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CARE AND RECOVERY OF THE ELDERLY WITH FALL-RELATED FRACTURE IN THE FAMILY CAREGIVER'S PERSPECTIVE

CUIDADO E RECUPERAÇÃO DO IDOSO COM FRATURA DECORRENTE DE QUEDA NA PERSPECTIVA DO CUIDADOR FAMILIAR

RECUPERACIÓN Y CUIDADO DE LOS ANCIANOS CON FRACTURA DEBIDO A UNA CAÍDA EN LA PERSPECTIVA DEL CUIDADOR FAMILIAR

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Objective: to know the family caregiver's perspective on the care and the recovery of the elderly with a fall-related fracture. Method: descriptive and exploratory study conducted with 15 family caregivers of the elderly in the municipality of Borrazópolis, Paraná State, Brazil, in the months of June and July 2018, through semi-structured interviews submitted to thematic content analysis. Results: four thematic categories emerged: nursing team supporting family caregivers of the elderly with fracture; limb immobilization or restriction to bed as a dependency-generating condition; peculiarities of the care with the elderly with fracture; and religion/spirituality strengthening daily care. Conclusion: in the family caregiver's perspective, the care and the recovery of the elderly with a fall-related fracture involve dedication, changes in personal and family life and burden to the caregiver, besides difficulties arising from the lack of training and non-acceptance of the dependency condition by the elderly.

Descriptors: Caregivers. Aged. Accidental Falls. Rehabilitation. Nursing.

Objetivo: apreender a perspectiva do cuidador familiar sobre o cuidado e a recuperação do idoso com fratura decorrente de queda. Método: estudo descritivo e exploratório realizado com 15 cuidadores familiares de idosos no município de Borrazópolis, Paraná, Brasil, nos meses de junho e julho de 2018, mediante entrevistas semiestruturadas submetidas à análise de conteúdo, modalidade temática. Resultados: emergiram quatro categorias temáticas: equipe

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de enfermagem apoiando familiares cuidadores de idosos com fratura; imobilização de membro ou restrição ao leito como condição geradora de dependência; peculiaridades do cuidado ao idoso com fratura; e religiosidade/espiritualidade fortalecendo o cuidado cotidiano. Conclusão: na perspectiva do cuidador familiar, o cuidado e a recuperação do idoso com fratura decorrente de queda envolve dedicação, alterações no cotidiano pessoal e familiar e sobrecarga para o cuidador, além de dificuldades decorrentes do despreparo e da não aceitação da condição de dependência por parte do idoso.

Descritores: Cuidadores. Idoso. Acidentes por Quedas. Reabilitação. Enfermagem.

Objetivo: comprender la perspectiva del cuidador familiar en el cuidado y la recuperación de los ancianos con fractura debido a la caída. Método: estudio descriptivo y exploratorio realizado con 15 cuidadores familiares de ancianos en el municipio de Borrazópolis, Paraná, Brasil, en los meses de junio y julio de 2018, a través de entrevistas semi-estructuradas sometidas al análisis de contenido temático. Resultados: cuatro categorías temáticas surgieron: apoyo del equipo de enfermería a los cuidadores familiares de ancianos con fractura; inmovilización de extremidades o restricción a la cama como una condición que genera dependencia; las peculiaridades de los ancianos con fractura; y religión/espiritualidad fortaleciendo la rutina del cuidado. Conclusión: en la perspectiva del cuidador familiar, el cuidado y la recuperación de los ancianos con una fractura debido a la caída implican la dedicación, los cambios en la vida personal y familiar y la sobrecarga para el cuidador, además de las dificultades derivadas de la falta y no aceptación de la condición de dependencia por parte de los ancianos.

Descriptores: Cuidadores. Anciano. Accidentes por Caídas. Rehabilitación. Enfermería.

Introduction

The senescence, natural stage of the human life cycle, is characterized by physical, biological and psychological changes. In consequence of the demographic transition, the estimates, by 2050, are two billion people aged 60 years or more, representing a fifth of the world population[1].

In this life stage, one of the events that often prevent the individual from living with autonomy is the fall-related fracture of some body segment. It is an involuntary event often originated from the loss of balance. The highest rates of incidence and mortality from this cause occur in people aged over 60 years[2]. The fracture of the femur is quite frequent in this population, directly interfering in the mobility of the elderly and in the need for monitoring/supervision from other people, once it requires restriction to bed[1-2].

However, becoming dependent on care, even temporarily, reflects negatively in the quality of life of the elderly[3]. This is because the fall often occurs in people who, until then, were independent and the abrupt need for a caregiver is not an easily accepted condition.

In this context, the care act includes help and, sometimes, basic care, such as bodily hygiene, nutrition, physiological excretions, aid in locomotion and comfort, in addition to emotional support, encouragement to social interaction and personal assistance according to the needs felt and observed[4]. The care provision to the elderly is mostly performed by family caregivers, especially by women – wives, daughters and daughters-in-law –, who often struggle to reconcile activities related to their family, personal and work lives with the care responsibility to a dependent elderly person[5].

Nevertheless, the assumed function can be permeated by doubts, uncertainties and suffering, which affect not only the quality of the care provided but also the quality of life of the whole family. Therefore, the following questions arise: How does the caregiver perceive the dependency condition of the elderly after the fall? Which factors influence the recovery of the elderly with a fall-related fracture?

To answer those questions, the objective of this study was to know the family caregiver's perspective on the care and recovery of the elderly with a fall-related fracture.

Method

This is an exploratory descriptive study, of qualitative nature, carried out in Borrazópolis,

Paraná, a small municipality (slightly more than 6,000 thousand inhabitants) located in Southern Brazil. The health care network of the municipality has two Basic Health Units (BHU), both with Family Health Strategy (FHS) teams, Women's Clinic for prenatal care and a small-sized public hospital (35 beds).

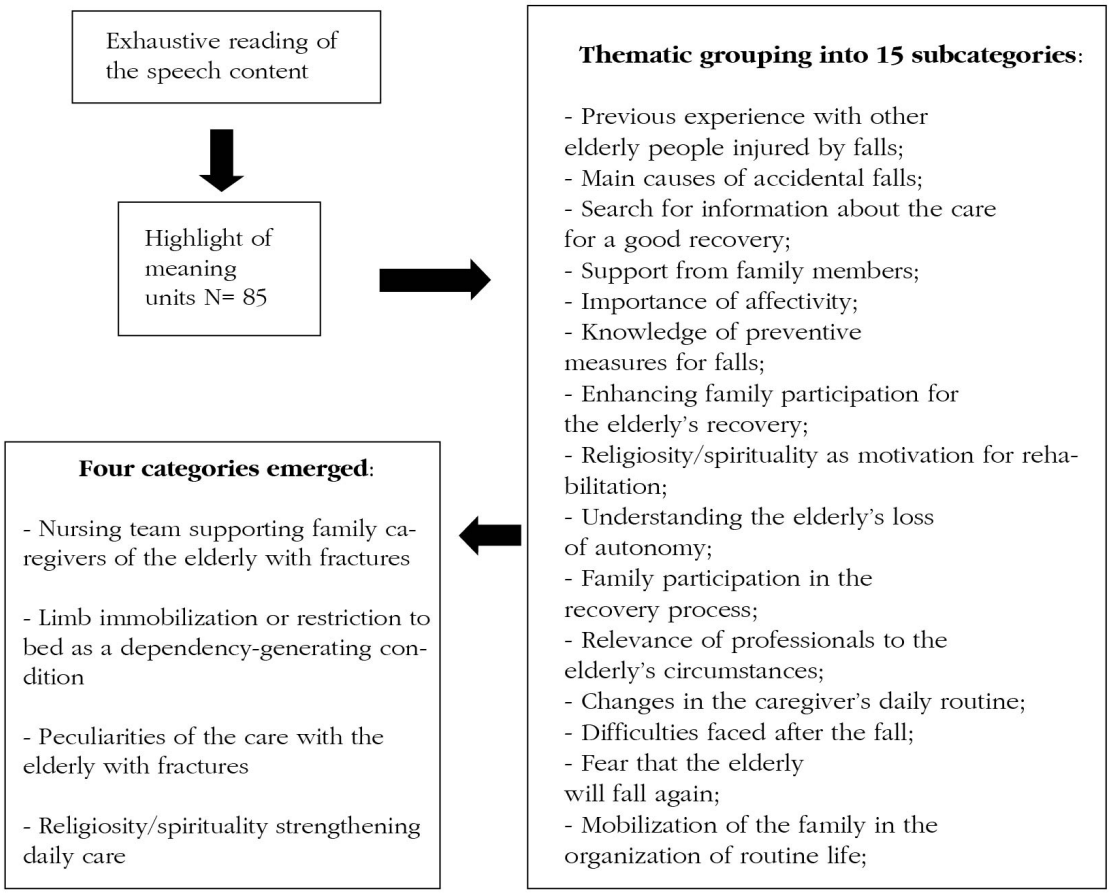
The participants were family caregivers of the elderly residing in the municipality and who suffered fall-related fractures in the years 2016, 2017 and 2018. For location of the elderly, the nurses and community health agents (CHA) of both BHU were requested to select those who met the eligibility criteria. The inclusion criteria were: persons aged 18 years or more and be the main family caregiver of the elderly who suffered a fall-related fracture in the period previously set. The exclusion criterion established was not locating the caregiver after at least five attempts carried out on different days and times (five cases). Before the indication, the CHA contacted the caregivers to inform about the study and request permission to provide phone contact.

The data were collected in the months of June and July 2018, through semi-structured interviews, previously scheduled by telephone, by the main researcher. They were carried out on days, times and locations defined by the participants, with five in the caregiver's own residence and ten in the elderly's homes. They lasted an average of 40 minutes, were audio-recorded upon the participants' consent and guided by the following questions: "Tell me how the fall happened", "How was/is the recovery process of the elderly person?" and "How was/is for you to take care of the elderly dependent on care?". A guide roadmap with questions addressing sociodemographic characteristics of the elderly and the caregiver was also used.

All interviews were fully transcribed preferably on the same day of their completion. Before starting the analytical procedure, the statements were edited, removing the language vices and correcting grammatical errors, in order to provide greater fluidity to the reading of the interviews, without, however, changing their meaning and content[6].

The transcribed material was submitted to thematic content analysis, according to the operational phases based on the establishment of the corpus, floating reading, material exploration, composition of record units corresponding to the meaning unit (clipping of speeches), with subsequent classification to compose the categories according to the semantic criterion, that is, the contents with similar characteristics were grouped, which culminated in thematic categories[6]. The process of analysis identified 85 record units, which, after grouped, allowed identifying 15 subcategories and 4 categories, as shown in Figure 1.

Figure 1 – Organization chart of the definition process of thematic categories



Source: Created by the authors.

The study was developed in line with the guidelines regulated by Resolution n. 466/12 of the National Health Council/Ministry of Health. Its project was approved by the Standing Human Research Ethics Committee (COPEP) of the signatory institution, (Opinion n. 2.698.673). All participants expressed their consent to participate in the study, signing the Informed Consent Form. To preserve their identity, the extracts of their reports are identified by the letter "C", indicative of caregiver, a number, which means the order of the interview, followed by the word indicative of the relationship with the elderly.

Results

The participants were 15 caregivers, being 13 were married and 2 widowed, being 13 females - 9 daughters, 2 nieces, 1 daughter-in-law and 1 friend. The male caregivers were 1 spouse and 1 son. Ten participants reported being the first time acting as caregivers

The elderly, in turn, were between 60 and 95 years (average 77.26 years), being 13 females. The body segment most frequently affected by the fracture was the femur. The treatment instituted for 11 elderly was surgery, while for the other 4, it was conservative. The recovery time ranged from 2 to more than 13 months and 10 patients were submitted to physiotherapeutic treatment.

The exhaustive reading of the interviews revealed that the caregiver's experience is marked by a trajectory, which allowed identifying the four categories described below.

Nursing team supporting family caregivers of the elderly with fracture

The family caregivers reveal that the professionals who comprised the nursing team had an important role in the recovery process

of the elderly that suffered a fracture, when proving guidance and assisting in the care implementation.

> *I just asked the nursing team's help, who received and helped us*. (C1, Daughter).

> *The nursing team taught me everything to provide a good quality of life to my mom*. (C2, Daughter).

> *We've had a great follow-up with the nurses who visited us and taught us all procedures to be performed from now on*. (C3, Daughter).

The meaning units showed the presence of a close relationship between health professionals and the family/caregivers of the elderly in a situation of fragility/disease.

> *I don't know if that made it easier, but I have nothing to complain about, everything was well used. From the support of how to organize the bedroom until how to act from that situation. When she got home from the hospital, the nursing team, in the first month, visited me three times a week and the doctor, every 15 days*. (C3, Daughter).

> *The doctor was excellent, but, of the health team that visited us, the nurse [name] was always available for all the care. Whenever we needed, we just had to ask him. It was an essential support for the recovery*. (C6, Friend).

> *The Unified Health System team helped a lot. The follow-up with the health team was important for the good recovery, especially to cope with difficulties we weren't used to*. (C7, Son).

According to the caregivers, nursing professionals guided the care implementation and habits that aimed to reduce risks of new falls and promote healthy aging.

> *The nurses made the dressings, guided us pretty well on measures to be taken*. (C12, Daughter).

> *All the elderly tend not to be willing to do things and, with the persistent nurses, it collaborates to a good aging and overcoming difficulties*. (C15, Daughter).

The meaning units in this category showed that the healthcare professionals, in particular those that comprised the nursing team, constituted an important element in the support network of family caregivers, as they helped in the care and recovery of the elderly who suffered a fracture.

Limb immobilization or restriction to bed as a dependency-generating condition

For all the elderly in this study, the limb immobilization or restriction to bed for some time, as part of the prescribed treatment, changed the locomotion and functional capacity and, consequently, reduced their autonomy. The length of restriction to bed or limb immobilization ranged from weeks to months and was higher among those who had undergone a surgical procedure, since it required time for surgical recovery and rehabilitation, through physiotherapeutic treatment.

The time the elderly were restricted to bed or with one limb immobilized triggered the need for a caregiver and a burden for the person who assumed the function.

> [...] *then I did everything for her, because she couldn't do anything, despite resting*. (C3, Daughter).

> [...] *he needed someone for everything*. (C9, Daughter-in-Law).

> *She totally depended on us* [...] *depended on us for everything*. (C15, Daughter).

> *She became more limited* [...] *became dependent and lost her life autonomy*. (C6, Friend).

For seven elderly, immobilization as a form of treatment was the only dependency-generating condition, since, before the fracture, they were totally independent.

> *It was a change in life. It was chocking the consequence of a fall, and what it caused to our lives, because we had to change our entire life. There's no way to say it wouldn't change*. (C2, Daughter).

> *Due to the restriction to bed, her acceptance was hard, because she became dependent* [...] *she was independent and suddenly, she depends on someone for everything*. (C3, Daughter).

> *Staying in a bed depending on someone for everything is awful for her. I can see the sadness in her eyes for no longer being independent*. (C11, Niece).

When describing the care performed in the home environment for the elderly's recovery, the caregivers revealed performing more than the fulfillment of basic needs, such as food and hygiene or health recovery through the correct use of the medicine. This is because their purpose, in addition to the recovery of health, was the physical, mental well-being and quality of life of the elderly.

> *I took care of her, bathed her, fed her with ice cream, mashed banana, water, juice, anyway, gave her all medications on time* [...] (C5, Daughter).

> *I did everything I could do to make her feel better. Everything was done for her to recover fast.* (C6, Friend).

> *There was a roster for each week for each one of us. So, everybody knew the schedule of medication, bath, change. Everybody did the same thing not to mess with her quality of life. We had schedule for everything.* (C2, Daughter).

> *I like to see her well. I gave up many things to provide her the best care, being able to offer quality of life, even with aging and the fracture.* (C11, Niece).

The meaning units included in this category showed that the effort undertaken by the caregiver was fundamental for the maintenance of the basic activities of life of the elderly and their recovery after an episode of fall. However, this effort generated physical and emotional burden for the caregiver.

Peculiarities of the care with the elderly with fracture

According to the participants, there were many difficulties to take care of an elderly person with fracture-related dependency. Some of them related to the own mode of being of the elderly, who had difficulty to accept the care; others resulted from the care process logistics.

> *She didn't accept that depended on the people. I wanted to do everything alone and, of course, could not. I wanted to make the food with one arm only, knocked things and hence spoke: because God did not take me once... it was a daily struggle, especially in the time of the bathroom.* (C2, Daughter).

> *The leg was with sequels, was pie. Then, to clean the groin, for example, she could not open too, it was very difficult.* (C15, Daughter).

> [...] *it is difficult, because they bathe in an elderly person is already difficult, even more fractured. It is complicated, demanded much effort* [...] *with one arm, she could not do anything.* (C3, Daughter).

A peculiar difficulty in the care with the elderly relates to the shame in exposing intimate parts while bathing or changing diapers. In those cases, the caregivers also felt difficulty/shame.

> *The hardest thing was the shame of seeing him naked, of bathing him.* (C9, Daughter-in-Law).

> *During the bath* [...] *showing intimate parts was hard for her* [...] *as an elderly woman, also while changing the diapers* [...] *it was hard to see our mother like that.* (C12, Daughter).

The difficulties found in the routine intensified the physical, emotional and social burden, triggering stress in the caregiver.

> *She depended on us, not the contrary. She depended 24 hours on our care.* (C2, Daughter).

> *She depended on someone for everything... I have no social life anymore, I spend all my time with him.* (C9, Daughter-in-Law).

> *The care totally depended on me* [...] *and everything she needed depended on me. That made her lose her autonomy.* (C14, Daughter).

> *I had to take care of her, had to bathe her, had to help in everything* [...] *she called me for everything* [...] *so it got rushed, because my life was already rushed. I've got a house, a son, husband and, after the fall, her* [...] *it got pretty rushed.* (C3, Daughter).

The various changes in the everyday life of the caregivers triggered important implications in family life.

> *We're three sisters and we had to adapt our works, our house, our family, our habits and custom. Everything had to change, everything, for this new process of recovery.* (C2, Daughter).

> *Any health issue or change that happened in her life, I had to be watchful. I felt so insecure with such responsibility. That changed my life.* (C15, Daughter).

> *I came to a conclusion with my husband, that we'd take her to our place. I knew my life would change* [...] *I quit my job, my tomes to go out were not the same. If I had to leave, do something, my husband stayed with her. This led to changes in my life and my husband's* [...] *my husband was very patient with the fact that our lives changed a lot when I brought my aunt.* (C11, Niece).

The context units in this category showed that taking care of an elderly person with fracture-related care dependency goes beyond the function, because the caregivers demonstrated abdicating from their social life and/or sacrificing/changing their professional life for the elderly's recovery. Furthermore, the peculiarities of the daily care culminated in stress and implications in family routine, in addition to burden.

Religiosity/spirituality strengthening daily care

The caregivers showed awareness of their mission and molded to the demands inherent in the care process, especially of an elderly person. For them, this improvement and the continuous demands were important to increase the bond

between the triad: caregiver-aged-family. The reflection about their role brought to light issues relating to human values and purpose, with emphasis on the religion/spirituality.

> *We believe in God* [...] *the surgery was not a man's work, but God's miracle. My head was spinning. I kept thinking if my wife would ever get better* [...] *I sat on the corner, prayed and asked God to give strength and to never let hope fade away* [...] *I clung to faith and will for her to live well, so I gave her trust and we faced the difficulties together* [...] *We made a promise to God: Together, for the worse and better. So we take care of each other. Partnership is always important to face difficulties.* (C4, Husband).

> *I had the support from religion, because only God can help us in moments of anguish and suffering. Nothing can explain that.* (C15, Daughter).

> *Having faith, regardless of religion, and pray* [...] *Keeping the focus from beginning to the end to take care, always being fine, happy and thanks to God, it's not only our merit but of tall those that help.* (C2, Daugther).

> *I was always thinking: God put her in my hands for me to take care of her, because He knew I was capable of taking care of and fighting for her health.* (C11, Niece).

> *I clung to faith and will for her to live well.* (C3, Daughter).

The context units reveal that religiosity/spirituality coupled to the family union was fundamental in the care process, because it strengthened and sensitized the caregiver to provide a a more affective care, based on human values, in addition to sensitizing the family about the importance of greater approximation with the elderly.

> *There must be love and caress to look after a person, regardless of a broken arm or leg, if they're older. Because that situation was not that person's desire, but resulted from an avoidable accident.* (C6, Friend).

> *I believe this family commitment and love sharing contributed for her full recovery.* (C2, Daughter).

> *What facilitated the recovery was the family union, persistence and showing how important she was for us.* (C14, Daughter).

According to the context units, although the care process involves suffering and self-denial, in some cases, it allowed recovering the caregiver-aged-family bond. They also showed that the caregiver found, in religiousness/spirituality, strength and encouragement to the care. In this way, the commitment with this function occurs when the caregiver is aware that the care constitutes a fundamental part for the elderly's recovery.

Discussion

There was predominance of female family caregivers, married, housekeepers and with some degree of kinship with the elderly – usually daughters. Those characteristics are associated with the cultural role assigned to women in our society, whose main functions is to promote the family care. This same profile was identified in a study with dependent elderly people assisted by the Pastoral Care of the Elderly in a municipality in Western Paraná[7].

The caregivers in the study made no reference to the motive that led them to assume the care role, which allows inferring it was "naturally assumed", different from what was found in a study conducted with informal caregivers of elderly inpatients at the Risoleta Tolentino Neves Hospital, in Belo Horizonte[8], and in a study carried out in Pelotas, Rio Grande do Sul, with two elderly relatives who had suffered fall[9]. In both cases, the care was perceived as a way of relieving the guilt by the person's illness process, in addition to fulfillment of duty.

In relation to the elderly who suffered falls, the characteristics found – aged over 70 years, females and fracture of the femur as most affected body segment – resemble those of a study conducted with 14 elderly patients hospitalized due to fall in a general hospital in Rio Grande do Sul, which revealed a predominance of females, about 80 years, femoral fracture from fall on the same level, which occurred during the performance of activities of daily living, and need for surgical treatment[10]. A similar result was found in a study conducted in Portugal with 60 elderly people, six months after the occurrence of the fall, aiming to identify the functional dependence[11].

The family caregivers were satisfied with the support received for performing the care, as well as with the guidance and assistance provided by the health team, especially the nursing team, in the household, which may be related to the performance of the FHS team. Furthermore, the close relationship between professionals, families and the elderly facilitated the care process and favored the recovery. That fact may derive from

the study development in a small municipality, which enables social relations to be established with greater ease.

This result is contrary to that found in a research conducted in Pelotas, Rio Grande do Sul[12], in which one of the four elderly women victims of fall-related fractures stated categorically having received little guidance from health professionals and that they were not clear; they also stated that the professionals criticized what they were doing at home, but did not explain what had to be done. That fact led the authors to consider that, although the families needed support for coping with the elderly's health recovery, there was a gap in what the FHS offered[12].

In the case of this study, the caregivers also highlighted the guidelines performed by the health team regarding the need for implementation of care and adoption of habits to reduce the risks of new episodes of falls and the importance of strategies for healthy aging, which corroborates the results of a study performed in a long stay institution in Porto Alegre (RS)[13]. The early identification of intrinsic and extrinsic risk factors for falls is also an important strategy to prevent new episodes.

The fall episode in the elderly is a situation that can have important consequences. Severe fractures can affect the quality of life not only of the elderly affected, but also of their family, because the restriction to bed or even the limb immobilization triggers dependency, which consequently affects the family functionality[14].

Seven of the study elderly were totally independent before the fall. The sudden loss of this condition - requiring help to perform tasks of daily living, such as meals, house chores, self-care and care with basic needs - was a great inconvenience for both the elderly and the family that assumed the function of caregiver.

Moreover, regardless of the elderly's sex, some types of care, such as bathing and changing diapers, can cause shame and embarrassment for both, especially in cases in which the daughter-in-law takes care of the father-in-law. In those cases, health professionals can help the caregivers talk with their families about the importance of other people – such as the elderly's children – help more effectively in care, in particular with the bath. It is more appropriate to change the bath schedule, so that a man of the family can be responsible for him, than working feelings of shame in an elderly person.

The family member that assumes the role of primary caregiver of the elderly person that is often physically and/or emotionally unprepared for this coping process. Some types of care require more than willingness and commitment, being necessary strength, skill and specific knowledge[12]. In this case, particularly, the caregiver must learn to perform numerous tasks/activities and, at the same time, offer emotional support, strength and courage to the elderly person, so that he/she can deal with his/her current condition and cope, in the best possible way, with the limitations arising from that condition. He/she also needs to learn how to cope with tensions and efforts arising from this care, whose implications will depend on the needs of each family and the one under the care[15].

Those factors cause physical, emotional and social burden to the caregiver, changing and limiting his/her daily routine, as mentioned by the caregivers in the study. These results reaffirm the consequences of the responsibility for the care of another person in personal and family life, regardless of the type of situation that generated the dependency. In this direction, a study conducted with caregivers of the elderly with dementia found that the time dedicated to care restricts the participation in activities within and outside the home environment[16]. This condition, in a certain way, is already known by professionals, since a study conducted with nurses in João Pessoa (PB) found that they considered that the burden acquired in the day-to-day was one of the main reasons for the tension of the caregiver's role[17].

In this context, as reported by the participants of this study, the presence of a health professional concerned about guiding and supporting the

caregiver for coping with the daily care is important, in addition to understanding their needs and limitations and appreciating their efforts. Actions in this direction may provide improvement of physical and psychological well-being of family caregivers, benefiting not only them, but also those who receive their care[16].

In the case of fall-related fractures in the elderly, the care offered in the home environment and developed by the family is fundamental to the well-being and quality of life of the elderly. This is because the instrumental care, when associated with affective support, is essential for coping with the constraints generated by the fall[8-9]. Moreover, among the particularities of the care with the elderly with a fracture, there stands out the difficulty to accept a situation of dependency not previously experienced, as well as the new routine to be adopted.

A study conducted in a large hospital in Rio Grande do Sul, after when assessing the care of the family with the elderly after accidental falls, identified that they play an important role in the recovery of the frail elderly, by providing confidence, emotional support and assistance during the phase of dependency[9].

Furthermore, changes in attitudes characterized by involvement and cooperation on the part of other family members will certainly contribute to the well-being of the elderly and their recovery. Thus, although there is a family member that usually bears the greatest share of responsibility for the care, others can and should share tasks, favoring the effectiveness of family functioning, once the sharing tends to reduce the physical and financial burden. In addition, the involvement of family members favors the support between them, whether by the fact that family ties become narrower, or through the shared search for resolutions of problems[18].

Other features of this care process result from changes caused by the elderly's dependency that interfere in the routine of the caregiver and even in the family[9], which causes suffering and feeling of burden. In any event, the changes always occur with the expectation of promoting a better quality of life and a faster recovery. Therefore, in the case of falls, the dependency on care, differently from what occurs in chronic diseases, tends to decrease with time and even cease to exist. In this sense, although the elderly feel weakened, the caregiver must encourage them to be the protagonist of care, so that their autonomy is established as soon as possible and sustained in everyday life[7].

In fact, living with the elderly who fell and present limitations/restrictions in the performance of daily basic activities can be marked by moments of great difficulty, because individuals experience differently its complexity and subjectivity, which leads them to deal differently with the limitations imposed by a condition, albeit temporary. Thus, the caregivers need to develop some skills in order to facilitate the activities on a day to day basis, prevent complications in the elderly's health status, promote their physical and mental well-being, in addition to organizing the physical space to prevent future falls. Moreover, the care actions provided by the health team need to be extended also to the caregivers/family, since the implementation of care constitutes a priority for the caregiver, who elft aside his/her self-care and well-being. This attitude, over time, can impair the physical and psychological health and, consequently, influence the care with the fractured elderly[7].

The context units showed that the caregivers sought in religion/spirituality a form of comfort to the suffering/anguish and relief from emotional burden. The relevance of faith and hope is in the own human existential context, by forming a link with the Divine, with each other and with everything around them. Families give a new meaning to faith in the Divine as a support and sustenance to the moments of pain and suffering caused by the loss of autonomy and dependency of the elderly, in addition to snagging on mysticism and trust in God to feel more secure in the face of the reality of living with the fractured elderly[9].

The religiosity/spirituality makes many find meaning for a negative situation or interpret it as

a larger plan of God. Thus, the religiosity/spirituality represents, for the caregiver, a coping mechanism able to relieve physical and mental stress, and even remove the desire to give up and the feeling of defeat/discouragement. Those data corroborate the result of a reflective study about the presence of spirituality and religion in the daily routine of nursing professionals who work in the hospital environment. According to the authors, spirituality is an effective resource to manage the care, which can benefit the one receiving the care and the caregiver[19].

An important limitation of the present study is its development in a small municipality, which enables social relations to be established with greater ease, favoring, for example, the bond between health professionals and the population. In any case, the results can subsidize reflections about the elements involved in the elderly's care process after a fall episode, directing, as well, the aspects to be considered in assistance to families who face this condition.

Conclusion

In the perspective of the family caregivers in this study, the care and the recovery of the elderly with a fall-related fracture is permeated by difficulties, in particular by the elderly's dependency condition, though sometimes temporary, due to the difficulty of the elderly to accept this condition by physical and emotional burden, in addition to the changes in their personal and family life.

The caregivers perceived that the recovery of the elderly with a fall-related fracture was influenced by the effort undertaken in the care performance, with a view to the maintenance of the basic activities of life of the elderly and their rehabilitation.

From the moment the elderly was affected by a fracture, depending on the body segment affected, their life and the lives of their closest family members, especially the one who assumed the role of main caregiver, significantly changed. Nursing has a fundamental role in this context, and may offer informational and instrumental support. On the other hand, the family caregiver finds, in spirituality, strength and encouragement to take care, because he/she recognizes that the care offered is indispensable not only to the clinical recovery of the elderly, but also to their own survival, as it is basic, but also essential to life maintenance.

Collaborations:

1 – conception, design, analysis and interpretation of data: Camila Moraes Garollo and Sonia Silva Marcon;

2 – writing of the article and relevant critical review of the intellectual content: Camila Moraes Garollo, Sonia Silva Marcon, Elen Ferraz Teston, Helen Cristina Bernardes Barbosa, Josane Rosenilda da Costa, Ivi Ribeiro Back and Patricia Chatalov Ferreira;

3 – final approval of the version to be published: Sonia Silva Marcon and Elen Ferraz Teston.

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