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Activities of daily living (ADL) and wellbeing assessment among Elderly

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Abstract

Aging is a complex process that can be described chronologically, physiologically and functionally. Despite of some cultural changes, becoming old retains many negative connotations, people do not know enough about the realities of aging and because of ignorance they are afraid to get old.
One of the major features of demographic transition in the world has been the considerable increase in the absolute and relative numbers of elderly people. This has been especially true in the case of developing countries like India, where ageing is occurring more rapidly due to the decline in fertility rates combined by increase in life expectancy of people achieved through medical interventions.
The present study aimed at assessing the activities of daily living and wellbeing status among elderly aged between 60-85 yrs. in a selected community area of Mangalore. The descriptive cross-sectional design was adopted and total of 100 elderly were selected for the study. The ADL was evaluated using standard tool by Katz el al 1963 and wellbeing was assessed using standard tool by Prof. B. Nagarathna and Mrs. T.D. Vimala. The results reveled that out of 100 elderly 95 were partially dependent and 5 were fully dependent on others in the activities of daily living status. Also 95 elderly demonstrated low wellbeing scores (95%) and 5 had moderate wellbeing (5%)

Keywords: Activities of daily living, ADL, Wellbeing assessment, Elderly, Old age

Introduction

With the emergence of an aging society and the increasing progress of health care concepts, the ability of older adults to perform activities of daily living (ADL) has been recognized and recommended by WHO for geriatric epidemiological studies as an important criterion for assessing and studying their physical health status [1]. The ADLs are a series of basic activities that people must perform in their daily lives to take care of their clothing, food, housing and transportation, maintain personal hygiene, and live independently in the community. These activities are an important indicator of older adults' health

status. Related studies have shown that individual socioeconomic factors, somatic health, depression status, and health insurance influence ADL function [2]

In order to encourage good ageing, thorough evaluations of physical well-being and nutritional health status are essential. Elderly people can retain their best health and well-being by addressing lifestyle variables, promoting regular physical exercise, and putting customized. nutritional solutions into practice. This study emphasizes how important physical examinations are for extending life expectancy, preventing age-related illnesses, and raising older individuals' general quality of life.

Materials and Methods

Research Design:

The descriptive cross sectional research design was used to conduct this study.

Research Setting:

The study was conducted in a selected Community of Mangalore

Population:

The target population in this study consisted of all elderly both Men and Women aged between 60-85 yrs.

Sampling techniques and sample size

Purposive sampling technique was used for the study. The sample consisted of 100 elderly both Men and Women residing in a community area of Mangalore

Instrument:

Base line variable

I – Baseline variables which consists of 8 items - Age, Sex, Education, Types of Family, Religion, Marital Status, Monthly family income, Association of caregiver with the client

II – Structured interview schedule using ADL Katz et al consisted of 25 items that were divided into 2 areas: self-care needs and instrumental activities of daily living. The grading was done with 3 categories of range score

III – Structured interview schedule using Prof. B. Nagarathna and Mrs. T.D. Vimala Wellbeing status score which is consisted of 40 items that were divided into 3 areas: physical wellbeing, psychological wellbeing and social wellbeing status of elderly people. The grading was done with the 3 categories of range score.

Methods of data collection

Ethical permission was obtained followed by which permission from the community authorities was taken. Based on the permission from the district and primary health center, the written consent was obtained from either the elderly people or their caregiver (for those who were unable to give consent). As the estimated sample size was 100, purposive sampling technique

was executed to collect the data. The data on demographics, ADL and wellbeing were collected through interview schedule and observation.

Results:

Table 1: Demographic Profile of the Sample

Variable		Percentage
1.	Age (in years) 60-69 70-79 ≥ 80	 39 27 34
2.	Gender Male Female	 57 43
3.	Education 3.1 Illiterate 3.2 Primary 3.3 Secondary 3.4 Higher Secondary 3.5 Graduate 3.6 Postgraduate	 28 34 26 12 - -
4.	Type of Family 4.1 Nuclear 4.2 Joint 4.3 Extended	 61 39 -
5.	Religion 5.1 Hindu 5.2 Christian 5.3 Muslim 5.4 Other	 43 30 27 -
6.	Marital status 6.1 Unmarried 6.2 Married 6.3 Divorce 6.4 widow/Widower	 18 79 - 3
7.	Monthly family Income (Rs.) 7.1 ≤ 2000 7.2 2,001-4000 7.3 4001 -6000 7.4 ≥ 6000	 10 35 44 11
8.	Association of the	

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	caregiver with the client	
	8.1 ≤ 6 months	-
	8.2 6 months – 1year	-
	8.3 1 year – 5 years	4
	8.4 ≥ 5years	96

The data presented in Table 1 regarding age shows that the subjects were almost equally distributed across the ranges ,39% were aged 60-69 years ,34% aged more than 80 years and 27% aged 70-79 years The data on education of the subject shows that highest number of subjects had primary education (34%) and 12% had higher secondary education and in type of family more than half of the subjects were living in nuclear families (61%) while others (39%) were living in joint families. The Highest percentage of subjects were Hindus (43%) followed by Christians (30%) and Muslims (27%).
The Majority of the subjects were married (79%) ,18% were unmarried and 3% were widows /widowers. The data on the monthly family income shows that highest percentage of the subjects earned Rs.4001-6000 and only 11% earned more than Rs. 6000.The almost all the caregivers had association with the client for more than 5years (96%) with the remaining (4%) associated with them for 1-5years.

Table 2: Frequency and percentage distribution of the subjects according to the level of dependence for activities of daily living

N=100

Level of dependence	Range of Score	f(p)
Fully Dependent	0-25	5
Partially Dependent	26-50	95
Independent	51-75	-

The data presented in Table 2 shows that most of the subject were dependent on the caregivers for their activities of daily living (95%) while 5% were completely dependent. None of the subject could carryout the activities of daily living independently.

Table 3: Mean, Standard deviation and mean percentage of the subject in sub areas of activities of daily living status

Area of ADL	No. of items	Max. Score	Mean	SD	Mean percentage
Self-care activities	10	20	17.60	1.456	58.67

Instrumental activities of ADL	15	45	19.96	2.772	44.29	N=100

The data presented in Table 3 shows that the mean percentage of activities of daily living status was higher in the area of self-care activities (58.67%) than in instrumental activities of daily living (44.29%). The mean score for the respective areas was 17.60±1.456 and 19.96±2.772 respectively. This shows that instrumental activities of daily living had more dispersion than self-care activities.

Table 4: Frequency and percentage distribution of the sample according to the wellbeing status of the subjects

N=100

Level of dependence	Range of Score	Percentage
Low	0-60	95
Moderate	61-80	-
High	81-120	5

The data presented in Table 4 shows that most of the subject had low level of wellbeing (95%). High level of wellbeing was observed in only 5% of the subjects.

Table 5: Area – wise mean, SD and mean percentage of wellbeing status of the subjects

Wellbeing Sub-areas	No. of items	Max. Score	Mean	SD	Mean percentage	N=100
Physical wellbeing	13	39	14.41	1.457	36.95	
Psychological wellbeing	14	42	15.44	1.585	36.76	
Social wellbeing	13	39	14.06	1.238	36.05	

The data in Table 5 shows the area – wise wellbeing score of the elderly where mean percentage of wellbeing score was low in all areas, the highest being in the area of physical activity (36.95%) followed by psychological wellbeing (36.76%) and social wellbeing (36.05%) .

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Table 6: Association between activities of daily living status and demographic variables

Variable		f	ADL Score		df	Pearson's P
			≤ Median	≥ Median		
1.	Age (in years)					
	60-69	39	21	18		0.754
	70-79	27	12	15	2	NS
	≥ 80	34	17	17		
2.	Gender					
	Male	57	31	26	1	0.313
	Female	43	19	24		NS
3.	Education					
	3.1 Illiterate	28	14	14		
	3.2 Primary	34	18	16	3	
	3.3 Secondary	26	13	13		0.930
	3.4 Higher Secondary	12	5	7		NS
	3.5 Graduate	-	-	-		
	3.6 Postgraduate	-	-	-		
4.	Type of Family					
	4.1 Nuclear	61	30	31		0.853
	4.2 Joint	39	20	19	1	NS
	4.3 Extended	-	-	-		
5.	Religion					
	5.1 Hindu	43	25	18		0.032
	5.2 Christian	30	89	21	2	S
	5.3 Muslim	27	16	11		
	5.4 Other	-	-	-		
6.	Marital status					
	6.1 Unmarried	18	7	11		
	6.2 Married	79	40	39	1	0.298
	6.3 Divorce	-	-	-		NS
	6.4 Widow/Widower	3	3	3		
7.	Monthly family Income (Rs.)					
	7.1 ≤ 2000	10	4	6	3	0.240
	7.2 2,001-4000	35	15	20		NS
	7.3 4001 -6000	44	27	17		
	7.4 ≥ 6000	11	4	7		
8.	Association of the caregiver with the client					
	8.1 ≤ 6 months	-	-	-		0.610
	8.2 6 months – 1year	-	-	-	1	NS
	8.3 1 year – 5 years	4	1	3		
	8.4 ≥ 5years	96	44	47		

S = Significant NS = Not Significant

The Pearson's chi – square test is calculated to find the association between activities of daily living status and selected demographic variables showed no association except for religion (Pearson 's P= 0.032). Hence the null hypothesis was rejected for religion but accepted for the remaining demographic variables.

Table 7: Association between activities of daily living status and demographic variables

Variable		f	ADL Score		df	Pearson's P
			≤ Median	≥ Median		
1.	Age (in years)					
	60-69	39	26	13		0.888
	70-79	27	18	9	2	NS
	≥ 80	34	21	13		
2.	Gender					
	Male	57	36	21	1	0.657
	Female	43	29	14		NS
3.	Education					
	3.1 Illiterate	28	15	13		
	3.2 Primary	34	26	8	3	
	3.3 Secondary	26	17	9		0.283
	3.4 Higher Secondary	12	7	5		NS
	3.5 Graduate	-	-	-		
	3.6 Postgraduate	-	-	-		
4.	Type of Family					
	4.1 Nuclear	61	44	17		
	4.2 Joint	39	21	18	1	0.062
	4.3 Extended	-	-	-		NS
5.	Religion					
	5.1 Hindu	43	25	18		
	5.2 Christian	30	20	10	2	0.386
	5.3 Muslim	27	20	7		NS
	5.4 Other	-	-	-		
6.	Marital status					
	6.1 Unmarried	18	10	8		
	6.2 Married	79	55	27	1	0.354
	6.3 Divorce	-	-	-		NS
	6.4 Widow/Widower	3	3	-		
7.	Monthly family Income (Rs.)					
	7.1 ≤ 2000	10	8	2	3	0.133
	7.2 2,001-4000	35	22	13		NS
	7.3 4001 -6000	44	31	13		
	7.4 ≥ 6000	11	4	7		
8.	Association of the					

	caregiver with the client					
	8.1 ≤ 6 months	-	-	-		0.173
	8.2 6 months – 1year	-	-	-	1	NS
	8.3 1 year – 5 years	4	4	-		
	8.4 ≥ 5years	96	61	35		

S = Significant NS = Not Significant

The Pearson's chi – square calculated to find the association between wellbeing status and selected demographic variables showed no association. Hence the null hypothesis was accepted for the selected demographic variables.

Discussion:

The selected subjects were between the age group 60 to 85. The maximum number of the subjects (39%) were in the age group of 60-69 years and maximum subjects (57%) were males. Majority of the subjects (95%) were partially dependent on activities of daily living and 5% subject were dependent on ADL. The mean percentage of ADL was higher in the area of self-care activities (58.67%) than in instrumental activities of daily living (44.2%). The mean score for the respective areas was 17.60±1.456 and 19.96±2.772 respectively. This shows that instrumental activities of daily living had more dispersion than self-care activities. Maximum subject (95%) had low level of wellbeing and 5% showed high wellbeing status. The area wise mean percentage of wellbeing score was low in all areas, the highest being in the area of physical activity (36.95%) followed by psychological wellbeing (36.76%) and social wellbeing (36.05%). There was no significance association between the activities of daily living status and wellbeing status (r=0.218, p=030) at 0.05 level of significance.

The longitudinal study was conducted in 2017 by Connolly D, Garvey J, McKee G.Disabil Rehabil. et all. The 60 Iris people to identify the factors associated with disability across many domains using a large powered sample in the activities of daily living (ADL) and instrumental activities of daily living (IADL). Those aged ≥65 years were included in this cross-sectional analysis. Three logistic regression models were used to examine the relationships between 25 health, psychological and sociodemographic variables and difficulties in ADL, IADL and ADL/IADL combined. The result of the study revealed that the proportion of those reporting combined ADL/IADL difficulties was 18%. More individuals reported difficulty with ADLs (13%) than IADLS (11%). The main model showed that after age, the top three factors associated with difficulty in ADL/IADL combined were pain, taking five or more medications and depression. After age, the factors with the highest impact on ADL disability were pain, taking five or more medications and body mass index (BMI); the factors with the highest impact on IADL were being separated or divorced, living with others (non-spouse) and self-rated memory.[3]

A cross-sectional study was conducted by Kumaran S, P M A, Raja A, Surya BN et all, to assess the QOL and performance of ADL among 250 elderly subjects visiting the Rural Health Training Centre (RHTC) of a private medical college in Chennai, Tamil Nadu. The majority of the study participants (72%) were in the age group of 60-69 years, while 28% were above 70 years of age. Out of the 250 study participants, 155 (62%) were female and 95 (38%) were male. Among these, 42% were dependent on others for social and financial support. The overall mean scores of QOL of elderly people living in rural areas were found to be average, except for the mean score of social domains, which was very low. The mean scores for the

environmental domain were higher compared to all other domains of QOL, indicating that elderly individuals living in rural areas were more satisfied with their environment. As age increases, dependence on performing daily activities also increases. However, physical independence was higher across different age and sex demographic variables, with a notable impact on activities under ADL.[4]

An assessment of self – rated life satisfaction and its correlation study was conducted and the data was collected from the first wave of the Longitudinal Ageing Study in India (LASI) in 2023 by Bramhankar, M., Kundu, S., Pandey, M., et al. It is a full-scale national survey of scientific investigation of the health, economic, and social determinants and consequences of population ageing in India. The first wave of the survey covered 72,250 older adults aged 45 and above and their spouses, irrespective of their ages, even under 45 years, across all states and union territories of India except Sikkim. A multistage probability stratified area cluster sampling design was adopted to arrive at the eventual units of observation. Detailed information on the survey design, instruments used, and data collection can be accessed from LASI India Report22. This study focused on eligible respondents aged 45 years and above only. The total sample size for this study was 65,562 older individuals of age 45 years and above.[5]

Conclusion:

The findings of the study showed that there is a significant association between activities of daily living and wellbeing status of elderly people. The concept of elderly is undergoing rapid exploration by various researchers. Professional organizations are convinced of the importance of nursing research as major contribution of meeting the health and quality of life of elderly.

Conflict of interest

The authors have no conflicts of interest regarding this research study.

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