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Awareness on Geriatric Care and the Quality of Life among Elderly

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Abstract - The study determined the awareness on geriatric care and the quality of life among elderly in the selected municipalities in the first district of Ilocos Sur during the calendar year 2009. The respondents of this study were the 355 elderly assisted by their significant others or family members taking care of them from the selected municipalities in the first district of Ilocos Sur namely Magsingal, Sto. Domingo and San Ildefonso. The descriptive method of research was utilized. The data were gathered through the use of questionnaire coupled with interview schedule. The data gathered were analyzed using the frequency count, percentage, mean and simple correlation analysis. The results revealed that most of the respondents are mature adults, mostly female, widowed, reached elementary level; most of them have no job but those who are still earning have a monthly income of Php 1,000.00 and below. Most of the respondents suffer from diseases such as diabetes mellitus, alzheimers and hypertension. They are generally supported with their family members and they are living with them. They are moderately aware on geriatric care along with

its dimensions namely: medication and supervision, physical care, and home safety. There is a "high" level of quality of life along with physical, psychological and economic factors. There exist significant relationships between the level of awareness on geriatric care along with age, educational attainment, occupation and pension of the respondents.

Keywords - geriatric care, quality of life, elderly

INTRODUCTION

Change is one of the important things that cannot be taken for granted. Life alone changes whether it be biological or psychological. Advancing age is one that is unavoidable and much is needed to adjust with these changes. Persons grow old as the result of biologic change. Along with this are the impairments that go with the aging process. Wear and tear of the biologic self is an inevitable phase of human existence.

Nothing is more certain than the passage of time and the changes that come with the passing of years. Enormous changes do occur at puberty, between childhood and adolescence. These are largely due to the increased activity of the endocrine glands. Is there any way of stopping the clock of time and prevent the process of aging? Unfortunately there's none. The passing of time bring subtle changes that cannot be ignored. With this, a foreseeable bulk of responsibility needs to be looked upon. (Anderson, 1976)

Traditionally elder care has been the responsibility of family members and was provided within the extended family home. Increasingly in modern societies, elder care is now being provided by state or charitable institutions. The reasons for this change include decreasing family size, the greater life expectancy of elderly people,

the geographical dispersion of families, and the tendency for women to be educated and work outside the home. (http://en.wikipedia.org/wiki/Nursing_homes)

Given the choice, most elders would prefer to continue to live in their own homes (aging in place). Unfortunately the majority of elderly people gradually loses functioning ability and requires either additional assistance in the home or a move to an elder care facility. The adult children of these elders often face a difficult challenge in helping their parents make the right choices. One relatively new service that can help keep the elderly in their homes longer is "respite care". This type of care allows caregivers the opportunity to go on vacation or a business trip and know that their elder has good quality temporary care, and without this help the elder might have to move permanently to an outside facility.

Elderly care emphasizes the social and personal requirements of senior citizens who need some assistance with daily activities and health care, but who desire to age with dignity. It is an important distinction, in that the design of housing, services, activities, employee training and such should be truly customer-centered.

In the past century, scientists have postulated theories of why people age. More recently, as both the absolute number and the population percentage of elders increase, there is renewed scientific interest in why people age, and what factors affect the physical, physiological, psychologic, and functional status of older persons. Extrinsic factors encompass factors in the environment; intrinsic theory addresses factors within the body.

Indeed aging cannot be prevented yet can be prepared upon in the future. Filipinos are known to have close family ties. The elderly whether abled or not are observed to be living along with other member of the family. Filipinos are known to be resourceful, creative, hard-working, hospitable, caring, with close family ties and polite in the whole world. They are able to adjust and cope to various changes and foreseeable crisis. Yet, several factors could hinder in the fulfilment of these good qualities like in the care of the elders and economic reason is one of them.

The Ilocanos are equally caring and equipped with qualities that are enough to provide care for their elderly. Unfortunately, elderly people

have specific issues and special needs that must be addressed upon which in case cannot be met due to various factors and constraints. They may not accept it but the fact is evident that some of their elderly folks are not well-cared for or worse taken for granted. This is a fact and an observation of the researcher that inspires her to conduct this research.

Review/Survey of Related Literature

The adult phase of development encompasses the years from the end of adolescence to death. Middle-aged adults (40-65 years) have been called the years of stability and consolidation.

For most people, it is a time when children have grown and moved away from home. Thus, partners have more time for and with each other and time to pursue interests they may have deferred for years. Older adults (over 65 years) are the fastest growing group. In the past century, scientists have postulated theories of why people age. With this age, significant physiologic and functional impairment occur. (Kozier, et. Al., 2004)

In the research on Women's Health "The relationship between depressive symptoms and should mobility among older women: Assessment at one year after breast cancer diagnosis," by Mabel E. Caban, M.D., Dr. Freeman, Dong D. Zhang, Ph.D., and others, in the June 2006 ***Clinical Rehabilitation*** 20, pp. 513-522. Older women who are depressed following breast cancer therapy are less likely to fully recover shoulder mobility. After breast cancer therapy, women often suffer from limited range of shoulder motion, as well as shoulder pain, weakness, and/or swelling. These problems can interfere with their ability to engage in activities such as cooking, housework, and grocery shopping. Older women newly diagnosed with breast cancer who have depressive symptoms 2 months after diagnosis are less likely to recovery shoulder mobility a year later, concludes a new study. Women with depression are probably less likely to adhere to treatment to improve range of motion, notes Jean L. Freeman, Ph.D., of the University of Texas Medical Branch, Galveston.

A r*esearch was done as dissertation submitted to Nanyang Technological University in partial fulfillment of the requirements for the degree of Master*

of Science (Human Factors Engineering) in 2008. 2Ex dissertation supervisor at Nanyang Technological University. There are two aims of this research. The first one is to find out what are the common types of environmental hazards the elderly living in rental 1-room flats in Singapore will face. The second aim is to find out if the measurements of the fixtures in the home environment of these rental 1-room flats complements with that of the anthropometric dimensions of the general elderly population.

The methods used include taking demography of the subjects, such as medical and social histories, assessing home safety using a standardized checklist, conducting field analysis of the subjects' homes, assessing the perception of safety in the elderly using a questionnaire and taking measurements of the fixtures in the home to find out if they are compatible with the anthropometric dimensions of subjects for ease of use. 12 interior measurements of fixtures in the 1-room flats of subjects were taken. 6 anthropometric dimensions, which included stature, standing elbow height, bi-deltoid shoulder breath, standing knuckle height, standing overhead grip reach and forward grip reach were also taken. Precision equipment was not available to take precise anthropometric measurements. Also, this is not an anthropometry study in its entirety.

Results were analyzed using Microsoft Office Excel 2003. A total of 41 male and female subjects aged 65 years old and above took part in the home safety checklist assessment and a total of 115 females and 62 male subjects aged 65 years old and had the 6 anthropometric dimensions measured. All gave verbal consent.

The results of this study showed that the kitchen is the most hazardous place, followed by the bathroom, living room and bedroom. Falls account for more than a third of all hazards, followed by fire hazards. Electrical hazards are the least. As for anthropometric issues, the main door grille and bathroom entrances are found to be too narrow for most of the elderly subjects, the worktop for the stove is too low, but this can be compensated by using a utensil of an appropriate height. The height of the kitchen window is too high for carrying a bamboo pole of laundry over the window sill and the width of the kitchen window is too narrow. Approximately 75% of the subjects are perceived to be engaging in unsafe practices at home which may lead to injury. Each home had on average 12 unsafe items

that can lead to a risk of injury, with risk of falls dominating the list. This study has identified the common hazards found in the homes of the elderly staying in 1-room flats which can compromise safety and has also established the safest and most unsafe place in the home. Since significance testing is not used, reliability and validity of the study cannot be proven. While it is ideal to have customization of the fixtures according to anthropometric needs, there is also a need to look into personal preferences and the social and cultural behaviors of the elderly population.

The study of Soriano (1990) found out that supportive setworks significantly contributed to life satisfaction, explaining about 31% of the variance in the morale of teh elderly. Several network dimensions has significant individual contributions to life satisfaction: (ordered according to decreasing contributions) degree of respect, service support received, perceived adequacy of economic support received, social support shared, frequency of interaction, and proximity. The total contribution of supportive networks and control variables significantly explained about 70% of the elderly's life satisfaction.

The study of Ward, et al. (1984) provided a more detailed in both objective and subjective measures, differentiating according to network members, type of relationship with the elderly and according to type of support. Objective measures were available for children, other relative, friends, neighbors, instrumental support and expressive support. Objective measures exhibit only weak associations with morale, with subjective measures more strongly indicative of subjective well being than their more objective counterparts. Variances explains in multiple regression also reflected this differences.

OBJECTIVES OF THE STUDY

The study aimed to determine the awareness on geriatric care and the quality of life among elderly in the selected municipalities in the first district of Ilocos Sur.

MATERIALS AND METHODS

This study used the descriptive research design utilizing both the descriptive and correlational methods of research. In this study, the existing status of the elderly was described, while the correlational method was employed in looking into the influence of the variables to the impact on the quality of life of the respondents. The respondents were the 355 elderly in the selected municipalities in the first district of Ilocos Sur namely Magsingal, Sto. Domingo and San Ildefonso. The study made use of a data gathering instrument which based on the Minimum Geriatric Competencies (July 2007 AAMC & John A. Hartford Foundation Conensus Conference on Competencies in Geriatric Education) and is composed of three parts: Part I gathered data on the profile of the respondents; Part II elicited information on the level of awareness of the respondents; and Part III gathered data on the impact on the quality of life of the elderly.

Processing of the data gathered in this study was done through the Statistical Package for Social Sciences (SPSS) making use of the following statistical tools: frequencies and percentages, and simple correlation.

RESULTS AND DISCUSSION

Distribution of respondents.

In terms of population, there is a total of 355 total of sample respondents in the three selected municipalities in the first district of Ilocos Sur, 54 from Sto. Domingo, 45 from San Ildefonso and 256 from Magsingal. Distribution of the Respondents in Terns of Personal Profile

In terms of age, majority of the respondents belong to the age bracket of 61-70. Most of them are female (238 or 67%) and generally widowed (175 or 49.3%). Majority of the respondents have reached elementary level (116 or 32.7%) and only 3 or .8% have attained post graduated studies.

With regard to occupation, most of them have no job (236 or 66.5%) but those who have earned an average monthly income of Php 1,000 and below.

In terms of support system, majority of the respondents (226 or

63.7%) are being supported by their family members and mostly (342 or 96.3%) living with them. This implies that the close family ties of the Ilocanos are still very evident as evidenced with the care they give to their elders.

Level of Awareness on Geriatric Care of the Respondents Along with its Dimensions. Table 4 presents the level of awareness of the respondents along with the dimension medication and supervision.

Medication Management and Supervision

Table 1. Mean ratings showing the level of awareness on geriatric care of the respondents along medication management and supervision

Item	Mean	DR
1. I am aware of the prescribed medication, its availability, and content and expiration date.	3.29	Moderately Aware
2. I am aware of the dose, route and frequency of the prescribed medication.	3.13	Moderately Aware
3. I am aware of the benefits and side effects of the prescribed drugs	2.48	Aware
4. I am aware that I should be supervised in taking the medication	2.56	Aware
5. I am aware that certain drugs can cause potential problems to older adults like anticholinergic, anticoagulant, hypoglycemic, and cardiovascular drugs.	2.15	Aware
5. I am aware that I should keep a record notebook if I can to list down the medication given to avoid duplication or missed medication.	2.10	Aware
Overall	2.62	Moderately Aware

Legend:

4.21-5.00 Very Much Aware

3.41-4.20	Much Aware
2.61-3.40	Moderately Aware
1.81-2.60	Aware
1.00-1.80	Unaware

In terms with medication and management, the respondents are aware with a mean rating of 2.15 in the potential problems which can be caused by certain drugs. Generally, the respondents are moderately aware with a an overall men rating of 2.62 along with medication management and supervision.

Physical Care. Table 2 reveals the level of awareness of geriatric care of the respondents along physical care.

Table 2. Mean ratings showing the level of awareness on geriatric care of the respondents along physical care

Item	Mean	DR
1. I am aware that the following are needed in the physical care:	3.33	Moderately Aware
a. Wound care if applicable.	2.66	Moderately Aware
b. Physical therapy techniques	2.99	Moderately Aware
2. I am aware that the following assistive devices should be provided if applicable).	3.62	Much Aware
a. slippers/molded shoes/open sandals	2.43	Aware
b. casting/splinting/drop foot support	2.41	Aware
c. walker/crutches/brace	2.82	Moderately Aware
Overall	2.91	Moderately Aware

In terms of the level of awareness on geriatric care along with physical care, the respondents are aware (2.41) in the item casting/ splinting and drop foot support. As a whole, the respondents are moderately aware on physical care.

Cognitive and Behavioral. It can be seen from Table 3 that the respondents are much aware (3.83) in terms of item 2 (I am aware that there is a decline in memory/function) and moderately aware in terms of awareness on dementia/forgetfulness. As a whole, the level of awareness of the respondents on geriatric care along with the dimension of physical care is much aware (3.47)

Table 3. Mean ratings showing the level of awareness on geriatric care of the respondents along cognitive and behavioral

Item	Mean	DR
1. I am aware that the following are observed and manifested by the elderly.	3.60	Much Aware
a. dementia/forgetfulness	2.76	Moderately Aware
b. delirium, and	2.95	Moderately Aware
c. depression	3.10	Much Aware
2. I am aware that there decline in memory/ function.	3.83	Much Aware
	3.47	Much Aware

Self-Care Capacity. It can be gleaned from Table 4 that the respondents are much aware (3.84 and 3.71 respectively) on both the items on the level of awareness on geriatric care along with the dimension of self-care. As a whole (3.77), the respondents are much aware in their level of awareness on geriatric care along witht he dimension of physical care.

Table 4. Mean ratings showing the level of awareness on geriatric care of the respondents along self-care capacity

Item	Mean	DR
1. I am aware that there exist functional deficits in my performance of my activitites of daily living.	3.84	Much Aware

2. I am aware that there exist deficits in my adaptive intervention.	3.71	Much Aware
Overall	3.77	Much Aware

Home Safety. As shown in Table 5 the respondents are aware (2.53) in terms of item 3. As a whole, the respondents are moderately aware (2.87) in geriatric care along home safety.

Table 5. Mean ratings showing the level of awareness on geriatric care of the respondents along home safety

Item	Mean	DR
1. I am aware of the importance of handrails in the bathroom,, toilet and in the bedroom.	3.05	Moderately Aware
2. I am aware that care should be given in the prevention of falls be removing throw rugs and other materials that could predispose falls and lose balance.	2.90	Moderately Aware
3. I am aware that yellow light be used instead of or very bright/glaring in the hallway and other areas to provide better recognition.	2.53	Aware
4. I am aware that slippery materials be removed like the wax, etc. to prevent the occurrence of falls.	3.02	Moderately Aware
Overall	2.87	Moderately Aware

Summary of the Level of Awareness on Geriatric Care of the Respondents. Table 6 shows the summary of the level of awareness on geriatric care of the respondents. The respondents are aware (3.77) in terms of self-care and much aware with respect to self-care capacity. As a whole, the respondents are moderately aware on geriatric care along with its dimensions.

Table 6. Summary of the level of awareness on geriatric care of the respondents

Dimension	Mean	DR
Medication Management and Supervision	2.62	Moderately Aware
Physical Care	2.91	Moderately Aware
Cognitive and Behavioral	3.47	Much Aware
Self-Care Capacity	3.77	Much Aware
Home Safety	2.87	Moderately Aware
Overall	3.13	Moderately Aware

Legend:
4.21-5.00 – Very High
3.41-4.20 _ High
2.61-3.40 _ Low
1.81_2.60 _ Very Low
1.00_1.80 _ No Impact

Impact on the Quality of Life. Another concern of this study is to look into the level of impact on the quality of life of the respondents along with dimensions such as physical and psychological, economic and social and cultural.

Physical and Psychological. As gleaned from Table 11, the respondents have a "high" (3.67) level of impact along physical and psychological. This implies that the respondents are very much concerned in terms of physical and psychological. However,the table shows that with regards to medication and consultation, a "low" (2.81) level of impact is very evident. These may be because of the lack of knowledge or resources to access on the part of the respondents.

Table 7. Mean ratings showing the level of impact on the quality of life of the respondents along physical and psychological

Item	Mean	DR
1. Performs (personal/family members/caregiver) activities relative to personal hygience and cleanliness in the maintenanceof physical health.	4.12	High
2. Maintains proper nutrition personally prepared of others.	3.95	High
3. Assisted/avail to avail bathroom priviledges.	3.93	High
4. Takes/ given time for relaxation and enough sleep.	3.74	High
5 Take the medications in the right amount/dosage prescribed by the physician.	3.25	Low
6. Take the medications in the right time as prescribed.	3.21	Low
7. Visits my doctor regularly as advised.	2.81	Low
8. Visits my doctor whem symptoms occur or worsen.	2.97	Low
9. participates in activities like exercises needed in the maintenance of physical self.	3.25	Low
10. Feels accepted to family members and oher members of the society.	3.75	High
11. able to tolerate pain and other bodily ailment.	3.46	High
12. Able to adapt and use effectivelly experiences in life and other unleasant and undesirable experiences in life.	3.73	High
13. Maintains self-confidence.	3.95	High
14. Maintains good spiritual life/relationship to God.	4.02	High
Overall	3.58	High

Economic. As a whole, Table 8 shows that the respondents have a "High" (3.67) level of impact along economic life. This suggests that the respondents have adequate resources or support with respect to economic aspect.

Table 8. Mean ratings showing the level of impact on the quality of life of the respondents along economic

Item	Mean	DR
1. Has sufficient source for everday living.	3.94	High
2. Has given the chance to execute functional skills.	3.55	High
3. Has limited capacity to execute working skills due to physical ailment.	3.54	High
Overall	3.67	High

Social, Political and Cultural. In terms of social, political and cultural, an overall "Low" (3.22) level of impact can be clearly seen in table 9. Only in the item of making decision regarding to self, family or the village has a "High" (3.86) level of impact. The presence of ailments could explain the result that limits the active participation of the respondents along with these endeavor.

Table 9. Mean ratings showing the level of impact on the quality of life of the respondents along social, political and cultural aspects

Item	Mean	DR
1. An active member of an organization/association. local or international.	3.02	Low
2. Actively participating in the social gatherings whether within the family or the village.	2.98	Low
3. Socialize and join gatherings with friends or other acquaintance.	3.01	Low
4. Able to make decision regarding self, family or the village.	3.86	High
Overall	3.22	Low

Summary of the Level of Impact on the Quality of Life. Table 14 shows the summary of the level of impact on the quality of life of the respondents along with physical, economic, social, political and cultural**.** It can be seen from Table 10. There is a "high" (3.58 and 3.67)level of impact along physical and economic and "Low" (3.22) level of impact in the quality of life of the respondents along with economic dimension.

Table 10. Summary of the level of impact on the quality of life of the respondents

Item	Mean	DR
Physical and Psychological	3.58	High
Economic	3.67	High
Social, Political and Cultural	3.22	Low
Overall	3.49	High

Significant Relationship Between the Level of Awareness

Age significantly influences the level of awareness along with the dimension of physical care (0.2012), cognitive and behavioral (0.1312), self-care capacity (-0.111) as well as home safety (-0.0670). This means that the older the respondents, the higher is their level of awareness.

Table 11. Correlation coefficients showing the relationship between the level of awareness on geriatric care of the respondents and their personal profile

Personal Profile	Awareness					
	MMS	PC	CB	SCC	HS	Overall
Age	0.0130	0.2012*	0.1312*	-0.1151*	-0.0673	0.0390
Sex	-0.0350	-0.0143	-0.0825	-0.1050*	-0.0327	-0.0806
Civil Status	-0.0240	-0.0649	0.0750	-0.0681	-0.0869	-0.0559
Educ'l Attain	0.1479*	0.0508	0.0138	0.1344*	0.0715	0.1334*
Occupation	0.1104*	0.0905	-0.0105	-0.0121	0.1702*	0.1152*

Income	0.0501	0.0280	-0.0640	-0.1161*	0.0593	-0.0065
Pension	0.1115*	0.0551	0.1194*	0.0282	0.0537	0.1132*

Legend:
* - significant at .05 level of probability
HS – Home safety
MMS – Medication Management and Supervision
PC – Physical Care
CB – Cognitive and Behavioral
SCC – Self-Care Capacity

Sex significantly influences only the self-care capacity(-0.1050). Educational attainment influences the following dimensions such as medication management and supervision (0.1479) and self-care capacity (0.1344). This means that the higher the level of educational attainment of the respondents, the better is their level of awareness.

Occupation yielded a significant relationship with medication management and supervision (0.1104) as well as home safety (0.1702). This implies that the existence of the occupation of the respondents prompts them to have a better awareness.

Income significantly influences the self-care capacity (-0.1161). in terms of pension, the following were influences such as medication management and supervision (0.1115) and cognitive and behavioral(-.1194). It means that the higher the pension of the respondents, the better is their level of awareness.

Table 12. Correlation coefficients showing the relationship between the level of awareness on geriatric care of the respondents and their health-related factors and support system

Health-Related Factors	Awareness					
	MMS	PC	CB	SCC	HS	Overall
Height	0.0332	0.0500	-0.0248	-0.0743	0.0541	0.0155
Weight	0.1176*	0.1340*	0.0488	0.0932	0.0830	0.1474*

Ailment	0.1180*	-0.0550	0.0482	0.0706	-0.0766	0.0331
Duration	0.1750*	0.0305	0.0250	-0.0648	0.0191	0.0631
Support System	-0.1621*	-0.0110	0.0491	0.0154	-0.0883	-0.0713

* - significant at .05 level of probability

It can be gleaned from the table that weight influences the following such as medication management and supervision ((0.1176) and physical care (0.1340). this means that the heavier the respondents, the better is their level of awareness. Likewise, a significant relationship is seen in ailment along with medication supervision and management (0.1180). It denotes that the presence of ailment increases the level of knowledge of the respondents along with medication and management thereby increases also their level of awareness.

Support system significantly influences(-0.1621) medication and management as clearly seen from the table. This means that the better or presence of support system, the higher the level of the respondents.

Table 13 . Correlation coefficients showing the relationship between the level of awareness on geriatric care of the respondents and impact on quality of life

Awareness	Quality of Life			
	PP	ECO	SPC	Overall
MMS	0.4863*	0.4373*	0.3224*	0.4779*
PC	0.3103*	0.4063*	0.2202*	0.3592*
CB	0.1462*	0.1368*	0.0680	0.1316*
SCC	0.3897*	0.2913*	0.2880*	0.3755*
HS	0.4625*	0.4379*	0.4416*	0.5292*
Aware	0.5694*	0.5393*	0.4286*	0.5948*

Legend:

* - significant at .05 level of probability
PP – Physical and Psychological
ECO – Economic
SPC – Social, Political and Cultural

As shown from the table, all of the dimensions on awareness namely: medication supervision and management ((0.4779), physical care (0.3592), cognitive and behavioral (0.1316), self-care capacity (0.3755) and home safety (0.5262) significantly influence the dimensions of the quality of life, namely: physical and psychological, economic, and social and cultural.

CONCLUSIONS

The following are the conclusions of the study:

1. Majority of the respondents are mature adults, widowed, female, have no job, with low educational attainment and low monthly income. Most of the respondents suffer from diseases such as diabetes mellitus, alzheimers and hypertension. They are generally supported by their family members and they are living with them. As a whole, the respondents are moderately aware on geriatric care along with its dimensions, namely: medication and supervision, physical care, and home safety.

2. The following variables were found to be significantly related:
   a. Age is significantly related to physical care, cognitive and behavioral and self-care capacity.
   b. Sex is significantly related to self-care capacity.
   c. Educational attainment is significantly related to medication management and supervision and self-care capacity.
   d. Occupation is significantly related to medication management and supervision and home safety.
   e. Income is significantly repeated to self-care capacity.
   f. Pension is significantly related to medication management and supervision and cognitive and behavioral.

3. The dimensions on awareness such as medication management and supervision, physical care, cognitive and behavior, self-care capacity and home safety are all significantly related to all the dimensions on the impact on quality of life, namely: physical and psychological, economic and social, political and cultural.

RECOMMENDATIONS

Based on the conclusions, the researcher proposes the following recommendations

1. A follow-up seminar-workshop to increase the level of awareness on both the elderly and their significant others should be conducted.
2. Maintain and improve the existing support system of the elderly; intensify the imposition of laws and policies that support the elderly.
3. A copy of the result of the study should be given to the municipal mayors of the places under study to further assess their programs for the benefit of the elderly.
4. Further study should be conducted involving other variables.

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