10	42.75	58.25	75	50
E11	42.75	66.5	75	56.25
E12	78.5	65	75	42.75

Discussion

The World Health Organization says that the marital status of individuals influences on family dynamics and self-care. For the elderly, family composition can be a deciding factor for the lack of stimulation to self-care and home[13]. When the elderly live in a long-stay institutions, the condition of caring is a further aggravating factor because it is away from family and inserted into the routines of the institution.

In this same context, the characteristics related to the elderly as your zip code, age, gender, education, marital status, living habits, and cultural aspects and socio-economic context may have interference in the quality of life[10]. Such variables can justify the need for a prior assessment of each of the participants.

Hypertension is an important risk factor, since it does not properly treated, can develop into its main complications such as cerebrovascular and cardiovascular diseases. Hypertension can lead to comorbidities such as diabetes, arthritis or osteoarthritis, chronic kidney disease and physical disability[14].

The elderly population is more sensitive to vitamin D deficiency due to less sun exposure, reduction of the production capacity of vitamin D, inadequate power supply, and multiple drugs that can interfere with the absorption of vitamin D. Within these features, institutionalized elderly may develop hypovitaminosis D, which carries an increased risk of fractures[15].

The person with chronic illness is limited to everyday activities by the need to change their habits and decrease their social relationships, leading to the elderly the impairment of quality of life[16].

As the assessment of life quality in question 1, assessments and nursing interventions in the context of long-stay institutions should be proposed, taking into account these data, in order to promote quality of life for institutionalized elderly especially those who consider their quality life neither good nor bad or bad. Assessments and nursing interventions in the context of long-stay institutions, should be proposed, taking into account these data, in order to promote quality of life for institutionalized elderly[9].

There are average indices of quality of life by analyzing the different areas. Among them the contributor in the quality of life is the Social Domain, followed by the psychological, physical and environment.

Live in home makes older people being less able to maintain quality of life. However coexistence with people of the same age favors the psychological and social well-being of the elderly. This fact can justify the social domain has the highest average in this study.

In the psychological domain, it is identified that seven of the elderly are satisfied with itself in their body image and appearance; however, the question of self-esteem, 6 participants showed very or completely accept their physical appearance.

A related issue spirituality/religion stood out among the older, 4 of them did not respond, one of them believes that his life has little meaning, 4 stated that the average life has meaning and only 3 reported that life has a lot of sense.

Psychological and social aspects can benefit from physical activity, which provides decreased anxiety, depression, improves cognitive, aesthetic enhancement, self-esteem and self-image, as well as providing integration and socialization[17].

Stands out, even in the physical domain of the 8 participants consider their activities of daily life as neither satisfied nor dissatisfied or satisfied. When addressing issues related to pain and discomfort, seven of the interviewees consider that your pain does not interfere with anything or nothing on their needs. This same data can be compared with a similar study that concluded that the limitations of daily life generated by physical pain, do not affect the perception of the elderly in relation to their health[6].

The Domain Environment showed the lowest average among the facets due to satisfaction of living in a long-stay institution. Older people who participated in the study are unsafe the responses to questions

related to the above domain. It was also observed that many elderly have demonstrated accept living in a long-stay institution: although they reported prefer to live with the family.

There are situations in which a family's ability may be compromised for the care, and the demands of everyday life, unable to reconcile care and work activity and the home, or for the inability to find one or more members to be available and be responsible for elderly care. One must consider that there is the stereotype of family that does not want to be responsible for the care of the elderly, they are independent or not. The family and its members should play the role of care and supervision in all situations for the elderly. There are situations however this lack of care being Institutionalization found a solution to the problem[18].

The absence of social network (family, spouse) associated with the residence time in a long-stay institution; contribute to the development of illnesses, decreased physical capacity, and autonomy and intimacy affect quality of life[6]. Even the institution and promoting leisure activities, and workshops motor and cognitive stimulation, such as crafts, body awareness, literacy, parties and trips, this variable when analyzed indicated that 6 of them believe that their leisure activities are averages, little or anything, which may indicate that elderly do not actively participate in the activities offered.

Measures to help the recreational activities should be prioritized in institutions for the aged, with this, if provides social contact, community participation, autonomy, and feel useful to live with quality of life and establish relationships with other seniors[6].

Considering the study, the results of the WHOQOL-bref showed that all areas showed an average on a scale of 100, up 60. This demonstrates that older, although being a resident of a long-stay institution, and submit intercurrent diseases of aging, all have good quality of life.

Conclusions

The elderly study participants considered themselves satisfied or very satisfied with it.

It can from this study understand what the main reasons that interfere in their quality of life; in particular aspects of physical capacity, autonomy, the absence of relatives, long residence time, among others are the main reasons to interfere in the quality of life of the elderly.

It is noticed that even with many factors that affect the quality of life of the elderly, the social sector is the largest contributor to their quality of life. Living with people of the same age can foster psychological and social well-being of the elderly.

Knowing the quality of life of hypertensive elderly residents in a long-stay institution can support the work of nursing in this population, whose goal is expanding this concept and enabling the improvement in the indicators have not shown to be satisfactory.

Colaborations

Visentin AV design and project or analysis and interpretation of data. Mantovani MF critical review article or writing material that intellectual content. Caveião C critical review article or writing material that intellectual content. Mendes TA and Neves AS design and project or analysis and interpretation of data. Hey AP approval of the final version one published.

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