CHAPTER-II

REVIEW OF LITERATURE

2.1 Introduction

Chapter two presents all the thoroughly reviewed literature on "Effectiveness of Comprehensive Nursing Interventions on Well-Being and Quality of Life among Senior Citizens in Rural Community, Nepal." The search was conducted from published articles, textbooks, and unpublished theses in English and Nepali mostly after 2013. The journals' original and reviewed papers were both searched for manually and online. HINARI, PubMed, Google Scholar, Medline, Research Gate, and other data bases were utilized for online searches, as well as manual library searches. Senior citizens, QOL, physical health problems or well-being, psychological problems/mental health status, psychiatric morbidities, social well-being/problems, spiritual well-being, extensive nursing interventions, and rural older persons were the main search keywords used to find relevant material. Following are some key areas where thematic summarizing, paraphrasing, and synthesizing were done throughout the literature review: The demographics and health of the Nepalese population, Policies and planning, well-being status and health related behavior of community-dwelling elderly, meaning and concept of QOL including its' measurement and QOL status, effects of various interventions on well-being and QOL, and effects of social, spiritual and other activities on QOL.

The conclusion was reached at the end of the review process and is reported in the last part, which is a summary of the material that was studied.

2.2 Review of Literature

Demographic and Physical Health Status of Nepalese Aged People

The number of elderly persons has increased along with the life expectancy of the Nepalese people. Womens' life expectancy is longer (73.3 years) than males (68.7 years). Due to rising life expectancy and declining infant mortality, Nepal has seen a demographic shift towards an older population. The health and other development policies need to be ready to handle this challenge when the elderly population grows along with high burden of NCDs like cardiac problems, COPD, lower respiratory infections, and the obvious factors of disability and death as a risk. Such as high systolic blood pressure, high blood glucose level, and smoking.[22, 23, 24]

No adult population, including older adults, has been spared from NCDs. Consequently, it is a difficult public health issue in Nepal. It has exacerbated the burden of illness particularly that brought on by COPD and ischemic heart disease. Disability-causing ailments include low back pain, musculoskeletal problems, migraines, COPD, and mental illnesses.[25]

The burden of disease placed on older persons by the existence of non-communicable diseases (NCDs), vision and hearing impairments, and incapacity brought on by dementia and osteoporosis has grown significantly. Older individuals die from NCDs in low- and middle-income nations at a rate of 4/5. Similar to physical sickness, mental illness poses a concern to the elderly since it worsens as individual aged.[26]

A research on basic healthcare in five Asian nations discovered that a large percentage of individuals had little or rarely experience with health screenings and at least one chronic condition. Concerns about the accessibility of rural health care

services had been voiced by older people themselves.[26]

Now a day, Nepalese villages are recognized as the "youth less and tooth less community" state since there are no young people to be found in the community owing to overseas migration for jobs. Elderly persons in this situation receive very little and challenging help from their relatives. Joint families have given way to nuclear families, with elderly individuals playing a smaller part in each. Younger people who are part of nuclear families do not respect their decisions. A longer life expectancy and a bigger population on the one hand, and fewer family members on the other, result in a rise in the requirements and care of the elderly. These diseases might be the root causes and contributing factors to a variety of all domains of health issues, may leave negative impact on general well-being and QOL of the senior population. [27]

Policy, Planning and Program of Senior Citizens in India and Nepal

The census of 2011 revealed a progressive acceleration in India's population ageing, with the senior population increasing to 8.6% of the overall population and expected to reach up to 12.40% by 2026. Article 41 of the Indian Constitution mandates the protection of elderly persons' rights and calls for effective legislation to do so.[28]

Reviewing the senior citizen-related documents, the government first declared India's "National Policy on Older Person" in 1999 in conjunction with a United Nations resolution. The elderly were treated as a national resource, and their income and safety were guaranteed. Later, the parliament introduced “the Maintenance and Welfare of Parents and Senior Citizens Act 2007” as ground-breaking law by the Government. The national government has made an effort to guarantee financial

stability for the senior people by providing monetory help of 200 and 500 rupees for aged more than 60 years and 80 years respectively which is known as "old age pension", with the assumption that the state governments will offer the same amount. Annapurna, widow pensions, and the supply of necessary assistance devices are further social programmes.[29]

In national level, an elderly care programme was launched in 2013 and is now expanding to regional facilities. The National Institute of Social Service coordinates the education, research, and training programmes for elderly persons. Senior citizens are being empowered at the national, district, and municipal levels by a number of NGOs and INGOs.[29]

Senior citizens' rights are outlined as fundamental rights in Nepal's constitution in Article 41, which also provides specific protection and social security for them. The government has been offering services through daycare facilities, nursing homes for the elderly, special discounts on public transportation, medical care, and social security benefits for the elderly aged 70 years and more. There was recent revision on age criteria of senior citizen to receive social security fund has been changed to 68 years by 2023. The government is also aware of theneed to preserve social justice by ensuring a decent lifestyle for seniors, ensuring their security and respect, and reducing elder abuse and inappropriate behaviour. Age-related disorders are not properly diagnosed or treated. The elderly become physically and mentally unable, helpless, and dependent on pain and agony to survive. Government-run facilities are few and far between, but the number of private facilities for the elderly is growing. According to senior citizens act 2006, the senior citizens have the right for being respected, right to live with family, receiving care, facilities and concession, senior

citizen card, prohibition to engage for begging. And there is a provision of development of senior citizens welfare committee in district and central level. [30]

Well-being Status of Community-Senior Adults

Physical and Mental Health Status

In the eastern region of Nepal, 530 older adults participated in an urban community-based cross-sectional study done by Poudel M et al. They discovered that 30.9% of the respondents had a single pre-existing chronic morbidity while 17.4% had multiple morbidities. Ailments affecting the circulatory system were the most common, with a 50.0% frequency. In-person interview with semi-structured pre-tested questionnaire was utilized in this study to collect data. The respondents' mean age was 72.3 years, female respondents were less than half (49.1%). Between the age group 60-69 years, there were 41.1% of respondents.The majority of respondents (41.1%) were between the ages of 60 and 69, were Brahmin/Chhetri ethnically (45.6%), and identified as Hindus (85.7%) by religion. For 40.0% of the respondents, physical activity was low, and for 30.8%, self-reported health state was subpar. Hypertension (34.0%) was the most prevalent chronic morbidity, whereas cancer (0.8%) was the least prevalent. The most common current health issues were circulatory (69.3%), followed by intestinal (68.3%). 19.2% of the respondents said it was tough to carry out everyday tasks. A third of respondents (35.57%) reported having a frequent doctor visit as a habit. The study recommended community programmes on health education and ongoing interventions addressing healthy ageing, which encourage older individuals to engage in healthy behaviour and seek appropriate medical attention.[15]

In the Pharping of Kathmandu, a community study on older adults aged 60 and over, by analyzing secondary data, revealed that more than three-fourth of older adults had

physical and more than half had mental health related issues as reported by themselves, and 14.6% had some form of physical disability. Physical health issues with the highest prevalence were respiratory issues (38.2%) and physical discomfort (60.4%). Anxiety/stress, boredom and a sense of insecurity, loneliness, depression/sadness, neglect, and other issues were included in the mental health issues. More people reported feeling anxious (46.1%) and bored (38.3%). The core data for this study was gathered verbally from 1326 respondents and six Village Development Committees (VDCs) via random selection. In terms of demographics, there were 50.5% of female respondents, an average age was 69.92 years, and 70% were literate. There were 58.4% more widows than widowers. Only 6.2% of respondents reported living alone, while 3.5% reported living with a neighbor or a brother or sister-in-law. Only 9.2% of older persons get pensions, but activity level is most essential because 70.7% of respondents were still employed. The gender gap in living situations, general health related issues (body & mind), literacy, pension status, and marriage status was clearly visible.[31]

High blood pressure was identified by Whelton PK et al. in their executive summary as one of the most prevalent causes of morbidity in older people. One of the aspects of ageing that contributes to the increased prevalence of arterial hypertension worldwide is stiffness of the arterial wall. A key risk factor for both cardiovascular and non-cardiovascular illness and death, such as cognitive decline and loss of autonomy, is chronically elevated blood pressure. According to American Heart Association recommendations from 2017, the target blood pressure should be less than 130/80 mm Hg after age 65, and according to recommendations from 2018, the target blood pressure should be less than 140/90 mm Hg.[32, 33]

Thapa DK et al. revealed that senior Nepalese adults frequently have mental health issues. A community research among 794 senior adults using standard tool (DASS-21), found that 18.1% had anxiety problem, 15.4% had depression and 12.1% had stress in different level as a predisposing factors for psychological problems. The mean score were 5%, 4.2% and 3.6% for stress, depression and anxiety, respectively. The link between the DASS-21 subscales was shown to be statistically significant. Depression was positively correlated with a number of characteristics, including chronic illnesses, traumatic life experiences, perceived low health status, working in agriculture, smoking, and currently being unemployed. The stress was positively correlated with receiving a pension as well as the aforementioned elements. In terms of demographics, the majority of older persons were in the 60–69 age range and the common age was 71.1 years. In this survey, there were more men (52.1%) than women. Among the elderly in the neighborhood, 17% had a bad perception of their health.[34]

According to Ryff's Psychological Well-being and Keyes' Social Well-being Scale, a hospital based study of 404 old patients with NCDs admitted to tertiary hospitals that used consecutive sampling, 96.5% of older sick adults and 96.3% were psychologically and socially well. Significant relationships existed between individuals' psychological health and their sex and place of residence. The study discovered a modest correlation (r=0.456) between older adult patients' psychological and social well- being.The psychological well-being of the adult patients from remote towns was poorer. In order to boost the psychological well-being of men and older adults living in rural municipalities, the research also recommended giving them precedence. [35]

Seniors living in nursing homes experienced greater rates of depression than those living at home. Similarly, a comparison research conducted in 2018 among 200 seniors residing in households and institution in Kathmandu revealed that 77% of seniors had a moderate degree of psychological well-being. 2.5% of older adults reported mild depression, compared to 1% of those with moderate depression. Compared to older persons living in old age homes, older people living at home had higher mean scores for psychological well-being and all areas of psychological well-being. The standard instruments were used in this study. [36]

In Khammam district of Andhra Pradesh, India, a comparison of mental problems in aged people in institutional and community setting with 120 participants indicated that persons living in community have larger prevalence of psychiatric disease (38.3%) than those residing in old age home (30%). And the most prevalent mental diseases weremood disorders including depression, which affected 21.7% of community residents and 25% of elderly residents, followed by anxiety and disorders linked to drug abuse. The diagnosis was based on the standard tool (ICD-10) and was reviewed twice, first by junior residents and then by a consultant psychiatrist. Females and illiterates were more likely to suffer from the ailments. The study emphasized the elderly's participation in routine and planned activities, group activities, and improved access to care as explanations for the lower occurrence of mental problems in residential care setting. It was concluded that provision of elderly care affects QOL and well-being more significantly.[37]

Nagaraja AK et al. evaluated the psychiatric morbidity and QOL between 100 seniors residing in institutions and communities through a cross- sectional research. These individuals frequently experienced cardiovascular illnesses, bronchial asthma and

bronchitis, hypertension, and diabetes mellitus. The majority of elder residents in the hamlet (n=30) were married and cohabitating. When compared to 22% of community members and 36% of residents of nursing homes, depression was frequent in 29% of the whole sample. Elderly residents in the neighborhood experienced psychosis in a 26% rate. In light of this, the study came to the conclusion that older adults generally have high rates of psychiatric illness, regardless of where they live.[38]

According to a research on nutritional assessment among 339 senior people in eastern Nepal, using Mini Nutritional Assessment (MNA) scores, 49.6% seniors were potential to have 'malnutrition' and 24.8% already had 'malnutrition' (95% CI 20.21-29.30). Only 25.6% of those surveyed had a normal nutritional state. In the Morang district of Nepal's province one, a cross-sectional research of people 60 and older was conducted. In the research, the common age for senior women was 69.89 years where as for men 71.03 years. There were 158 older women and 188 older men. Gender difference was found on malnourished condition (higher in males). The risk of malnutrition is 2.69 times higher for elderly dalits than for higher caste individuals. Elderly malnutrition was significantly impacted by the unemployment rate, with the likelihood of development increasing by 3.23 times. In terms of demographics, the majority of participants (96.2%) were Hindus by religion, 67.3% were married, and 55.8% were illiterate. The majority of participants (62.2%) resided in nuclear households, while 37.8% did so in mixed families.[39]Similar to what Lahiri S. et al. reported, MNA determined that a significant portion of old people (60.4%) were at risk for malnutrition and that 29.4% of elderly people in rural India had malnutrition. Men were less malnourished than older women. The report also recommended dietary assistance for elderly residents in remote communities.[40]

High prevalence of malnutrition was found in a rural Nepalese community by systematic random sampling among 242 older adults (60+) in Okharpauwa in the Nuwakot region. The average score for MNA was 19.3±4.2, and the average BMI was 21.4±3.9 kg/m2. The risk for 'malnutrition' was higher (65% respondents), and 24% of cases had 'malnutrition'. The malnutrition impacted older women (29%) more than males (18%). Additionally, compared to other ethnic groups, dalit marginalized people had a 40% higher rate of malnutrition. In terms of demographics, an average age of seniors was 69.8 years, with older women (131) outnumbering men.[41]

According to an elderly study among 114 people from the institution, 22.8% of the elderly were undernourished and 57.9% were at risk of nutritional issues. Among 75 senior people, 21.3% showed serious depressive symptoms and 34.7% had less severe symptoms. The GDS score was inversely correlated with their nutritional state; the more severely malnourished they were, the higher the GDS score. The study also showed the linkage of hunger, depressive symptoms and QOL of senior citizens. All the used instruments were standard to measure above condition.[42]

According to a comparative research conducted in Nepal by Ghimire H et al., institutional older adults (52.73%) had higher rates of depression than community-dwelling older adults (25.45%). In the institutional residence, 93.1% of older women had experienced depression, compared to just 6.7% of older males, however in the community, male older adults (64.3%) had a higher frequency of depression than female older adults (35.7%). One hundred ten older persons were included in the cross- sectional study; 55 were from an old-age home and 55 were from the neighborhood in Chitwan district of Nepal. The majority of responders (60.91%) were women, and 72.73 years was found as older residents' common age who were

residing in town. In this study, depression was found to be predicted by poor income, lack of social support, female gender, and illiteracy.[43]

A descriptive cross-sectional research conducted in Nepal revealed a significant frequency of insomnia (71.1%). Additionally, the study discovered a strong connection between sleeplessness and co-morbid illness, financial dependence, regular medication usage, rising age, and literacy.[44]

The Athens Insomnia Scale (AIS) was used in a Chinese cross-sectional research of 3045 older adults aged 60 and above, and it revealed 24% prevalence of insomnia and 9% suspected insomnia. Insomnia is more common in older persons who live alone, have less social interaction, have less money, and have no permanent income.[45]

Co-morbidities are more prevalent in older adults which leave impact on their psychological issues. According to Momtaz YA et al.'s descriptive research of 385 seniors (≥60 years), the morbidity was seen among 77.7% and the mean psychological well-being score was 57.96%. Malaysians from the north were chosen at random from a multi-stage sample. Self-reported chronic morbidity, the WHO-5 Well-being Index, and socio-demographic data were employed as study methods. According to multiple regression analysis, older people's psychological health is significantly impacted by the existence of chronic illnesses.[46]

Depending on the culture and country, various people may see ageing differently. In 2001, the elder population grew by 3.39 percent. Therefore, the population is ageing; from 6.1% of the total in 1991 to 9.1% in 2011, older individuals made up a growing portion of the population. Also, 75.8% of the people over 65 reside in villages.

Strong social ties are crucial for everyone's emotional and physical well-being, but elderly people especially need them. Social pain is the term used to describe the uncomfortable experience of feeling alone and cut off from society. Such loneliness and isolation may raise the risk of several illnesses, including cardiovascular disease and stroke, dementia, type 2 diabetes mellitus, and common mental health issues including anxiety and depression. Additionally, it can make their lives less enjoyable and possibly shorten them. According to a new study from 2021, the global estimate of the proportion of loneliness is relatively high in Latin America and India, and hardly detectable in China. The estimation by comparing was extremely few for low- and middle-income nations. When comparing the frequency of loneliness between older persons living in care homes and their own houses, older people as care home residence had a higher incidence of loneliness. A comparison of loneliness in middle- and high-income nations revealed that 35% of elderly residents in residential and nursing care facilities experience extreme loneliness. As a result of life changes like widowhood and relocation, loneliness in later age affects women more than it does men. Both social exclusion and loneliness affect on mortality due to known relative conditions, such as obesity, inactivity, substance misuse, and inadequate use of medical resources. Globally, senior citizens are living alone in increasing trend. Globally, 24% of older women verses 11% of older males live alone. Specific treatments, such as social skills training, befriending, encouraging age-friendly communities, and developing laws and regulations, can alleviate social isolation and loneliness.[47]

In Amsterdam, a long-term research on ageing revealed gender variations in older people's social support and levels of despair. The 13-year follow-up on the start of

depression comprised a total of 2823 older individuals, ages 55 to 85. Older men were found more depressed than younger women. Men's depression was linked to a small network and the absence of a spouse, but women's depression was linked to a greater desire for connection.[48]

The differences in functional abilitites related to age was found to be 78% in men and 75% in women, in a senior adults' study (≥60 years) in Mysore's community, India. With no gender differences, 4% of the aged population exhibited significant functional disability. The functional scores of the young and old who are literate, from the middle class, and who are employed were much higher. The elderly have physical problems (3.4%), anxiety and sleeplessness, and even severe depression (1.1%). Elderly ladies had a higher level of psychological suffering than younger women. In addition, 1.5% of them experienced social dysfunction. As older individuals age, such as when they reach 75 years old, the prevalence of mental disease rises.[49]

The most frequent issue hurting older people's health and well-being is chronic back pain. Back discomfort was notably common among middle-aged adults. In compared to India (19.8%), Bangladesh (64.8%), Pakistan (40.6%), and Sri Lanka (36.2%), Nepalese individuals reported a higher prevalence of back pain (69.5%). More women than men reported having back discomfort. Men who walked practically seldom were likewise linked to back discomfort during physical exercise. In Pakistan and Nepal, the chances (OR) of reporting back discomfort were 2.9 times greater. Few days of moderate physical activity (MPA) each week were nearly never linked to back pain reports. There was a greater odd ratio (OR). This study employed cross-sectional data from the World Health Survey (WHS) 2002, which included 8502 participants.[50]

An examination of senior individual’s activities is a key for determining a person's level of handicap. A large number of disabled seniors live in China‘s urban and rural regions, according to a research by Zhang H and colleagues. The level of impairment was highest for both instrumental and basic daily living activities (IADL and BADL). Females, the widowed, the uneducated, and elderly people with low or high BMI had a greater disability rate associated with BADL. The prevention of intervention is crucial for enhancing older people's ADL.[51]

For the improvement of the gastritis status of hospital visited participants from a cross sectional research in Ethiopia, Feyisa ZT et al. in 2020 proposed avoiding hazardous behaviour, improving relaxation and sleep. In the study, younger people had slightly less gastritis than older people. Also mentioned as contributory causes were hot meals, stress, a lack of regular exercise, and drug usage.[52]

Spiritual Well-Being

Without an awareness of spiritual wellbeing, human health cannot be determined. By defining the purpose of life and extending life spans, spirituality has a significant influence in enhancing QOL. An Iranian study conducted cross-sectionally in 2015 among 500 Iranian elders over the age of 60, Sadrollahi A & Khalili Z found that only 14.8% of the elderly reported having a good degree of spiritual well-being. Their demographical variables such as gender, marital status, number of children and income were substantially linked with the spiritual well-being score. Therefore, seniors who were working, married, had fewer children, and identified as masculine had better spiritual well-being. Multi-stage cluster sampling was employed in the study along with a standardized questionnaire of spiritual well-being (SWB) as a tool.[53]

A descriptive correlational research of 822 senior people in Tehran who were over 60 years old found a correlation between the average score for religious and existential health and found good spiritual score (73.72). 33.8% of the individuals reported a moderate degree of spiritual health, whereas 66.2% had a high level. The relationship between spiritual well-being and marital status and activities of daily living (ADL) was quite significant. There were twenty statements in the scale, with 10 pertaining to spiritual health and 10 pertaining to existential health, was utilized in a multi-stage sampling procedure with random selection of the sample. The six-point Likert scale has a range of 10 to 120 points. Higher scores indicate more spiritual wellness. The level was categorized from low to high based on the scores. Male seniors outnumbered female seniors (61.3%). About 60% of the elderly were married, and 50.6% had 0–3 kids.[54]

Health Related Behaviour of Senior Citizens and their Well-being and QOL

According to a cross-sectional research conducted in 2021 by Muhammad T et al. in India using nationally representative data from 2011, the prevalence of tobacco use among older people in rural regions was 16.5% for smoked tobacco and 23.7% for smokeless tobacco. Older adults in rural areas (7.9%) drink alcohol at a somewhat greater rate than those in cities (6.7%). The percentage of elderly adults with cognitive impairment was 62.8%. When older persons used cigarettes or drank alcohol, the chance of cognitive impairment was considerably greater by 24% and 30%, respectively. Older adults with habit of smoking and drinking had higher chance of worse cognitive outcomes than non-drinkers and abstainers (OR: 1.56, CI: 1.21-2.00).[55]

The trend is rising for using self-medication by senior citizens. In a cross-sectional survey of 26,277 older Spanish community residents, self-medication was found to be 10.7% common and poly pharmacy to be 21.7% common. The commonest conditions for self-medication were blood pressure including cholesterol and the pain. Priority should be given to behaviour adjustment to lower the hazards of self-medication.[56]

A cross-sectional research including 1159 older individuals was conducted in four autonomous communities of Japan to identify relation between self-medication usage and QOL among older rural people over 65. Statistics show that the exposure group had health index scores (341 individuals) than in control group. The exposure group had better ratings on self-care (1.29±0.69), movement (1.57±0.91), and regular activities (1.65±0.87).[57]

Meaning and Assessing Quality of Life

The WHO defines **"**quality of life as a person's sense of their place in life in relation to their objectives, aspirations, standards, and concerns as well as the culture and value systems in which they live. It is a wide notion that is intricately influenced by a person's physical and mental well-being, amount of independence, and interactions with important environmental elements**"**.

A wide notion, QOL includes both types of variables; objective like health, living conditions, and possessing resources, and subjective like perceptions of one's own life. It has several sub-dimensions. The term "quality of life" refers to how content or satisfied an aged person is with their life; it emphasizes health and happiness rather than money. A higher QOL is a result of healthy lives in senior people. The eight and a half dimensions of QOL, also recognized as the 8+1 dimensions, are influenced

by a variety of factors, including social interaction, health status, education, leisure activities, spiritual activities, physical and psychological safety, level of productivity or activity, and fulfilment of basic rights. It would be more practical to quantify life quality using a multidimensional method.[58]

Quality of life was described by Koller and Lorenz as “a person's sense of their place in life in relation to their objectives, expectations, standards, and worries as well as the culture and value system in which they live.” Negative affect is one psychosocial characteristic that affects life quality. It is a person's self-perception and self-report of physical, psychological, and social expectations and coping mechanisms, as well as health and therapy-related expectations.[59] Due to the complexity of its many dimensions, including psychological ones that relate to a person's worth and purpose in life, quantifying QOL is the challenging endeavor. The QOL is a culturally based, highly non-objective representation of one's perspective in relation to one's own circumstances, the environment, and social interaction.

Personal characteristics that have a noticeable impact on QOL include overall health, inner life, behavioral and emotional capacities. Social interaction importantly impact on QOL and health state. While accessibility and adaptability to the physical and social surroundings are essential environmental determinants for older quality of life, active engagement, social roles, substantial daily activities, and health habits are crucial elements in social involvement.[60]

QOL Status of Senior Citizens

A survey of 547 senior persons from 396 homes in a rural village in far-western Nepal revealed that 19% of the respondents believed their quality of life to be low, almost

50% believed it to be neutral, and 35% believed it to be excellent. Only 17.2% of elderly victims of abuse said their QOL was excellent. Educated seniors enjoyed higher QOL than un-educated. While age, gender, bodily health, marital status, and living situation were adversely connected with QOL, educational status, property ownership, and QOL perception were positively correlated. About 69% of senior people reported having physical health issues. Two village development committees with a cluster of 18 wards were chosen in this study in 2017. 22 households from each cluster were chosen as part of the sample using the systematic random sampling approach.[61]

In a cross-sectional QOL research, Shah VR et al. found among 250 old people aged 60 and above, a variety of common morbidities, including joint pain (42.8%), high blood pressure (22.4%), and diabetes mellitus (17.2%). Only 12.4% of older individuals had oral issues. More over half of the elderly reported great QOL, which was shown to be much better among seniors who were male. Three facets of the QOL (body, mind and environment) were greater for educated, married seniors who were now living with their spouses. [11]

Better healthcare has to be provided for the elderly, especially for those living in rural regions. Elderly special education programmes are crucial for their physical and mental well-being. The results of a cross-sectional research conducted in Palestine in 2010 brought this to light. A convenient sample of 291 senior persons 65 years and older participated in the exam of QOL, psychological condition, and distress. Tools included the WHOQOL-BREF and the Brief Symptom Inventor. 13% (37) of senior individuals had severe or very severe depression, while 9% (27) had severe or very severe anxiety.

The WHOQOL-BREF's physical health domain had the lowest scores (mean 50.9 and SD21.4) among the elderly, (46%) who assessed their QOL as sound. 33% of seniors regarded their social life as very or very good. Additionally, 41% of respondents assessed their psychological health as good or very good. The study discovered a distinct relationship between a low quality of life and being older, being financially reliant on others, not having a college degree, and staying at home with their kid.[62]

By analyzing 166 samples using the mix technique, the QOL of individuals with chronic ailments who were in their later years was evaluated. Plotting participant mean subscale data over the previous 18 months showed quality of life trajectories, and data from interview were used to analyze participant subjective experiences and cognitive processes. The physical and functional subscales showed a progressive drop, although social QOL scores improved during the last three months, according to the research. In order to maintain better health and to obtain practical and emotional assistance, people build and cultivate partnerships.[63]

Praveen V & Rani AM (2015) in their study based on fifty community old persons (≥60 years) in South India showed that while their quality of life was average, they scored poorly on social relationships. The middle-aged group has a poorer quality of life score than the younger group. The elderly who live in rural areas are content with their surroundings. The senior patients were enlisted from the OPD of PHC using the WHO questionnaire (WHO-QOL-BRIEF). The study came to the conclusion that older people require health education urgently to boost their confidence. This study concluded that the QOL could be improved also by educating family members about general senior care.[8]

A cross-sectional research of 80 senior residents of aged homes and those living with family in the neighborhood revealed that the social relationship domain of QOL of those residing in home, was greater than that of those residing in the institute (mean score 2.82±1.10). Elderly residents of nursing homes had higher environmental health than those living with family (20.02±3.44) (mean score: 23.15±2.58). On the two domains of QOL, (third & fourth), a substantial disparity was discovered. Elderly residents in old age homes had a greater overall QOL than elderly lived with their families (mean score: 61.62±8.52) (mean score: 65.17±7.29).

When comparing the average scores for every dimension of QOL, elderly people living in nursing homes had somewhat better physical health (mean score 21.75±3.73) than elderly people living with families (mean score 20.45±4.07). Similar to this, elderly residents of old age homes had somewhat higher average psychological health scores (19.40±3.11) than elderly residents of family homes (18.32±3.09) in the neighborhood. The average age of the elderly was 72.37 in families and 72.90 in nursing homes, with a greater percentage of females (62.4%). The majority of responders (71.25%) were widows (53.75%) and widowers (17.5%).[64]

Older persons with chronic diseases that influence their QOL, frequently experience psychological anguish and morbidity. One crucial factor of the QOLis spiritual well-being. The average global QOL and average spiritual well-being among 68 cancer patients in Iran were 41.42 and 28.41, respectively (SD: 18.02 and 6.95). Poor life quality was seen, particularly in the social, emotional, and spiritual spheres. Therefore, it is possible to include psycho-social and spiritual assistance in patient treatment. Additionally, a strong positive link between the overall QOL ratings and spiritual wellbeing was discovered. In terms of predicting overall QOL, pain, social

functioning, and arm symptoms were all very significant. All the instruments utilized were standard ("EORTC QLQ-C30, QLQ-BR23 and FACIT- Sp12").[65]

Based on the results of the National Health and Nutrition Examination Survey, Baernholdt M et al. conducted a study in 2007 to determine associations between three aspects of QOL (health related QOL (HQOL), social functioning, and emotional well- being) among rural and urban individuals 65 years and older. The results showed that older persons in rural areas performed less socially than those in metropolitan areas. Daily living activities were linked to all three aspects of QOL, whereas other activities were only linked to one or two of the QOL dimensions. The study came to the conclusion that elderly adults in rural areas may experience social isolation, which lowers social functioning. In order to preserve their physical and mental health, boost their community involvement, and improve their social connections, they require particular treatments.[66]

The Old adults have comparatively low health-related QOL (HRQOL), according to Tajvar M. et al.'s cross-sectional survey of 400 old community members in Tehran. Univariate analysis revealed that women have considerably worse HRQOL. The demographic factors like gender, age, education and financial position were the primary drivers of worse physical health- related quality of life (SF-36), but only sex and economic status were the primary factors of the mental component summary score. The research suggested to prioritize for health and financial situation.[67]

Using the Older People QOL, a community based cross-sectional survey of 336 senior individuals in Sri Lanka aged 60 and above revealed a moderate level of QOL, with a score of 63.86 on the standardized QOL. According to domain-specific scores, "home

and neighborhood" had the highest standardized score (71.4), while "financial circumstances" received the lowest (51.8). Religious statements like "religious faith is important to my QOL" were largely supported by older adults (96.5). The study also identified the factors that contribute to low QOL, including solitary living circumstances (such as living alone), poor family financial standing, co-morbidity of chronic kidney disorders, and poor health state as assessed by the individual.[68]

Effects of Various Interventions/Nursing Care on Well-being and Quality of Life

Individual's lifestyles and hypertension are intimately associated for both management and prevention. The enhancement of the HRQOL is greatly influenced by the health-promoting lifestyle (HPL). Health-Promoting Life Style Profile- II (HPLP-II) for assessing HPL and SF-36 for HRQOL were utilized in a cross-sectional survey among 504 elderly patients with hypertension in community. The outcome showed that the elderly hypertensive patients had moderate levels of both HRQOL (54.36±21.18) and health-promoting lifestyle (125.02±21). However, their nutrition score was higher than their health score under the HPL. Additionally, there was a favorable connection between HRQOL and HPL-II 3 in senior hypertension patients. The better the HPL, the greater the QOL of older individuals with hypertension will be, it was established. Other research has shown the link between healthy behaviour and QOL of senior people.[69]

Breathing involving diaphragm can enhance quality of life. A four-week diaphragmatic breathing programme applied to improve QOL and lessen stomach reflux in 96 individuals with gastro-esophageal reflux disease (GERD). There were 49 individuals who received only standard therapy (control group), compared to 47 people who participated in breathing exercises for four weeks (interventional group).

While comparing between the groups, substantial greater mean score changes found between and after intervention in the intervential one (QOL p=0.004).[19]

It has been discovered that breathing exercises can help older persons with several respiratory conditions, particularly asthma. A blinded randomized controlled study with 90 elderly asthma patients over 65 years old, an equal of 45 in exercise and non-exercise group, revealed that the exercise was beneficial. The majority of the participants (87%) also suggested that their friends do breathing exercises. Both groups showed improvement on the ACT for Asthma Control and the mini-AQLQ for Asthma Quality of Life.[70]

Deep diaphragmatic breathing, guided visualization, and progressive muscle relaxation were also found to have a profound impact on participants' QOL of 50 older individuals with breast/ prostate cancer based on RCT. Two minutes of diaphragmatic breathing were used every day for a month. Three different times—before the intervention, immediately after it, and six weeks later—the QOL was evaluated. In both groups, there were more female respondents (72%), with the mean for the study group being 66.28 (SD 3.94), and 66.16 (SD 3.96) for the non-study group. After intervention, the improvement on physical functioning and QOL was noticed significantly. When comparing the mean functional QOL score of the experimental group before and after immediate intervention, as well as again when comparing the mean functional QOL score before and after six weeks of intervention, a higher mean score was observed clearly (p=0.001) in the study group. The study group showed increased mean value for the overall QOL domain, comparing to non-study group. The study group's mean score ranged from 36.33 ±13.14 before the intervention to 64.33 ±10.77 right away to 52.33 ±10.62 after six weeks of the

intervention.[71]

A community survey of 1588 older persons had discovered a link between the kind of exercise and quality of life was discovered. The results from the national health and nutrition checkup survey conducted in 2014 were utilized. Effectivenessof resistance, flexibility, and walking exercise on older people's QOL were examined. Association was evaluated using the EuroQOL (EQ-5D), which has five subsets: 'regular activities, self-care, mobility, pain/discomfort, and anxiety/depression'. For all forms of exercise (three), older persons who exercised scored higher than those whodid not. The flexibility and walking exercise were independently linked to the mobility and self-care QOL components. Therefore, regular walking and flexibility improve QOL in seniors. Based on the study, the respondents' mean age was 73.3±6.1, and older women made up more than half (56.6%) of the sample. The average BMI was 23.8 ±3.1 kg/m2, too.[80]Exercise and physical activity are protective factors for preventing cognitive deterioration as we age. Therefore, it was incorporated into the psychosocial plan for older individuals with both impaired and unimpaired cognitive performance.[72]

An experimental study (RCT) observing the exercise's effect on physical performance and QOL reported that healthy older persons aged 60 to 80 in Thailand benefited from regular exercise and aerobic exercise for at least 12 weeks. For eight weeks, the experimental group engaged in stepping exercises three times a week whereas the control group (n=21) merely received group health education. The exercise group performed better on physical tests (six-minute walk test, the time-up-and-go test, five-time sit-to-stand test). With a p-value of 0.03, the quality of life score increased from 98 to 105, which was substantially different from the control group.[73]

A quasi-experimental investigation on the impact of group exercise frequency on health- related QOL among institutionalized seniors revealed that exercising two or three times per week had a favorable impact on social functioning and mental health. Whether you exercise twice a week or three times, you can still reap the benefits. Additionally, a substantial impact size was observed to make three times per week of exercise more helpful for improving the mental health component. The enhancement of mental stimulation and prevention of cognitive decline in older people was found to be improved by group exercise. Hundred older adults from five African nursing facilities for the elderly participated in this study, which used random sampling to divide the sample into groups according to age. Their average age was 71 years and there were more female respondents (79%) than male respondents (21%).[74]

A community-based fitness programme has been proven to improve physical skills including balance, muscular endurance, and lower extremity agility. According to 'WHOQOL-BREF', the QOL score dramatically increased as well. According to each QOL dimension, the mean pre-training score rose in the post-training period, going from 20.4 to 21.4 for physical health, 17.8 to 19.8 for psychological health, 10.3 to 11.2 for social relationships, and 23.6 to 26.4 for the environment. Additionally, the post-test Quality of Life score increased from 72.0 to 79.4. After exercise, the psychological, social, and environmental QOL ratings all showed substantial improvements. In a community hall, 46 senior citizens (≥ 65 years) engaged in an eight-week fitness programme that consisted of 16 sessions of 80 minutes each.[75]

A research conducted cross-sectionally using 'the 36 Item Short Form Health Survey (SF-36)', among 100 seniors over 60 who participated in a community physical activity programme as one group and did not participate as a sedentary group was

conducted. In comparison to the sedentary group, the physically active group reported better scores on the SF-36's overall health perceptions subscale and greater functional ability scores. However, there were no variations in the two groups' SF-36 subscale ratings. Their role was found to be constrained by issues with their physical and emotional well-being, mental health, and social interaction.[76]

Another cross-sectional research that divided 200 older persons into two groups and looked at the impact of physical exercise did something similar. All the used study tools were standard (HADS, the Modified Beck Questionnaire and SF-36). The results of the study demonstrated a link between low levels of physical exercise and psychological issues, i.e. anxiety and depression, among the residents of the neighborhood. While another group (sedentary) scored greater on anxiety and sadness, the active group scored better on bodily activity and QOL. Therefore, it is possible to consider physical exercise as a preventive element for anxiety and sadness during advanced ages.[77]

Effect of Nursing Care/Interventions on Elderly Health

A large percentage of participants in a Norwegian community-based cross-sectional research of 83 patients living at home in the years 2013 and 2014 reported having limits in their activity of daily living (ADL). The study had an eight-month follow-up. The medication that 60% of responders were using was unknown. Only 25% of elderly males and 78% of homebodies were alone. The median Barthel ADL-Index score for the 72 respondents was 12, with an inter quartile range of 10 to 14. At baseline observation, 75% of respondents had grip strength indicative of sarcopenia; at follow-up, 82% of respondents had this indicator. Similar to this, mobility impairment affected 33% of people at baseline and 43% at follow-up. Home nursing

care lasted 3.6 hours each week, or 31 minutes per day split between two or three visits. Twenty three percent of those surveyed had used a blood pressure and weight monitoring service, and 8 percent had received physiotherapy as part of in-home nursing care. For their greatest possible health and function, this study has emphasized the requirement for certified assessment/ observations and targeted modification.[78]

Regular exercise has a favorable impact on physical health, which reduces the need for medical treatment. It could enhance QOL of senior people. The QOL is a subjective view of four factors, with socio-economic level and general health/functional status acting as the two objective conditions and the other two reflecting the individual's own evaluation.[79]

People’s living environment has an impact on their perception. The QOL may be measured objectively using a variety of scales. It is frequently utilized in the fields of politics, health care, and mental health.[80]

Physical exercise training as a non-pharmacological intervention on older persons was successful in reducing pain intensity from 4.19± 2.25 to 2.67± 2.08, which is a larger reduction. An evaluation of outcome of a physical exercise programme (PEP) on 396 elderly patients with chronic pain residing in 10 nursing homes was conducted as part of a quasi-experimental research. Five nursing homes (n=225) were randomly chosen for the experimental group with PEP, and five more (n=171) were chosen for the control group without PEP. For eight weeks, nurses and a physiotherapist gave an experimental group PEP once a week, which included warm-up exercises, stretching, and balance exercises with acupressure. By giving them booklets with illustrations of

tasks, the training also improved their ability to govern their own behaviour. The experimental group's psychological health, including happiness, life satisfaction, loneliness, and depression, dramatically improved as well.[81]

According to a research on the nursing care model for elderly patients, functional issues are not anticipated in patients under the age of 74 and are only somewhat problematic in patients above that age. The study found that when a person is older than 74 years, the likelihood of developing problem is increased that they will exhibit a "mild problem" as opposed to "no problem".[82]

Effects of Social and Spiritual Activities on Health and QOL

Recreational and religious activities assist senior persons improve their quality of life and preserve and improve their mental health. In an urban Nepalese community, a quantitative and cross-sectional study of 489 older people found a correlation between prayer, activity physically and recreational activities (watching television and listening to the radio), and lowering depression in older men. Fewer link found between recreational activities and reduced depression in older women. When praying and taking part in religious activities, there was no gender difference that was shown to be statistically significant. The standard scales 'Geriatric Depression Scale' (GDS) and 'the Satisfaction with Life Scale' (SWLS) were the instruments used in the study. Involvement in social and religious life was also linked to Nepalese people's contentment with their later years. While friends visiting, socializing with others and involving in recreation (watchingtelevision and listening to the radio), were substantially connected for older women, socializing with others was significantly correlated for older males (B= 1.22; p 0.05).[83]

Elderly depression symptoms and HRQOL were found to be mediated by spiritual well-being (SWB) in a cross-sectional research of 150 Taiwanese seniors. The spiritual well-being was adversely correlated with depressed symptoms but favorably correlated with the HRQOL. The research provided the suggestion that health care professionals may create treatments to raise SWB for the enhancement of older people's well-being and QOL.[84]

Management of Elderly Issues

Elderly people have a variety of health issues due to biological, psychological, and socioeconomic changes. These issues include despair, anxiety, poor nutrition, and decreased mobility. Their primary issue with healthcare is poly pharmacy. A thorough assessment and an action plan are part of a preventive and practical approach to dealing with senior challenges. Under the fifth stage of preventive, there are 85 actions. There are 32 primary preventive activities and 20 primordial activities that may be used in a community environment, for example senior persons can benefit from health educationfor themselves and their families as well as instruction on self-care and self-monitoring. Strengthening of the elderly's muscles and nutritional status may be helped by an increase in physical activity and malnutrition. A thorough, evidence-based training should be given.[85]

Comprehensive Nursing Interventions

The function of the nurse has expanded to include public health nursing and geriatric nursing, where they are able to create and implement autonomous nursing care and interventions to cope with ageing and enhance their quality of life by preserving the well-being of older individuals. Seniors' anxiety and depression have been found to be reduced and their QOL has been improved by an organized nursing treatments lasting

50 minutes.The investigator designed the following interventions based on a literature review: group discussions, relaxation training using yogic breathing techniques, muscular relaxation, and guided imagery, leisure activities, and audio of raga music played on a flute together with warm-up exercises.[86]

The multi domain intervention was shown to be successful in a randomized controlled study that lasted two years and involved 1260 older persons. ADL baseline scores ranged from 17 (no difficulty) to 85 (complete ADL dependency), with a mean of 18.1 (2.6). In the intervention group, the ADL scores were shown to remain comparatively steady, whereas they marginally rose in the non-intervention group. There was a somewhat increased chance of physical performance improvement (scores from 3 to 4; p=.041) in study group.[87]

According to a number of ageing theories, ageing cannot be prevented intentionally but can be delayed by hobbies and exercise. In an experimental investigation conducted over a 12-week period with 20 women to evaluate the effectiveness of combined exercise on hormonal status related to aging among Korean older women, the exercise group considerably increased oestrogen levels and dramatically decreased glucose levels. The study has gathered data to support the therapeutic use of exercise in reducing resistance of insulin and promoting the release of hormone related to aging in older women.[88]

A randomized technique was used to conduct a home survey of 941 community adults to determine the effect of health promotion practices on respondents' quality of life. Adults in their community engaged in a variety of behaviour linked to health promotion, such as choosing nutritious foods, decompressing, and avoiding risky

behaviour including smoking and alcohol use. Males were more inclined to engage in regular exercise, while females were more likely to choose nutritious foods and abstain from unhealthy behaviour like smoking and drinking. The study also discovered a link between a greater degree of education and healthy behavior such as not smoking or drinking alcohol excessively, but rather engaging in social activities. Significant improvements in both genders' quality of life were predicted to result from stress management and social interactions. The QOL of the general public is significantly impacted by health promotion initiatives.[89]

Music, QOL and Health

As an interpersonal process, music has a significant positive effect on people's or patients' ability to maintain and enhance their health. It is a component of human life from conception to death. Music may make it easier for people to convey their feelings nonverbally and have a biologically significant impact on human behaviour, such as memory and learning. Additionally, music may be employed as therapeutic and promotional means. Independent of the time period examined, a comprehensive evaluation of the literature revealed favorable benefits of music as a therapy on QOL of older adults. In the treatment of depression in 76 working individuals, the combination of music therapy and conventional care has demonstrated excellent results. Comparing individuals who received this form of care to those who just received normal care, the results were better. [90, 91]

The quality of life (QOL) of elderly individuals can be improved by the use of various music therapeutically. The quality of life can be enhanced by using music as an emotional catharsis and nonverbal form of expression. A randomized controlled experiment with 66 Chinese older adults done at a community center in 2007 revealed

that the music group's QOL improved in the course of the week than the controls. Over a four-week period, an overall QOL was improved significantly but not in any sub-score.[92]

Through non-pharmacological therapies, music may be used as a safe and effective method to enhance the quality of sleep for senior members of the community. In particular, it enhances sleep quality and lessens daytime dysfunctions. This outcome was demonstrated in the randomized controlled experiment on the impact of music on elderly Chinese sleep quality. In a study involving 64 older participants, 32 members of the intervention group received an MP3 player with a music database and were told to practice listening for 30 to 45 minutes every evening for three months. The results revealed that sleep quality was continuously improving, with the intervention group seeing the greatest improvements. The PSQI was assessed at the beginning and then every month for three months. The baseline global PSQI score was 13.53, followed by monthly scores of 9.28, 8.28, and 7.28.[93]Another randomized controlled trial with 42 older individuals in a home environment revealed that the use of music therapy significantly decreased geriatric depression ratings and improved sleep quality. In one community service facility, the participants were chosen. For four weeks straight, a half hour of their preferred music was played in their home environment as a form of intervention.

Older women (60) in India's old age homes who were depressed were also treated with music therapy in a control group design study. The intervention group had 15 days regular 30-minute music therapy sessions in the morning, whereas the control group received standard nursing care. According to the study, music therapy is effective in lowering depressive symptoms.[94]

Aged persons who are lonely or separated may find music therapeutic. It could make it easier for people to convey their emotions nonverbally, which would have a significant biological impact on things like memory and learning. Listening to music can help sustain compliance and long-term lifestyle improvements. The choice of music should be made with a comprehensive perspective. Twenty seven people who were 60 years or older participated in this study.[95]

Flute: Music without vocals is referred to as instrumental music. The bamboo-based flute belongs to the family of musical instruments known as the woodwinds. Low-pitched, harmonizing music is comforting and calming, lowering the heartbeat and breathing rate, among other physiological effects. The limbic system is impacted by music, which impacts emotion.

An experimental investigation employing the Balinese flute as the primary music therapy instrument discovered that elderly patients' cognitive performance improved and their serum dopamine levels increased. 36 people aged 60 to 74, took part in this research; 18 were in the control group, which included just western classical music, and another 18 were in the experimental group, which included both western classical music and Balinese flute. Using earphones, the music was continuously played for 21 days, once in the morning before beginning daily activities. It was discovered that listening to flute music significantly improved cognitive performance, particularly in the area of memory. Compared to the non-study group (4.67), the mean gain in cognitive function was larger (5.22) among study group.[96]

Other Activities and Programs

Ageing persons who live in the community may benefit significantly from training and rehabilitation programmes relating to gait, balance, strengthening, and flexibility. The improvement was based on the program's instructional sessions as well as training performance. Exercise and group therapies improve social connections and a sense of belonging, which may have a good effect on QOL. By raising their levels of confidence, it could also lower their risk of developing depression.[97]

Using a longitudinal and multi-site methodology, the Lighten up (8-week) Program's efficacy was evaluated. There were 169 participants from three localities in Wisconsin who were 60 years and more and of both sexes. Following the completion of a pilot trial, the impact of the Lighten up programme was shown on depression, life satisfaction, eudemonic well-being (EWB), and other health outcomes both before and after the programme, as well as during a six-month follow-up. The results on EWB showed a considerable rise, and improvements largely persisted after six months. Strong gains were made in the EWB-specific areas of self-acceptance, constructive relationships, and personal development. Significant reductions in the signs of aggression, anxiety, and sadness were also seen. [98]

Reminiscence is a process of discourse that involves remembering the past and engaging in former actions like story telling and using objects. According to a quasi-experimental study including 30 older participants with a pretest-posttest and control group, the effect of group recollection has been shown to be beneficial on boosting happiness and life expectancy of elderly in Tehran city (p 0.05). 30 initial samples were chosen using convenient sampling, and two groups—experimental and control—were then randomly allocated. Miller's life expectancy and the Oxford Happiness

Questionnaire were the two instruments utilized to gather the data. Reminiscence training and introduction to families, social professionals, and health care counsellors may increase happiness and life expectancy.[99]

Similar to this, it has been discovered that reminiscence-based therapies have a good impact on psychological health, self-esteem, and happiness. This study found that the intervention may be a useful means of enhancing older persons with cognitive intact psychological well-being. Therefore, the suggestion to intervene at the community level can be implemented.[100]

Interventions on Interpersonal support

The social and mental well-being of older adults is correlated with social support. Social support-related therapeutic activities aid in enhancing psychological and social well-being. This was discovered in a research study conducted in Iran in 2017 that included 337 seniors over the age of 65 through the use of multi-stage cluster sampling. Wick's Social Support Questionnaire (WSSQ) and Goldberg and Hiller's General Health Questionnaire (G & H GHQ) were two instruments used to gather data.[101]

The world's population is more socially isolated than ever. Due to a number of risk factors, including some elderly persons living alone, diminished senses like eyesight or hearing, decreased mobility, and an increase in chronic diseases, elderly individuals are more likely to experience loneliness and social isolation. Loneliness and social isolation have a negative impact on both physical and psychological disorders later in life, which is a growing global public health concern. Increased social activity was linked to decreased levels of frailty, according to a research of 606 older adults

aged 60 and above. Higher frailty levels were correlated with loneliness feelings. Social isolation and fragility did not go hand in hand. It may be helpful to regularly assess and manage elderly people's loneliness and frailty.[102]

In a cross-sectional research of 377 older persons with disabilities, it was discovered that there is empirical evidence of a link between spiritual well-being and bio-psychosocial factors. A structural equation modelling technique was employed in the study along with a number of measures, including the Spiritual Well-being Scale and others. According to the study's findings, senior depression and perceived social support have a direct impact on spiritual well- being, whereas functional ability has an indirect impact on spiritual well-being via sadness or perceived social support. Therefore, for their mental health and spiritual well-being, psychosocial therapies for the elderly should emphasize excellent nurse-client contact and fulfilling social activities. [103]

Every nation should conduct frequent evaluations of nurses' attitudes towards care for elderly patients. With the results of their attitude research, an aged health programme may be planned and implemented successfully. The majority of nurses (89.7%) expressed favorable attitudes about working with elderly patients according to an explanatory model concerning registered nurses' attitudes towards older persons that was used with a sample of 579 nurses attending continuing education in London. With regard to many factors, such as awareness of ageing, the distribution of healthcare resources, the interaction of ethnic groups, and concern related to ageing oneself, the difference in their attitudes towards older individuals was 42.6%, whereas it was 16.7-34.3% with regard to older patients. [104]

2.3 Summary of Reviewed Literature

The existing literature research identified that the world's ageing population has turned into a public health problem for every nation's social and health systems. Nepal is in a demographic transition period as seen by the steadily rising number of elderly individuals when comparing census data from different years. Although it is insufficient and the implementation phase has been determined to be unproductive, senior health care and services have been incorporated in national and state policy and planning.

Numerous chronic conditions, in particular non-communicable diseases (NCDs), affect older adults. NCDs are thought to be the cause of almost two thirds of deaths. With NCDs present, the physiological ageing process causes a variety of degrees of impairment, with smoking, high blood pressure, and blood sugar levels being the most prominent risk factors. Physical and mental illnesses are risks that might worsen as people age, ultimately harming their QOL, health and well-being.

Senior individuals often suffer from loneliness and isolation as a result of shifting family structures and young people migrating. Such diseases cause the progression of physical and psychological issues, such as depression and anxiety, which negatively effect the person's overall QOL and well-being.

In several researches, the majority of which were cross-sectionally designed, the quality of life was shown to range from bad to average. The QOL status at the domain level varies according to the reports of various researches. There aren't many community studies among elderly people to determine their issues and QOL, particularly in rural areas. For the prevention and management of geriatric issues in

the community, interventional and experimental researches are also required.

The previously employed single or multiple therapies have been proven as successful for lowering physical and psychological issues and for improving elderly adults' well-being and QOL. Therefore, the scope of nursing is expanding from curative and hospital care to preventative and promotional community care, and the nursing care and interventions programme may be extended to the community as well. In order to provide appropriate care and interventions, nurse researchers must first have a favorable attitude towards the elderly or senior citizens. In other contexts, but not in Nepal, a variety of treatments programmes for older people, such as exercise, including diaphragmatic breathing, meditation, employing music and health and psycho education, have been proven to be beneficial in improving their well-being, minimizing impairment, and improving quality of life. According to the review, no such interventional trial using nursing interventions could be discovered in Nepal. And it was determined that now, at this period of demographic change, was the ideal moment to put it into practice, particularly in rural regions where health services are constantly insufficient.

Therefore, a priority community activity and the implementation of comprehensive nursing interventions (CNIs) were to identify the overall status as well as predictors of QOL and well-being among senior people for improving their status of QOL and well-being in line with the concept of healthy ageing. As they cover all facets of health, well-being, and QOL, the therapies can enhance both QOL and well-being.