
# QUALITY OF LIFE AMONG HOSPITALIZED GERIATRIC PATIENTS IN MEDICAL WARD HOSPITAL UNIVERSITI SAINS MALAYSIA (HUSM) KUBANG KERIAN KELANTAN

by

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**Dissertation submitted in partial fulfillment of the requirements for the degree of Bachelor of Health Sciences (Nursing)**

**April 2011**

## ACKNOWLEDGEMENT

This research was supported by Universiti Sains Malaysia which was supervised by Puan Rahimah Mohd. Anshari, senior lecturer from School of Health Sciences. The author would like to sincerely showed appreciation for her patience and guidance in this research and gave gratitude to Dr Soon Lean Keng as the course coordinator for this Research Project. Additional support was provided by Medical Ward of Hospital Universiti Sains Malaysia that allows the author to collect data in the presenting ward.

The author would like to thank all the participants and interviewer who cooperated and made this research possible. Special appreciation goes to Yee Siau Lin, a 3rd year Master student of Statistic who calculate the sample size and guide the author the correct way for data analysis in this research. For the achievement of this data collection, the author would like to acknowledge the help and support from Rohayu Zahari who provided the Malay version of WHOQOL-BREF questionnaires to exclude my pilot study.

My warmest appreciation goes to my beloved Liu's family and friends. Thank you to all for sharing knowledge and emotional support until this research was completed and also for their constant encouragement and guidance.

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# QUALITY OF LIFE AMONG HOSPITALIZED GERIATRIC PATIENTS IN MEDICAL WARD HOSPITAL UNIVERSITI SAINS MALAYSIA (HUSM) KUBANG KERIAN KELANTAN

## ABSTRACT

Quality of Life (QoL) is unique in different individuals. The measurement of QoL among the geriatric patients can assist health professionals in achieving clinical objectives which included assessing the effects of illness and treatment, identifying the need of support services and developing health enhance environment. Objective of this study was to assess the QoL among hospitalized geriatric patients in Medical Ward Hospital Universiti Sains Malaysia (HUSM), Kubang Kerian, Kelantan. A cross-sectional study was conducted among geriatric patients who were admitted to Medical Ward HUSM with any diagnosis. There were 51 respondents participated in this study. Data was collected using self-administerd questionnaire (WHOQOL-BREF) with enquiring and explaining about the existence of phenomena understudy by the researcher.

Overall finding of the study revealed that majority of the independent variables, demographic data are not significant with the dependent variables, QoL of the hospitalized geriatric patients. Among all the study variables, QoL of the respondents were not associated with age, race, marital status and financial sources. However, there is an association between educational level and satisfaction with health status among the respondents. In addition, the mean different of physical health and psychological health among gender of respondents also showed significantly

different. Finding showed QoL in male respondents were higher than female respondents in all aspects.

As a conclusion, QoL of the geriatric patients will not decline just because of ageing and there is a significantly different between male and female's QoL. Hence, the health care providers should be cautious before making any assumptions about the QoL of individual patients and just not merely based on their health status.

# KUALITI HIDUP PESAKIT GERIATRIK DALAM WAD PERUBATAN HOSPITAL UNIVERSITI SAINS MALAYSIA (HUSM) KUBANG KERIAN KELANTAN

## ABSTRAK

Kualiti hidup adalah berbeza dalam setiap individu. Mengkaji dalam kualiti hidup pesakit geriatrik boleh membantu ahli kesihatan untuk mencapai klinikal objektif termasuk menilai kesan-kesan penyakit dan rawatan, mengenal pasti keperluan sokongan dan meningkatkan kesihatan persekitaran. Objektif dalam kajian ini adalah untuk menilai kualiti hidup pesakit geriatrik yang dimasukkan ke wad perubatan Hospital Univerisiti Sains Melaysia (HUSM), Kubang Kerian, Kelantan. Kajian secara keratan lintang dijalankan di kalangan pesakit geriatrik yang dimasukkan ke wad perubatan HUSM dengan menerima rawatan. Lima puluh satu responden telah menyertai dalam kajian ini. Data dikumpul menggunakan borang soal selidik (WHOQOL-BREF) dengan penjelasan fenomena kajian ini dilakukan oleh penyelidik.

Keputusan bagi kajian ini mendedahkan majoriti responden dan 'independent variables' (data demografi) adalah tidak ada hubung kait dengan 'dependent variables' (kualiti hidup pesakit geriatric). Berbanding dengan semua kajian 'variables', kualiti hidup responden adalah tidak berhubung kait dengan umur, bangsa, status perkahwinan dan sumber kewangan. Walau bagaimanapun, peringkat pendidikan adalah berhubung kait dengan kepuasan kesihatan responden. Di samping itu, perbezaan antara kesihatan fizikal dan kesihatan psikologi dengan jantina

responden adalah berhubung kait. Keputusan menunjukkan kualiti hidup responden lelaki adalah lebik baik berbanding dengan perempuan responden dalam semua aspek.

Kesimpulannya, kualiti hidup pesakit geriatrik tidak akan menurun disebabkan penuaan dan kualiti hidup di antara pesakit lelaki dan pesakit perempuan adalah berbeza. Maka, ahli kesihatan mestilah memberi perhatian sebelum membuat tanggapan bahawa kualiti hidup pesakit geriatrik hanyalah berdasarkan status kesihatan.

# CHAPTER 1

# INTRODUCTION

## 1.1 Background of the study

Until 1993, empirical research into Quality of Life (QoL) occupied the attention of sociologists, social psychologists, and economists, rather than health-care workers (Nussbaum & Sen, 1993). However, the last few years had seen an exponential increase of QoL studies on the effects of medical and health practice (Arnold, 1991; Lawton, 1991; Tilson & Silker, 1990). An extensive literature concerning health-related QoL of older persons has accumulated (Fretwell, 1990; Guyatt & Jaeschke, 1990; Spilker, 1990; Williams, 1990).

QoL is widely used as the research topic in the research field because the QoL of every target group are unique. The number of older people is increasing and which with higher expectations of 'a good life' within society and with their high demands for health and social care, has led to international interest in the enhancement, and measurement of QoL in older age (Bowling, 2007) . According to Hasanah (2003), QoL is being incorporated into pre-consultation and follow-up assessment on individual patients and had become an integral variable of outcome measures in clinical research.

Previously, few studies seem to use QoL and health-related quality of life (HRQoL) measures simultaneously in older people, although these measures may be complement with each other rather than reflect the same phenomenon (Borglin, Jakobsson, Edberg, & Hallberg, 2004). Additionally, the general public and many researchers seek a link between increasing age and decreased subjective well-being

are related to social, physical and psychological losses which are strongly accompanied by the transition to old age (George, Okun & Landerman , 1985).

According to Frytak (2000), a challenge for researchers and health care providers in area of older population are important to avoid measure of QoL which exclude explore areas that bring disadvantages to elderly in health decisions (p.200). Furthermore, Fry's (2000) research which based on a combination of survey data and in-depth interviews with older people living in Vancouver has reported that they are valued most of their personal control, autonomy, self-sufficiency, right to privacy and right to pursue a chosen lifestyle.

Based on a random sample of adults in Britain, earlier research done on the most important things in people's lives was found that people prioritized their own health and health of close one, finances, standard of living, housing, relationships with relatives and friends, social and leisure activities. However, there were variations by age and gender. As an example, social relationships and work have been reported to be prioritized more by younger than by older adults. Hence health and family, more by people aged 65 and over (Brown, et al., 1994; Farquhar, 1995; Bowling, 1995a,b, 1996; Bowling & Windsor, 2001).

A single health complaint and its prediction of elderly who age of 65 and above, QoL are commonly studies as investigating. The studies showed that depression (Burggraf & Barry, 1996), sleeping problems (Grimby & Wiklund, 1994) and pain (Dening, et al., 1998; Ross & Crook, 1998; Jakobsson, Klevsgard, Westergren & Hallberg, 2003) had a negative impact on elderly QoL. But, also other studies indicated that older women in general reported lower QoL than older men did (Kendig, Browning & Young, 2000; Limand & Fisher, 1999). According to Abbasimoghadam, et al. (2009), QoL in men in all domains and summary scales were

higher then women. His finding were supported by others studies which conducted in other countries. These studies were previously done by Ware, Kosinski and Gandek (1993); Wyss, et al. (1999); Sullivan and Karlsson (1998) and Jenkinson, et al. (1999). The QoL is more essential for women because they are more responsible for many household duties, social roles, puberty as well as menstruation, pregnancy, breast feeding and menopause will affect their QoL but yet the appraisal of QoL in different groups is particularly important in health care (Holms, 2005).

Meanwhile, Hellstromand Hallberg (2001) and Jakobsson, Hallberg and Westergren (2004) indicated that only a limited numbers of studies were found to investigate among other variables, various health complaints simultaneously and their prediction of QoL in older populations. Hellstromand Hallberg (2001) investigated that older people's which from range 75 to 99 years and showed that depressed mood, loneliness, fatigue, sleeping problems and the number of reported diseases were significantly associated with low QoL. In addition, Jakobsson and colleagues (2004) demonstrated that the factors which associated with low QoL among older people's which age 85 and above is in pain functional limitations, fatigue, sleeping problems and depressed mood.

The study done by Abbasimoghadam, Dabiran, Safdari, and Djafarian (2009) showed that education levels, being employees currently, having working experience, having a spouse and live with a spouse as well as children were increase QoL, whereas smoking and having disease were decrease QoL scores in the elderly. This is clearly explained that socio-demographic data were mostly had impact on QoL. However, the extent of this socio-demographic factors affect QoL need to be access in different societies (Abbasimoghadam, Dabiran, Safdari, & Djafarian, 2009).

According to Borglin, et al. 2004, he commend that many health complaints were likely to be of relevance for nursing care. Furthermore, in most cases the elderly which age 75 to 84 and oldest old which age 85 and above live with one or more disease that cannot be cured may be focusing on their health complaints and QoL. Issues of QoL influenced the planning, delivery, and evaluation of health and medical services (Renwick & Brown, 1996). Thus, in the assessment of outcomes of health and social care, QoL become commonly used as an endpoint in the evaluation of public policy (Bowling, 2007).

As we know, improved QoL is a desired outcome of interventions. Hence, QoL assessments can identify individuals who are at-risk for poor health in the absence of diagnosed illness. Thus, from a health promotion perspective, QoL assessments can be identify interventions that promote health and prevent illness through enhancement of older person's environments (Raphael, et al., 1996).

From the background of study, we know that gerontology studies about QoL are widely influence the clinical outcome so that it can prevent poor health toward hospitalized geriatric patients. Hence, the continue study may need to confirm the outcome since there is lack of specific study about QoL among geriatric patients in Malaysia. However, the researcher found an Institute of Gerontology (IG) which was launched on 1 April 2002 by Dato' Seri Shahrizat Abdul Jalil, Minister of Women, Family and Community Development after it had been approved by the Ministry of Education on 8 January 2002. IG is one of the research institutes in University Putra Malaysia and its main function is to conduct research related to older persons.

## 1.2 Problem's statement

The geriatric are intensively impinged by major life events in the final stage of life. The major life events such as the concomitant social, physical, and psychological losses, retirement and marriage dissolution influenced the QoL among geriatric. In year 2006, the total number of geriatric patients who were admitted to medical ward in HUSM were 1814 patients, followed by 1920 patients in year 2007, 2008 patients in year 2008 and 2041 patients in year 2009. The total numbers of geriatric patient admitted are increasing year by year. However, the total number of patients in year 2010 was not completed yet. There were total of 1052 geriatric patients admitted to medical ward in HUSM until July 2010 (*RecordUnit of* HUSM, Kelantan, 2010).

Since the proportion of geriatric patients aged 60 or above have reached 41.6% of total patients admitted in medical ward in HUSM (*Record Unit of HUSM*, 2010), there is a need in this area of study. An early examination of the QoL of geriatric patients must be helpful for the planning of social welfare programs for the elderly.

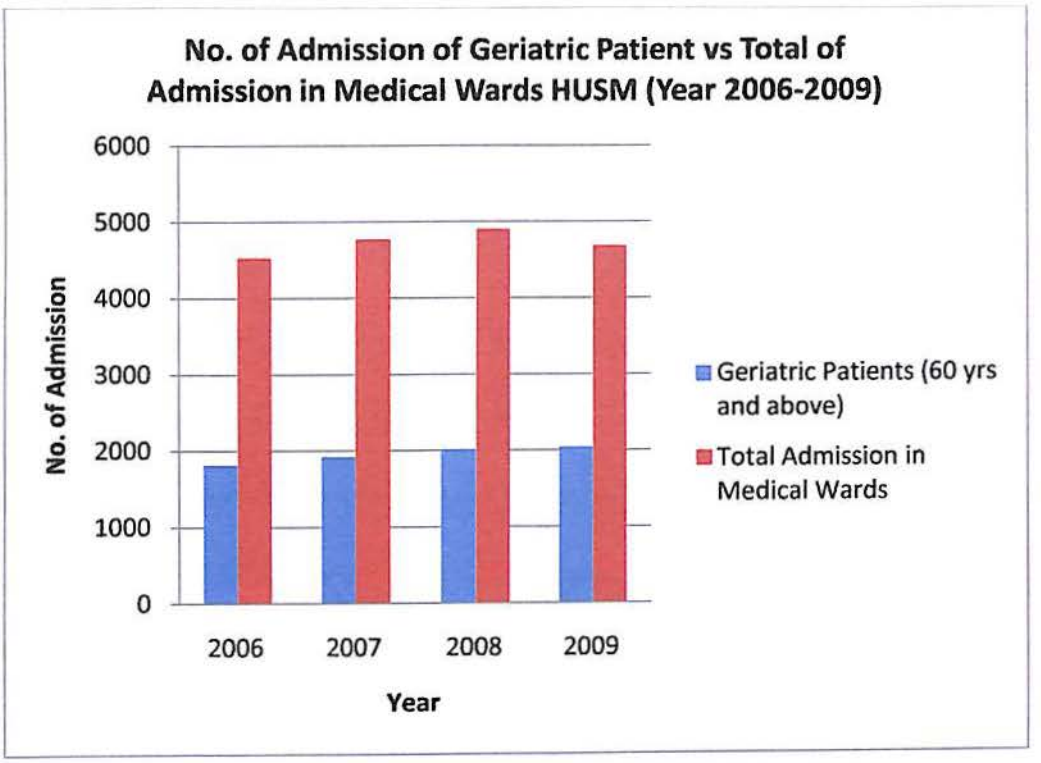


**Figure 1.1 Numbers of admissions of Geriatric Patients vs Total of Admission in Medical Wards HUSM, Kubang Kerian, Kelantan (Year 2006-2009)**

As we know that, everyday life marked by different health complaints wills most likely affect the geriatric's QoL. Thus, goals of nursing should be to promote health and to help maintain or improve the geriatric patient's QoL (Borglin, et al., 2004). The interventions which were used as sensitive measure to indentify those in need especially at early stage of the health decline elderly is an important stage to prevent unnecessary outcome when provide health care. This is important to understand the most common health complaints and geriatric's impact on QoL if health care provider needs to develop an adequate nursing intervention for the geriatric patients and not merely according to the judgments. By assessing the QoL and the perception of health complaints among the hospitalized geriatric patients, we can gain our health care knowledge because as a health care provider we need to assess QoL in several directions.

According to Meeberg, 1993, p.36, "For QoL, no generally agreed-upon referents exists". Hacker (2003) argue that "there is a lack of a gold standard for measuring QoL" (p. 613). Attempts are made to measure QoL in research as well as in clinical practice. If individuals are considering satisfied, happy and healthy within physical, psychological, and social contexts, they are probably having a high level of QoL.

QoL assessments are helpful in identifying persons at risk of poor health who were absence of diagnosed illness (Raphael, et al., 1996). Thus, a desired outcome of nursing interventions is to be improved QoL of geriatric patients in HUSM. Besides, from the findings of Borglin, et al. 2004; Vernon, Ross and Gould (2000) suggested that the assessments of individuals in general can serve as a diagnostic process which facilitating the development of suitable nursing interventions. However, systematic

assessment and interventions need to be supported by knowledge about what may affect the older person's every day life negatively.

Even though, health-related QoL in older people is generally assessed by measuring specific domains of health status, which are activities of daily living or pain, but the association between health-status measures and patients' perceptions of their QoL is not clear (Covinsky, et al., 1999). Hence, the research about controversial whether these health-status measures as well as the selected demographic data should be considered to measures of QoL of geriatric patients in HUSM is needed.

### 1.2.1 Conceptual Theoretical

Health Belief Model used as the conceptual framework, as geriatric patient's belief are unique and important in the study about the QoL among geriatric patients in HUSM. QoL indicator is always in measures activities of daily living and functional dependence frequently (Buchner & Wagner, 1992; Guralnik & Simonsick, 1993; Rockwood et al., 1994). Within these frameworks, there is focus upon physical, and sometimes, social functioning, but broader concepts of well-being and functioning (Bowling, 1991; McDowell & Newell, 1987) tend to be ignored.

Borglin, et al. 2004 described that the theoretical framework of Health related QoL is largely based on the multidimensional perspective of health such as physical, psychological and social functioning and well being. This is according to WHO's definition of health which explained that 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organisation, 1992).

## 1.3 Objectives of the Study

The general objective of the study is to assess the QoL among hospitalized geriatrics patients in Medical Ward HUSM.

### 1.3.1 Specific Objectives

1. To describe the socio-demographic characteristic among hospitalized geriatric patients in Medical Ward HUSM.
2. To determine the mean different of QoL among gender, race, marital status, education level and financial sources of hospitalized geriatric patients in Medical Ward HUSM.
3. To determine the significant association between age and QoL among the hospitalized geriatric patients in Medical Ward HUSM.

## 1.4 Research Questions

1. Does the mean different of QoL different between gender, race, marital status, education level and financial sources among hospitalized geriatric patients in Medical Ward HUSM?
2. Does the age of the geriatric patient associated with QoL among hospitalized geriatric patients in Medical Ward HUSM?

## 1.5 Hypothesis

1. Ho = There is no significant different in term of QoL among hospitalized geriatric patients in Medical Wards HUSM with gender, race, marital status, education level and financial sources of the patients.

$H_A$ = There is significant different in term of QoL among hospitalized geriatric patients in Medical Wards HUSM with gender, race, marital status, education level and financial sources of the patients.

2. Ho = There is no significant association between age and QoL of hospitalized geriatric patient in HUSM.

   $H_A$ = There is significant association between age and QoL of hospitalized geriatric patient in HUSM.

## 1.6 Definition of Terms

There are three important terms that extensively used in this study. The definitions are below:

### 1.6.1 Quality of Life

The Canadian Oxford Dictionary (1998, p. 827) defines life as a condition in which there is "a capacity for growth, functional activity, and continual change", "human condition; existence". Quality is defined as "the standard of something when compared to other things like it" (Canadian Oxford Dictionary, 1998, p. 1180).

Thesaurus definitions also provide additional depth to the analysis. According to Roget's Thesaurus (Soukhanov,Vianna, Steinhardt,Harris and Boyer, 1998), synonyms for the term life include: "duration, existence, and lifetime" while synonyms for the term quality include: "attribute, character, characteristics, feature, calibre, and merit".

A measurement of QoL requires a definition of the concept. The QoL theoretically encompasses the individual's physical health, psycho-social well-being and functioning, independence, control over life, material circumstances, and external

environment. This is a concept that is dependent on the perceptions of individuals, and is likely to be mediated by cognitive factors (Bowling, 2005a,b).

Additionally, Raphael et al. (1996) defined QoL as 'The degree to which a person enjoys the important possibilities of his/her life'. Meanwhile, the discussion about philosophical foundations was appears in Renwick and Brown (1996); Woodill, Renwick, Brown and Raphael (1994). However, from the study of Rapheal et al, 1996 was summaries that individuals have physical, psychological, and spiritual dimensions.

### 1.6.2 Geriatric

The Medical Dictionary by Geddes & Grosset (2005, p.101) defined geriatrics as 'the sub-discipline of medicine that deals with the diagnosis and treatment of disease and conditions that affect the aged'. The term of geriatric are immediately conjures the old and the aged. However, the aim of geriatrics in medical is to ensure the disease is prevented while disabilities and illnesses are treated in elderly people.

Most of the developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but there is a different concept in Asian. In the developed countries, the elderly is stated as, who received the pension benefit. At this moment, there is no United Nations (UN) standard numerical criterion, but the UN agreed the cut off for the definition of age for the elderly is 60 years old and above. This category will be referring to older population.

### 1.6.3 Hospitalized

The McGraw-Hill Concise Dictionary of Modern Medicine (2002) is defined hospitalized as 'The period of confinement in a health care facility that begins with a patient's admission and until patient's ends with discharge'.

### 1.6.4 Medical ward

The medical glossary.com defines 'Medical Wards' as a ward for people who do not have to undergo surgical operations.

## 1.7 Significance of the study

The significance of the problem is supported by other research studies which have studied the problem or the relationships among the concepts of the problem. The significance about the study is to determine the QoL in hospitalized geriatric patients in HUSM. This is because understanding QoL among the geriatric patients is important for the health care giver to provide the better health care to their geriatric patients.

Patient's assessments of their medical providers are an important aspect of effective care (Hershey and Grant, 2002). This is because, health care provider are improving their medical services, especially primary care for those vulnerable populations (Hooker and McCaig, 2001). Cohen, Mount, Tomas and Mount (1996) emphasize that "QoL always matters to the patient" (p. 576). If we can be responsive to patients' perceptions of their QoL, then we can successfully intervene and ultimately ensure the positive impact toward health care field.

Commonly, the geriatric's experience explained as the reason why the relationship between age and subjective well-being turns positive after relevant losses which occurred in the aging process have been controlled (Chen, 2000). In fact, everyday life will be mark by different health complaints which will most likely affect the older people's QoL. Hence, to promote health and to help in maintaining or improve the older people's QoL as one goal of nursing practice as well as the intervention included thorough and systematic assessment can be an important means

for the health care providers to effectively pinpoint the care deliver for the need of geriatric patients. In another way, to help saved the strained resources so that where the geriatric patients' most needed can be allocated. Additionally, to maintaining or improving the QoL among hospitalized geriatric patients and to keep on managing an independent life, nurses needs to consider targeting several health complaints simultaneously to effectively promote the older person's ability (Borglin, et al., 2004)

QoL of older person's measurement can assist health professionals in achieving an amount of important objectives of the health care given. The measurement include assessing the effects of illness and treatment, identifying need for the services support, and developing health enhance environments (Raphael, et al., 1996). Besides that, from the clinical perspective, the systematic nursing assessment for these specific health complaints is concluded as a great importance in order to facilitate early detection and interventions of the problems for the geriatric patients.

Furthermore, this study will contribute to the practice of health professional, such as doctors or nurses, so that they can clearly acknowledge and understood the needs of geriatric patients in order to plan a package of rational care as well as ensure the best practice and offer the better support for the geriatric patients.

# CHAPTHER 2

# LITERATURE REVIEW

## 2.1 Introduction

Over the past 20 years, due to profound changes in the social and economic context, the concept of QoL has progressively evolved with represented by demographic imbalance, growth of secondary needs and development of social and occupational status (Alesii, Mazzarella, Mastrilli, & Fini, 2006). From the literature, there are various definitions of QoL but the most forceful and applicative had summarized by Alesii, et al., 2006. QoL is the level of real and perceived well-being versus the ideal and wished-for-well-being in regard to a specific condition. Meanwhile, the study of QoL started from the medical and technical scientific concept in order to reach an understanding of individual and social welfare. The individual and social welfare are emerging from the complex combination of factors such as values, perceptions and pragmatic environmental conditions (Alesii, et al., 2006).

Furthermore, World Health Organization (WHO) defined QoL as 'the individual's perception of his or her position in their life within the cultural context and system value where they lived in and in relation to their goals, expectations, parameters and social relation' (WHOQOL Group, 1993,1995). Persson, et al. (2001) stated about the well known of various health problems that increased with age and as a consequence of the increased health problems, people might needed assistant to manage activities in daily life. Nurses can be more cognizant of concept, patient's

perception of their own QoL, and ultimately the positive role which nurses can play by examining QoL among the geriatric patients (Lynda & Diana, 2005)

The concept as ''health-related QoL'' are commonly refered by healthcare literature (Derrett, Paul & Morris 1999; Gill & Feinstein, 1994). The fundamental in healthcare is using of this concept, with that it recognizes the effects of illness (Schweitzer, Kelly, Foran ,Terry & Whiting, 1995), evaluates treatments (Rotstein, Barak, Noy & Achiron, 2000), and facilitates resource decisions (Ager, 2002). Smith, Watson, Roger, McRorie, Hurst, Luman and Palmer (2002) argued when the nurse has a sound knowledge of issues associated with QoL then the nursing care can be improved. From the systematic review of the literature on nurse practitioners (NPs) and how they compared to physicians, the increasing availability of NPs in primary care is likely to lead to high levels of patient satisfaction and high-quality care was concluded (Horrocks, Anderson, Salisbury, 2002)..

**2.2 QoL of Geriatric Patients**

From the study of Bowling, Seetai, Morris, and Ebrahim (2007), the results showed that 21% of respondents (older people with age 65 and above) were reported have fairly to severe levels of functional difficulty and 62% of respondents rated their QoL as 'good'. The researcher used the better self-rated health, lower burden of chronic disease, not having fallen from height, higher social engagement and higher level of perceived control over life to distinguish between the people who had difficulties with physical functioning.

Moreover, Rossen and Knafl (2003) found that among 31 womens who aged 61–91 which the sense of security, competence and the capacity to handle demands in new situations was important for feeling well when their health problems increased

and ADL capacity deteriorated. From a study by Pietila and Tervo (1998) that included Finnish people over 75 also confirmed this assumption.

From the study of Covinsky, et al. (1999), the results suggested that the clinicians should be cautions before making assumptions regarding the QoL of individual patients based on their health status. As an example, 15% of elderly patients who reported to the highest scores (top tertile) had fair or poor global QoL, whereas 11% of patients with poor physical capacity scores (lowest tertile) reported very good or excellent QoL.

### 2.3 Factors affecting QoL of Geriatric Patients

According to Jenkins, Jono, Stanton and Stroup-Benham (1990), Cella (1992) and Breslin (1991), the importance of a multidimensional assessment is increasingly recognized in the literature pertains as first guiding principle. This is because physical assessments alone are not accurate enough (Greenfield & Nelson, 1992) to measures the QoL among the geriatric patients with highlighted by findings of low correlation between self-rated QoL and functional capacities (Pearlman & Uhlmann 1988). Thus, the measurement of QoL is widely recognized that should include the person's physical health, day-to-day functioning, psychological well-being, social relationships and environment (Alesii, et al., 2006). Alesii, et al., (2006) also described that what is important in his or her own QoL is unique for every single individual's perspective. It is the meaning given to each event recognized as significant that will cause or not an improvement in the perception of QoL.

Cassel, Cohen, Larson, Meier, Rensnick, Rubenstein and Sorenson (1996) described that there is a general agreement that measures of health status, such as physical function and psychological well-being which are important related to the

patient outcomes. From the study, they found that it is especially true for older patients, in whom these outcomes may be as important as length of life.

Borglin, et al, (2004) indicated that some of the health complaints such as pain, fatigue and mobility impairment were proven to be significant in predicting a low QoL among elderly people. When the older people experienced pain, they tried to avoid their movement, hence, cause further mobility impairment. It is known that pain is common among older people who have a negative affect on their QoL and mental health related QoL. Apart from that, older people who suffered from fatigue faced the deficient strength to carry out daily activities and thus decrease their QoL.

Furthermore, from Lachman and Weaver (1998), the previous researcher indicated that the elderly with lower social class are showing more negative outcomes in health and well-being. In the other hand, the poorer physical health conditions also make the older individuals perceived their own aging and health status more negatively (Borawski, Kinney & Kahana, 1996; Idler & Weaver, 1998).

## 2.4 Medical Wards

HUSM provides treatment services to its patients based on dedicated administration and management approaches using high quality services, a commitment to teaching and research, optimal financial strategies, core human resources values, and sensitivity to the social needs of the East Coast community (Kamari, 2009).

As health care providers, nurses have to understand the individual, and medical nursing is about providing holistic care to patients who don't need a surgical procedure. They need to be able to assess the patients, pick up the gaps in care, recognize symptoms and do the tests to get a baseline picture (Parker, 2004).

## 2.5 Instrument used

The WHOQOL-BREF is a brief version which was developed from the origin WHOQOL-100. The WHOQOL-BREF included 4 domains and 2 individual questions, giving a total of 26 questions. The domains asked about physical health, psychological health, environment health and social relationship. Whereas, the two individual questions asked about overall QoL and general health (Naumann & Byrne, 2004). The scoring of WHOQOL-BREF was scaled in positive direction, with higher scores denoting higher QoL. This questionnaire was later used in the study of Naumann and Bryne (2004) with the aims to assess the reliability and concurrent validity of the questionnaire. The study was done in a clinical sample of depressed older people as well as to determine the association between QoL with clinical and socio-demographic variables.

## 2.6 Conceptual Framework

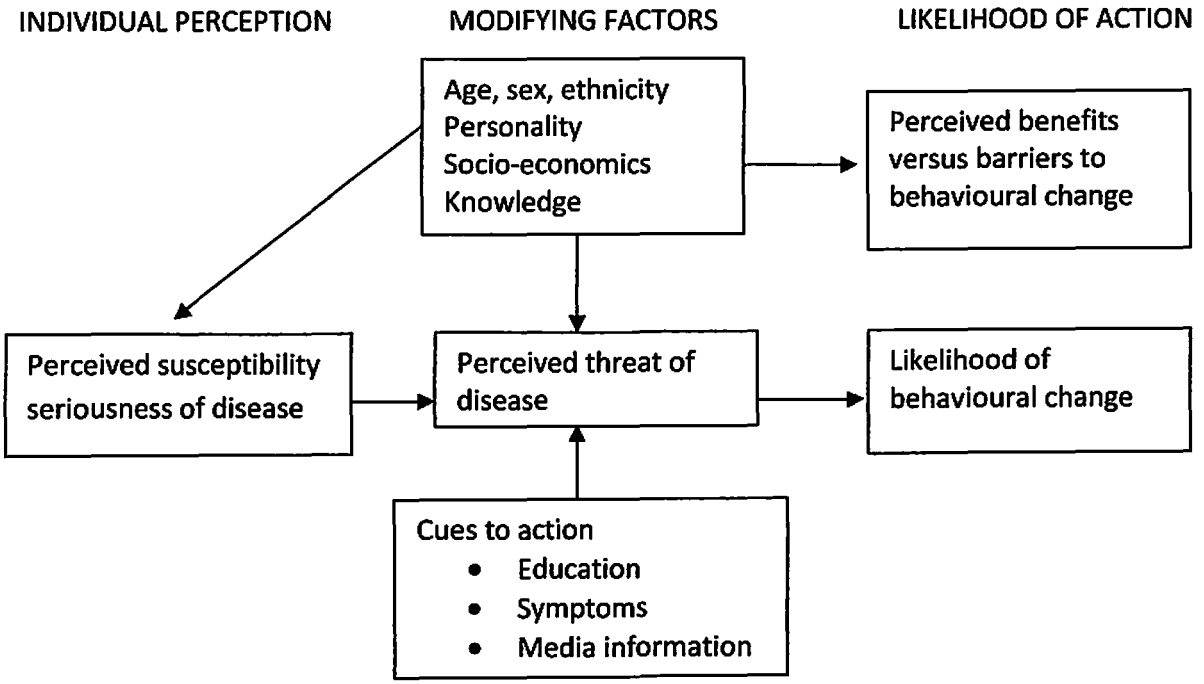


**Figure 2.1 Conceptual Model**
**Source: Glanz et al., (2002, p. 52)**

Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors which focus on individual's attitudes and beliefs. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels who worked in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. It attempted to explain and predict a given health-related behavior from certain patterns of belief about the recommended health behavior and the health problems that the behavior was intended to prevent or control. The model postulates that the following four conditions that both explained and predicted a health-related behavior (Lawrence, 2010).

Nevertheless, HBM is based on the understanding that a person will take a health-related action such as the people who believed that his or her health is in jeopardy although they did not feel any symptoms yet. The HBM was spelled out in terms of four constructs representing the perceived threat and benefits: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. Yet, these concepts were proposed as accounting for people's "readiness to act" and add on cues to action, would activate that readiness and stimulate overt behavior. A recent addition to the HBM is the concept of self-efficacy, or one's confidence in the ability to successfully perform an action. This concept was added by Rosenstock and others in 1988 to help the HBM better fit the challenges of changing habitual unhealthy behaviors, such as being sedentary, smoking, or overeating. Table 2.1 explained the four constructs represent the perceived threat and net benefits.

**Table 2.1 "Theory at a Glance: A Guide for Health Promotion Practice" (1997)**

| Concept | Definition | Application |
|---|---|---|
| **Perceived Susceptibility** | One's opinion of chances of getting a condition | Define population(s) at risk, risk levels; personalize risk based on a person's features or behavior; heighten perceived susceptibility if too low. |
| **Perceived Severity** | One's opinion of how serious a condition and its consequences are | Specify consequences of the risk and the condition |
| **Perceived Benefits** | One's belief in the efficacy of the advised action to reduce risk or seriousness of impact | Define action to take; how, where, when; clarify the positive effects to be expected. |
| **Perceived Barriers** | One's opinion of the tangible and psychological costs of the advised action | Identify and reduce barriers through reassurance, incentives, assistance. |
| **Cues to Action** | Strategies to activate "readiness" | Provide how-to information, promote awareness, reminders. |
| **Self-Efficacy** | Confidence in one's ability to take action | Provide training, guidance in performing action. |

Becker (1974) developed the concepts of a HBM by expanding upon the works of Rosenstock who studied individuals' reasons for not participating in health-screening programs. From the point of view of Backer, health belief is based upon the idea that an individual must have the willingness to participate in health interventions and believed that being healthy is a highly valued outcome. Therefore, by determining the individuals' perception of the disease, illness or accident, identification of modifying factors, and the likelihood that the individual will take some action, it was possible to predict if an individual would engage in positive health behaviors.

HBM framework is presented as one of the theoretical approaches to promote and maintain a life style change that encourages health promotion, health maintenance,

and assist in decreasing complications due to chronic illness. By using HBM, can assist nurses in seeing the health concerns from the client's perspective (Mackey, 2002). There were many cases which the patients and families are referred for any health education without assessing the patient's learning needs and merely just follow the treatment plans. By using HBM, health providers can empower patients to become active participants by including them in the decision making process through adequate collection of information from the patient's perspective especially in geriatric patients who need more concern care. This will provide the better nursing outcomes in geriatric field by not just following the treatment plan and hence to improve theirs QoL.

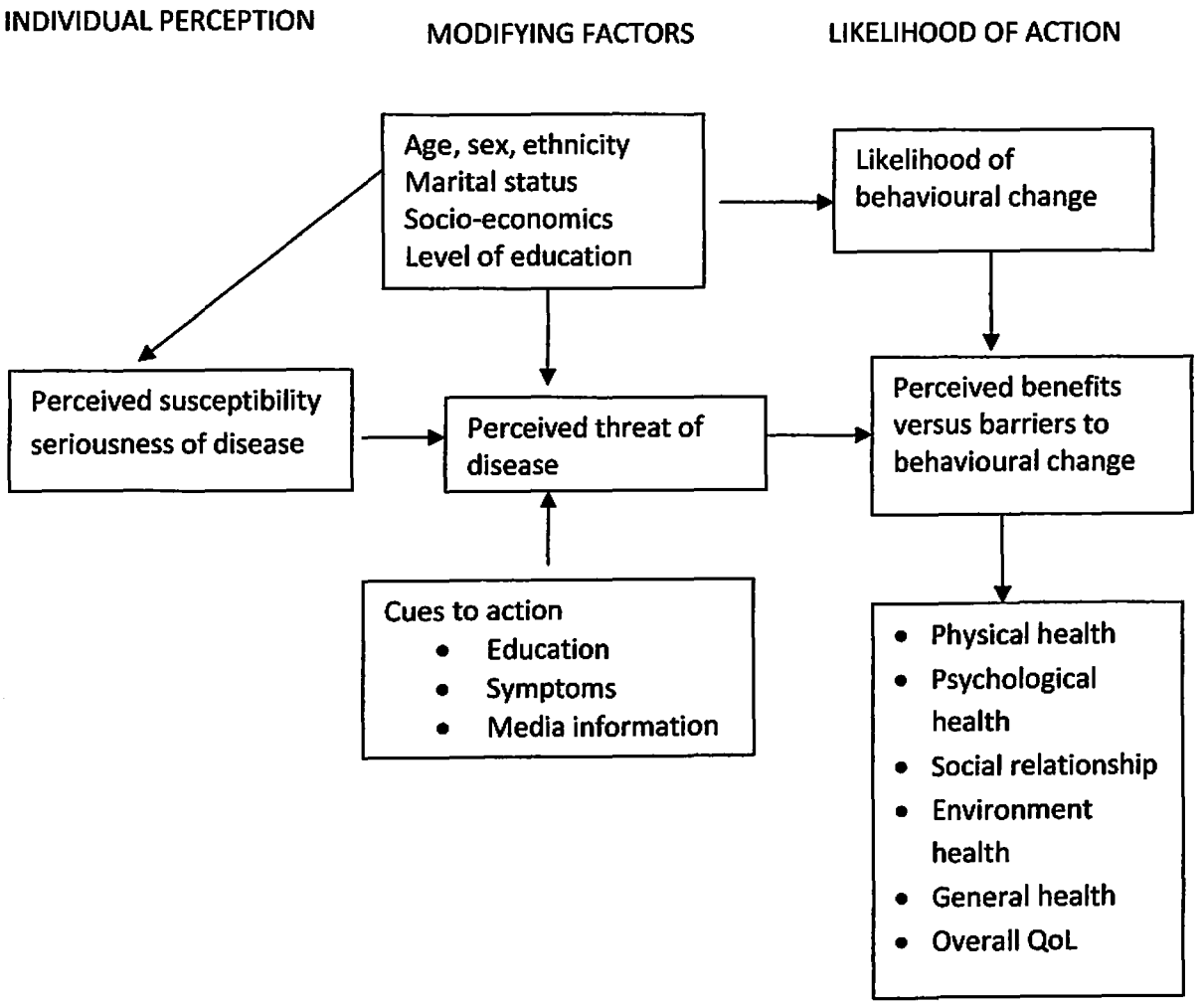


**Figure 2.2 Study framework (Modified from Figure 2.1)**

# CHAPTER 3

# RESEARCH METHODOLOGY

## 3.1 Research Design

This was a cross sectional study using questionnaire to survey on the hospitalized geriatric patients who were admitted to medical ward HUSM.

## 3.2 Population and Setting

The populations in this study were geriatric patient who were admitted to medical ward in HUSM and suffered from any acute or chronic medical conditions, as well as they were 60 years old and above were eligible as the populations of this study.

## 3.3 Sample

The sample in this study consists of geriatric patients who were admitted to medical wards in HUSM.

### 3.3.1 Sample Size

The sample size was calculated using Power and Sample Size program. By using the level of significance, $\alpha$ (0.05), power of the study (0.80), detectable different, $\delta$ (5.13), standard deviation, $\sigma$ (10.26) (Naumann & Byrne, 2004), the sample size was 64. Nevertheless, this is based on assumption of 100% response rate. Considering that 20% of the respondents from the calculated sample size will drop out from the study, a total of 77 geriatric patients will be the appropriate sample size. However, there were only 51 respondents recruited in this study.

### 3.3.2 Sampling Method

This study used purposive sampling which was useful in circumstances when the researcher has specific knowledge about the population and therefore it was 'handpick' cases to be included in the sample. Only hospitalized geriatric patients with age 60 years old and above with any acute or chronic medical condition were recruited in this study.

### 3.3.3 Inclusion and Exclusion Criteria

The inclusion criteria used:

1. The patients who were admitted to Medical ward, aged 60 years old and above.
2. The geriatric patients who suffered from any acute or chronic medical conditions.
3. Able to understand Malay language.

The exclusion criteria of respondents:

1. Diagnosed as semi-conscious and loss of consciousness.
2. Patients who had speaking problems.
3. Refused to complete the questionnaire.

## 3.4 Instrumentation

This was a quantitative study, thus the data were collected by self administered questionnaires with enquiring and explaining about the existence and persistence of phenomena understudy by the researcher based on the philosophy of logical empiricism as a basis of maintaining the true meaning of validity and reliability in the research.

The questionnaire consists of 32 questions, which were 6 questions for demographic data and 26 questions from WHOQOL-BREF questionnaire.

### 3.4.1 Instrument

The questionnaire in this study used the combination between the demographic data with the World Health Organization Quality of Life (WHOQOL-BREF) questionnaire.

WHOQOL-BREF was the short version of the World Health Organization Quality of Life Assessment which has been developed using data from the field trial version of the WHOQOL-100 (WHOQOL Group 1998). The WHOQOL-BREF consist of 26 items, with one item representing each facet and two general items which was conceptually fits with the WHO definition of QoL (Saxena, Carlson, Billington & Orley, 2001; WHOQOL Group, 1998a). This questionnaire was group as a self-report questionnaire that is comprised of 24 items grouped into 4 domains of QoL which included physical health, psychological health, social relationships, and environment, and 2 items which measure overall QoL and general health. Each items in WHOQOL-BREF uses a 5-point Likert scale such as intensity (not at all – completely), capacity (not at all – completely), frequency (never-always) and evaluation (very dissatisfied – very satisfied).

Therefore, the questionnaire in this study was divided into 2 parts, which are:

Part A: Demographic data questions which consisted of gender, age, race, and marital status, educational level and financial sources.

Part B: World Health Organization Quality of Life (WHOQOL-BREF) with 26 items measured using 5-point Likert scale.

### 3.4.2 Measurement of Variables

The relationship between the demographic data, physical health, psychological health, social relationship, environment, general health and overall QoL among hospitalized geriatric patients was the important variable in this study. Independent variables were the demographic data and the individual perception of physical health, psychological health, social relationship, environment and general health, while the dependent variable was the QoL among hospitalized geriatric patients. All the variables data were collected through self-administered questionnaires that involved demographic data and 5-points Likert Scale questionnaire.

The self-administered questionnaire included 4 Domains which was physical domain, psychological domain, social domain and environment domain. This provided a broad and comprehensive assessment. In addition, two items from the Overall QoL and General Health facet have been included: question 1 asked about an individual's overall perception of QoL and question 2 asked about an individual's overall perception of their health. The four domain scores were scaled in a positive direction, was to say that higher scores denoted higher QoL.

### 3.4.3 Translation of Instrument

Translation and back translation of the origin questionnaire was done previously by Hasanah, Naing, & Rahaman (2003). The translation processes are proposed by WHO that involves a number of steps.

### 3.4.4 Validity and Reliability

A pilot study was done previously by the researcher in Universiti Sains Malaysia. According to Hasanah (2003), the abbreviated version with 26 items was more acceptable by subjects, especially those with illness compare with WHOQOL-100. The validation of WHOQOL-BREF incorporated data from its collaboration