

FALL OF ELDERLY: REVEALING VULNERABILITY SITUATIONS

QUEDA DE IDOSOS: DESVELANDO SITUAÇÕES DE VULNERABILIDADE

CAÍDAS EN EL ADULTO MAYOR: EXPONIENDO SITUACIONES DE VULNERABILIDAD

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ABSTRACT

The aging of the population has impacted the situations of vulnerability to which the elderly are exposed. In the context of external aggravations, there is the fall as an accidental and multifactorial event, of great concern in both health and social areas, as proportional to the increase in the elderly population, are the situations of vulnerability scenarios. **Objective:** to reveal the vulnerability situations reported by elderly and caregivers in a public hospital in a capital city in southern Brazil. **Methodology:** descriptive, qualitative research, with 16 elderly. We used Bardin's Content Analysis. **Results:** the thematic axis Queda was evidenced, with four categories: How was the Fall; First Service and Hospitalization; Causality of the Fall; Meanings and Feelings Caused by the Fall. Individual vulnerability was revealed by the comorbidities of the elderly. Institutional vulnerability revealed itself in hospitalization and the meanings of the fall, warning of fear of falling, guilt, disability, loss of autonomy, pain and discomfort. **Conclusion:** the relevance of preventive strategies in the dimensions of vulnerability is observed, increasing the attention given to the elderly. Such strategies may lead to a mapping of the fall itinerary of each hospitalized elderly person, diagnosing their needs in order to provide qualified care through an efficient clinical practice.

Keywords: Accidental Falls; Health of the Elderly; Risk; Health Vulnerability.

RESUMO

O envelhecimento populacional tem impactado nas situações de vulnerabilidade a que os idosos estão expostos. No âmbito dos agravos externos, encontra-se a queda como evento acidental e multifatorial, de relevante preocupação tanto nas áreas da saúde, quanto social, pois proporcional ao aumento da população idosa encontram-se as situações dos cenários de vulnerabilidade. **Objetivo:** desvelar as situações de vulnerabilidade relatadas por idosos e cuidadores em um hospital público em uma capital no sul do Brasil. **Metodologia:** pesquisa descritiva, qualitativa, com 16 idosos. Utilizou-se análise de conteúdo de Bardin. **Resultados:** evidenciou-se o eixo temático queda, com quatro categorias: como foi a queda; primeiro atendimento e hospitalização; causalidade da queda; significados e sentimentos provocados pela queda. A vulnerabilidade individual desvelou-se pelas comorbidades do idoso. A vulnerabilidade institucional revelou-se na hospitalização e nos significados da queda, alertando para o medo de cair, o sentimento de culpa, a incapacidade, a perda de autonomia, a dor e o desconforto. **Conclusão:** observa-se a relevância das estratégias preventivas nas dimensões da vulnerabilidade, ampliando o olhar na atenção ao idoso. Tais estratégias poderão levar a um mapeamento do itinerário da queda de cada idoso hospitalizado, diagnosticando suas necessidades para assim prestar assistência qualificada, por meio de uma prática clínica eficiente.

Palavras-chave: Acidentes por Quedas; Saúde do Idoso; Risco; Vulnerabilidade em Saúde.

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RESUMEN

El envejecimiento de la población ha impactado en las situaciones de vulnerabilidad a las que están expuestos los adultos mayores. Entre las lesiones externas, las caídas son eventos accidentales y multifactoriales sumamente preocupantes, tanto para las áreas de la salud como en lo social, ya que las situaciones de vulnerabilidad aumentan proporcionalmente al aumento de la población de adultos mayores. Objetivo: mostrar las situaciones de vulnerabilidad relacionadas por adultos mayores y cuidadores en un hospital público de una capital del sur de Brasil. Metodología: investigación descriptiva y cualitativa realizada con 16 adultos mayores. Se utilizó el análisis de contenido de Bardin. Resultados: del tema principal, la caída, se establecieron cuatro categorías: cómo ocurrió la caída; primeros socorros y hospitalización; causa de la caída y significados y sentimientos provocados por la caída. La vulnerabilidad individual quedó expuesta por las comorbilidades del adulto mayor. La vulnerabilidad institucional se reveló en la hospitalización y en los significados de la caída, mostrando el miedo de caerse, el sentimiento de culpa, la incapacidad, la pérdida de autonomía, el dolor y el malestar. Conclusión: se observa la importancia de las estrategias preventivas en las dimensiones de la vulnerabilidad, fijando el foco en la atención del adulto mayor. Tales estrategias podrían trazar el itinerario de la caída de cada una de estas personas hospitalizadas para elaborar el diagnóstico de sus necesidades a fin de brindar atención de calidad a través de la práctica clínica eficiente.

Palabras clave: Accidentes por Caídas; Salud del Anciano; Riesgo; Vulnerabilidad en Salud.

INTRODUCTION

Population aging has impacted on the situations of vulnerability to which the elderly are exposed. The circumstances adjacent to aging presuppose fragilities that can potentially be effected by the presence of susceptibilities present in the context of people's lives.

In the scope of the injuries is the fall as an accidental phenomenon. This is a multifactorial event and occurs through unintentional contact with the surface on which the body is displaced from one level to another, lower than that of the initial position.¹

The fall emerges as a subject of relevant concern for the health area and for society, since with the increase of the elderly population the situations arising from a scenario of vulnerability multiply. Vulnerability in the universe of the elderly has often been associated with the concept of fragility, since fragility constitutes a multidimensional syndrome resulting from a complex interaction between biological, psychological and social factors.²

The occurrence of falls in the elderly is directly linked to risk factors, which can be divided into intrinsic (related to the elderly) and extrinsic (related to the environment). The intrinsic factors include physiological changes, presence of diseases, psychological factors and reactions to medications. Extrinsic factors refer to behavioral and environmental risks at home and away.³⁻⁵

The concept of vulnerability, observed through these dimensions, is comprehensive and involves behavioral, cultural, economic, and political aspects. The three dimensions of vulnerability are expressed by the biological / individual dimension, which translate personal self-care behaviors; Social situations, which are the lived social situations that interfere in the health conditions; And, institutional / programmatic, which represents the commitment and actions of institutions that affect people's health.⁶

It is understood as relevant to highlight the subjective dimension of vulnerability, since there are research spaces to be filled as to the analysis of the aspects of aging with the situations of vulnerability of the elderly, from a point of view that

surpasses the clinical aspects. Thus, the objective of this study was to reveal the situations of vulnerability, reported by elderly and caregivers, in a public hospital in Florianópolis, from October to December 2014.

METHODOLOGY

A descriptive study was carried out with a qualitative approach, which respected the different ways of thinking that emerged from the manifested contents. The Governador Celso Ramos Hospital, in Florianópolis / SC, from October to December 2014 was the data collection scenario.

Elderly and caregivers were invited to be part of the research and were informed about the objectives, risks and benefits of the research, responding to a semi-structured interview script. The interviews were recorded and lasted from 40 to 60 minutes, being transcribed in full to preserve the meaning of the speeches.

Inclusion criteria involved people who were 60 years old and more hospitalized due to falls and who agreed to participate by signing the Free and Informed Consent Term (TCLE), as well as caregivers who were better respondents in the face of some impossibility of the elderly person, such as Mental confusion, cognitive deficit, coma and hospitalization in an isolation area.

In order to preserve the anonymity of the participants, codes consisting of letters and numbers were used, identifying the elderly by the letter "I" and numbers from 1 to 8 (I1, I2, I3 [...] I8), as in the same way "C" "For caregiver, following the same numbering (C1, C2, C3 ... C8).

Data analysis followed the Content Analysis process, according to Bardin (2011)⁷, through three steps: 1) pre-analysis; 2) exploitation of the material; And 3) treatment of results, inference and interpretation.

The pre-analysis was the stage of material organization, operationalization and systematization of the initial ideas. It corresponded to the phase in which the transcribed contents were organized in electronic records and subjected to float-

ing reading, making the content of the messages clearer. In this stage the markings in the transcribed texts were realized, identifying native categories and sense nuclei.

The exploration of the material was the phase in which the decisions taken in the pre-analysis took place. The common information from the interviews laid the groundwork for further categorization. It followed with the extraction of sense nucleus and native categories for a second electronic document.

The third stage was effected by the treatment of the results obtained and the interpretation of the units of meaning of the manifested contents.

The study was approved by the Human Research Ethics Committee of the Federal University of Santa Catarina (CEPSH / UFSC), under protocol number 748,950, and by the Research Ethics Committee of Go Hospital (CEP / HGCR), through protocol 2014/00017, which followed the norms of Resolution 466/2012 of the National Health Council for human research.⁸

RESULTS AND DISCUSSION

The interviews were conducted with 16 participants, which eight were elderly and eight were caregivers. The elderly interviewed were between 60 and 84 years old. The majority of participants were female (six). Half of the elderly group was married, and the other half was a widow. Six elderly people were retired, two due to disability, one of whom was wheelchair-bound. One of the elderly women was from the home and the other worked at home as a carpenter. The group of caregivers was all made up of women and only one was single.

The caregivers were between the ages of 28 and 65 years. Most caregivers maintained occupations related to the home and the care activity with the elderly. Two caregivers maintained activities outside the home with an employment relationship, an audit and the other was a caregiver for the elderly in a Long Stay Institution for the Elderly (ILPI). From the participants' speech emerged the theme axis Fall, around which four categories were organized, namely: How was the Fall; First Service and Hospitalization; Causality of the Fall; Meanings and Feelings Caused by the Fall. In the category How the Fall was, the participants described the fall scenario, revealing the points of risk and vulnerability, as well as the intrinsic and extrinsic factors to which the elderly were exposed.

The talk of the caretaker and daughter (C5) describes how it was to her the fall of her father, happened by slip in the bathroom:

He fell into the bathroom. Slipped. He was bathing alone [...] He wore a sandal to bathe, inside the stall [...] That day he took off his sandal before leaving the stall [...] I think that's why he slipped. When we opened the bathroom he was on the floor without the sandal [...] I realized

he took it off [...] I would never imagine that this could happen to him. (C5).

This elderly had Alzheimer's Disease and Diabetes Mellitus, according to the daughter's report and confirmation of the nursing team during hospitalization. Her hospitalization occurred after finding a femoral fracture due to the fall, the need for surgery, and the intercurrent of bronchoaspiration due to vomiting, caused by an intense pain crisis in the immediate post-fall. In an extended perspective, it is sought to relate the risk factors of the fall to the notion of vulnerability. In the case reported, vulnerability points coexisted in that home environment, exemplified by the current health condition of the elderly, in the presence of cognitive deficit and risk for hypoglycemia, translating biological / individual vulnerability. In addition, points of social vulnerability were also observed by the presence of environmental risks, such as the use of inappropriate footwear, flooring and the absence of protection bars.

The family nucleus is another fundamental question, being the support that the elderly needed to perform routine activities, such as bathing alone, since it had a dementia picture. In this context, access to the information and resources available to promote the well-being of the elderly is another relevant aspect of social vulnerability, in which the support network needs information and knowledge to actually be able to support and care for this elderly person.⁹

The daily life and the risk exposure posture were determinant in the fall of the elderly I4, which evolved to fracture of femur and humerus, hospitalization, surgery and immobility for an indeterminate time, due to the characteristics of the lesion:

[...] was making food and I use a ladder to pick up the spices in my hanging garden [...] To give a better support [...] I put three tiles under the foot of the stairs, because the ground is irregular [...] there the ladder gave way and I fell [...] But I was not so high no [...] (I4)

A bibliographic review study analyzed the national scientific productions on risk factors extrinsic to falls in the elderly. The selected studies pointed out that in the domestic environment the stairs, the bedroom, the living room and the bathroom are the places that the elderly people most fall, either by slipping, stumbling or climbing objects; By the presence of carpets, lack of light, lack of bars in the bathroom, inadequate use of cane, walker and wheelchairs [...], in addition to the use of inappropriate footwear. Consideration should be given to the domestic environment as a whole, as the obstacles are varied and require monitoring of the specific elements of vulnerability for each elderly person.¹⁰

Keeping household objects such as carpet can represent an obstacle to the mobility of the elderly in their home, being

an environmental risk factor for the event fall. During the interview the old woman showed great sadness at having experienced the fall, besides a feeling of revolt and guilt for having stumbled on the carpet herself, repeating her discontent several times during the interview:

[...] I was dumbass! Very dumb for not taking the carpet away [...] now I will take everything [...] will not get anything and I want to leave this house because it is full of things here to make me fall! (17)

Situations of vulnerability of falling due to tripping on carpets and other obstacles at home were evidenced in the study by Lopes, 11 who conducted semi-structured interviews with 20 participants. The results showed that 55% of the elderly interviewed had fallen in the last 10 years. Most of the falls occurred by slipping indoors, usually in the kitchen and bathroom, as well as stumbling on carpets or objects on the floor and bumping into furniture. Other falls occurred in the yard. The risk of falling is present in the domestic environment, but also outside. According to the testimonies it was noticed that the environment outside the home presented important risk factors and social and institutional vulnerability:

The fall in itself was when he was on the street. [...] He had lunch and was going to the service [...], information given by SAMU is that he had hit his head on one of those iron covers on the street [...] His blood glucose was at 54, I do not believe It was because of blood glucose! He may have had a lightheadedness, may have stumbled on his own foot. (C1)

I fell as I got off the bus. [...] it was night [...] I did not see it.), "I lost my foot" on the last step, and that's when I went to put my foot on the ground [...] silly [...] we lose our balance. The worst part was that I fell on my foot. My foot twisted and I could not get up. (15)

Risk factors for falls in the elderly at home and abroad do not allow full management of services and health professionals. In this way, social vulnerability is close to risk factors, drawing attention to the vulnerability of the elderly and their families who do not have access to information, physical and structural resources appropriate to the needs of the individual.⁹ Institutional / programmatic vulnerability is the Actions of national, regional or local programs to prevent falls and provide care for the elderly. This dimension of vulnerability also guides educational actions related to the empowerment of the subjects.⁹

After suffering a fall, most of the time, the elderly will need some type of care and depending on the degree of complex-

ity there will be a need for urgent care and hospitalization. This need was reported by the elderly and caregivers, as evidenced in the First Care and Hospitalization category. In this category it was possible to analyze in the participants' reports the meaning attributed to the first care received by the elderly, at home or on the street or in their hospitalization experience, as Participants C2 and I4 stated:

[...] we called SAMU and the nurse who examined her said that she had a 90% chance of breaking the femur. [...] arrived here in the hospital and that was it [...] the femoral fracture was confirmed. It was all very fast. (C2)

The rescue was very fast, the neighbors called the firemen [...] they took me straight to the UPA and there they did the first care. When the doctor pulled my leg [...] that pain [...] I asked to give an anesthesia [...] the doctor said there was no time [...] it was necessary to put the bone in place due to obstruction Of the artery at risk of losing the leg. (I4)

Content about the perception of the elderly and caregivers about experiences during hospitalization emerged, exemplified by the speech of participant I1.

After the accident [...] of this period here in the hospital [...] I was very stressed, I feel bad [...] I'm taking medicine for stress. [...] this "Amitriptyline" [...] and I am even taking the "Diazepam" of the husband [...] (I1)

The elderly I3 related their discomfort in relation to hospitalization, mainly, to the interruption of their food routine And the need to adapt to the institution's dietary standards, which at the time did not offer the option of a diet that was closer to what the elderly woman had every day:

I'm sick and bored [...] I'm not feeling well in this hospital. [...] I can not do anything, I feel trapped, sad [...] I'm not eating right [...] this food here can not give me [...] my food is all natural. (I3)

The institutional vulnerability of the hospitalized elderly is perceived as having to adapt to the functioning of a service that does not anticipate the needs of the aging population, especially because "hospital admission can be considered a factor of physical and emotional disruption for the person Elderly, since the interactions occur in a bond established by situational and structural force."¹²

The caretaker C5 showed great anxiety and regret for the hospitalization of his father:

[...] he has to be tied to not tamper with the probe .. It was a pain to put on this probe and when it went out they had to put it back [...] it does not imagine the suffering that was for him [...] He screamed, swore [...] he spoke ill of everybody! It was I do not know why he screams so much, it seems like it's pain, but they said it's because of the disease [...] they told me that if it's from the disease, then it does not need medicine for pain [...] I do not know [...] (C5)

Caregiver C5 demonstrated a strong emotional mobilization during the interview, motivated by the doubt that the elderly shouted for the agitation or for being in pain, a situation that for her was not well explained. Caring for hospital admission in the elderly with dementia, Often represents a highly challenging situation for the multiprofessional and stressful team for the caregiver accompanying the elderly at that time. The state of disorientation to which the elderly are subjected, in addition to the psychiatric manifestations that may be present, make the hospitalization situation and the hospital routines a painful experience for all involved. The hospital structure aims to recover the health of the elderly, besides having norms, routines and procedures that are not always flexible and that are focused on the resolution. Thus, these standardizations connect the elderly to the domain of the institution, leaving no room for personalization of care.¹²

Programmatic / institutional changes could account for promoting comprehensive care for the elderly by knowing their morbidity profile, as well as avoiding Compromise functional capacity. It is the responsibility of the multiprofessional team and the service management team to plan and plan care that prevents complications of hospitalizations, and to plan strategies for care after hospital discharge.¹³

From this, the category Causality of Fall arose in which the participants identified The reasons why the elderly fell, the reasons and the circumstances in which the fall occurred. This topic explicitated the relationship between a condition of exposure to risk experienced by the elderly and the fall as a consequence of this situation. In the speeches of the participants, the cause and effect relationship was explained by the current health condition, centered on the disease presented by each elderly person, such as Diabetes Mellitus, dementia, cardiopathy, and the unfolding of these diseases.

[...] I believe the fall was due to hypoglycemia. (C3)

[...] her fall was triggered by dizziness [...] She fell sideways on the right femur. (C4)

The causality for participants C3 and C4 was most evidently expressed by the association of falls with symptoms

such as hypoglycemia and dizziness. Causality converges to risk factors, expressing individual, social or programmatic vulnerability, but it is not always possible to isolate one Effects are directly perceived, such as injuries, fractures, surgeries, incapacity, and death.^{9,10,14} Thus, it is fundamental to identify the individual vulnerability points, realizing how it is possible to contribute to Prevention potential. In order to do so, the health professional must be able to participate in all three levels of prevention. Primary prevention may occur through the evaluation of the elderly during home visits, as well as during educational processes, to strengthen self-care. In secondary prevention a more detailed evaluation is important, since cases of recurrent falls often associated with health problems that require systematic follow-up are seen. In tertiary prevention, in a hospital environment, for example, the elderly, their caregiver and their families should be alerted to the possible risks of falls.¹⁵

In the hospital context, the institutional vulnerability that the elderly person is exposed to, which can overlap with the Biological / individual vulnerability, culminating often in falling within the hospital environment. In this scenario, the lack of information and the interaction of professionals with caregivers and the elderly, which reinforces vulnerability, are present.⁹

Thus, measures for the protection and safety of the elderly should be adopted, seeking the preservation of physical and mental integrity, preventing Unfavorable and often fatal outcomes. Observing the testimony of the caregiver C6, one can perceive the context of vulnerability to which her mother was exposed during the hospitalization process in two institutions, the first one in which the fall occurred and the second that was the scenario of this study.

She was hospitalized to find out a possible stone in the region of the abdomen, in another institution [...] not here. I brought her here after she fell there [...]. Now [...] in this hospital I'm careful that this does not happen again. I've already been told that her case is not good, but they do not say much more than that [...] She has dementia [...] she's confused [...] but I'm not sure if she understands what's going on [...] I do not know What is the disease and what is the consequence of the fall. (C6)

For the elderly and their caregiver to understand the process that led to the fall is not always easy task. In the C4 care the fall meant dependency, limitation, because in his professional experience he often sees institutionalized elderly people fall and have to live with the Outcomes, in addition to the need for intensive care for dependency and functional disability:

[...] for me, "it is dependency." [...] I have had elderly people who were independent and today are "bedrid-

den" due to a fall. They lose a lot of independence [...] to do things when they want [...] they become dependent on other people. (C4)

Her fall was an accident [...] "Fall is a fatality" [...] No one was to blame [...] She wonders [...] why? [...] Why did not you just sit and wait for the secretary to get out of the bath [...] why did you have to get up and walk alone? She ventured [...] (C7)

It is interesting to analyze the speech of the participant C7 mentioning that the fall was a fatality and that no one was to blame, she or the elderly. It is common to blame the individual in the spaces of care relationship, often, the feeling of responsibility that runs through this scenario. The meanings of the falls were linked to moments of tension and guilt associated with the time of the fall and the way the participants saw themselves on the scene, being the guilt manifested by the elderly or caregiver himself, as well as by the people living in the social conviviality network. In the speeches of some of the participants one can see the sense of responsibility for oneself and the other, the sense of regret for what has happened, carried by the reflection of what could have been done to avoid the fall, from an individual attitude. The feeling of guilt appears as a manifestation of the elderly and the caregiver related to the fact that they could not avoid the accident, according to C8, 18:

I felt guilty about her fall [...] I thought she was my responsibility [...] (C8)

[...] I was very upset [...] I even hurt myself, because he took care of me "a barbarity". I feel a little guilty [...] because I should not have facilitated, I should have waited for that leg to create more force [...] I was forcing [...] doing the exercises. (18)

The falling elderly, their caregiver and their family should be aware of the risks and vulnerabilities present in their daily lives, but they are not alone responsible for their well-being. Institutions and public policies that guide health guidelines are also responsible for maintaining the health of the elderly. The situation of the fall experienced is described by the participants' speeches as something unbearable, which brings the unpleasant feeling associated with the outcomes of the fall, according to The statements of the elderly I1 and I7:

[...] on Friday they put that "iron" and on Tuesday I did the surgery. [...] what a horrible thing [...] what a pain. This situation was horrible [...] I had never been hospitalized. (I1)

I'm very annoyed [...] What a horrible situation! Even talking is bad. I am angry. I can not even move. I depend on my son to change sides. I do not look good on either side. If I turn I have the dressing, on the other I can not because it hurts me too. (I7)

The expression reported as "horrible situation" is linked to the sensation of pain, discomfort and irritation associated with the very experimentation of the consequences of the fall such as immobilization and the diminution of independence and autonomy. The discomfort can be identified in the situation of fall and trauma of the elderly, in the presence of fractures, injuries, after surgery and in recovery at home. Tertiary care health services should follow specific criteria for evaluation and pain relief in the elderly. According to Eliopoulos,¹⁶ pain without relief in the case of the elderly can lead to many complications such as lack of appetite, lack of motivation to eat and drink, limitation of mobility to avoid feeling more pain, besides pneumonia, depression and hopelessness. Fear of falling again and recurrent falls have been reported in a number of studies.¹⁶⁻¹⁸ An exploratory-descriptive study conducted with community elders aimed at assessing fear of falls and their correlation with functional and cognitive performance in the municipality Of Guaxupé-MG. Statistical analysis showed that 96.43% of the elderly presented a concern to fall, in addition to the significant correlation between fear of falls and the difficulty to perform activities of daily living.¹⁷ Carrying out activities of daily living becomes a concern for The elderly by fear, which increases risks and vulnerabilities. The feeling that the elderly person remains after an accident due to falling can generate insecurity and the expectation of what can happen, a situation highly influenced by the fear of new falls:

A thing that stays after a fall and more still when it has more than one is The fear of falling again. There is always that fear [...] expectation that will happen again. (I2)

Health professionals should be able to prevent falls among the elderly and their families.¹⁸ Public policies should be prioritized in order to minimize falls, encouraging the practice of physical activity as a form of prevention.¹⁹

FINAL CONSIDERATIONS

It is believed that the objective of the study was reached, once the situations of vulnerability of the elderly hospitalized in a hospital service were revealed.

Thus, it was possible to visualize the sequence of events that involved the reported falls. From this, emerged the thematic axis Quedas, that was characterized by means of four

categories. The Fall, First Attendance and Hospitalization categories, Causality of Fall, Meanings and Feelings caused by the Fall translated stages of a process experienced by the elderly, from the occurrence of the event to the manifestation of the feelings attributed to him.

Health services should be prepared to act in situations of falling, through adequate physical and human resources. Professionals must be able to attend elderly people, from the identification of situations of vulnerability of the elderly to fall and with this act in a preventive manner.

As limitations of this study we can refer to the impossibility of generalization of data and that some elderly were unable to be interviewed, due to neuropsychomotor limitations, in this case, the interviewee was the caregiver. In addition, we suggest the production of intervention studies to prevent falls that can be applied in clinical practice and that make it possible to manage the vulnerability.

It is observed the importance of preventive strategies that perceive individual vulnerability in relation to the comorbidities of the elderly, such as dementia and Diabetes Mellitus; Institutional vulnerability on the risks of hospitalization and the meanings attributed to falling by the actors involved, warning of the fear of falling again, guilt, disability, loss of autonomy, the sensation of pain and discomfort. The importance of these strategies is undeniable, due to the possibilities of acting with an expanded view on the health care of the elderly.

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