

FRAILTY ASSESSMENT IN THE ELDERLY ASSISTED AT A FAMILY HEALTH UNIT

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ABSTRACT: Frailty is an important health status indicator in the elderly. The Edmonton Frail Scale, a multidimensional tool validated and culturally adapted into Brazilian Portuguese, may be used for its assessment. A cross-sectional, descriptive study was developed to identify the presence of frailty in the elderly assisted by the Family Health Program in a city in São Paulo, Brazil. All ethical considerations were observed. A sample of 128 older adults was interviewed. There was predominance of female older adults, aged between 60 and 69 years, with low education and personal income. Considering all the older adults who answered all the questions in the scale, 103 had their level of frailty assessed. Of these, 21.4% were apparently vulnerable and 30.1% had some level of frailty, varying among low, moderate and severe. The 25 older adults who failed to answer all questions presented vulnerability to frailty. In conclusion, the scale is suitable for frailty assessment in primary care, as long as it is adjusted to the characteristics of the target population.

DESCRIPTORS: Frail elderly. Family Health Program. Primary health care. Public health

AVALIAÇÃO DA FRAGILIDADE DE IDOSOS ATENDIDOS EM UMA UNIDADE DA ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO: A fragilidade é um indicador importante da condição de saúde de idosos. A *Edmonton Frail Scale*, instrumento multidimensional validado e adaptado culturalmente para o português do Brasil, pode ser usada para avaliá-la. Realizou-se estudo transversal, descritivo, com objetivo de identificar a presença de fragilidade em idosos atendidos pela Estratégia Saúde da Família em um município paulista. Os cuidados éticos foram observados. Foram entrevistados 128 idosos. Houve predomínio do sexo feminino, faixa etária de 60 a 69 anos de idade, baixa escolaridade e renda própria. Somente 103 idosos que responderam a todas as questões da escala tiveram o grau de fragilidade avaliado. Desses, 21,4% eram aparentemente vulneráveis e 30,1% apresentavam algum grau de fragilidade, entre leve, moderada e severa. Os 25 que deixaram de responder alguma questão apresentavam vulnerabilidade à fragilidade. Conclui-se que escala é adequada para avaliação de fragilidade na Atenção Básica, desde que adequada às características da população-alvo.

DESCRIPTORIOS: Idoso fragilizado. Programa Saúde da Família. Atenção primária à saúde. Saúde pública.

EVALUACIÓN DE LA FRAGILIDAD DE PERSONAS MAYORES ASISTIDOS POR LA ESTRATEGIA SALUD DE LA FAMILIA

RESUMEN: La fragilidad es un indicador importante del estado de salud de los ancianos. La *Edmonton Frail Scale*, herramienta multidimensional validada y culturalmente adaptada al portugués de Brasil, puede ser usada para su evaluación. Estudio transversal, descriptivo, con el objetivo de identificar la presencia de fragilidad en personas mayores atendidas por la Estrategia de Salud de la Familia en un municipio de Sao Paulo. Todas las consideraciones éticas fueron observadas. Se entrevistaron 128 ancianos. Hubo predominio del sexo femenino, entre 60 y 69 años de edad, bajo nivel educativo y con ingresos propios. Sólo 103 personas mayores que contestaran a todas las preguntas de la escala tuvieron su grado de fragilidad evaluado. De estos, el 21,4% eran aparentemente vulnerables y el 30,1% tenía algún grado de fragilidad, entre leve, moderada y severa. Los 25 que no responderán a todas las preguntas presentaban vulnerabilidad a la fragilidad. Se concluyó que la escala es adecuada para la evaluación de la fragilidad en la Atención Primaria, se adecuada a las características de la población-objetivo.

DESCRIPTORIOS: Anciano frágil. Programa Salud de la Familia. Atención primaria de salud. Salud pública.

INTRODUCTION

The growth of the elderly population in Brazil presents countless challenges to public policies. In the health sector, this pressure is particularly intense, given the fact that older adults constitute the population segment that uses health services more often, mainly due to chronic diseases and their complications.¹

The National Health Policy for the Elderly (PNSPI, as per its acronym in Portuguese) places the frailest elderly among the population group with greater vulnerability² and recommends that once the condition of frailty is recognized, local resources must be used to decrease or reverse it.

This policy makes reveals the scarcity of home care services available to the frail elderly and recognizes the family as the main care provider for the elderly in Brazil. It recommends that the primary health care network should provide support to family caregivers, offering them the appropriate assistance to the provision of the care required by the elderly, especially those with functional impairment and dependence.²

Currently, the National Policy of Primary Health Care proposes that the provision of health care to the elderly population from an area submitted to the Family Health Program happens both in the scope of the health units and at home and community places (schools, neighborhood associations, among others) and that all members of the family health team provide humanized care through the qualified listening of the clients' needs.³⁻⁴

Frailty is an important health status indicator of the elderly. However, given the multidimensional characteristic of the concept,⁵ its definition remains without a consensus, which makes it difficult to be used in the formulation of health promotion strategies. The elaboration of an operational definition of frailty that may be used in the practice of the health services still represents a challenge to be overcome.

Until 2010, there were two international study groups working on the definition of the concept of frailty and on the instruments for its operation, one of them in the United States⁶ and the other in Canada,⁷ the latter with the collaboration of Israel, Japan and countries in Europe.

The North American researchers define frailty as a syndrome in which there is decrease of the energetic reserve and resistance to stressors, as a result of the decline of the physiological systems

and the decreased efficiency of the homeostasis in situations of stress, such as variations in the health condition.⁶ According to the definition of this group, this syndrome is based on a tripod of alterations that may be related with aging: sarcopenia, neuroendocrine unbalance and immunologic dysfunction, which will compose the frailty phenotype.

The researchers of the Canadian Initiative on Frailty and Aging (CIF-A) accept the model of the North American phenotype of frailty, but consider it to have restricted usefulness in the assessment of the vulnerability related to health, since they understand that this assessment cannot be separated from other important elements, such as cognition, mood and social support. They consider frailty as a multidimensional concept, which, being heterogeneous and unstable, is even more complex than disability or aging.⁷ They also argue that most frailty assessment tools do not allow tracking assessments, since they use multidimensional clinical data, which are typical of a broad geriatric assessment. Therefore, they propose the use of a clinical tool to detect frailty in older people; the Edmonton Frail Scale (EFS). This is a comprehensive scale, as it considers aspects related to cognition, mood and social support, which may also be indicators of frailty among the elderly.⁷ The scale was validated and considered reliable for routine use.

In Brazil, there are studies using both scales, the North American model of frailty phenotype and the EFS.⁸⁻⁹ In this study, the EFS was used to assess the frailty of older adults in the context of the family health program, since it may be used by professionals who are not experts in the geriatric and gerontological areas.⁷

PURPOSE

The purpose of this study was to verify the presence of frailty in a group of older adults using the Edmonton Frail Scale, and assess the applicability of this scale in primary health care. The subjects were clients of the family health program of a local health care unit.

METHOD

This observational, descriptive, cross-sectional study was performed with a quantitative approach at a family health unit in Embu, a city in the metropolitan region of São Paulo, chosen according to its social vulnerability index (IPVS,

as per its acronym in Portuguese)¹⁰ in 2000, both regarding the city and the regions in which the health unit was implemented. In 2000, the population of Embu presented an IPVS of 54.2%, which represented average vulnerability. In order to allow a broader view of the social context, a health care unit in *Jardim Dom José* was selected, a region with similar IPVS.

The population comprised older adults registered in one of the family health units. In order to define the sample, the authors obtained, through the Information System of Primary Health Care (SIAB, as per its acronym in Portuguese), the number of older adults who are assisted by the selected primary health care unit. This number was compared with the list of families with members aged 60 years and older, aimed to identify the real number of older adults assisted, and to avoid sampling errors. The SIAB survey identified a population of 485 older adults. However, in the relationship of the families with members aged 60 years and over, there were 432 older adults, which was the value considered for the reference population.

The sample was calculated estimating the proportion of frail older adults in the studied population, already considering the necessary corrections for the finite population. The confidence index adopted was 95% and the sample error, 5%. Since the proportion of frailty was unknown, a proportion of 0.5 was admitted,¹¹ which resulted in a sample of 128 older adults. Participants were selected by means of simple random sampling.

The inclusion criteria were: being an older adult aged 60 years or older, living in the area covered by the primary health care unit at the moment of study, being capable of communicating and being at home in at least three consecutive visits. The exclusion criterion applied to those who did not accept to participate in the study.

Regarding ethical procedures, the participants were informed regarding the purposes of the study and data confidentiality, as per the terms of the resolution 196/96 and, once they agreed to participate, participants signed the Free and Informed Consent Form. The project was registered under number 915/2010 and approved by the Research Ethics Committee at University of São Paulo School of Nursing.

Data were collected after the approval of the Ethics Committee, between June and July of 2010. Dates and times were scheduled for the interviews, which took place at the house of the participants.

Community health agents, previously instructed as for the study purposes, monitored all home visits.

In order to identify the characteristics of the elderly, the authors used a questionnaire with demographic (age, gender, race/skin color, marital status, number of people living in the house) and socioeconomic variables (education, income of the older adult and family income *per capita*).

Frailty was assessed using the Edmonton Frail Scale version culturally adapted to Brazilian Portuguese, which is considered reliable, valid and easy to be applied, including by professionals who are not specialized in geriatrics or gerontology.¹²

The EFS assesses nine domains: cognition, overall health status, functional independence, social support, medication use, nutrition, mood, continence and functional performance. Cognition is assessed through the "Clock Test". The domains 'overall health status', 'functional independence' and 'social support' are assessed through multiple-choice questions (three or five options of answers - Likert scale). The domains 'medication use', 'nutrition', 'mood' and 'continence' are assessed through dichotomous self-excluding answers ("yes" or "no"). The domain 'functional performance' is assessed through the timed test "Stand up and Walk".

Possible answers are divided into three columns, A, B and C. Column A represents answers that express favorable conditions, whose score equals zero. Column B gathers answers that demonstrate intermediate conditions of frailty, which score one point. Column C represents severe conditions of frailty, which score two points. A score between zero and four indicates the individual does not present frailty; a score between five and six indicates they are apparently vulnerable; a score between seven and eight means low frailty; between nine and ten, moderate frailty; 11 or more, severe frailty.¹²

In the model used in the analysis of the results, the variable answer considered was the presence of frailty in the elderly. In order to achieve this, a dichotomized score was defined, in which a cut-off point was considered at seven or more points to define the individual with low, moderate or severe frailty. The demographic and socioeconomic variables that were not dichotomous, were also dichotomized as it follows: gender (male and female), age (60 to 69 and 70 years and over), race/skin color (white and *pardo* or black), marital status (married and single/divorced/widowed), education (literate and illiterate), religion (catholic

and protestant), personal income (more than one minimum wage and until one minimum wage), family income *per capita* (more than two minimum wages and until two minimum wages) and people in the family (more than three and until three).

The analysis plan consists of the presentation of the frequencies of all variables regarding the outcome. In the analytical approach, a univariate analysis was performed, and the magnitude of the associations was estimated through the odds ratio (prevalence in the exposed divided by the prevalence in the non-exposed), and the confidence interval. The statistical significance of the associations was calculated by means of Pearson's χ^2 test, with the correction of Yates. Finally, a multivariate analysis was performed through the logistic regression method in order to verify whether the studied variables together were enough to predict frailty in the elderly.

RESULTS

Among all 128 older adults interviewed, 25 (19.5%) did not answer all questions. Of these, 24 (96.0%) did not answer the clock test, which assesses cognition, claiming they were not interested or did not feel capable of doing it and, for one subject, it was not possible to obtain the answer to the question that assesses mood. Hence, for

these 25 people, it was not possible to calculate the index of frailty. However, given the fact that these people had answered other questions, it was decided to compare the dimensions assessed by the scale between the group that answered and the one that did not answer all questions.

Demographic data

Among the 128 older adults interviewed, 86 (67.2%) were women, 77 (60.2%) between 60 and 69 years of age, ranging from 60 to 103 years [mean 68.9 (SD \pm 7.8) and median 67 years], 52 (40.6%) stated they were white, 69 (53.9%) married, 72 (56.3%) had not completed primary education and 68 (53.1%) described themselves as Catholics.

Of the 103 individuals who answered all questions, 64 (62.1%) were women, 65 (63.1%) between 60 and 69 years of age, ranging from 60 to 103 years [mean 68.4 (SD \pm 7.8)], 43 (41.7%) stated they were white, 58 (56.3%) married, 63 (61.2%) had not completed primary education and 51 (49.5%) were Catholics.

Regarding the 25 interviewees who left one or more questions unanswered, 22 (88%) were women, 12 (48.0%) between 60 and 69 years of age, ranging between 60 and 83 years [mean 71 (SD \pm 7.7)], 09 (36.0%) stated they were white, 11 (44.0%) married, 13 (52.0%) illiterate and 17 (68.0%) Catholic.

Table 1 - Distribution of the interviewed elderly as for demographics. Embu-SP, 2010

Variable	Number	Frailty (%)	Odds ratio	CI95%	P
Gender					0.449
Male	42	23.8	1.0		
Female	86	30.2	1.378	(0.60; 3.23)	
Age					0.620
60-69	77	26.0	1.0		
70-older	50	30.0	1.22	(0.55; 2.69)	
Race/skin color					0.067
White	52	19.2	1.0		
Pardo or black	76	34.2	2.184	(0.95; 5.04)	
Marital status					0.873
Married	69	27.5	1.0		
Single, D. W.	59	28.8	1.065	(0.49; 2.31)	
Education*					0.115
Literate	78	23.1	1.0		
Illiterate	50	36.0	1.88	(0.86; 4.10)	
Religion					0.965
Catholic	68	29.4	1.0		
Protestant	47	29.8	1.02	(0.45; 2.30)	
Personal income					0.357
More than 1 minimum wage	28	21.4	1.0		

Variable	Number	Frailty (%)	Odds ratio	CI95%	P
Until 1 minimum wage	92	30.4	1.60	(0.59; 4.39)	0.182
Family income					
More than 2 minimum wages	51	21.6	1.0		0.740
Until 2 minimum wages	77	32.5	1.75	(0.77; 3.97)	
People in the family					0.740
More than 3	38	26.3	1.0		
Until 3	89	29.2	1.16	(0.49; 2.72)	

Table 1 presents the sociodemographic variables that were found to relate with low, moderate and severe frailty. Being *pardo* or black constitutes a marginally significant risk factor for frailty in the elderly. The other variables did not present enough evidence and, therefore, it is not possible to state they constitute a risk factor for frailty in the elderly.

The results presented in table 1 allowed determining the variables that were introduced in the multiple regression analysis, that is, all of those with $p < 0.2$. The result of this analysis was not presented, since none of the studied variables remained in the model with a statistically significant coefficient.

Assessment with Edmonton Frail Scale

Among the 103 older adults who answered all questions, 72 (69.9%) failed with significant errors in the clock test, 87 (84.5%) had not been hospitalized in the past year, 56 (54.4%) considered their general health status to be excellent, very good or good, 66 (64.1%) informed they require

help to perform, at most, one activity, 82 (79.6%) stated they can always count on someone to meet their needs, 81 (78.6%) stated they do not use five or more different prescribed medications, 67 (65.0%) do not forget to take their medications, 76 (73.8%) have not lost weight recently, 65 (63.1%) stated they do not often feel depressed, 74 (71.8%) do not have a problem to control their urine and 67 (65.0%) did not have difficulties performing the "Stand up and Walk" Test.

Regarding the 25 older adults who did not answer all questions, 20 (80.0%) had not been hospitalized in the past year, 14 (56.0%) considered their general health status fair, 17 (68.0%) require help for, at most, one activity, 18 (72.0%) stated they can always count on someone to meet their needs, 20 (80.0%) stated they do not use five or more different prescribed medications, 17 (68.0%) said they do not forget to take their medications, 19 (76.0%) have not lost weight recently, 12 (50.0%) stated they do not often feel depressed, 15 (60.0%) do not have a problem to control their urine and 15 (60.0%) did not have difficulties performing the "Stand up and Walk" test.

Table 2 - Description of the answers obtained in the domains assessed through the application of the Edmonton Frail Scale. Embu-SP, 2010

Domain/Item	Possible answers (score)	Complete answers		Incomplete answers	
		n=103	%	n=25	%
Cognition Clock Drawing Test *	Approved (0)	25	24.3	--	--
	Failed - minimum errors (1)	7	6.8	--	--
	Failed - significant errors (2)	71	68.9	1	100.0
General health status In the past year, how many times have you been hospitalized?	Zero (0)	87	84.5	20	80.0
	1-2 (1)	16	15.5	5	20.0
	>2 (2)	-	-	-	-
	Excellent, very good or good (0)	56	54.4	9	36.0
In general, how would you describe your health?	Fair (1)	35	34.0	14	56.0
	Poor (2)	12	11.7	2	8.0
	Functional independence With how many of the following activities do you require help?†	0-1 (0)	66	64.1	17
	2-4 (1)	20	19.4	3	12.0
	5-8 (2)	17	16.5	5	20.0

Domain/Item	Possible answers (score)	Complete answers		Incomplete answers	
		n=103	%	n=25	%
Social support	Always (0)	81	78.6	18	72.0
When you need help, can you count on someone who is willing and able to meet your needs?	Sometimes (1)	9	8.7	4	16.0
	Never (2)	13	12.6	3	12.0
Medication use	No (0)	81	78.6	20	80.0
Do you use five or more different prescription medications on a regular basis?	Yes (1)	22	21.4	5	20.0
	No (0)	67	65.0	17	68.0
At times, do you forget to take your prescription medications?	Yes (1)	36	35.0	7	28.0
	No (0)	76	73.8	19	76.0
Nutrition	Yes (1)	27	26.2	6	24.0
Have you recently lost weight such that your clothing has become looser?	No (0)	65	63.1	12	50.0
Do you often feel sad or depressed?	Yes (1)	38	36.9	12	50.0
	No (0)	74	71.8	15	60.0
Continence	Yes (1)	29	28.2	9	36.0
Do you have a problem with losing control of your urine when you do not want to?	0-10 seconds (0)	67	65.0	15	60.0
Functional performance	11-20 seconds (1)	18	17.5	10	40.0
	>20 seconds (2)	18	17.5	-	-

* 24 people did not answer. Percentage was calculated for those who answered; †activities considered were: preparing a meal (cooking), transportation (going from one place to another), housekeeping (cleaning/tidying up the house), shopping, using the telephone, doing laundry, managing money, taking medications; ‡one person did not answer. Percentage was calculated for those who answered.

DISCUSSION

The sociodemographic characteristics of the older adults interviewed are similar to those observed in other studies developed in Brazil,¹³⁻¹⁴ with prevalence of women, who had low education and were Catholic.

Among the older adults who answered the clock test, most presented indicative score of cognitive deficit. This group denied having difficulties in understanding or executing the test. However, the 24 (18.8%) individuals who refused to take the clock test claimed lack of interest or difficulties understanding and/or executing it. Both the low performance verified in the clock test and the refusal to perform it may be associated with low education, since it is necessary to know the numbers in order to understand and read the time. Among the group of people who did not take the test, 16 (54.0%) were illiterate or could only write/read their own name.

A literature review of 108 studies published between 1980 and 2001, regarding the applicability of this test to track cognitive deficit, identified that, in most of the studies, the higher the age and the lower the education, the worst the performance in the test. The authors of this review concluded that the clock test should not be used as the only diagnosis criterion for the cognitive function,

but in association with other assessment tests.¹⁵ Nevertheless, this test has been found efficient to track cognitive alterations in population groups with eight or more years of education.¹⁶

Health self-assessment was predominantly positive among the interviewees who answered all questions. It is important to observe that in the Edmonton Frail Scale the alternatives to this question are predominantly positive and those who assess their health as "good", "excellent" or "very good" receive identical score. The fair assessment of the general health status was the most frequently mentioned alternative among the elderly who did not answer all questions (56%).

This health self-assessment is an overall measure that captures the physical, mental and social wellbeing of the individual. It is a good predictor for undesired outcomes, such as functional dependence and mortality in older adults, since it reflects the perception of the individual regarding his/her condition. It is considered an important indicator to monitor the health conditions of the population and, for this reason, it is broadly recommended.¹⁷ Some studies have verified a significant correlation between education and health self-perception: older adults with higher education assess their own health better.¹⁸ It is possible that the low education verified among the older adults

who did not answer all questions reflected the way they perceive their own health.

In both groups, most of the interviewees required help to perform, at most, one activity of daily living (ADL). A review study indicates that the functional capability is significantly related with the self-perception of health.¹⁸ In the present study, it was possible to observe a slightly higher proportion of people who require help to perform five to eight activities and a worse self-assessment of health in the group who did not answer all questions. Older adults with limited assessment for the execution of ADL have their quality of life compromised and an increased risk for dependence, institutionalization and premature death.¹⁹

Considering the social support dimension, most interviewees stated they "can always count on someone", in both groups. Social support is usually associated with better health conditions, since it favors coping with stressful situations that impact mental health, such as the loss of a spouse, financial crises and health problems. It allows people to feel loved and safe and to have a better self-esteem, which influences positively their psychological wellbeing. However, social support may produce negative effects when the older adults feel they are a burden for those they love. This feeling may lead to decreased self-esteem, dissatisfaction, stress and depression.²⁰

The elderly represent 50% of the groups of people who use multiple medications. In the present study, however, in both groups most of the people stated they did not take more than five different medications daily nor forgot the time to take them. This does not mean they do not take any medication or that they do not have difficulties in their administration.

In this age group, the main difficulties concern compliance with therapeutics, which is more compromised in situations that require long treatments and/or changes in lifestyle, greater complexity of the drug schemes, decreased visual acuity and manual dexterity, forgetfulness and lack of comprehension regarding the prescription due to low education, which, either in isolation or in association, contribute to increase medication errors.²¹

In both groups, most of the interviewees had not lost weight in the months prior to the study. Weight loss may be the least frequent component in people who become frail, however, since it results from the energetic unbalance caused by neuroendocrine and musculoskeletal alterations,

malnutrition, inflammation and diseases that compromise the metabolism of muscular cells and decrease muscle mass, it is used as reference to assess the risk of other components.²²

When questioned regarding their mood, positive feelings prevailed among the older adults who answered all questions. However, among the 25 who did not answer all questions, half the individuals stated they often feel depressed. Depressive symptoms are significantly associated with a poorer self-perception of health.¹⁸ The higher proportion of people with depressive symptoms in the group who did not answer all questions may be attributed to the fact that this group is mostly made of women, with a more advanced age and low education, which agrees with the findings of other studies. Education is a protective factor for the occurrence of depressive symptoms and literature evidences a higher mean of depressive symptoms in women and older people.²³

In both groups, most of the interviewees did not present problems controlling their urine. A slightly higher proportion of people with continence problems was found in the group who did not answer all questions. Evidence indicates that urinary continence is an early sign of pre-frailty and frailty in the elderly, affecting approximately 20% of the women and 10% of the men over 60 years of age, given the functional and structural modifications in the urinary system, expected with aging, and which lead to functional decline. In order to provide an adequate diagnosis, it is important to assess the cognitive condition (whether the older adults are capable of describing the symptoms and their respective impact on their quality of life), the presence of obesity and mobility, as to elect the most appropriate treatment.²⁴⁻²⁵

Mobility is an important requisite for functional independence. In this study, it was found good for most of the studied older adults, indicating less risk for falls. Aging leads to the loss of muscle mass and strength, which affects especially the lower limbs, compromising the range of movements and predisposing the individual to falls and functional disability. Studies indicate lower severity and duration of the functional disability in older adults between 65 and 74 years of age.¹⁹

A study developed in the municipality of Ribeirão Preto, São Paulo, which also used the Edmonton Frail Scale¹² with 137 older adults, revealed that 31 (30.1%) of them were considered frail, a similar percentage to that found in this study. In the study SABE, developed in the mu-

nicipality of São Paulo using Fried's phenotype of frailty,²⁶ the prevalence of frailty, which was 14.1% in 2006, increased to 45.0% in only two years²⁷, demonstrating that the increase in frailty is related with the advance in age, which should be taken into consideration in the assessment of the quality of life of the older adult and his/her family.²⁸

In the studied sample, the older adults who did not answer the clock test could not be classified as for their degree of frailty, but they presented poorer scores in the other dimensions analyzed. Despite the fact that this limitation and the regression analysis did not allow to identify predictors of frailty in the elderly, these data emphasize the applicability and usefulness of the scale in the assessment of frailty in the elderly assisted at the primary health care network, since it allows to identify the determinants and conditions involved in the development of the syndrome and to make preventive actions feasible, as long as other diagnosis criteria are considered for the cognitive function, depending on the studied group.

CONCLUSION

In this study, in which non-frail older adults prevailed, the Edmonton Frail Scale was found easy to be applied, which recommends its use in primary health care, especially in home assessment, since it requires only a measuring tape, pen and the printed instrument. Nevertheless, since there is not a differentiated scoring for population groups with low or no education, who may present difficulties answering the clock test, its applicability may be reduced in these groups.

The professional who works in primary health care, especially in the family health program, must be attentive not only to the guidelines of the Ministry of Health regarding frailty and the alterations resulting from the aging process, but also to the aspects subjective of the older person and his/her family dynamics, since the reduction of functional capability caused by frailty may result in dependence, consequently compromising the quality of life of the elderly and their families as well.

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