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The living of elderly people after stroke

O viver de idosos após o acidente vascular cerebral

La vida de ancianos después del accidente cerebrovascular

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Abstract: Objective: to understand the living of elderly people after the occurrence of a Stroke (FAST). **Method:** qualitative and descriptive research. Data collected between January and March 2018 in three Family Health Strategies (FHS), through semi-structured interviews with elderly people, stroke victims, whose information was analyzed according to thematic analysis. **Results:** the data allowed the construction of three categories: the functional and social changes in the lives of elderly people after the occurrence of stroke; the (lack of) care after stroke in the understanding of the elderly person; and the future perspectives of the elderly person after stroke. Immediate and resolutive assistance in the hospital, the follow-up at FHS and the family involvement are essential for the rehabilitation of the elderly person. **Final considerations:** the results allowed us to understand the lives of the elderly patients, who showed changes in their daily lives after stroke, with different degrees of physical and psychological impairment.

Descriptors: Nursing; Stroke; Elderly; Family Health Strategy

Resumo: Objetivo: compreender o viver de idosos após a ocorrência de um Acidente Vascular Cerebral (AVC). **Método:** investigação qualitativa e descritiva. Dados coletados entre janeiro e março de 2018 em três Estratégias Saúde da Família (ESF), por meio de entrevista semiestruturada com idosos, vítimas de AVC, cujas informações foram analisadas conforme análise temática. **Resultados:** os dados permitiram construir três categorias: modificações funcionais e sociais na vida de idosos após a ocorrência do AVC; o (des) cuidado após o AVC no entendimento da pessoa idosa; e perspectivas de futuro da pessoa idosa após a ocorrência do AVC. A assistência imediata e resolutiva na instituição hospitalar, o acompanhamento da ESF e o envolvimento familiar são

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fundamentais para a reabilitação da pessoa idosa. **Considerações finais:** os resultados permitiram compreender o viver de idosos, que apresentaram mudanças em seu cotidiano após a ocorrência do AVC, com diferentes graus de comprometimentos físicos e psíquicos.
Descritores: Enfermagem; Acidente Vascular Cerebral; Idoso; Estratégia Saúde da família

Resumen: **Objetivo:** comprender la vida de ancianos después de la ocurrencia de un accidente cerebrovascular. **Método:** investigación cualitativa y descriptiva. Datos recopilados entre enero y marzo de 2018 en tres Estrategias de Salud Familiar (ESF), mediante entrevistas semiestructuradas con ancianos, víctimas de accidente cerebrovascular, cuya información se analizó de acuerdo con el análisis temático. **Resultados:** los datos permitieron la construcción de tres categorías: los cambios funcionales y sociales en la vida de los ancianos después del accidente cerebrovascular; el (des) cuidado después del accidente cerebrovascular en la comprensión del anciano; y perspectivas futuras del anciano después del accidente cerebrovascular. La atención inmediata y resolutiva en el hospital, el monitoreo de la ESF y la participación familiar son esenciales para la rehabilitación del anciano. **Consideraciones finales:** los resultados permitieron comprender la vida de los ancianos evaluados, que mostraron cambios en su vida diaria después del accidente cerebrovascular, con diferentes grados de discapacidad física y psicológica.
Descriptores: Enfermería; Accidente Cerebrovascular; Anciano; Estrategia de Salud Familiar

Introduction

Stroke (FAST) is a neurological injury caused by decreased or interrupted blood flow in the brain. It is divided into two groups, ischemic and hemorrhagic. The ischemic has a higher incidence rate, with 87% of cases, and is characterized by obstruction of a vessel, resulting in necrosis of brain tissue. As for the hemorrhagic, in 13% of cases, it is evidenced by the rupture of a vessel in the brain, with blood dripping into the intraparenchymal or subarachnoid space. [1-2] It constitutes a disease with acute symptoms, rapid loss of neurological function and may present changes such as paresis (decreased motor strength) and coma.[1]

Cerebrovascular diseases have a higher incidence in people aged 65 years or over, that is, the elderly population is more vulnerable to the FAST than any other age group.[1] Data shows that, in 2013, 1.5% of individuals, aged 18 and over, had a diagnosis of FAST, encompassing a population of 2.2 million people.[3] According to the 2013 version of the handbook containing the Guidelines for the Rehabilitation and Care for People with Stroke, the annual incidence of this morbidity is 108

cases per 100,000 inhabitants, with a mortality rate of 18.5%, 30 days after its occurrence, and 30.9% after 12 months, where the chances of recurrence after an episode are 15.9%.[3]

A study shows an increased number of cases of elderly people affected by the FAST, indicating that this is the second leading cause of death in the world, resulting in sequels that may affect the elderly physically and psychologically, depending on the injured area, and they are often responsible for social exclusion. Moreover, people who experienced one or more episodes of this morbidity have an increased risk of death in the acute phase, probability of recurrences and as well as disabilities that may undermine their daily life in the long term.[1]

The high incidence, the high social burden and the significant increase in stroke-related disability in the elderly population in recent decades have posed a challenge for society. Nevertheless, the structured and multidisciplinary rehabilitation reduces stroke-related disability in both older and younger survivors, regardless of severity. Moreover, there is increasing evidence to support the clinical effectiveness of specific rehabilitation interventions for individuals who have been affected by the FAST. When it comes to elderly people, it is necessary to pay attention to their particularities, due to their age group, the existence of comorbidities, the adherence to drug treatment, the rehabilitation, the social conditions (family and financial), among others.[4]

After a stroke episode, the rehabilitation process should be conducted as early as possible, preferably still in the hospital environment, through assistance from the multidisciplinary team. Accordingly, residual sequels may be excluded or mitigated, thereby promoting the individual well-being and quality of life, whether in the family, social and/or community context.[5] If the individual affected by the FAST has remained with sequels, these may lead to a situation of dependence for the performance of activities of daily living. In elderly people with stroke sequels, the limitations are exacerbated and contribute significantly to the reduction of their autonomy and independence. Once this condition is installed, there is a need for a caregiver, who may be a family member (informal caregiver) or a health professional (formal caregiver). Regarding the specificity of caring

for a family member, ambivalent feelings may emerge with characteristics of satisfaction, generosity, affection, love, overload, suffering, uncertainty and stress.[5]

It is worth noting that part of the population victim of the FAST has functional restriction with intellectual, cognitive, motor or communication impairment, which may hamper the performance of daily activities, besides the access to health services. [1-2,5] When performing a search in the national literature, we found that there is a few number of studies addressing the daily lives of those who have experienced the FAST. [2,4-5] Therefore, it is essential to be able to understand how is the way of living of these people from the moment of illness by the FAST. By considering the described aspects, the following research question was raised: how do elderly people conduct their lives after a stroke? With a focus on this issue, the objective was: to understand the way of living of elderly people after a stroke.

Method

Qualitative study, typified as descriptive, carried out in a city located in the northwestern region of the State of Rio Grande do Sul, linked to the Family Health Strategies (FHS). The research was attended by elderly people victims of the FAST, who complied with the following inclusion criteria: elderly (aged 60 years or over), of both genders, diagnosed with stroke and residents in the area of coverage of the respective health units. Elderly patients who revealed a linguistic deficit or had a clinical condition, for example, dementia, that could prevent them from holding an interview were excluded.

Data collection took place between January and March 2018, in three FHS: FHS I, FHS III and FHS IV of the studied city. FHS I was selected because it is the unit that concentrates the largest number of users, with a population average of 4,330 inhabitants. As for the FHS III and IV, we opted for the fact that they are located in the same physical space, covering, respectively,

a population of 2,304 and 2,500 users, besides the fact that they concentrated the largest number of elderly patients who were victims of the FAST in the city.

In order to locate the participants, we made contact with the Community Health Workers (CHW), and they were asked to list the elderly patients linked to the FHS in their area of coverage and that experienced a situation of illness due to the FAST, with conditions of verbal communication, as well as their addresses. With such information, we made a visit to the home of each elderly person, thereby explaining the research objective and requesting their collaboration to take part on it. After acceptance, he/she signed, as well as the researcher, the Free and Informed Consent Form.

We conducted semi-structured interviews with application of a form with questions related to sociodemographic variables: gender, age, education, marital status, work condition, income, self-perceived health, smoking, alcohol consumption, stroke type, stroke time, recurrence, sequels and leisure activities. The interviews were recorded in digital media and, subsequently, transcribed in their entirety. In addition to the data collection instrument, the researcher made notes regarding non-verbal communication, such as expressions and looks, identified during the interviews, which were registered in a field diary. The interruption of data collection occurred after the researcher perceived that there was saturation of information.[6]

The analysis refers to the research techniques used to make the data validated and capable of reproducing information about a certain context or situation, through scientific production and specialized procedures.[7] Accordingly, we followed the precepts of the thematic analysis,[7] which covers three stages: pre-analysis, where the research objectives were resumed, floating reading and constitution of the study corpus; exploration of the material, through the classification of the text, with clippings in recording units, which may be phrases, words, ideas or events, with the purpose of constructing the classification and aggregation of data; treatment and interpretation of the results, where inferences and interpretations were proposed, relating them to the pertinent literature. After the data analysis, three categories were organized based

on the convergence of ideas: the functional and social changes in the lives of elderly people after the occurrence of stroke; the (lack of) care after stroke in the understanding of the elderly person; and the future perspectives of the elderly person after stroke.

The research project was registered in the Institutional Research Ethics Committee with the CAAE nº 80235417.7.0000.5346 and approved under the opinion nº 2.435.518, on December 13rd, 2017. The statements were coded by the letter E (*Entrevistado* [Interviewee translated into Portuguese language]), followed by a number according to the sequence of the interviews.

Results and discussion

The study was attended by 12 elderly people, 6 males and 6 females, aged between 60 and 94 years old, with an average of 72 years old; 1 reported not being literate, 10 had incomplete elementary school and 1 had completed high school; 7 were married, 3 widowed, 1 divorced and 1 single. As for work conditions, 11 were retired and 1 was still working in the domestic space. Interviewees who had an income of one to three minimum wages, with 10 participants, predominated, while 2 reported that they gained between three and five monthly wages. Regarding self-perceived health, 6 rated it as good, 4 as bad and 2 as very bad.

As for the stroke type, the prevalence of the ischemic was identified with nine events, one hemorrhagic and two patients did not know how to inform about it. The time elapsed since the occurrence of stroke ranged from five months to eight years. With regard to recurrence, only one interviewee reported having experienced more than one episode. In the elderly with stroke sequels, especially those with motor impairment, we identified that they have difficulty to perform leisure activities; eight elderly patients reported the non-adherence to this practice, while four reported the development of at least one activity. Among the leisure activities, the most prevalent mentioned were: visits to family members, growing flowers, caring for the garden and watching television.

After the sociodemographic characterization, we read the information, thereby organizing it, based on the convergence of ideas, into categories, which will be described and discussed below.

The functional and social changes in the lives of elderly people after the occurrence of stroke

When experiencing a stroke, there are sudden changes in the lives of elderly people, both from the functional and the social point of view, thereby imposing limitations on them, with reduced autonomy, independence and sociability, which vary with the degree of impairment of the illness. However, it is possible, in some situations, that an individual, even experiencing a stroke, has the potential to rehabilitate himself/herself functionally and cognitively, from the perspective for resuming the performance of his/her basic and instrumental activities of daily living, without any limitation. In this sense, the sequels usually resulted from the illness are mitigated, which may be attributed, in part, to the technological advances in the field of health and to the different forms of care. This understanding may also be identified in the testimonies of the elderly citizens participating in this study:

> *There are people who are beaten, have a stroke, but they become forgotten [...] that wasn't my case, I remained normal about everything.* (E12)
>
> *Well, I don't feel anything, it's normal. But, things have changed, because I'm taking care of myself now.* (E4)

With regard to functional disabilities, we found that the difficulty to walk prevails. The limitations, which usually remain, are the result of the impairment of some bodily functions, where the presence of more than one is frequent. A study[8] found that an elderly person with stroke sequels has difficulty in at least three and at most five body functions, where the most frequent were: difficulty to walk, difficulty to move the arms and loss of memory. These disabilities sometimes restrict the dislocation of their homes, due to the presence of physical barriers, as well as making it difficult to seek health services. From this perspective, we can infer that, in the presence of

limitations, the disease becomes more disabling, with a negative impact on the individual's life, as the elderly person has the priority desire of being rehabilitated in the face of paralysis.

> *If God helps me to get my steps again, my legs to walk, and heal me from this paralysis, I don't know how I would be grateful [crying].* (E6)

Elderly people who experienced a stroke episode had the need the and desire to recover their functional abilities to resume their activities of daily living (ADL) and also to practice instrumental activities of daily living (IADL), which were performed before the FAST. It is worth noting that basic tasks such as self-care, mobility, eating, dressing, cleaning and the ability to control bladder and bowel eliminations are ADL. On the other hand, IADL are those that allow the integration of people in the community, i.e., managing their home and life, such as shopping, administering their money, using the phone and using transportation.[9] A study that sought to estimate the prevalence of functional disability and its associated factors in elderly people who suffered a stroke showed that 58.2% had limitations to go out of their homes due to architectural barriers and 40.4% had restrictions to access health services.[10] Studies suggest a deterioration of IADL with the passing of the years in the presence of chronic diseases, including stroke sequels.[9-10]

> *I can't work, that's changed, I can't do anything, but I wanted to hold it, I really want to work.* (E7)

Functional changes are often responsible for alterations in living habits of the elderly people with stroke sequels. From this perspective, it is necessary that they seek new shortcuts in their daily lives in order to meet the demand of their ADL and IADL. Moreover, these limitations hinder the departure of their homes because of the presence of physical barriers, thereby undermining the physical and social well-being of these individuals.[5]

Functional restriction also requires changes in the physical environment where the elderly, after experiencing the occurrence of the FAST, started to live. This is because, normally,

they started to need equipment to help them to conduct their daily lives. In addition, they often needed help from another person to move around inside and outside their homes.

> *My house is very small, cramped; so, when I need to go to the bathroom, there is no way for me to get in front, then I have to go in reverse with the wheelchair, I adjust myself there and, later, I leave through the front part. It is no longer easy; that's why I need people to move me on this task. (E3)*

Experiencing a stroke leaves negative memories in the life of the person who experienced it. Moreover, because it is a condition that requires slow recovery and makes the process of recovery and community reintegration difficult.[11] Research found that 27.7% of the elderly stroke survivors had depressive symptoms. In addition, the degree of functional dependence was a factor that favors the occurrence of depression in these patients.[12] Allied to this, the recovery time may be related, since it decreases the hope of achieving rehabilitation of these individuals.

Some interviewees also mentioned the fear of a new hospitalization, as well as experiencing a new stroke. This feeling is associated with the stroke sequels, since they caused functional limitations and made them dependent on continuous care. From this perspective, they performed the necessary care in such a way as to avoid the occurrence of a new episode.

> *I was afraid to go back to the hospital, because I was sick of the hospital, I came home, I'll have to get a consultation, I'm drowning.* (E10)
>
> *I'm afraid, that's why I take care of myself, take care not to get sick anymore, and I'm always taking an exam, every month I take an exam.* (E4)

It is assumed that the greater the knowledge related to the modifiable risk factors of the FAST, the more sensitive the individual practice will be for self-care. Such information favors changes in lifestyle, especially with regard to healthy eating, regular physical exercise, smoking and drinking cessation, as well as primary care in the prevention of this cerebrovascular disease.[13]

Moreover, we should emphasize the importance of adhering to these recommendations, as well as taking periodic consultations, with a view to preventing an initial event, besides the recurrence of stroke, condition responsible for high rates of sequels and mortality.

Concerning functional disabilities, it was possible to identify, in the testimony of a participant who experienced a stroke, limitations in his sexual life, function that is normally undermined by this disease and responsible for contributing to the reduction of sociability and integration of the individual in society. As for stroke sequels, it was noticed that the sexual function is not often considered by the health team and by the elderly themselves as a functional limitation that may undermine the physical and emotional well-being of this individual.

> *To tell you the truth, I haven't had sex relations in four years. Every man needs sex. That has changed a lot. I take too many remedies and I think it's these drugs that are offending me.* (E11)

A study that sought to assess sexual function after stroke in individuals over 18 years of age found that approximately half of them remained sexually active after experiencing the illness. These, in their entirety, perceived their health as good, unlike those who no longer had an active sexual life.[14] It is normal for individuals with stroke sequels to experience severe functional and social changes. Functional disabilities are considered as determining factors in the social relationships of individuals and undermine their daily lives.

> *Everything has changed in my life, and I actually have considered myself a prisoner, because everything has to come to me, has to reach me. Thus, it's just that I'm behind a fence; if I need something, you have to bring me.* (E3)

The impairment in daily life can be attributed mainly to difficulties in family relationships, evidenced by the decreased ability to perform ADL, work and social, since the individual is often prevented from returning to their job and social activities.[15] Regarding the way the FAST took place, we identified that this is a condition that happens suddenly, with the potential to cause emotional

dysfunction, resulting in negative changes in the lives of these people. However, individuals are generally unaware of the causes that led to the occurrence of the illness.

> *I was fine, it was good in the evening and I woke up like that, it was sudden.* (E5)
>
> *So, to tell you the truth, I don't know when it came.* (E12)

Given this condition, the multidisciplinary assistance to elderly stroke victims becomes necessary as a way of providing care that contemplates the physical and emotional aspects, aiming at the rehabilitation and community reintegration process. In this sense, it becomes essential that health services are enabled to follow-up the elderly who experienced a stroke, through qualified, holistic and comprehensive care. In addition, the joint assistance of the health network provides the caregiver with emotional support, thereby offering greater well-being to the family member, which contributes to recovery.

The (lack of) care after stroke in the understanding of the elderly person

The elderly with stroke require continuous assistance at FHS and at home, in such a way that it can favor his/her cognitive, functional and emotional rehabilitation or mitigate the sequels installed. However, unpreparedness to care causes emotional instability in the family, in addition to undermining the rehabilitation and the well-being of the individual with stroke sequels. This condition, evidenced by the ignorance of the family member regarding the care line, may be attributed to the lack of guidance from professionals, still in the hospital, as well as the non-involvement of the primary care health team in the process of caring for an elderly person.

In order to mitigate the consequences of the FAST, immediate medical and hospital care becomes essential, with qualified listening and effective behaviors. However, we found, through a statement that, when seeking care, the participant did not have his complaints valued, a fact that may have aggravated the clinical condition due to the lack of blood supply in the area

where the injury took place. Accordingly, it is possible to identify a certain professional negligence in the way of providing care, thereby representing a lack of care:

> *I didn't need to have this stroke, I had a headache and feeling bad, we got there and asked to shake his hand [of the doctor] and I couldn't do it. He said that I was joking, that I wanted to show myself, to draw attention. I came home, I got sick; then, very early, my daughter took me to the hospital again, this doctor had already left there, there was another doctor [...] he said 'you have a stroke', at that time, he noticed it!* (E10)

A study that sought to understand the lives of people after a stroke found that almost all individuals involved in the care of the elderly patients are unaware of the causes and symptoms of a stroke, as well as how they could provide assistance to these people. In addition, the care for pressure injuries and the guidelines after the occurrence of this disease were neglected by caregivers in the same proportion.[16] It is noteworthy that this information is essential in the care of the individual and that should be known by caregivers, in order to qualify the assistance to those who need it, who are often weakened in their homes.

When seeking care, an individual that mentions signs and symptoms characteristic of stroke, such as headache, seizures, aphasia, hemiparesis and deviation of the labial commissure, finds weaknesses in the service related to the time of assistance and the lack of professional qualifications to provide care actions.[16] Moreover, with regard to the transition of care after hospital discharge, the majority of people affected by stroke and their relatives/caregivers stand in the same need of special individualized care and follow-up. For the continuation of care initiated in the hospital space, it becomes necessary that those involved receive guidance according to the demands and limitations arising from the disease.[17]Although there is the family availability for the provision of care, the lack of care on the part of the health service may be identified:

> *There is no guidance, but now how am I going to hold it? Then, my brother said: no! I'll take care of you. Even the girlfriend didn't want to do it, she gave up.* (E5)

The elderly participants in this study signalized as a positive point the family involvement in the process of caring for and rehabilitating their clinical condition. In this sense, it is assumed that the presence of the family caregiver has a double impact on the life of the elderly person who was a victim of the FAST. It has a fundamental role in providing the necessary care and also constitutes an element of emotional and affective support. Nevertheless, this task has been carried out alone, without the help of health services.

For health services to also offer quality care, it is necessary that they include the family care. This is because the family is the link of access of the elderly, stroke victim, to health services and, also, it is this entity that will ensure the maintenance of care.[18] Therefore, health services can provide support to family caregivers and interact with the patient-family, considering the peculiarities of each situation and the identities of the individuals involved, making the family subject of the care process:

> *I felt very well. It was a better way for me because my kids were caring and running for me.* (E4)
>
> *She takes good care of me and has patience with me.* (E1)

In a study performed with the aim of understanding the meanings of the experience of the disease from the perspective of stroke survivors, the authors found that family involvement, as a determining factor in the rehabilitation of the individual victim of the FAST, took place through dialogue, walks, coexistence with friends, relationships that allowed to expand the bond and the affection among those involved and, consequently, were beneficial in terms of clinical and emotional condition.[18] On the other hand, we should notice that the family context is different and, therefore, there may be situations where, usually, there is an absence of family

support to the elderly with stroke sequels. From this perspective, based on the report of one of the interviewees, we should denote the feasibility of the presence of a family member in their rehabilitation. This condition may also be considered as (lack of) care on the part of the relative:

> *I think they don't care [crying], they don't even know they have a mother, but I think a son should pay more attention, give more love, for his mother. I wanted him to pull me more to walk, in order to check if I could walk.* (E6)

In addition, the absence of some relatives sometimes results in emotional abandonment and/or overload for the family caregiver, since there is no division of responsibilities among the family members. In this sense, there may be impairment in the assistance provided to the stroke victim, which implies the rehabilitation or not of this individual, as well as the presence of conflicts among family members. In view of the continuity of care, it is important that, after hospital discharge, the assistance service is held by primary health care coupled with family involvement.[17]

Faced with the occurrence of a stroke, the individuals involved, victim and relatives, undergo changes, as there are, routinely, sequels and disabilities to the detriment of the autonomy and independence that previously existed. In this sense, we noted the onset of feelings related to their dependence on a caregiver to perform basic activities of daily living. Although undesirable, this condition is perceived and accepted with some tranquility by the interviewed elderly patients:

> *If I had someone else to take care of me, more people, they were even freer. They want to go out, but they can't because of me; however, I want them to go out, go for a walk, they have their lives.* (E7)

As mentioned by E7, there is dissatisfaction of the individual with stroke sequels, especially due to the fact that it requires the presence of a caregiver and he/she identifies that the leisure of his/her family is impaired, i.e., undermined by his/her need for care, as he/she experienced the disease and is in need of care for the performance of daily activities.[18] Faced

with a disabling condition, one participant recalled the independence he previously had when performing ADL and IADL, while another expressed his desire to overcome, in an attempt to be independent, even with disabling sequels:

> *Oh! For sure! I wouldn't want to be demanding and asking for this and that because I was never used to asking for anything, I was used to helping, but not to be helped.* (E3)
>
> *I bathe alone, I'm getting used to doing I have to do, not depending on other people, trying to overcome myself. I have these people who take care of me, but I try to do what I can.* (E5)

From this same perspective,[19] the individual who is a stroke victim perceives the disease and its current condition as a way of seeking to overcome it in an attempt to aim for his/her rehabilitation. Moreover, it becomes necessary to support the family in the face of this condition as a form of encouragement and support for the disabled elderly person. The triad of assistance to the elderly patient after a stroke is the health team, the family and the elderly himself/herself. The health team is responsible for developing immediate and resolutive assistance in the hospital and following-up this individual at home through the FHS team. The family needs to be prepared to provide care to the individual victim of a stroke, as well as providing him/her with support to cope with the disease and enable rehabilitation. Accordingly, the desire to rehabilitate themselves will be proportionate to their chances of recovery.

The future perspectives of the elderly person after stroke

The occurrence of the FAST produces a negative impact on the lives of individuals and their families. This condition seems to make the rehabilitation process more difficult when it comes to an elderly person, which can favor his/her emotional destabilization and may lead him/her to accept the new condition imposed in terms of physical limitations. On the other hand, it is possible to observe that there are attitudes capable of overcoming obstacles in the

search for a better quality of life. Accordingly, we observed that each individual who has a chronic and disabling disease reacts in a different and unexpected way, which determines the need for care from the perspective of the elderly person who experienced a stroke.

In this context, the elderly, victim of a stroke, with positive expectations about his/her rehabilitation, has a determining point for the recovery of his/her health condition, autonomy and independence. Moreover, the presence of family and health services is necessary as motivational elements. Regarding the need for care, it is assumed that the care demand is greater in those who had good expectations, when compared to those who did not have them, as they accepted the disease in a passive way:

> *I'm in full recovery. As I have to use the left side, I still can't write, I can't sign the name, but I can already eat with my left hand, if I have to make a meal, I warm up with my left hand; therefore, I try to overcome myself, ok? We think we can't hold it, but trying, even as many times as necessary, we can.* (E5)

Moreover, it was possible to observe a transition period between the onset of the disease and the resumption of their functional and/or cognitive capacity. It is a slow rehabilitation process and it is necessary for the elderly to be aware of this process for achieving a greater engagement in the course of their recovery:

> *Look! I still intend to get better. Everything is a matter of time, it's a slow recovery, it's not like that overnight you recover, like the flu, you have the flu today, but tomorrow you're nice.* (E5)

Even though some interviewees showed good perspectives for future recovery, expressions of sadness and uncertainty prevailed after the experience of the FAST. Such feelings contribute to the acceptance of the disease and its complications, thereby hampering the rehabilitation of these individuals. The suffering after a stroke may entail the development of depressive episodes that, sometimes, made the elderly express that death is a perspective for the disease evolution:

> *To tell you the truth, I think I've lived a long time, if it happens to have another stroke, it's time to go. I'm already 74 years old, as the saying goes: 'I think it's time to pass away'.* (E11)

We should highlight that, in general, it is a long-term recovery due to the complexity of the rehabilitation of bodily functions. Given this condition, multidisciplinary and holistic assistance is necessary so that care is focused on the physical and mental aspects of the individual victim of a stroke.

Faced with the occurrence of a stroke, the elderly person has to adapt to the limitations and conditions that emerge, being necessary to adjust the individual experiences, besides learning to coexist with the disease and/or sequels.[20] In addition, when faced with a chronic disease, feelings such as fear, concern and distress are inserted in the daily life of the elderly person and his/her family. These situations may take place due to the difficulty of the limitation entailed by the disease, thereby favoring fragility and requiring the need to adapt to the new condition. Last of all, it is denoted that disabilities contribute to the deficit of self-care, making qualified follow-up necessary, as well as adaptations at home, as a way of mitigating aggravations and providing greater autonomy and independence at the same time.

Final considerations

This research allowed us to show that, after the occurrence of a stroke, sudden changes emerged in the daily lives of the elderly individuals, which sometimes caused them limitations. These restrictions were characterized by different degrees of impairment, physical and psychological, resulting in changes in the well-being and sociability of the elderly person.

The disabilities showed by the elderly person, stroke victim, may result in emotional, physical and psychological impairment, thereby also affecting social relationships. The difficulty to walk stood out, with the desire of the elderly patients of being rehabilitated, in order to resume their functional abilities. It is noteworthy that, sometimes, the recovery of these

functions did not happen or happened partially, leading the elderly patients who experienced the FAST to seek alternative ways of meeting their daily life needs, such as, for example, making changes in the home environment and having the presence of caregivers.

There was mention regarding the fear on the part of the elderly patients to experience new episodes of stroke, hospitalizations and limitations. As a way of preventing future events, they highlighted the care with healthy eating, physical exercise, smoking and drinking cessation, as well as the accomplishment of regular consultations.

As for the care aspects, it was possible to identify that there are strengths and weaknesses with regard to the health care for these individuals, whether in the hospital, family or primary health care. The family should be prepared to support the elderly patients, helping them in their disabilities and encouraging them to seek recovery.

We can consider that this study has as a limitation the fact that it was carried out in a single reality, with the participation of the elderly population, condition that prevents its generalization. Accordingly, it is suggested to carry out further investigations, which can expand the territory and, also, the participants, where other actors involved in the care of the elderly individuals who experienced one or more episodes of stroke may be included.

Finally, we understand that these results may be used by members of the health team, including nursing, and family members of the elderly individuals who experienced one or more episodes of stroke as a way of enhancing the care offered to these individuals. In this context, the results may contribute to nursing practice, since they provide important information that allows us to guide care actions for elderly stroke victims and their relatives. In addition, we hope that managers and health professionals may have a look focused on health promotion and stroke prevention, in order to reduce the morbidity and mortality rates associated with this disease, especially among the elderly population.

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Substantial contribuitions, coordination in conception of the study, analysis, interpretation and disucssion of the datas, elaboration of the manuscript with the critical revision and final approval of the version to be published.

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