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A study to evaluate the quality of life among the elderly people in selected areas of badrachalm

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Abstract
This study aimed to assess the Quality of life among Senior Citizens in selected areas of Bhadrachalm. The purpose of the study is to assess the quality of life among senior citizens and to associate the quality of life of senior citizens with their selected demographic variables.
A quantitative Descriptive research approach was adopted for this study with a descriptive research design. The study was conducted at Badrachalam with a sample of 50, with the age group of 60- 75yrs of age. The non-Probability convenient Sampling technique was adopted. The instruments used to collect the data are Socio-Demographic data and the World Health Organization (WHO) Quality of Life (QOL) -BREF scale. It's a Standardized tool.
According to the findings, 3% of 50 elderly persons had a bad quality of life, 17% had a middling quality of life, and 30% had a great quality of life. There was a substantial relationship between their quality of life and their education, employment, health condition, NGO programs accessible for financial assistance, medical assistance, and Government programs.
Conclusion: Based on the results, the researcher created a booklet that will assist them in improving their quality of life by following the advice for dealing with change, remaining connected, sleeping, healthy eating, living with loss, and avoiding and controlling issues that develop throughout their old age.

Keywords: Life satisfaction, elderly people, quality of life

Introduction
The final stage of life is regarded to be old age. Ageing is a natural, unavoidable, biological, and universal condition that affects everyone, regardless of caste, creed, or socioeconomic status. It is the result of structural and functional changes that occur in the primary organs of the body as we age. Sir James Sterling Ross once remarked, "You do not repair old age; you preserve it, encourage it, and prolong it." The elderly population is expanding at an unprecedented pace. The world's population is ageing, with emerging nations ageing faster. The United Nations deemed 60 years to be the dividing line between "Old age" and the "middle and younger age group" threshold of old age. People above the age of 60 are called "Old" in most gerontological literature and comprise the elderly section of the population [1].
Age-related population growth in India is 5.5%. 51 to 6.5% in 1991, 7% in 2001, and projected to reach 12% in 2025. Numerous effects on the economy, security, family life, well-being, and quality of life will result from changes in population structure. The interconnected nature of an individual's quality of life is reflected by all facets of "mental Health," "Health Status," "Life Style," "Life Satisfaction," and well-being [2].
A holistic view of the quality of life places equal emphasis on an individual's physical, psychological, and spiritual well-being as well as their relationships to and chances for skill development in and with their environment. Ageing impairs quality of life coupled with a functional decrease in the economic, dependent, and social cutoff, as well as the independence of the younger generation [3].
The word "elderly" conjures up feelings of resentment and sympathy, illness and destitution, hopelessness and senility, maturity, warmth, and accountability. It could be too simple to assume that they are in a severe condition when considering their age. The elderly are, as we all know, a valuable resource for our country. Their extensive knowledge and insight would serve as mentors and advisors for our country's advancement. When issues with the fulfilment of fundamental needs, such as social interactions, personal care, nutrition, and housing, are combined with age-related health issues, life for the elderly becomes increasingly challenging [4].
The biological phenomenon of ageing should be seen as normal and inevitable. Worry,

insecurity, fear, anxiety, and memory impairment are issues brought on by aging. There are some chronic diseases that are more prevalent than others, such as cancer, accidents, diseases of the locomotor system, and respiratory ailments. There are psychological and social repercussions [6].

Quality of life (QOL) is described by the World Health Organization as "an individual's perspective of their place in life, within the context of the culture and value systems in which they live, and in connection to their objectives, expectations, standards, and worries." Macro (societal, objective) and Micro (individual, subjective) are two ways that Bowling *et al*. (2001) defined the quality of life. The latter comprises judgments of the general quality of life, individual's experiences and values, and has included associated "proxy indicators" such as well-being, happiness, and life satisfaction. It also covers income, employment, housing, education, and other living and environmental factors. Quality of life in old age is not universally agreed upon, but it includes physical functioning and symptoms, emotional, behavioral, cognitive, and intellectual functioning, social functioning and the presence of social support, life satisfaction, health perceptions, economic status, sexual functioning, energy, and vitality, among other things. Even while every person's view of their own quality of life is inherently unique [7].

A lack of consistency exists in the theories of quality of life, which range from need-based theories based on Maslow's hierarchy of needs (deficiency needs include hunger, thirst, loneliness, and security, while growth needs include learning, mastery, and self-actualization), to two established theories based on psychological well-being, happiness, morale, and life satisfaction, as well as contemporary theories based on social expectations or an individual's particular perceptions. Consequently, quality of life is a complicated interplay of both objective and subjective factors [8].

The measuring change in the quality of life, several variables need to be taken into account, including actual changes in circumstances, interests (e.g. health), stable or dispositional characteristics of the individual (personality); behavioural, cognitive, or affective processes which might accommodate the changes, such as making social comparisons, re-ordering of goals and values [9].

"Maintenance of the quality of life" is one of the fundamental goals of supporting services for the elderly. A sufficient income, appropriate health care systems, housing, and environmental factors including personal and family safety and accessible transportation are the key factors associated with the retention of high quality of life for older people [10].

Changes in how the body functions, staying physically active, living arrangements and family relationships, retirement and time management, the economics of ageing, spirituality, and sustaining positive interpersonal relationships and happiness via excellent health are all aspects of quality of life. It entails getting enough clean air, water, food, and recreation as well as getting enough exercise, rest, and a positive outlook, among other things15. Among the factors influencing life satisfaction Social support, sexual activity, social activities, objectives, strengths, and shortcomings in personal relationships are all important [11].

Health promotion behaviours are even more crucial as people live longer, especially for maintaining functional independence, enhancing quality of life, and increasing life satisfaction [12].

In the year 1995, the total population of the planet was 5.7 billion. It is projected that the number would reach 10.8 billion by the year 2050, and between the years 1995 and 2000, it was predicted that 81 million individuals were added to the global population each and every year [13].

It is anticipated that the proportion of elderly people in the global population will more than double over the next three centuries, from 9.5% in 1995 to 20.7% in 2050 and 30.5% in 2150 [14].

Materials and Methods

For this study, a descriptive research design was used in conjunction with a quantitative research strategy. The research was carried out at Badrachalam with a sample size of 50 people in the age range of 60 to 75. If a sample was available, the non-Probability Convenient Sampling Technique was used. The WHO-BREF scale and socio-demographic data are the tools utilized to gather the data. It is an established instrument.

This tool is standardized. Experts such as Psychiatrists, Psychologists, and Mental Health Nursing Staff validated the instrument. The split-half method was used to calculate the tool's dependability. The tool's reliability score, r = 0.98, indicated that it was trustworthy. Which shows that the tool was very reliable.

Results

Section-I

Distribution of level of quality of life among senior citizens

Table 1: Percentage distribution of level of quality of life N=50

Quality of life			
S.No.	**Level of quality of life**	**Frequency**	**Percentage (%)**
1	Very poor	0	0
2	Poor	3	3
3	Moderate	17	17
4	Good	30	30
5	Very good	0	0

The table shows that 3(3%) senior citizens were had poor quality of life, 17(17%) were had moderate quality of life, 30(30%) were had good quality of life.

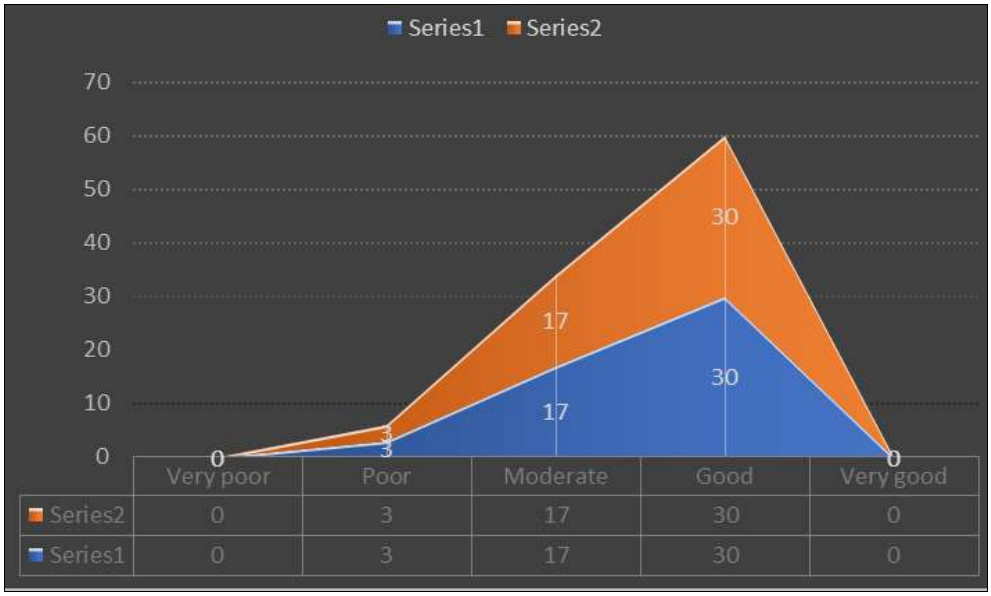

Fig 1: Percentage distribution of level of quality of life among senior citizens.

Section II
Mean, standard deviation of quality life among senior citizens

Table 2: Mean, the standard deviation of quality of life among senior citizens

S.No.		Mean	Std. Deviation
1	Quality of Life	78.11	11.34

Pertaining to quality of life the mean value was 78.11 and the standard deviation was 11.34.

Section III
Association of demographic variables with level quality of life among senior citizens

Table 3: Association of demographic variables with the level of quality of life N=50

S.No	Demographic variables	Poor		Moderate		Good		Chi-square value X^2
		N	%	N	%	N	%	
1	**Age in years**							
	60 – 70	1	1.00	11	11.00	20	20.00	3.61
	71 - 80	2	2.00	8	8.00	8	8.00	DF=2 @
2	**Gender**							
	Male	1	1.00	9	9.00	14	14.00	0.710
	Female	2	2.00	8	8.00	16	16.00	DF=1 @
3	**Religion**							
	Hindu	4	4.00	16	16.00	28	28.00	
	Muslim	0	0.00	0	0.00	2	2.00	2.532
	Christian	0	0.00	0	0.00	0	0.00	DF=6 @
	Others	0	0.00	0	0.00	0	0.00	
4	**Marital Status**							
	Unmarried	0	0.00	0	0.00	7	13.00	
	Married	0	0.00	13	13.00	17	35.00	8.12
	Divorced/Separate	0	0.00	0	0.00	0	0.00	DF=6 @
	Widow/Widower	0	0.00	4	4.00	9	9.00	
5	**Education**							
	Illiterate	1	1.00	7	7.00	4	4.00	
	Up to 10th standard	2	2.00	5	5.00	8	8.00	
	Intermediate	0	0.00	3	3.00	6	6.00	16.710
	Graduate	0	0.00	2	2.00	12	12.00	DF = 8 *
	Post graduate	0	0.00	0	0.00	0	0.00	
6	**Occupation**							
	Home maker	0	0.00	7	7.00	13	13.00	
	Retired being at home	2	2.00	6	6.00	6	6.00	
	Retired and doing other job	0	0.00	1	1.00	8	8.00	14.172
	Business	1	1.00	3	3.00	3	3.00	DF = 8*
	Employee	0	0.00	0	0.00	0	0.00	

7	**Family income**							
	1000-10,000	3	3.00	11	11.00	15	15.00	8.131 DF = 6*
	10,001-20,000	0	0.00	3	3.00	12	12.00	
	20,001-30,000	0	0.00	3	3.00	3	3.00	
	30,001-40,000	0	0.00	0	0.00	0	0.00	
8	**Financial Support**							
	Pension	0	0.00	4	4.00	18	18.00	22.101 DF = 6**
	Fixed Deposit	0	0.00	0	0.00	2	2.00	
	From children	1	1.00	6	6.00	5	5.00	
	Others	2	2.00	7	7.00	5	5.00	
9	**Regular Income**							
	Yes	2	2.00	12	12.00	25	25.00	4.813 DF = 2
	No	1	1.00	5	5.00	5	5.00	
10	**Family type**							
	Nuclear	3	3.00	10	10.00	17	17.00	0.315 DF = 4 @
	Joint	0	0.00	7	7.00	13	13.00	
	Extended	0	0.00	0	0.00	0	0.00	
11	**Place of residence**							
	Urban	2	2.00	15	15.00	22	22.00	8.941 DF=6 @
	Rural	2	2.00	2	2.00	7	7.00	
	Semi Urban	0	0.00	0	0.00	0	0.00	
	Urban Slum	0	0.00	0	0.00	0	0.00	
Residence Type								
12	Own House	3	3.00	9	9.00	20	20.00	4.910 DF= 6 @
	Rental House	0	0.00	6	6.00	10	10.00	
	Provided by employee	0	0.00	2	2.00	0	0.00	
	Others	0	0.00	0	0.00	0	0.00	
Present living								
13	Single	2	2.00	5	5.00	5	5.00	5.920 DF = 6 @
	With spouse	3	3.00	7	7.00	7	7.00	
	With Children	2	2.00	3	3.00	10	10.00	
	With Others	0	0.00	2	2.00	4	4.00	
Type of problem								
14	Physical	2	2.00	15	15.00	24	24.00	0.419 DF = 3 @
	Psychological	2	2.00	2	2.00	5	5.00	
15	**Health Status**							
	Good	1	1.00	10	10.00	25	25.00	7.954 DF =3*
	Poor	2	2.00	7	7.00	5	5.00	
Medical help								
16	Yes	2	3.00	10	21.00	25	52.00	9.613 DF = 2**
	No	3	3.00	6	13.00	4	8.00	
Government Schemes								
17	Yes	2	1.00	7	16.00	21	43.00	10.140 DF = 2 *
	No	3	5.00	9	18.00	8	17.00	
18	**NGO's Programs**							
	Yes	0	0.00	6	6.00	15	15.00	6.921 DF=2 *
	No	3	3.00	12	12.00	14	14.00	

@: Not significant, **: Significant at 0.01 level, *: Significant at 0.05 level.

The data presented in the above table revealed that there was a statistically significant association exists between the quality of life among senior citizens with their education, occupation, health status, and NGO programs available for them at 0.05 levels. Financial support, medical help, and Government schemes at 0.01 level. There was no statistically significant association existed between the level of quality of life among senior citizens with their gender, age, religion, marital status, family income regular income, place of residence, residence type, present living, and type of problem.

Discussion

The present study mainly concentrates on the quality of life among senior citizens in the age group of 60-75 years.

The major findings of the study were among 50 senior citizens 3(3%) senior citizens had poor quality of life, 17(17%) had a moderate quality of life, and 30(30%) had a high quality of life. The study shows that related to QOL the mean value was 78.11 and the standard deviation was 11.34. The chi-square value revealed that there was a significant association between the quality of life with their education, occupation, health status, and NGO programs available for them at 0.05 level and financial support, medical help, and Government schemes at 0.01 level.

Conclusion

The study findings show the implication of the future. It has implications related to various areas like nursing practice, nursing education, nursing administration, and nursing research.

Nursing practice

Community practice setting

In the provision of care to senior citizens, nursing personnel and students will be able to

- Assess family members' knowledge and skills that are essential to delivering care to senior citizens, and communicate effectively, respectfully, and compassionately.
- Prevent and reduce common risk factors that contribute to functional decline and impaired quality of life.
- Evaluate the utility of complementary and integrative healthcare practices on health promotion and symptom management of senior citizens.
- Guide senior citizens and their family members regarding the various resources available in the community setting to utilize rehabilitative health care services.
- Educate the senior citizens and their family members regarding various healthcare policies and facilities that are available to fulfill their various needs.

Hospital Setting

In the provision of care senior citizens, nursing personnel, and students will be able to

- Assess the needs of senior citizens and provide appropriate care to improve their Quality of life and life satisfaction.
- Participate with interest, in the provision of care with the use of modern technology and extend the highest cooperation with interdisciplinary teams to carry out various procedures and policies.
- Communicate with individuals, family members, and the health team regarding needs and the resource of fulfillment to live it good Quality of life and high life satisfaction.
- Appropriate Maintaining of the environment and resources to avoid unnecessary accidents.

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Author's Contribution

Not available

Conflict of Interest

Not available

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