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Seniors and Their Quality of Life

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Research Article

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Abstract

Aim: We aimed to find out whether the quality of life of seniors is higher in either home or institutional environment.

Methods: We´d realized the on the sample of 128 seniors living in institutional and home environment. We studied their quality of life via structured questionnaire WHOQL - BREF.

Results: The achieved results show correlation between satisfaction with the health and perception of quality of life. We found that in the domain of physical health (presence of pain, degree of mobility, fatigue, loss of energy, the ability to do work, self-reliance, the need for frequent medical attention) the final domain score was 16.63 at home and 16.37 in the institutional environment (on a scale of 4-20). The scores found in our research are lowered compared with population norms. Quality of life of elderly living in their homes was 14.8 ± 10 and in the institutional environment it was 12.8 ± 11.09. The respondents from home environment reported better quality of life than respondents in the institutional environment.

Conclusion: The support of quality of life should be one of the basic aims of nursing care. Nurses should make early identification of negative factors affecting quality of life and eliminate them by suitable nursing interventions.

Keywords: Nursing care; Quality; Life of seniors

Introduction

The risk of institutionalization of a client lies primarily in the changing environment, disturbance of privacy and existing social and family relations. Many clients, due to the elimination of duties that they had in the home, fall into passivity, resulting in loss of life perspective and self-realization. The objective of institutionalized nursing care facilities is primarily activation of the client and maintaining his/her self-sufficiency for the longest possible time and as much as possible [1]. But an individual approach and respect for fundamental human rights and freedoms must also be present. The priority of seniors is acceptance of their state of health and current life situation to the greatest extent possible [2]. The physical and mental quality of the individual gradually decline and old age is burdened by polymorbidity and deterioration of physical fitness and self-sufficiency. For seniors living at home and in the institutional environment the ability to be independent is a very important factor that affects their quality of life [3].

Objective

The aim of the study was to compare the different domains of quality of life for the elderly at home and in the institutional environment and to compare the findings for the population with the standards from the authors Dragomirecká, Bartoňová [4]. Within each subscale, we evaluated the feeling of satisfaction with health as part of the quality of life of seniors living in institutional environments and seniors living at home. We examined the extent to which physical pain affects the mobility of both groups studied and

also the incidence of emotional distress to the quality of life of seniors living in institutional environments and seniors living at home.

Methods

We used the method of standardised of questionnaire for study. In this work we used the WHOQL - BREF standardized questionnaire of quality of life. The results of the WHOQOL-BREF questionnaire are expressed as domain scores and the values of answers under two separate headings. Domain scores are an average gross score calculated from the relevant items, including normalization to a range of 4-20 or 0-100 (given in %). The answers under two separate headings assess quality of life and overall health. For the statistical processing of data, we used SPSS software version 18.00 and Microsoft Office Excel 2018. The individual statistical results for domains were compared with the given intervals for the population domain on the WHOQL-BREF questionnaire.

Research work was conducted on a sample of 128 seniors living in institutions and at home. The sample of respondents consisted of 64 seniors living in at the Naruc seniors' facility in Prešov and 64 seniors living at home. Since we had to take account of involutionary changes in the elderly, when completing the questionnaire, the presence of another person was required. For cooperation in completing the questionnaire, we asked the nursing service of the city of Prešov, home nursing care agency personnel in Bardejov and in Poprad. Of the respondents, a total were 86.4% of women and 13.6% men (Table 1).

Gender	n		%
	Home environment	Institutional environment	Together
Men	8	12	13,6
Women	56	52	86,4

Table 1: Gender of respondents.

The sample of respondents consisted of 64 seniors who lived in the Náruč Facility for Seniors in Prešov. Compatible sample for comparison was obtained in the home (64 of seniors). We asked for cooperation the care service of the city of Prešov, ADOS employees in Bardejov and Poprad in filling out the questionnaire. We obtained the research sample by deliberate selection. With the help of him, we wanted to select seniors after 75 years of age (sénium).

The presence of another person was required when completing the questionnaire, because we had to take into account the involutional changes in the elderly. The average age of respondents was 81 years (Table 2).

Age	n		%
	Home environment	Institutional environment	Together
75-80 years	26	32	45,25
81-85 years	28	18	31,25
86-90 years	6	11	18
91-100 years	4	3	5,5

Table 2: Age of respondents.

Interpretation of Results

For the needs of statistical data processing, we used the program SPSS version 22.00 and Microsoft Office Excel 2010. We recorded the research results in relative and absolute numbers. We used descriptive statistics for statistical data processing: mean median, standard deviation, variance, sharpness, skewness. The results were evaluated at a 95% confidence level. We compared the obtained statistical results of domains with the intervals of population domains of the WHOQL-BREF questionnaire.

In order to comply with ethical principles, we needed the approval of the management of the Náruč facility for the implementation of research in the Facility for the Elderly.

Significantly, indicative results were recorded in the satisfaction with health subscale where the values of confidence levels (0.593) were found among respondents from home environment in this subscale. This is confirmed by the comparison of averages in the sample (for respondents in the home environment, mean = 2.78, and for respondents in the institutional environment, mean = 2.93). The achieved results show correlation between satisfaction with the health and perception of quality of life (Table 3).

	Satisfaction with health		Quality of life	
	Institutional environment	Home environment	Institutional environment	Home environment
ME	12	15,50	8	10
SD	9,41	3,74	11,09	10,30
Score	1,169	0,593	1,378	1,279
M	2,78	2,93	2,60	2,62

Table 3: Satisfaction with health and quality of life.

For the sake of a comprehensive understanding of the issue of the quality of life of seniors in the population, we conducted a comparison of findings in various domains with the standard population norms in the WHOQL-BREF questionnaire from Dragomirecká and Bartoňová. We then compared these domains in the institutional environment and at home (Table 4).

	Domains	M	M	M
			Institutional environment	Home environment
domain 1	physical health	15,55	16,37	16,63
domain 2	mental health	14,78	16,71	17,02
domain 3	social relations	14,98	14,43	14,74
domain 4	environmental conditions	13,30	15,17	14,94
Q 1	quality of life	3,82	2,78	2,93
Q 2	satisfaction with health	3,68	2,60	2,62

Table 4: Comparison of domains in the institutional and home environments.

Using the WHOQOL-BREF questionnaire, we found that in the domain of physical health (presence of pain, degree of mobility, fatigue, loss of energy, the ability to do work, self-reliance, the need for frequent medical attention) the final domain score was 16.63 at home and 16.37 in the institutional environment (on a scale of 4-20). This means that the scores for the two environments are in the interval of standard average and standard lower limit of the range. The scores found in our research are lowered compared with population norms. Our results also confirm research aimed to evaluate the quality of life of seniors in community settings [5] which found equally reduced physical health scores (11.7).

In the domain of mental health - "experiencing" we found a domain score of 16.71 among respondents in the institutional environment and 17.02 among respondents living at home (on a scale of 4-20), representing an increase in reference values for "normal experiencing and normal mental functioning" as stated by Dragomirecká and Bartoňová. The mental health score found confirms that despite polymorbidity with all its physical impacts and constraints, seniors can keep their psychological stability.

Good social functioning with maintaining existing relationships is significant for the perception of good quality of life, contributing to a sense of personal security. The scores found in the domain of social relations in our group were 14.74 for the home environment and 14.43 for the institutional environment (on a scale of 4-20) which just as for physical health is in the interval of the norm of the average and the interval of the norm of the lower bound. The results found in our study are, similar to the group of respondents of in the study by Farský, et al. reduced in comparison to population norms.

We found the highest scores in the domain of environment, which evaluates not only the natural environment but also the availability of adequate health care, access to information and the opportunity to realize their interests. In the institutional environment the domain score was 15.17 and in the home environment the score was 14.94 (on a scale 4-20). Compared with standard average from Dragomirecká and Bartoňová, these values are in the interval of the norm of the upper bound and the interval of the slightly increased bound, which represents an increase of reference values. Excellent scores in the domain environment are not typical only for the

senior population. They are also indicated by Siverová and Bužgová (in a group of patients with tuberculosis. In their research they state that excellent score for the environment domain is observed with other chronic diseases, such as diabetes mellitus [6].

Within descriptive statistics we conducted an analysis of the data obtained (Table 5) in both study groups.

	Physical health		Mental health		Social relations		Environmental conditions	
	IP	DP	IP	DP	IP	DP	IP	DP
ME	2,98	2,62	2,95	2,78	2,87	2,86	3,00	3,00
SD	0,28	0,21	0,29	0,22	0,30	0,53	0,20	0,30
Variance	0,07	0,04	0,08	0,05	0,09	0,02	0,04	0,001
Sharpness	-3,08	0,83	3,78	-1,53	1,18	-1,05	2,52	1,09
Skewness	-0,61	1,00	-1,88	0,68	-1,34	0,74	-1,42	0,86
Min	2,46	2,42	2,32	2,62	2,34	2,45	2,60	2,96
Max	3,04	2,94	3,06	3,15	3	3,64	3,14	3,06
Score	0,35	0,26	0,36	0,28	0,48	0,84	0,25	0,04

Table 5: Statistical analysis of individual domains.

There is negatively skew in the domains analyzed in the institutional environment (physical health -0.61, mental health -1.88, social relationships -1.34 and the environment -1.42) indicating that the median is greater than the mean and we record a more frequent occurrence of large values. Variance in the domain of environmental conditions (0.001) and the domain social relationships (0.2) confirmed that the values found were close to the average and in other areas confirmed the homogeneity of the group (physical health = 0.04, mental health = 0.05 in the home environment). When calculating the critical values for confidence level ($\alpha = 0.05$), we found a significant correlation in the domain of living conditions of the respondents in the home environment ($p < 0.04$), confirming the presumption of better living conditions for the elderly in the home environment.

Discussion

The quality of life is closely linked with the quality of health; it is multidimensional and represents an individual's overall perception of the disease itself or his treatment. The research results showed that respondents rated the quality of life most often as average (47.65% of respondents). Approximately a quarter of respondents (25.78%) rated their quality of life as good, but 13.28% of respondents stated their quality of life as very bad. Compared to the average values of quality of life, there was a significantly greater difference between the results. In the home environment, the average value of the quality of life was 14.8 ± 10 and in the institutional environment it was 12.8 ± 11.09. We can conclude that respondents from home environment reported better quality of life than respondents in the institutional environment. Other studies [7,8], focusing on the quality of life of seniors agree in saying that potential health greatly influences the quality of life. Research conducted in Finland which evaluated the quality of life of seniors by examining health, functional status, demographic changes and income levels has led to the conclusion that the quality of life of seniors is higher in the home environment than in old people's homes [9]. Wilhelmson, et al. conducted a study in Sweden (Gothenburg) which surveyed seniors over 65 years of age on their perception of quality of life. Excluding criteria of the research were social factors, poor health and lack of interest. Interviews were conducted using a semi-structured questionnaire for 138 people (77 men and 61 women) and an evaluation of disability. Priority in the research was attributed to social relations, health, activity, functional capacity, wellbeing, personal beliefs and attitudes. The study confirmed the fact that social relations, functional ability and activity affect the quality of life of seniors to the same extent as their health status [10].

Currently, about 650 million people over the age of 65 live in the world. In 2050, for the first time in human history there will be more seniors than children under 15, and one in five people in the world will be a senior. At the present rate, seniors over 65 will make up 35% of the population of Slovakia in about 50 years. With an ageing population and improved quality of health care, the needs of seniors' lives have changed and there is now an assumption of integration through active ageing. Due to the fact that old age is accompanied by polymorbidity, physical pain in the elderly is relatively common phenomenon of old age. Physical activity significantly increases physical performance, as

demonstrated by the research of Horňáková implemented in Zlín, Czech Republic. In the study on a sample of 188 seniors it was found that 22% of seniors living at home and 21% of those living in social institutions reported improved physical fitness from the performance of physical activity. It was also interesting that physical activity brought positive aspects not only in relation to their physical condition or state of chronic disease. Up to 53% of seniors said exercise improved their mood and 31% stated that their memory and thinking improved. The above findings suggest that it is important to encourage seniors to experience an active old age. In facilities for seniors a priority objective should be achieving the most effective mobility of clients through rehabilitation procedures (diadynamic therapy, magnetic therapy, application of paraffin wraps, massage, respiratory gymnastics, physiotherapy, etc.). For clients of the facility there should be available a gymnasium where group therapy takes place under the supervision of a physiotherapist. For achieving the best mobility, a variety of mobility aids should be used (walking frame, forearm crutches, walkway with bars etc.). The social area includes not only family relations but also social support and relationships with other people [11]. It is a great benefit for senior community to promote social contact with other seniors and social integration. Currently, there is an extension of the average life expectancy of the population, creating a societal need for a deeper perception of the causality of somatic aging, but also of the psychological problems of aging and old age in order to improve the quality of life of older people.

It was interesting to follow the results of the analysis of the subscale of emotional distress. The average value of the subscale of emotional distress in the institutional environment was 13.5 ± 5.25 and in the home environment it was 11.5 ± 4.65. The results testify of a lower incidence of psychological discomfort in seniors living in the home environment. Surveys have found that the fear of mental ill health and its consequences has a linear increase depending on aging. Depression is among the most common mental disorders of the elderly. The health, economic and social impacts of these disorders in old age is more relevant than in younger age groups. There were interestingly results from the research by Fertaľová, Boroňová, which focused on mapping the occurrence of depressive symptoms in seniors living at home and seniors in institutionalized care. The sample consisted of 129 respondents, seniors aged 65 and over living at home and 121 seniors living in institutionalized care. For the evaluation of depressive symptoms, they used the GDS 15 Geriatric Depression Rating Scale and PHQ - 9 self-assessment questionnaire. In interpreting the results, they did not find statistically significant differences based on the location of seniors. Based on the analysis of the results we found that the emergence of depression was significantly impacted by bereavement, prospects for the future, i.e. level of hope and maladaptation, which is often associated with placing seniors in the social facilities [12]. A beneficial solution in the future seems to be the creation of day centres for seniors, a kind of replica of kindergarten for that community, in that it substitutes for the absence of relatives during the day and at the same time to provides for personal.

Conclusion

The decline in the quality of life of seniors may be expressed in the presence and absence of negative feelings or the meaning of life. Demographic indicators motivate us to perform analysis of the life of the senior population. The role of the National Programme for the protection of the elderly is to maintain their self-sufficiency, social participation, integration and thus promote the quality of life of the senior. The geriatric age is characterized by many specifics; however the satisfaction of hospitalized clients is an important indicator of quality of care from the perspective of nursing. The support of quality of life should be one of the basic aims of nursing care. Nurses should make early identification of negative factors affecting quality of life and eliminate them by suitable nursing interventions.

Authors' Contributions

Conceptualization: ĽM. Data curation: AH. Formal analysis: AH. Funding acquisition: AO., Investigation: ĽM. Methodology: ĽM. Project administration: AO. Resources: AH. Software: AH. Supervision: ĽM. Validation: AH. Vizualization: A.O.

Disclaimer

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Declaration of Interest Statement

None of the following authors has any proprietary interests or conflicts of interest related to this submission. The authors themselves supported this work.

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