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Homes for the Aged: a study of a Health Region in Rio Grande do Sul, Brazil

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ABSTRACT

Introduction: With the aging of the population, the demand for Homes for the Aged (HFAs) grows. **Objective:** To analyze resources and population of HFAs and to check the fulfillment of the criteria from the national regulations. **Methods:** Descriptive quantitative study including 11 philanthropic HFAs in the state of Rio Grande do Sul, Brazil. Data was collected through a questionnaire applied to the responsible for the facility. **Results:** The study comprised 318 workers and 522 elders. HFAs presented: some accommodations without private bathrooms (100%); external area and administrative office (72.7%); cafeteria and support room (54.5%); ecumenical room (36.4%); rooms with more than four beds (45.5%). The prevailing reasons for admission were brought by family member (69.2%); social vulnerability (36.4%). Death was the main reason for leaving the facility. The average age of elders was 76.8 years, 58.4% were women. The dependence grade was I for 31.1%; II for 33.9%; and III for 35%. Leisure and cultural activities occurred in 72.7% of HFAs. In 27.3% there were records of visits. Only 9.1% had cooperation from families. Available human resources were nurses (72.7%); physicians and nursing assistants (63.3%); physical therapists (45.5%); psychologists (36.4%); caregivers (27.3%); occupational therapists (9.1%). In 63.3% of facilities, workers carried out mixed activities. The costs were covered by retirement pensions, partnerships, and donations. The main obstacles were financial resources or dependence on donations and rigorous health surveillance or compliance with standards. **Conclusion:** The HFAs partially fulfill the national criteria, impairing the quality of care provided to elders.

Keywords: aging; old age assistance; homes for the aged; structure of services.

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INTRODUCTION

Population aging is a process of changes, presenting itself as a challenge, especially for developing countries like Brazil[1-3]. The high rates of population aging are explained by demographic changes in Brazil and in the world, mainly the fall in birth rates, mortality, fertility, and the reduction of infectious and parasitic diseases[4]. From these transformations, there is a new epidemiological profile of the population, which started to live longer, with a considerable number of people aged 60 years or more[3].

In Rio Grande do Sul (RS), Brazil, the elderly population has increased significantly in recent years, advancing from 1,105,807 (10.7% of the state's population in 2001) to

1,762,169 elderly people (15.7% in 2015). It is estimated that, in 2030, the elderly should reach 24% of the total population living in RS[5].

In response to the increase in life expectancy and the reduction in the availability of family resources for the care of the elderly, the demand for Homes for the Aged (HFAs)[1] increased. Lately, HFAs operate practically with maximum capacity and, according to the forecast, in the next ten years, an increase of between 100% and 500% in the number of elderly people who will need to live in HFA can be expected[6].

Brazilian HFAs are regulated by the resolution RDC 283/2005 from the national health surveillance agency ANVISA (*Agência Nacional de Vigilância Sanitária*)[7]. RDC 283/2005 establishes minimum criteria for the functioning of the HFAs and for the provision of services to elderly residents, mainly in the physical-structural and organizational aspects, considering the degree of dependence of the residents. In RS, there is no database that contains information and/or registration of all HFAs. Seventy-seven HFAs are registered, totaling 4,022 vacancies[5].

Faced with this scenario of aging and family difficulties regarding the care of their elderly, there is an increasing concern with the necessary conditions for dignified care for this population[8].

Therefore, this study aimed to know the philanthropic HFAs of the 4th health region in the state of Rio Grande do Sul, Brazil, their human resources and the population served, and to verify the fulfillment of the criteria established by RDC 283/2005.

METHODS

Cross-sectional study approved by the Research Ethics Committee of the Federal University of Santa Maria (2,048,595).

Initially, a survey was carried out of all philanthropic HFAs of the 4th health region of Rio Grande do Sul, by phone call to the city hall of each of the 32 municipalities comprising the region. Thirteen HFAs were found, they were distributed in 11 municipalities. Then, the manager of the HFAs were reached by phone call to present the study and to ask for authorization. Two HFAs were excluded, one for being involved in legal processes, and the other for declining participation. Therefore, a date was set for the visit of the researcher in 11 HFAs. Three HFAs are located in the same municipality and the others, distributed in eight municipalities. They were identified by a code, from A to K, to preserve the confidentiality.

The collection of data was carried out between May 2017 and November 2018. HFAs were visited by the researcher, signed the institutional consent term (in two copies). An instrument with questions about the management, structure and functioning of the HFA was applied to the person responsible for the institution[9]. This instrument aimed to access the infrastructure, legal nature, operating regime, available human resources, cost and financing structure, partnership network, main difficulties encountered by HFAs. Some characteristics of residents from the HFA, such as sex, age and dependency level were also collected. The data referring to the elderly were collected by the responsible for the institution in medical records of the residents. In relation to the dependency level of elderly, the classification of the Brazilian regulations was used[7]. Independent elderly, even those who require the use of self-help equipment were classified as Grade I; elderly with dependence on up to three self-care activities for daily life without cognitive impairment or with controlled cognitive impairment as Grade II; and elderly with dependence in all self-care activities for daily life and/or with cognitive impairment as Grade III.

At the end of the collection, a descriptive statistical analysis of the data found was carried out and the discussion took place according to the national and international literature available.

RESULTS

The 11 HFAs surveyed have been operating, on average, for 57 years; the youngest being 20 years old and the two oldest at 81 years old. Regarding the nature of the HFAs, three were religious, philanthropic and private and eight were non-profit, lay and philanthropic. They work in a closed regime. For six HFAs, the elderly can leave only accompanied by a family member or employee of the institution; in five, the elderly independent and authorized by the responsible can leave alone, with a pre-established time for return.

Regarding the structure of the HFAs, 100% have rooms, shared bathrooms, TV/living room, kitchen, pantry and laundry; 72.7% have a garden or outdoor area and an administrative room; 54.5% have a cafeteria and room for individual support activities and 36.4% have an ecumenical room or chapel. Table 1 shows the total number of accommodations in each HFA and the maximum number of beds.

Only three HFAs (27.3%) have wards, a place with several beds, with elderly people in total dependence, with or without the use of stomas or tubes, which require greater care from the team; or elderly people with acute pathologies being treated.

Regarding the admission criteria, the following were cited: being in social vulnerability (36.4%), having a minimum wage before admission (27.3%), having a legal guardian (27.3%), being independent in activities of daily living (18.2%), being over 60 years old (27.3%) and not having a family relationship (9.1%). Most of the residents under the age of 60 years have psychiatric diseases, syndromes or motor and/or cognitive disabilities, Grade III for dependency level, and no family support. As for the arrival of the elderly, 69.2% of the HFAs reported that they were brought by a family member; 18.7% reported that it was by public agency/social assistance and 12.1% by friends, neighbors and/or any acquaintances of the elderly. Regarding the departure of the elderly,

100% of the HFAs highlighted death as the main reason and only 18.2% reported reintegration into the family.

Table 2 presents the data referring to the number of residents in the HFAs, highlighting the gender, age and degree of dependence of the elderly. In this sense, the characteristics of residents under 60 years of age are not presented.

All elderly contribute with the cost for their maintenance of the HFA. HFAs accepting elderly without retirement pension or benefit (45.5%), seek governmental financial support. In 54.5% of the HFAs, the elderly's entire income is used by the institution. In 45.5%, independent elderly (those who can leave the facility) receive part of their money balance for small purchases. Generally, the full amount of the income is kept in the institution for any health event, such as: payment of caregivers when admitted to hospital, purchase of medication and/or diapers. If there is little donation in the month, laboratory tests and images are dependent on the public health system (*Sistema Único de Saúde* - SUS).

It was found that 100% of HFAs use over 70% of the elderly's monthly income. The average expenditure of each elderly person was R$1,153.00, the lowest amount being R$805.00 and the highest R$1,470.00. To meet these values, some partnerships are established, in addition to voluntary donations, received at 100% of the HFAs. The aforementioned partnerships or agreements were: city hall (54.5%), through medications, diapers and/or assigned professionals; educational institutions (45.5%), with supervised internships; public health system - SUS (45.5%), with consultations, hospitalizations and medicines; lay associations and individuals (45.5%) and religious associations (36.4%), with consumables and cash value.

In case of need for hospital care, 100% of the HFA use resources from the public health system – SUS, both in Primary and Secondary Care. In primary care, HFAs use basic health units for regular monitoring of the elderly, when there is no doctor at the HFA. In secondary/specialized care, receiving the same attention provided to the general population. It is worth mentioning that, if the elderly need professionals who are not available at the HFAs,

Table 1: Accommodation characteristics for the Home for the Aged (HFA) of the 4th Health Region of Rio Grande do Sul, Brazil.

HFAs	Rooms						
	1 bed	2 beds	3 beds	4 beds	5 beds	6 or more beds	Maximum capacity (beds)
A			X				26
B					X		70
C		X					21
D		X					12
E					X		74
F		X					21
G						X	15
H						X	68
I			X				80
J			X				35
K						X	200

Table 2: Number of residents and characterization of the elderly in Home for the Aged (HFA) of the 4th Health Region of Rio Grande do Sul, Brazil.

HFA	Residents			Sex		Age (md±sd)	Dependence Grade*		
	Total	<60 years	≥60 years	F	M		I	II	III
	(n)			(n)			(n)		
A	17	2	15	7	8	75.3±8.9	5	6	4
B	66	8	58	32	26	77.7±9.1	18	22	18
C	16	0	16	6	10	76.4±8.8	6	7	3
D	11	1	10	4	6	76.0±9.2	6	3	1
E	71	13	58	24	34	77.4±8.4	21	19	18
F	16	1	15	6	9	77.5±7.9	6	5	4
G	19	0	19	9	10	75.6±7.9	5	8	6
H	62	8	54	28	26	74.7±10.2	12	12	30
I	77	2	75	1	74	76.0±9.5	30	24	21
J	31	0	31	17	14	77.4±10.2	13	10	8
K	198	27	171	171	0	77.6±9.1	40	61	70
Total	584	62	522	305	217	76.8±9.2	162	177	183
%	-	-	100	58.4	41.6	-	31.1	33.9	35

*Dependence Grade - I: Independent elderly, even those who require the use of self-help equipment; II: elderly people with dependence on up to three self-care activities for daily life without cognitive impairment or with controlled cognitive impairment; III: elderly people with dependence in all self-care activities for daily life and/or with cognitive impairment.
n: number of elderly; %: percentage of total elderly; F: female; M: male; md: media; sd: standard deviation;

they can be hired by the family. In addition, partnerships with educational institutions, which carry out internships with the HFA, help to expand the health care for the elderly. Leisure and cultural activities are carried out in eight HFAs (72.7%). As for the type of cultural and leisure activity, the managers reported activities such as: walks in clubs/establishments, charity parties, balls, elderly groups and workshops. Only three HFAs (27.3%) claimed to have some kind of record of visits to the elderly. Only one (9.1%) reported to work with families in order to maintain the elderly/family bond.

All HFAs have a president or manager, designated for management. It should be said that in seven HFAs (63.6%), they were not present. In those cases, an administrative employee or nurse responsible for the institution was interviewed.

Table 3 shows the human resources present in each HFA (number, professions/occupations and employment).

For the main difficulties encountered in maintaining HFAs, the following were cited: lack of financial resources and dependence on donations (81.8%); strictness of Health Surveillance and compliance with laws and regulations that govern the HFA (63.6%); lack of human resources (36.4%); lack of support from the municipality (27.3%) and lack of specialized therapeutic assistance/care for the elderly (18.2%).

DISCUSSION

Throughout the 19th century, the so-called asylums were spreading in Brazil, having a charitable character with the function of providing shelter for homeless people, the mentally ill and abandoned children. The HFAs in this study are old (average of 57 years old). As they admit elderly people in social vulnerability (36.4%) and non-elderly people (72.7%), it can be inferred that they present a strong charitable/assistance character. This condition no longer recommended by the Brazilian legislation that assumes the HFA as institutions, governmental or not, of a residential character, dedicated to the collective address of people aged 60 or over, who have or not family support, in a situation of freedom, dignity and citizenship[7].

Regarding the structure, it was evident that the HFAs partially meet the criteria of RDC 283/2005[7]. Dormitories must be separated by sex and have a maximum of four people, which was not the case in five HFA (45.5%). They have rooms with a number of beds greater than the maximum allowed. All rooms must have private bathrooms. This condition was the least observed, since it was not entirely fulfilled by any of the HFAs. Collective toilets were identified in the corridors and often were not separated by sex. The resolution determines that all HFAs must have: a TV and/

Table 3: Human Resources present in Homes for the Aged (HFAs)

Employees	HFA											Professional relationship with the HFA		
	A	B	C	D	E	F	G	H	I	J	K	Volunteer	Assigned	Hired
President	1	1	1	1	1	1	1	1	1	1	1	7	-	4
Secretary	-	-	-	-	-	-	-	1	1	1	1	-	-	4
Physician	1	1	-	-	1	1	-	-	2	1	2	6	1	2
Nurse	-	1	-	-	1	1	1	1	2	1	7	1	-	14
Nursing Technician	-	10	1	-	-	2	-	7	8	6	48	2	-	80
Care Giver	-	16	-	-	-	-	-	4	8	-	-	-	-	28
Social Assistant	-	1	-	-	-	-	-	-	2	1	1	-	-	5
Psychologist	-	-	-	-	-	1	-	-	1	1	1	1	-	3
Nutritionist	-	-	-	-	1	-	-	1	1	-	1	1	-	3
Pharmaceutical	-	-	-	-	-	-	-	-	2	-	1	2	-	1
Dentist	-	-	-	-	1	-	-	-	2	-	-	3	-	-
Occupational Therapist	-	-	-	-	-	-	-	-	-	-	1	-	-	1
Physiotherapist	-	-	1	-	-	1	-	1	1	-	1	1	2	2
Speech Therapist	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Physical educator	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cook	-	-	1	-	4	1	2	3	2	1	4	-	-	18
Washer	-	-	-	-	2	-	-	-	2	3	4	-	-	11
Doorman/Watchman	-	-	-	-	-	1	-	-	2	3	5	-	-	11
General Services	-	2	-	-	-	-	1	5	8	2	34	-	-	52
Mixed*	7	-	7	3	20	7	6	-	2	-	-	-	-	52
Total	9	32	11	4	31	16	11	24	47	21	112	24	3	291

*Mixed: workers who perform various services in different areas at the institution.

or living room, kitchen, pantry and laundry, and they were present in all surveyed HFAs. In addition, HFAs must also have cafeteria, room for individual support activities, garden or outdoor area, administrative room, ecumenical room or chapel, but not all HFAs complied with these requirements.

Other studies show the same reality: the Brazilian resolution is not being followed in full[10,11]. The concern with the environment of the HFAs is based on the risk for the health of elderly[11]. The inadequate physical structure, in addition to the lack of trained human resources, charitable and professional, commonly indifferent to the potential of the elderly and their freedom to choice, can exacerbate the level of dependence, isolation and loss of hope in living actively and with quality[12,13].

Regarding the functioning related to freedom and citizenship, for example, the studied HFAs keep much of the origin of asylums with regulated spaces and charitable purpose[14]. This fact can be explained by the lack of professionals who understand the recommendations of the World Health Organization[15], the national public policies for the elderly[15], as well as the Brazilian statute of the elderly from 2003[16], RDC 283/2005[7] and the health needs of the elderly (multidimensional care)[17]. The lack and scarcity of competent professionals in the elderly area, in HFAs, result in the maintenance of the old conception, thus advancing little in the conception of managers and society, about how the HFAs should be structured and functioning.

In assuring the professionalism required by Brazilian law, the HFAs must have human resources with a formal employment relationship to carry out the care activities. Therefore, the HFA is expected to have employees for leisure, cleaning, food and laundry activities, according to their size and the number of residents[7]. In this study, there were eight (72.7%) HFAs which failed in this aspect. In most of them, the same employee performs several functions compromising the quality of care and, also, the quality life/health of the worker.

Such data confirm those of another investigation[18], which found duplicate assignments in philanthropic HFAs, such as, the same worker cleaning the institution and washing clothes. The reports of some professionals demonstrated the negative influence of the non-division of tasks on the quality of care, highlighting the lack of time for good care. These results are also consistent with a survey that outlined the profile of nine HFAs in the municipality of Botucatu, São Paulo, Brazil in which four of them did not have employees exclusively responsible for laundry, food and cleaning[19].

It was found in this study that, when the functions were not mixed, the largest number of professionals corresponded to those who perform the direct task of caring for the elderly (nurses, nursing technicians and caregivers). This data is in agreement with studies carried out in other HFAs in Brazil[9,20]. The lack of professionals specialized in caring for the elderly was evident, including physiotherapists, speech therapists, physical educators, psychologists and occupational therapists. It is known that these have important knowledge to recognize the needs of the person in the process of healthy and/or pathological aging. Although it is not mandatory to hire all health professionals at HFAs, it is extremely important to have a multidisciplinary team for comprehensive care for institutionalized elderly people[11,21].

One of the difficulties reported by those responsible for the HFAs was the lack of therapeutic assistance (18.2%). It is known the importance of a team to achieve a qualified job, an extended assistance to the elderly, encompassing their needs and providing comprehensive health care, with a multidimensional view[22]. Although the percentage of HFAs who recognized the lack of therapists is low, there is an advance in the conception of managers, since they assume the expansion of the team of professionals, highlighting the role of HFAs also providing longitudinal care (in health) in addition to medicines and medical and/or nursing care focused on biological aspects.

Regarding the admission of elderly people to the HFA, this study found that 69.2% of the elderly arrived at the HFA accompanied by a family member. Studies justify this fact due to changes in family arrangements (insertion of women in the labor market, reduction in the number of children), difficulties with care and financial and breaking of family ties[1,23-25]. Allied to this, the issue of neglect, discrimination, family abandonment and intrafamily violence against the elderly is presented[26].

As for the elderly residents in the HFAs, there was a predominance of women (58.4%), in agreement with the literature[27-32]. Feminization in aging, that is, the fact that women are living longer than men, can be explained by several factors: lower consumption of alcoholic beverages and tobacco, higher frequency in health services and less exposure to risk factors of an occupational nature[27,30].

With regard to age, it was found that most of the elderly were between 70 and 79 years old, a situation also found in the study by Lenardt et al.[33] in several regions of Brazil, with institutionalized elderly. Most of the elderly (64.9%) in this study were classified, by the person interviewed, as belonging to the degrees of dependence I and II. The reasons that can explain this fact are that 18.7% of HFAs do not accept totally dependent elderly people (Grade III), in addition to the fact that the predominant age was not so high. Research that analyzed the functional capacity of institutionalized and non-institutionalized elderly, in the city of Barbacena, Minas Gerais, Brazil, relating the presence of comorbidities, medications, sociodemographic data and institutionalization, showed that the largest number of independent elderly people was found in the age group between 60 and 69 years old and that the dependents were 80 years old or more. This relationship showed a statistically significant value, showing that functional disability increases progressively with age[34].

The totality of HFAs highlighted death as the main reason for the elderly to leave the HFAs, followed by reintegration into the family (18.2%). These results allow us to reflect on how an HFA should be a place of comprehensive care, respect and warmth, as it is the last home of most of them. It is reaffirmed, here, the need for the HFA to comply with the principles of the legislation in force in Brazil for this age group.

The practice of leisure and cultural activities was mentioned in eight HFAs, with none in four. The legislation determines that, among its tasks, the HFA should promote the practice of leisure, through physical, recreational and cultural activities. In order to achieve this standard, it is recommended that there should a professional, with higher education and a workload of 12 hours/week for every 40 elderly people[7]. This study revealed this proportion in only two HFAs in the form of an institutional contract, and in six, leisure and culture activities took place without hiring a professional, being in charge of volunteers and assigned. Although the importance of leisure for the elderly and of requests for exercise is well known, a Brazilian survey found that less than 40% of these institutions offered such activities[19].

Philanthropic HFAs are known to have difficulties with regard to human and material resources. Depending on the management, leisure opportunities may come from partnerships or may not exist, which facilitates the isolation of the elderly. Leisure is seen as superfluous and, therefore, it is often the responsibility of volunteers or interns, without the necessary preparation[35]. A recent study[36] evaluated the perception of institutionalized elderly about leisure and found that activities were not offered according to the preference of the elderly, nor were they adapted to their limitations. Even so, he found that, in those who participated in the activities, it provided biopsychosocial comfort, facilitated the adaptation to the routine and the creation of bonds, and alleviated the bad factors, such as the pain of abandonment and living with people outside their family circle[36]. The elderly should be perceived in their potential, and not as sick and unproductive, but as beings capable of carrying out various activities, acting in the choices about their life. Life experiences, new knowledge, culture and leisure must be included in the daily lives of the elderly, in order to give meaning to a life that follows after retirement[37].

With regard to living with family members, only three HFAs (27.3%) had a record of visits and only one (9.1%) performed any intervention with the families, aiming to maintain the elderly/family bond. The Elderly Statute, in its article 4916, determines that entities with an institutionalization program must carry out activities that prioritize the maintenance of family bonds. This condition reveals that there is much to be done in the HFAs in the researched region; certainly the presence of health professionals with the appropriate competence, could promote elderly/family relationships, improving institutional progress and the bond between families and society. Greater proximity, with regular family visits to the HFA and not just for visits, but to collaborate in the institutional routine, would favor daily life and divulge the facilities and difficulties of comprehensive and dignified care.

When faced with the difficulties faced to maintain the HFA, those responsible mainly highlighted the lack of financial resources and the dependence on donations (81.8%), corroborating with a study that revealed that the resources of the elderly added to the government are insufficient to maintain the HFA, depending on society, both donations in cash, geriatric diapers or food, as well as voluntary work[38]. In addition to the lack of human resources, lack of support from the municipality and lack of provision of therapeutic processes appropriate to the health needs of the elderly, discussed previously, the rigor of health surveillance to comply with laws and regulations (63.6%) also appeared great difficulty faced. In the region, HFAs, because they are old, usually occupy houses that were not originally built to be an HFA, revealing inadequate structure by legislation and the need for reforms. Without the relevant professional assistance it becomes difficult to adapt them. It was often found that there was a lack of space and the number of elderly people above the permitted limits. It should be noted that the lack of financial resources directly and negatively implies questions about care, structure and institutional functioning. In this way, how to comply with the laws and norms foreseen?

This study made it possible to get to know the reality of the HFAs, spaces where care and administration are generally developed by lay people and with "good will", so that they do it with little or no financial retribution to match the daily complexity of work in and HFAs. Society support is irregular and government support is scarce. Strong disclosure of HFA conditions is required and strong appeal for legal solutions involving society in general, beyond government spheres.

The above considerations are echoed, in part according to Carvalho[39], who states that, despite the fact that regulations have been in place for the functioning of HFAs since 2005, it is necessary to raise awareness and demand from those responsible for ensuring the successful aging of elderly residents[39].

It is concluded that the HFAs in the 4th health region of Rio Grande do Sul, Brazil, partially meet the criteria of RDC 283/2005[7], especially in the criteria of infrastructure, human resources, percentage of retirement of the elderly and leisure and cultural activities. Therefore, it is necessary to have a technical-scientific discussion and in society, in general, about the role of HFAs and their maintenance, since it was found that the arduous work of the managers and workers of the HFAs surveyed was almost solitary. It is also believed that the mobilization of society, as a whole, can improve the quality of HFAs, the lives of workers and institutionalized elderly.

Much of the current conditions of HFAs can be attributed to the lack of competent health professionals who know the needs of the elderly. This study revealed that institutionalized

elderly are in social and health vulnerability and that, as health conditions worsen, the HFAs tend to take care of organic decline through medication, neglecting the aspects of subjectivity. It is believed that professional attitudes may be different, such as those provided for in palliative care. In this sense, the final stage of life of institutionalized elderly people could happen to improve the quality of life of elderly people with chronic-degenerative pathologies, through the prevention and relief of suffering, with the early detection and comprehensive assessment and treatment of pain and physical problems, psychosocial and spiritual[40]. Thus, it is suggested that more research be carried out exploring this topic, with other methods and scenarios (including the private system), covering other regions of the state and the country.

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