Acta Scientiarum. Health Sciences
ISSN: 1679-9291
eduem@uem.br
Universidade Estadual de Maringá
Brasil

Santos, Nilce Maria de Freitas; Tavares, Darlene Mara dos Santos; Dias, Flavia Aparecida; Diniz, Marina Aleixo; Martins, Nayara Paula Fernandes
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Acta Scientiarum. Health Sciences, vol. 35, núm. 1, enero-junio, 2013, pp. 49-57
Universidade Estadual de Maringá
Maringá, Brasil

Acta Scientiarum

http://www.uem.br/acta
ISSN printed: 1679-9291
ISSN on-line: 1807-8648
Doi: 10.4025/actascihealthsci.v35i1.10463

Functional capacity and quality of life of elderly people with a history of stroke

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ABSTRACT. Household Survey, a cross-sectional study aimed to describe the quality of life and functional capacity of elderly people with a history of stroke and compare the scores of quality of life with the number of functional disability. Data were collected at home, with the semi-structured instruments, WHOQOL-BREF and WHOQOL-OLD. Descriptive analysis was performed, as well as ANOVA and Tukey-F test ($p < 0.05$). Most individuals are males (53.3%), aged 70 ├ 80 years old (45.6%), married (57.8%), 4 ├ 8 years of study (36.7%) and income of a minimum wage (66.7%). The activities of daily living most affected were: cutting toenails and walk up and down stairs. The highest scores of quality of life were: the social relationships and the facet death and dying. The lowest scores were related to the physical domain and autonomy. The highest number of functional disability was associated with lower scores for physical and psychological domains and on the facets of autonomy and social participation. The elderly people with stroke have their functional status impaired, which affects their quality of life in aspects related to mobility, body image, decision-making capacity and living in the community.

Keywords: life quality, health of the elderly, stroke, activities of daily living, geriatric nursing, aged.

Capacidade funcional e qualidade de vida de idosos com histórico de acidente vascular encefálico

RESUMO. Estudo tipo inquérito domiciliar transversal que objetivou descrever a qualidade de vida e capacidade funcional de idosos com histórico de acidente vascular encefálico e comparar os escores de qualidade de vida com o número de incapacidade funcional. Os dados foram coletados no domicílio com instrumentos semi-estruturado e a qualidade de vida mensurada pelo WHOQOL-BREF e WHOQOL-OLD. Foi realizada análise descritiva e os testes ANOVA-F e Tukey ($p < 0,05$). A maioria é do sexo masculino, faixa etária de 70-80 anos, casados, 4-8 anos de estudo e renda de um salário mínimo. As atividades da vida diária mais comprometidas foram cortar as unhas dos pés e subir e descer escadas. Os maiores escores de qualidade de vida foram no domínio relações sociais e na faceta morte e morrer. Os menores escores estiveram relacionados ao domínio físico e a faceta autonomia. O maior número de incapacidade funcional relacionou-se com menores escores nos domínios físico e psicológico e nas facetas autonomia e participação social. Os idosos com acidente vascular encefálico possuem o *status* funcional comprometido repercutindo na sua qualidade de vida nos aspectos relacionados à mobilidade, a imagem corporal, a capacidade de decisão e o convívio na comunidade.

Palavras-chave: qualidade de vida, saúde do idoso, acidente cerebral vascular, atividades cotidianas, enfermagem geriátrica, idoso.

Introduction

The population ageing is characterized when the proportion of people of 60 years or older reaches 7% tending to grow. This phenomenon is already part of the reality of the majority societies (WHO, 2005). The projections of the ONU indicate that the population of elderly is expected to triple in the next years. It is estimated that in 2050 will exist around two billion of people of 60 years or older in the world, 80% living in developing countries (UNITED NATIONS, 2007). In Brazil, the life expectancy was less than 50 years old in 1940, reached 62.6 in 1980 and 70.4 in 2000, and may rise to 81.3 years old in 2025 (IBGE, 2004).

Currently, the Brazilians elderly represent 10.2% of the total population, while the Minas Gerais State possesses 11.1% (DATASUS, 2009).The elderly are more susceptible to polymorbidities, specially the chronic and degenerative diseases, highlighting the arterial hypertension, the diabetes mellitus, and the

stroke (CHAVES, 2000; CRUZ; DIOGO, 2008; LAVINSKY; VIEIRA, 2004).

In the present study it will be carried out an overview for the stroke, defined as a clinical sign of fast growing in focal disorder of brain function, with presumed vascular origin with more than 24 hours duration (WHO, 2004). It is worth mentioning that the probability to suffer an stroke increases with age, having as the most evident factor of risk, the arterial hypertension. Among other factors are the cardiopathies, diabetes mellitus, dyslipidemias, high salt diet, smoking and arteriosclerosis (PIRES et al., 2004).

Clinical evidences show that the stroke is one of the leading causes of inability in elderly people, with high incidence in this age group. Despite the high rate of survival, about 90% of the survivors remain with some kind of disability (COSTA, DUARTE, 2002; LAVINSKY; VIEIRA, 2004).

After the stroke, the individuals may present sensorial, cognitive, and motor alterations such as the muscular weakness, spasticity, abnormal patterns of movement and physical deconditioning. These deficits can limit the functional capacity, making necessary assistance to carry out their daily life activities (ADL) (PEDRAZZI et al., 2007; SOUSA et al., 2003).

The functional capacity is understood as the potential to preserve the individual's capacity to conduct the ADL, whether in performing primary or instrumental activities of daily life, which is closely related to quality of life (NERI, 2005).

In this perspective, it is necessary to develop health actions which add quality to life after the stroke episode. The quality of life is related to the self-esteem and the personal well-being encompassing the functional status. It is considered a subjective concept, varying according to the socio-cultural level, the age range and the personal aspirations (SOUSA et al., 2003).

In this study, it will be adopted the concept of quality of life defined by a group of scholars supported by the WHO, which proposes a concept considered subjective, multidimensional, with positive and negative aspects, as follows,

> […] the individual's perception of his position in life in the context of the culture and value system in which he lives and in relation to his goals, expectations, patterns and concerns (THE WHOQOL GROUP, 1995, p. 1405).

Considering the ageing process, the quality of life and the implications of this complex net on the health, is verified an increase in knowledge production concerning this issue in the recent decades (CHACHAMOVICH et al., 2008; GARRIDO et al., 2003; VECHIA et al., 2005). However, by associating the quality of life of elderly people with history of stroke we have found few studies. Among them, the research performed with the quality of life instrument *Short Form-36* (SF-36), which evidenced the lowest score in the domain of functional capacity, and the highest, in the general state of health (CRUZ; DIOGO, 2008).

Other researches concerning the longitudinal analysis of quality of life for the survivors of stroke observed that the elderly people presented lower score in the physical domain. The other domains had been associated with the influence of the ADL, disability, and depression (PAN et al., 2008).

However, still is observed the need of deepening the knowledge about the quality of life of elderly with history of stroke. In this sense, this research intends to contribute using specific instrument for this age range, WHOQOL-OLD, aiming to identify the relationship between functional capacity and the quality of life of elderly with history of stroke.

In this perspective, the purpose of this study was to describe the quality of life and the functional capacity of elderly with history of stroke and compare the scores of quality of life with the number of functional incapacity.

Material and methods

The present research is part of a larger study, population-based, household survey and cross-sectional type, which evaluated the quality of life of 2,142 elderly living in the urban area of the city of Uberaba (Minas Gerais State). To define the population of the larger study, was used the population sample, by means of the calculation of proportional stratified sampling, performed in previously study by the Center for Collective Health Research.

The sampling calculation has considered the confidence interval of 95%, test power of 80%, margin of error of 4% for the intervallic estimates and a estimated proportion of $\pi = 0.5$, for the proportions of interest. After the calculation of the elderly number, for the sample in each neighborhood, were considered at least 10 elderly for those neighborhoods where the sampling calculation was lower than 5 and, it was used the technique of systematic sample to select, within each neighborhood, the residences, in which the elderly were interviewed.

To perform this survey were used the inclusion criteria: age 60 years or older; threshold of 13 points in the cognitive evaluation; to live in the urban area,

to report previous history of stroke and agree to participate in the study.

The cognitive evaluation was based on the Mini Mental State Examination test (MMSE), short version validated by the researchers of the SABE Project. In this version was established a cut-off point of 12/13, achieving a sensitivity of 93.8 and specificity of 93.9.

The cognitive deterioration was indicated by a score equal or less than 12. The questions of the cognitive test were subdivided into temporal and spatial orientation, record, attention and calculation, recent memory, execution of commands and copy of figures. For each hit was considered one point, with the maximum score of 19 points (LEBRÃO; DUARTE, 2003). An amount of 90 elderly people met the established criteria.

To characterize the sociodemographic data and the evaluation of the functional capacity, was used structured instrument based on the questionnaire Olders Americans Resoucers and Services (OARS), adapted to the Brazilian reality (RAMOS et al., 1987).

The studied variables were: gender (male and female), age range (60|-70,70|-80, 80 years or older), marital status (married or in civil union; separated/legally separated/divorced, widowed and single), education, in years of study (without schooling; 1├ 4; 4├ 8; 8; 9├11 and 11 or more), individual income, in number of minimum wages (without income; <1; 1; 1-|3; 3-|5; >5); ADL; number of functional incapacity (0; 1├4; 4├13; 13 and more); quality of life measured by the WHOQOL-BREF domains and aspects of the WHOQOL-OLD. It was characterized functional incapacity when the elderly said that could not perform the ADL without a third party assistance. The number of functional incapacity was obtained by the sum of ADL that the elderly were not able to perform.

The WHOQOL-BREF is composed of 26 questions and evaluates the domains: physical (pain and discomfort; energy and fatigue; sleep and rest; activities of daily life; medication or treatments dependence and capacity to work); psychological (positive feelings; to think, to learn, memory and concentration; self-esteem; body image and appearance; negative feelings; spirituality, religiosity and personal beliefs); social relationships (personal relationships; social support and sexual activity); environment (physical security and protection; atmosphere at home, financial resources; health and social cares: availability and quality; opportunity to acquire new information and skills; participation and opportunity for leisure/recreation; physical environment: pollution, noise, traffic, climate, transport) (FLECK et al., 2000).

The WHOQOL-OLD possesses 24 items of the Likert scale distributed into six aspects: the sensory functioning (evaluates the impact on the loss of the sensorial skills and the capacity to interact with other people in the quality of life of elderly people); autonomy (describes to what extent the elderly person is able to live autonomously and make their own decisions); past activities, present and future (reflects the contentment concerning the achievements and future hopes); social involvement (in daily activities, particularly in the community); death and dying (preoccupations, inquietudes and fears), and; intimacy (evaluates the capacity to personal and intimate relationships) (FLECK et al., 2006).

The decision was to perform direct interview in the application of the instruments of quality of life given the possible difficulty to read, vision problems and illiteracy among elderly people. The questions were replied based on the last two weeks.

A MS Excel® spreadsheet was constructed, and the data collected were typed, in double data entry, for subsequent verification of consistency between the fields. When there were inconsistent data we returned to the original survey for correction. The data were submitted to descriptive analysis through simple frequencies and mean. To compare the quality of life and the number of functional incapacity was used ANOVA-F and the Tukey's test ($p < 0.05$). Each domain of the WHOQOL-BREF and the aspect of the WHOQOL-OLD were analyzed separately, tabulated and strengthened with the software Statistical Package for the Social Scienses (SPSS), with their referred syntaxes.

The scores of quality of life vary from 0 to 100. The higher the score better the quality of life.

The present study was approved by the Research with Human Beings Ethics Committee of the Universidade Federal do Triângulo Mineiro, protocol nº 897. The elderly people were contacted in their residences; the goals were presented to them, as well as the informed consent form and the relevant information. Only after the respondent approval and the signing of the referred statement of consent was carried out the survey.

Results and discussion

In the Table 1, are described the sociodemographic characteristics of the elderly people with history of stroke.

Table 1. Distribution of frequencies of the sociodemographic variables of elderly people with history of stroke. Uberaba (Minas Gerais State), 2010.

Variables		N	%
Gender	Female	42	46.7
	Male	48	53.3
Age range (in years)	60 ├70	33	36.7
	70 ├80	41	45.6
	80 and more	16	17.7
Marital State	Married or in civil union	52	57.8
	Separated/Legally separated/Divorced	7	7.8
	Widowed	27	30.0
	Single	4	4.4
Education (in years)	Without schooling	26	28.9
	1 ├4	20	22.2
	4 ├8	33	36.7
	8	3	3.3
	9 ├11	1	1.1
	11 and more	7	7.8
Income (in minimum wage)*	Without income	7	7.8
	< 1	1	1.1
	1	60	66.7
	1-├3	18	20.0
	3-├5	2	2.2
	>5	2	2.2

*value of the minimum wage: R$ 415.00

Among the elderly people with history of stroke the majority was male (53.3%) (Table 1). The results of this research corroborate the findings of other studies which present higher occurrence of stroke among the 60 years males or older (CRUZ; DIOGO, 2008; MARQUES et al., 2006). It is well known that men are often less likely than women to seek health service and consequently more vulnerable to diseases, particularly serious and chronic infirmities, explaining the presented findings (BRASIL, 2009).

There was predominance of the age range 70 ├80 years old (45.6%) (Table 1). A result which corroborates the study carried out with elderly people with stroke, in which predominated those of 70 to 79 years old (PEREIRA et al., 2009). As age advances, it is observed an increase in the disease prevalence (PEREIRA et al., 2009).

The highest occurrence was among married elderly people or in civil union (57.8%) (Table 1). The same was observed in other surveys, in which the majority of elderly people affected by stroke are married (CRUZ; DIOGO, 2008; MARQUES et al., 2006; PAN et al., 2008). It is known that many spouses exert the role of caregivers of elderly affected by stroke and this should be taken into account by health professionals that shall offer them support and guidance for insertion to care play a positive role in the rehabilitation process.

Note that, for those are widowed (30%), the studies reveal that most of them live in multigenerational residences. In this way, there is the need to reorganize the family acquaintanceship given the situation of the elderly with stroke, since generational conflict can favor the highest occurrence of depressive symptoms (LIMA et al., 2009). On the other hand, the health team is able to identify how family relationships are given aiming to identify potential caregivers that will contribute to confront possible family conflict and the co-responsibility of care to the elderly.

Regarding the income, the highest percentages were found among elderly people who receive a minimum wage (66.77%), which corroborates other studies (CRUZ; DIOGO, 2008; MARQUES et al., 2006; PAN et al., 2008).

There was a predominance of elderly people that possess 4 ├8 years of education (36.7%) (Table 1). The low level of education is still present among the elderly people. A research carried out in the interior of São Paulo State verified that 45.4% of the elderly people could read and write, but they did not have complete primary education (MARQUES et al., 2006). In this context, the health professionals must valorize the elderly presence in the health services, performing educational actions concerning health aggravation, as well as the necessary cares. It is necessary the use of educational and communication technologies which allow the effective understanding, by the elderly, concerning the performed educational health.

In the Table 2 is presented the distribution of frequency of the ADL of the studied elderly people.

Table 2. Distribution of frequency of the ADL of the elderly people with history of stroke. Uberaba (Minas Gerais State), 2010.

Daily life activities	Without		With difficulty					
			Little		Great		Unable	
	N	%	N	%	N	%	N	%
Feeding	70	77.8	8	8.8	5	5.6	7	7.8
Bathing	64	71.1	7	7.8	9	10.0	10	11.1
Getting dressed	63	70.0	10	11.1	9	10.0	8	8.9
Combing the hair	69	76.6	7	7.8	7	7.8	7	7.8
Lying down/getting out of bed	60	66.7	11	12.2	12	13.3	7	7.8
Going to bathroom in time	65	72.2	11	12.2	10	11.1	4	4.5
Urinary control	60	66.7	14	15.5	12	13.3	4	4.5
Intestinal control	60	66.7	24	26.6	2	2.2	4	4.5
Walking on a flat surface	40	44.5	20	22.2	13	14.4	17	18.9
Walking up and down stairs	29	32.2	11	12.2	24	26.7	26	28.9
Changing seat and bed and vice versa	70	77.8	3	3.3	5	5.6	12	13.3
Walking near home	44	48.9	13	14.4	14	15.6	19	21.1
Cutting toe nails	31	34.5	2	2.2	12	13.3	45	50.0

Note that 46.8% of the elderly people with history of stroke did not present functional incapacity. Regarding the other 53.2%, the percentages for the number of dependence to perform the ADL were 1 ├ 4 (34.4%), 4 ├13 (14.4%) and 13 and more (4.4%). Studies carried out in the interior of São Paulo State showed that 100% of the elderly people affected by stroke were dependent and 82.6% had interference degree in 7 or more ADL, result superior than found in the present study (RODRIGUES et al., 2008).

The elderly people with history of stroke present a high impairment degree of the ADL, interfering with their daily lives (KRIEGSMAN et al., 2004). In view of this situation, the ADL evaluation became fundamental to plan the health care of elderly people with stroke in an effective way, since these variables leave them vulnerable both for a higher risk of comorbidity or hospitalization (RODRIGUES et al., 2008).

The higher percentages of functional incapacity are related to the cutting toe nails (50%) and the walking up and down stairs (28.9%) (Table 2). In a study with individuals participant of the home care programme, in which there was predominance of people affected by stroke (40.5%), was found higher percentage of complete dependence in transferences, bathing and walking (ALENCAR et al., 2008).

Among the activities made with great difficulty are: the walking up and down stairs (26.7%), and the walking near home (15.6%) (Table 2). Discordant result was obtained in a research performed in Canada, the greater difficulties found by the individuals with stroke were to get dressed, bathing and the personal hygiene (VICENT et al., 2007).

In this study, the most affected ADL in the elderly with stroke are those related to mobility due to the motor sequels generated by the disease. These data emphasizes the importance of the health professionals to dedicate efforts for the recovery of functional capacity and/or maintenance of the elderly with stroke, aiming to optimize their independence.

Most elderly people who had stroke episode became dependent of other people to conduct the self-care. The elderly who have had stroke present six times more chances to the occurrence of moderate and severe dependence (CRUZ, DIOGO, 2008; ROSA et al., 2003).

The appearance of functional incapacities in the elderly people can generate social withdrawal, as well as from the activities which afforded personal satisfaction. The multidisciplinary team must stimulate the practice of leisure activities which are of interest to the elderly people, favoring the contact with society and with their surroundings (TAVARES et al., 2007). Furthermore, the health professionals can propose preventive actions for diseases and promotional for health, which contribute to postpone the appearance of functional incapacities, promoting the autonomy and the independence.

Regarding the self-evaluation of quality of life, the elderly people rated it as good (63.3%) and neither good nor bad (27.8%). These results can be considered positive once the studies show that the individuals affected by stroke suffer deterioration of quality of life resulting from the limitations and incapacities of physical and cognitive nature. Besides, family maladjustments may occur, which can be caused by situation of physical, psychological and/or economical dependence, and even of social exclusion (CRUZ, DIOGO, 2008; PAN et al., 2008).

In relation to the health self-evaluation, the highest percentage of elderly people were satisfied (48.3%) followed by dissatisfied (31.5%). This result diverge to the found in a study in São Paulo, in which the elderly people with chronic diseases, among them the stroke, possessed a poor health perception (ALVES; RODRIGUES, 2005).

The highest score of quality of life was for the domain social relationships (64.63), corroborating the surveys conducted in China (66.62) (PAN et al., 2008). However, divergent result was obtained in Croatia, since the elderly people affected by stroke presented higher score in the domain environment (BRAJKOVIC et al., 2009). It is possible that the cultural differences between European countries and those of Latin culture, such as Brazil, where the emotional ties are stronger, are the responsible for the difference between the studies (CORDINI et al., 2005).

The lowest score of quality of life was obtained in the domain physique (48.89), similar to the result of the research conducted in China (58.49) (PAN et al., 2008). Other study revealed higher impairment of physical aspect, although it was used instrument of quality of life different from the used herein. Note that, the inquiry conducted with individuals who had hemiplegic caused by the stroke, has verified the worst scores in the physical aspects (47.69) and in the functional capacity (40.46) (MAKIYAMA et al., 2004). On the other hand, a research performed among elderly people with previous history of stroke, using the instrument *Stroke Specific Quality of life Scale* (SSQOL), showed that 39.8% have referred losses in the domain of energy and work, 38% in the function of the upper

limb and 37.4% in the social relationships (CORDINI et al., 2005).

The lowest score in the domain physique can be explained by deficits from the stroke, which lead to a reduction of mobility, difficulty to perform activities of daily life and reduction of work capacity, aspects evaluated in this domain (FLECK et al., 2000). Also is relevant that the highest proportion of functional incapacity of the elderly people, in the present study, is related to mobility. Another point worth to mention is the presence of sequels which prejudice the elderly people functionality (CRUZ; DIOGO, 2008).

In relation to the analysis of quality of life, evaluated by the WHOQOL-OLD, it was verified a higher score in the facet death and dying (80.90). This facet evaluates the elderly perception in relation to preoccupations, inquietudes and fears in relation to death (FLECK et al., 2006).

The lowest score of quality of life was for the autonomy facet (53.86), which evaluates the freedom of the elderly people to take their own decisions, to feel in the control over their own future, to be able to do what they like, and to believe that people around them respect their freedom (FLECK et al., 2006). The autonomy is highlighted as one of the determinants of a good quality of life and a basic assumption for decision-making (CELICH; GOLDIM, 2010). The lowest score in this facet can be related to the depreciation of the elderly people desires by their familiars, taking into account the aggravation of a disabling morbidity like stroke. The health personnel must stimulate and guide familiars, caregivers and elderly people about the need to respect the decisions taken by this population.

The Table 3 lists the distribution of scores of quality of live according to the number of functional incapacity. A significant decrease was observed in the score quality of life relative to the physical domain, with increasing the number of functional incapacities among the elderly people with history of stroke ($F = 12.347$; $p < 0.001$) (Table 3). The increase of the number of functional incapacities lead to the compromising of discomfort and pain, energy and fatigue, activities of daily life, aspects evaluated in the physical domain (FLECK et al., 2000). Other aspects that must be considered is the fact that during the rehabilitation process after the stroke, there is the engaging of the elderly with the medicinal treatment, physiotherapy, speech therapy, nutritional treatment, among others. According to the individual's condition, the required treatment, which contributes with the motor function recovery, may become difficult due to familiar and financial issues (CAETANO et al., 2007).

Moreover, the work capacity, measured in this domain, may be reduced by the great number of functional incapacities causing a higher impact in the quality of life of these individuals (CHACHAMOVICH; FLECK, 2008).

These data reveal that the health professionals need to follow and monitor these elderly people indentifying their difficulties in the treatment. It is necessary to develop strategies of coping and monitoring in order to stimulate the functionality of the elderly affected by stroke. These strategies must be able to facilitate the rehabilitation process of the elderly people regardless the number of functional incapacities. It is known that a good follow up post-stroke can reduce the number of installed incapacities as well as prevent the appearing of new ones.

As the number of functional incapacity increased, was verified a decrease in the quality score relating to psychological domain among the elderly people with history of stroke ($F = 4.365$; $p = 0.007$) (Table 3).

Table 3. Distribution of quality of life in relation to the number of incapacities of the elderly people with history of stroke. Uberaba (Minas Gerais), 2010.

Score of quality of life	Number of functional incapacity					
	0	1 4	4 13	13 and more	*F*	p
WHOQOL-BREF						
Physical	53.67	38.48	29.95	28.57	12.347	< 0.001*
Psychological	66.49	57.02	57.69	54.17	4.365	0.007*
Social Relationships	65.08	64.78	62.18	66.67	0.269	0.847
Environment	60.34	54.84	64.18	57.81	1.750	0.163
WHOQOL-OLD						
Sensorial Ability	72.17	64.52	73.08	46.88	2.055	0.112
Autonomy	58.84	50	55.29	28.13	7.637	< 0.001*
Past, present and future activities	64.73	59.88	61.06	53.13	2.718	0.05
Social Participation	61.31	52.42	49.03	25	5.370	0.002*
Death and dying	81.99	77.82	82.69	87.50	0.326	0.806
Intimacy	67.11	66.13	73.07	71.86	0.566	0.639

$p < 0.05$, considered as significant.

The change in mood and the emotional lability of the individual post-stroke are situations expected and also difficult to deal with (LAVINSKY; VIEIRA, 2004), which can be associated with the loss of the functionality contributing to the advent of negative feelings, evaluated in this domain (CHACHAMOVICH; FLECK, 2008). Furthermore, the highest number of functional incapacity can affect negatively the self-esteem, body image and appearance; aspects evaluated in this domain (CHACHAMOVICH; FLECK, 2008). This fact is reinforced by the possibility of the individuals with stroke to present varied levels of physical, functional, and emotional limitations which disable them to the self-care (BRITO; RABINOVICH, 2008).

In this context, the health personnel should be aware to the advances of the functional incapacities, prevent, and intercept their development. The professionals can also develop actions to facilitate the elderly adjustment to their new conditions, imposed by the limitations originated from the disease.

Regarding the autonomy facet, the elderly people with history of stroke possessing 13 and more functional incapacities presented lower score of quality of life compared to the others ($F = 7.637$; $p < 0.001$) (Table 3). The motor, cognitive, emotional and social sequels resulting from the stroke stand out for compromising the execution of the ADL and consequently, the autonomy and independence (CRUZ; DIOGO, 2009).

Thus, the individual with higher number of functional incapacities become more dependent on third parties to execute the desirable activities and, this fact can be understood by the familiar or caregiver as, also, inability for decision-making.

In this context, the health professionals must stimulate the caregivers and familiars to respect the elderly desires, by offering them the capacity to live autonomously within their functional limitations.

Also, it must be developed actions for the recovery of the motor ability, necessary to the reintegration of the individuals in their activities, which could contribute to enhance the autonomy. This is strongly dependent on the stimulus offered to the elderly people affected by stroke, since its initial phase. The treatment must be addressed to the maintenance and stimulus of the functionality (BRITO; RABINOVICH, 2008).

The highest number of functional incapacities was related to a significant reduction in the score of quality of life of the facet social participation among the elderly people with history of stroke ($F = 5.370$; $p = 0.002$) (Table 3). The participation in social activities is strongly hindered by the level of functional incapacity (BRITO; RABINOVICH, 2008). Note that the stroke can cause sequels which interfere in the ADL, making the elderly people dependent, causing social isolation and disorganizing these people lives and, consequently, their family life (BRITO; RABINOVICH, 2008; CRUZ; DIOGO, 2009).

The limitations imposed by the sequels generated by the disease can lead the individuals to become dependent on others to participate in activities jointly with the community. According to the observed in this research, the highest number of functional incapacities affects negatively the elderly social participation, which may lead to confinement in their homes. In this perspective, the health professionals may be able to identify the activities present in the community and discuss strategies that allow the social integration of the elderly people. Furthermore, the formation of groups may be promoted, stimulating an active social life through recreational, physical, and cultural activities.

Conclusion

Most elderly people with history of stroke is of the male sex; 70 ├-80 years old; married or in civil union, 4 ├-8 years of education and monthly individual income of a minimum wage.

A percentage of 53.2% of the elderly people presented functional incapacity to perform the ADL, in which 34.4% possessed of 1 ├-4. The highest percentages of functional incapacities were related to motor abilities, such as to cut toe nails, to walk up and down stairs and to walk on a flat surface.

The highest scores of quality of life were to the domain social relationship and the facet death and dying, while the lowest were to physique and the facet autonomy. The highest number of functional incapacity was related to lower scores of quality of life in the physical and psychological domains and in the facets autonomy and social participation.

These data show that the possible sequels derived from the stroke, temporary or not, can affect the functional capacity, the self-esteem, the decision power and the social relationships of the elderly people, deteriorating their quality of life. Therefore, the health professionals must initiate very early the specific activities for the maintenance and the stimulation of the elderly functionality, allowing minimizing the impact of functional incapacities in their daily lives. Furthermore, it is necessary to give priority to actions that stimulate the respect to the elderly decisions and the participation in activities according to their interests.

It is worth to mention that, as limiting factor of the present study, by virtue of the cross-sectional design, there is no assurance for the implicit relationships at random among the studied variables.

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Received on June 21, 2010.
Accepted on August 24, 2011.